

PERCEPTIONS OF WELLNESS FROM ADULTS WITH MOBILITY
IMPAIRMENTS

A Dissertation

By

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

There is limited information available concerning the perceptions of adults with mobility impairments regarding wellness. The purpose of the present qualitative study was to describe the perceptions of wellness from adults with mobility impairments utilizing phenomenological-heuristic inquiry.

The grand tour question was, How do mobility impaired adults perceive wellness? Eight individuals agreed to participate and were interviewed. Six core themes emerged in relation to the perception of wellness from adults with mobility impairments: overcoming barriers, pain management, psychological wellness, physical activity and nutrition, social connectedness and family support, and spirituality.

The number of people with mobility impairments is on the rise. As a result, counselors and counselor educators regardless of their fields will be asked to provide services and/or educational instruction to clients and students with various types of disabilities at some point during their careers (Smart & Smart, 2006). Implications for current and future counselors and counselor educators as well as suggestions for future research were presented.

DEDICATION

This work is dedicated in part to my participants “Brenda,” “Dana,” “Eric,” “Leslie,” “Monica,” “Paul,” “Tanya,” and “Wendy.” Thank you so much for trusting a complete stranger enough to tell your wellness stories. Through sharing laughter, tears, and an occasional Sunday dinner, I learned so much from each of you. I am grateful to you for agreeing to blaze this trail with me. I will do my very best to “make sure something good comes of this,” as promised.

This work is also dedicated to my “Pretty.” I don’t even know where to begin to say thank you for all that you have sacrificed for me along the way. There is no way I could have done even a fraction of this without your dedication and support. Thank you for always being my set of legs, both literally and figuratively-for offering your strength when I don’t have enough to stand on my own. Thank you for reminding me to keep the “I” out of run, that while having CP may *run* my life at times, it certainly hasn’t *ruined* anything. Most of all, thank you for raising me as “Little Miss Sunshine.” If not for that, my life would be much less adventurous and fulfilling for sure! We have faced so much adversity and overcome so many obstacles together over the years that it’s hard to believe. I’m envious of, and eternally grateful for your “MacGyver skills.” They are definitely the best around and have undoubtedly saved me on a number of occasions throughout this process! Thank you for “knowing my life.” You are truly amazing, Pretty, and “I love you toots!”

And finally, to my guardian angels Pop, Grandma and Grandpa Tex, Peter and Heidi Serrao, Jill Cooke, and Gina Reynolds. Words will never completely express the depth of the love and gratitude that I hold for each of you in my heart. Your

dedication at various points during my life to helping me fight for my wellness and maintain my independence has made such a difference in the quality of my life, especially now. Your belief that I would one day walk, ride a bike, swim, walk again, and even surf the North Shore, means everything to me. It is with the memory of each of you in my heart and mind that I will continue to advocate for others and pay forward all of the goodness you selflessly bestowed upon me during your own lifetime. Thank you for always having my back and watching over me. I love you beyond all measure and will continue to honor our relationship in your absence just as I did in your presence.

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teach somebody something is to have them think they're learning something else.” This is what you did for me in terms of statistics my very first semester on this campus over 10 years ago, and what you have continued to do in some capacity ever since. You were the first professor in my life who found a way to make numbers *and* academic life much easier for me to understand and yes, even enjoyable. My dad is also grateful to you for this because your ability to facilitate my understanding of all things statistics put an end to my book throwing frustration that often took place in the middle of math related study sessions at our house. During one of our conversations in your office a few years ago, you told me that if and when I was going to become a professor, to keep in mind that we (professors and students) are all on the same side, working together to achieve the same goal. What I have learned from you along the way are important things like the true value of hard work, not giving up, and especially perseverance. Thank you for calling to check on me when I was in the hospital recovering from my pump surgery. The fact that a professor would go above and beyond like that meant a lot and has stayed with me over the years. Thank you for encouraging me to push through all of my frustration via your use of humor and great taste in music. Your respect and support of my love and admiration for Switchfoot also means a lot to me...and you thought you were just teaching me statistics.

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Chapter One: Introduction

The purpose of this chapter is to introduce the research topic, provide the conceptual framework utilized within the study and explain the connection to perceptions of wellness from adults with mobility impairments, as well as to provide definitions for the terms used throughout this study. The literature presented in this chapter highlights the need for more research regarding wellness as it pertains to adults with mobility impairments.

The idea that an individual can have a disability *and* be well at the same time is a relatively new one (Krahn, 2003). According to De Jong and Nosek, (as cited in Drum, Krahn, Culley, and Hammond, 2005), “until recently, disability was presumed equivalent to illness, and it elicited all the associations of dependence, lack of productivity, and physical and sexual inactivity that are incumbent to the notion of illness” (p.29). However, clients with mobility impairments are just as interested in achieving and maintaining a healthy lifestyle as nondisabled clients. For the 50 plus million Americans with disabilities (U.S. Census Bureau, 2012), maintaining health and wellness and minimizing secondary conditions are important contributors in decreasing impairment as a result of secondary conditions. Participating in physical exercise and activities, maintaining good nutrition and emotional health, managing stress, and creating social supports are all factors to consider when promoting health and wellness among the disabled (Myers & Sweeny, 2005; Rosenberg, Bombardier, Hoffman, & Belza, 2011; Seybold, Fritz, & MacPhee 1991; Wenz-Gross and Siperstein, 1996).

Exercise and good nutrition are important; however, finding the appropriate level of activity and health promotion information that pertains to unique conditions, as well as

the conceptualization of wellness is a challenge for clients with disabilities, their families, and service providers (Nosek, 1992).

According to Kailes (2004), “Unfortunately health promotion and preventative health care for those with mobility impairments have received little attention due to the perception that health and disability are mutually exclusive” (p. 2). Because of a limited number of resources, people with mobility impairments have a difficult time obtaining helpful information regarding the types of exercises best suited for their specific limitation, which is of major concern when taking into account that physical activity is credited with the ability to decrease depression rates and increase one’s quality of life. Further, there is an abundance of misconceptions and non-constructive attitudes toward older adults and those with disabilities when considering one’s quality of life and/or life satisfaction (Rosenberg et al., 2011). According to Hiss and Rauworth (2007), professionals such as doctors, nurses, fitness, and wellness instructors “need to acquire the knowledge to dispel and redirect these misconceptions, as well as treat clients with the respect and sensitivity needed to provide a high-quality service” (p. 42). This knowledge includes “understanding the prevalence and characteristics of common activity limitations, knowing the Americans with Disabilities Act (ADA) as it relates to recreation facilities, and developing an awareness of how people with health considerations may differ from one another and from the general public”(p. 42). Although good health habits, including diet and exercise, do not guarantee a long life, they may increase one’s chance for leading a higher quality of life (Kailes, 2004). Additional research that will help clients with mobility impairments deal with these issues is needed.

The Problem Statement

According to the United States Department of Health and Human Services (as cited in Putnam et al., 2003), “Issues of health and wellness for people with mobility impairments are becoming prominent concerns on the national health agenda”(p.37). Studies involving disabled individuals indicate that they share similar and unique ideas related to health and wellness (Maley, Constanza-Smith & Tangeman, 1998; Nosek & Turk, 1997) when considering factors such as physical health, social connectedness, environmental and contextual factors, as well as spirituality. Frustration arises for individuals with mobility impairments because professionals have limited knowledge or experience in working with clients who have these types of issues. Additionally, people with disabilities have historically been excluded when key decisions were made about how disability and health were to be conceptualized and measured, often to their disadvantage (Becker, 2006). Although health care systems and professionals are becoming more aware of the special needs of active older adults, they are essentially unprepared to handle the special needs of active, younger adults with disabilities (Myers & Sweeny, 2005). There are a multitude of studies in existence, which examine wellness programs for non-disabled adults, children with disabilities, and the elderly. However, there is limited information available concerning the perceptions of wellness among adults with mobility impairments. The aim, therefore, was to begin to fill this gap by exploring the lived experiences of wellness from adults with mobility impairments.

The Purpose of the Study

The purpose of this study was to explore the perceptions of wellness from mobility impaired adults. Most definitions of health reflect that of the World Health

Organization (1948), which defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Elements of wellness considered based on this definition include physical activity, psychological health, and social connectedness. Further, participants’ views of their needs for enhancing wellness were solicited.

Research Questions

In order to examine the conceptualization of wellness as it relates to mobility impaired adults, semi-structured interviews were used to evaluate participants’ responses to the following grand tour question: How do mobility impaired adults perceive wellness?

Theoretical Perspective

This research utilized two related analytical perspectives to organize and frame the participant’s perceptions of wellness. Phenomenological research is a subjective method, which seeks to examine the truth and understanding of life that emerges from a person’s actual experiences (Walters, 1995). Similarly, heuristic inquiry, which stems from humanistic psychology, seeks to discover and explore the depths of an individual’s experience, while shedding light on events and relationships, thoughts and feelings, values, and beliefs (Moustakas, 1990). The purpose of this method is to recreate the lived experience of an individual. According to Patton (2002), doing so allows for a greater understanding of the phenomenon of interest. Additionally, “A deeper understanding of the meaning of human experience not only extends scientific knowledge, but also illuminates the self of the researcher” (Moustakas, 1994, p.15).

During this study, the researcher explored and described how adults with physical disabilities, including the researcher, perceive wellness. Thus, phenomenological-

heuristic inquiry methods were used to collect and analyze data. Additionally, the use of this type of inquiry allowed the researcher to focus not only on the lived experiences of the participants, but on her personal bias and ability to be flexible and open to the experience as well.

Significance of the Study

This research may provide information useful to guide policy and practice with the diverse population of clients diagnosed with mobility impairments. Because of the increasing number of people with mobility impairments, counselors and counselor educators from all fields and theoretical orientations will be called upon to provide services and/or educational instruction to clients and students with various disabilities (Smart & Smart, 2006). However, information about disability culture, despite the large number of individuals with disabilities, remains invisible in most university curricula (Bauman & Drake, 1997; Hogben & Waterman, 1997). Understanding wellness and the meaning it holds for these clients is an essential component of building effective wellness models and programs, and designing new and effective intervention strategies for adults with disabilities (Myers & Sweeney, 2005), may contribute to the development of best practice recommendations. Results of this study may also provide information that indirectly strengthens the support systems utilized by these clients via providing parents, spouses, caretakers, educators, physicians, mental health professionals, friends, and the community at large with valuable data about wellness in the context of disabilities, thus enabling them to incorporate this understanding into their clinical and/or everyday practices. Further, results of this study may challenge negative misconceptions and stereotypes about wellness, health, and health care needs of clients with disabilities.

Finally, both the American Counseling Association (ACA) Code of Ethics (2005) and the accreditation standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) indicate that it is important for counselors to possess an understanding of the cultural contexts of working with individuals, as well as an understanding of developmental crises, disability, exceptional behavior, addictive behavior, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior.

Population and Sample

Adults 18 years of age and older who have been diagnosed with a mobility impairment were solicited to participate in the present study. Racially diverse participants from both a university setting and physical therapy programs within the local community were asked to participate via flyers and face-to-face contact. The researcher contacted the assistant director of the disability services office located on the local university campus and provided the office with flyers to distribute to qualified and interested students who wished to participate in the present study. Businesses offering physical therapy services in the local community were solicited in the same manner. A sample of eight disabled participants was asked to participate in a semi-structured interview where they offered their perceptions of wellness in the context of physical activity, psychological health, and social connectedness.

Data Collection

Individuals who received flyers were provided with an explanation of the study and the researcher's contact information. Data was collected from participants enrolled in a university as well as from those who participate in a physical therapy program within

the local community. Individual semi-structured interviews were conducted with those participants who agreed to participate and continued until the saturation of data was obtained. In addition, the researcher kept a reflective journal to track observations during the interview process as well as her own reflections regarding her personal experiences pertaining to perceptions of wellness.

In order to ensure participant confidentiality all data gathered from interviews was audio recorded, and all materials including informed consent forms and audiotapes were kept in a locked file cabinet at the researcher's place of residence and will be destroyed once the appropriate amount of time has passed.

Methods and Analysis

To gain a better understanding of wellness as it relates to adults with mobility impairments, individuals with mobility impairments were asked to participate in a semi-structured interview. Data from interviews was transcribed and themes and meanings were identified. In depth interviews offered new insight as to how appropriately structured wellness programs are perceived and valued.

Trustworthiness is a means of establishing credibility and rigor within a qualitative study (Patton, 2002). For those participants who agreed to be interviewed, there was a triangulation of data via the utilization of three data sources: the interview, a peer reviewer, and a reflective journal. Member checking (Patton, 2002) was used as well. Participants who provided interviews were given a copy of their interviews in order to validate or correct the transcription, allowing participants to clarify their intent and meaning. In addition, the researcher maintained a reflective journal, both to track observations during the interview process and throughout the study and to detail her

personal experiences in the process. In this way, any bias of the researcher was bracketed (Patton, 2002). Phenomenological-heuristic inquiry was used to discover and understand any patterns, themes, and/or categories that arose during data analysis (Patton, 2002).

Instrumentation

In order to examine the conceptualization of wellness as it relates to disabled adults, semi-structured interviews consisted of asking participants to discuss the following questions:

1. What does wellness mean to you?
2. What do you do to manage stress?
3. What role does physical activity play in your life?
4. What contributes to your sense of psychological health?
5. In what ways are social relationships important to you? With whom?
6. Tell me about any wellness program in which you are currently involved. How could that be supported or enhanced?

Delimitations and Limitations

Delimitations of the present study include the restriction of the population to university and physical therapy office locations. Individuals participating in university life or physical therapy may hold views or practice behaviors that are not representative of the population of persons with disabilities as a whole. Additionally, those with disabilities other than physical mobility impairments were not included in this study. As with any research, there are limitations, which must be kept in mind when considering the results of this study. First, heuristic inquiry allows much latitude with regard to procedures (Djuraskovic & Arthur, 2010). In an attempt to address the potential for laxity

in methodology, I carefully followed Moustakas' (1990) explication of phases and data analysis in qualitative research. Second, by its nature, heuristic research emphasizes subjective experience and may increase the researcher's bias. Synthesis depends on the researcher's interpretation, and since the researcher also experiences the studied phenomenon, the interpretation of findings can be influenced by the researcher's experience (Djuraskovic & Arthur, 2010). Further, social desirability bias may have caused participants to self-censor their actual views.

Definition of Terms

Amputation

According to the National Amputation Organization (n.d.), amputation is defined as “the removal of part or all of a body part that is enclosed by skin which can occur at an accident site, the scene of an animal attack, or a battlefield.... it is also performed as a surgical procedure to prevent the spread of bone cancer as well as gangrene, which is a complication of frostbite, injury, diabetes, arteriosclerosis, or any other illness that impairs blood circulation...the purpose is to curtail loss of blood and infection in a person who has suffered severe, irreparable damage to a limb” (www.nationalamputation.org).

Baclofen Pump

A Baclofen pump is an implanted medical device used to deliver very small quantities of the medication directly into an individual's spinal fluid. It is used to improve mobility for individuals who have spasticity resulting from a neurological injury or disease such as Cerebral Palsy or Multiple Sclerosis (Beard, Hunn, & Wright, 2003).

Cerebral Palsy (CP)

According to the United Cerebral Palsy Foundation (n.d.), “CP is the term used for a group of nonprogressive disorders of movement and posture caused by abnormal development of, or damage to, motor control centers of the brain. It is the result of negative events before, during, or after birth.”

Disability

According to Disabled World News (n.d), disability is “a condition or function judged to be significantly impaired relative to the usual standard of an individual or group.”

Health

The World Health Organization (1948) defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

Heuristics

Heuristic research method is defined as "a way of self-inquiry and dialogue with others aimed at finding the underlying meanings of important human experiences" (Moustakas, 1990, p. 15).

Impairment

According to the Infinitec Organization (n.d.), impairment includes physiological as well as mental or physical conditions. “It is a disorder or condition, a cosmetic disfigurement or an anatomical loss affecting any of the major body systems...a psychological or mental impairment includes most disorders, such as mental retardation, organic brain syndrome, emotional or mental illness and special learning disabilities.”

Major Life Activity

A major life activity is defined as “the ability to provide self care, perform manual tasks, see, hear, speak, walk, reproduce, breathe, learn, work, sit or stand, lift or reach, think, concentrate, and interact with others” (Infinitec Organization, n.d.).

Mobility Impairment

Mobility impairment refers to “the inability of a person to use one or more of his or her extremities, or a lack of strength to walk, grasp, or lift objects. The use of a wheelchair, crutches, or a walker may be utilized to aid in mobility” (United Cerebral Palsy Foundation, n.d.).

Multiple Sclerosis (MS)

According to the National MS Society (n.d.), Multiple Sclerosis is defined as “a chronic autoimmune disorder affecting movement, sensation, and bodily functions caused by destruction of the myelin insulation covering nerve fibers (neurons) in the central nervous system (brain and spinal cord).”

Phenomenology

Phenomenology is the study of the structures of subjective experience and consciousness (Zahavi, 2003).

Secondary Condition

A secondary condition is defined as “any additional physical or mental health condition that occurs as a result of having a primary disabling condition i.e. arthritis, cardiovascular disease, and depression” (Marge, 1988, p.30).

Substantial Limitation

Having a substantial limitation means that the “impairment must ‘substantially limit’ one or more major life activities, and is more than inconvenient or bothersome” (Infinitec Organization, n.d.).

Super Crip

Super crip is a term used by some persons with disabilities to describe persons with disabilities who are seen as “heroes,” who are admired for their “courage” and “determination.” This term stems from the belief that life with a disability must be terribly miserable and unsatisfying, resulting in the idea that individuals with disabilities must be admired for being able to live their lives. This stereotype is also linked to the idea that having a disability in one area means that one must have enhanced abilities in another area (e.g. deaf individuals have superior eyesight and/or sense of smell) (McDougall, 2006).

Traumatic Brain injury (TBI)

According to the Brain Injury Association of America (n.d.), a TBI is defined as “an alteration in brain function, or other evidence of brain pathology, caused by an external force.”

Wellness

Wellness is defined as "an active process through which people become aware of, and make choices towards, a more successful existence" (Hettler, 1984, p. 14).

Researcher Perspective

We are encouraged as qualitative researchers to immerse ourselves in the data so that we might have a better understanding of what it is like to live as our participants do.

As luck would have it, I have had both the privilege and the curse of living with Cerebral Palsy, otherwise known as Spastic Dyplegia, since birth. Depending on the day and even the weather, I may or may not need the assistance of a wheelchair or walker to get around. At the moment, I am living this “half in, half out” kind of lifestyle, which confuses and even shocks people who do not know me. They are not sure what to make of the woman who wheels into the grocery store for example, sitting in her chair one moment and then walking out of the store pushing the same chair with a seat full of white plastic grocery bags instead of herself, the next.

I became interested in doing research in this area during the 2010 fall semester. When I enrolled in the required advanced stress management doctoral course, I entered the classroom full of skepticism but it became increasingly worse when I realized that I would actually be asked to lie down on the floor, close my eyes, and relax during some of our meetings. “Does no one, including this professor, understand the potential problems that can arise from asking someone with spasticity to relax?” I thought to myself. The last thing I wanted was to be in a situation where I felt forced to pay attention to pain. “What good can possibly come of this?” I wondered. Then, as the class progressed from week to week, I began to figure it out.

It is my frustration with having to constantly adapt to a predominantly nondisabled world that prompted my desire to focus on wellness as the topic of this dissertation. Do I wish that I didn’t have Cerebral Palsy? No. I have lived with this condition since birth so I don’t know of any other way to live. Do I wish that “things” like buildings, bathrooms, parking lots, social activities, and exercise/wellness programs and even people were more easily accessible and accommodating than they currently are?

Absolutely! Do I wish for a life absent of so many doctors, physical pain, and secondary conditions? Of course. Do I wish that my doctors viewed me as something other than a “pharmacological experiment?” No doubt. In my opinion, it is society and our environment that make having a disability seem and/or feel like a disadvantage to us. It is my hope that the results of the present study will prompt the implementation of more wellness programs and applicable wellness models for individuals living with mobility impairments both inside and outside of the world of academia.

Organization of Remaining Chapters

The present study is based on the need to examine perceptions of wellness as they relate to adults with mobility impairments. Chapter one serves as an outline and establishes the conceptual framework for the study. Chapter two provides a literature review addressing major areas concerning wellness. Chapter three is focused on the design, instrumentation, data collection and analysis of the study. Chapter four offers a detailed description of the processes as well as the results of the study. Chapter five includes a summary of the study, implications for counselors and counselor educators, and recommendations for future research.

Chapter Two: Literature Review

The idea that wellness can exist for, and be practiced by, people with mobility impairments is a relatively new one (Becker, 2006). Some traditional definitions of wellness describe health and disability as existing at opposite ends of the same spectrum, which often leads many people to view health and wellness and disability as an either/or situation (Krahn, 2003). When society as a whole takes the time to explore and understand the meaning of wellness, not only for the nondisabled population but also for mobility impaired individuals, the misconceptions surrounding wellness for the mobility impaired may be eliminated altogether (Welner & Temple, 2004).

The purpose of this qualitative study was to examine the perceptions of wellness from people with mobility impairments. This chapter begins with an explanation of wellness and the different conceptions, followed by a discussion about wellness for mobility impaired children and the elderly. An overview of the barriers faced by mobility impaired adults is also provided. Finally, the ethical and multicultural competencies to be considered when working with members of this population are presented.

Defining Wellness

What is wellness? Because the definition is subjective and continuously evolves, defining wellness is difficult. However, there does seem to be agreement about some general characteristics found within most definitions. For example, the World Health Organization (1948) defined health as “a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity.” Similarly, The National Wellness Institute (n.d.) defined wellness as “an active, multidimensional process

through which people become aware of, and make choices toward, a more successful existence.”

General Population

The development of the *concept* of wellness as described above can be traced as far back as the 19th century American intellectual and religious movements, which were tied to ideas about active health promotion through lifestyle change (Miller, 2005). A wellness movement grew out of the definition of wellness beginning in the 1970s, where Dr. Halbert Dunn (1961) was credited with the use of the term “wellness” in connection with this concept. He emphasized wellness as a positive state that is beyond simply nonsickness, and defined high-level wellness as “an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable” (Dunn, 1961, p.4). Similarly, Travis and Ryan (as cited in Roscoe, 2009), conceptualized wellness as “comprising self-responsibility and love” (p. 216). Despite some focus on mental and emotional aspects, these definitions of wellness are primarily concerned with the state of one’s physical health. Alternatively, Myers, Sweeney, and Witmer (2000) defined wellness from a mental health perspective in which they considered wellness to be “a way of life oriented toward optimal health and well being, where mind, body, and spirit are integrated by the individual to live life more fully within the human and natural community” (p.252). Renger, et al. (2000) shared a similar perspective and considered wellness to mean achieving balance amongst emotional, spiritual, physical, social, intellectual, and environmental dimensions, and reaching “optimal health” according to one’s life circumstances.

Despite the variations and subjective nature of the definition of wellness, there are similarities among them, including the idea that being well is a multifaceted, continuous process which requires balance, self-responsibility, and motivation in order to be obtained and maintained (Ardell, 1977; Clark, 1996; Dunn, 1977; Hettler, 1980; Teague, 1987).

Mobility Impaired Population

Approximately 1 in 5 Americans have a disability, 8 million of whom require the use of an assistive device such as a cane, crutches, a walker, wheelchair, or a scooter (U.S. Census Bureau, 2012). Many individuals with these types of disabilities are living normal or near-normal life spans (Vandenakker & Glass, 2001); therefore, it is important to ensure that perceptions of wellness from people with mobility impairments are understood so that they might achieve their highest level of health and wellness possible. According to The American Physical Therapy Association (2012), wellness is defined as a “ multidimensional state of being describing the existence of positive health in an individual as exemplified by quality of life and a sense of well being.” The American Occupational Association organization (2008) expanded this definition and characterized wellness as “a balance of physical, mental, and social well being attained through socially valued and individually meaningful occupation; enhancement of capacities and opportunity to strive for individual potential; community cohesion and opportunity; as well as social integration, support, and justice, all within and as part of a sustainable ecology” (p. 656). Similarly, in their article on recognizing and responding to the health disparities of people with disabilities, Drum, Krahn, Culley, and Hammond (2005) described health and wellness as including not only physical and mental factors, but

social, spiritual, and “other factors that enable individuals to maximize their potential and fully participate in their community,” (p. 29). Likewise, Lanig, Chase, Butt, Hulse, and Johnson (1996) specified health as a dynamic balance of physical, social, emotional, spiritual and intellectual factors. When applying this definition to those with disabilities “disability poses no obstacle to maximizing health and one's potential” (p.13). In a study regarding health, wellness, and disability conducted by the Independent Living Research Utilization Organization (n.d.), researchers found that disabled participants defined wellness as “being able to function and having the chance to do what they want to do; being independent, having self-determination regarding choices, opportunities, and activities; having physical and emotional states of well being; and not being held back by pain.” The researchers recognized the need for a comprehensive definition of wellness, as well as the development and implementation of a national research agenda, which examines both the facilitators and barriers to health and wellness; a need for educating the members of the disabled population about how to advocate for access to health and wellness programs; and finally, a need for providers to enhance their ethical and multicultural competence in relation to working with disabilities. According to Kailes (as cited in Drum, Krahn, Culley, & Hammond, 2005), whatever the dimensions or factors to be considered when defining wellness, it is important to keep in mind that “a person’s unique circumstances and a wide variety of contributors define his or her optimal health” (p. 30).

Perceptions of Wellness

In addition to the importance of defining wellness, the significance of the perceptions of health and wellness is supported via evidence-based bodies of research as

well. For example, according to Wilson and Cleary (1995), perceptions of health and wellness are important because they are “among the best predictors of the use of general medical and mental health services” (p. 62). Epidemiological researchers have found that self-reported perceptions of health are one of the most significant predictors of physical and mental health outcome because they may promote the use of early intervention strategies and decrease the manifestation of illness as a result (Idler & Angel, 1990; Kaplan & Gamacho, 1983; Mossey & Shapiro, 1982). Similarly, social science researchers have indicated that perceived social support, as well as the ability to maintain independence and continue with everyday roles also has a positive impact on health and well being (Procidano & Heller, 1983; Wethington & Kessler, 1986). The results of each of these studies indicate that our worldview appears to significantly impact our overall health and wellness.

Conceptions of Wellness

In addition to the difficulty associated with defining wellness, there are major differences in the ways in which wellness models are conceptualized for the general population and the disabled population. For example, while wellness models for the general population tend to include attention to the whole person, models for people with disabilities are considered disability models rather than wellness models.

General Population

While there seems to be countless definitions for the concept of wellness, there are, in comparison, only a few wellness models (Ardell, 2010). The multidimensional aspects of wellness and wellness models are discussed by several researchers including Dunn (1977); Travis (1975); Hettler (1980); Witmer and Sweeney (1992); Adams,

Benzer, Drabbs, Steinhardt, and Zambarano (2000) and finally, Myers and Sweeny (2000).

High-level wellness model. The origin of the term high-level wellness is credited to Halbert L. Dunn (1977). “It involves (1) moving forward toward a higher level of functioning; (2) an open-ended tomorrow with its challenge to live at a fuller potential; and (3) the integration of the mind, body, and spirit in order to reach one’s maximum potential” (p.787). Dunn focused attention on factors other than physical mobility when considering the elderly and their ability to achieve high level-wellness or not. This wellness model is comprised of five dimensions including self-responsibility, nutritional awareness, physical fitness, stress management, and environmental sensitivity. Self-responsibility according to this model requires an understanding of how the body functions, as well as how to manage personal health and wellness. Dunn (1977) based his nutritional awareness dimension on the idea that healthful eating should be pleasurable and that individuals should sustain themselves with what he called “live foods,” which contain complete protein, such as whole grains and legumes. Physical fitness is also an important component of Dunn’s model. He stressed the importance of an individual getting to know his or her body and being sensible about exercise by creating a personalized program to become both physically and mentally fit.

Managing stress is an important factor in achieving both physical and mental fitness as well as high-level wellness in this model. Stress management as described by Dunn (1977) implies having the ability to live with purpose and to function creatively in stressful circumstances. Stress management plays an important role in determining one’s environmental sensitivity level, which is the fifth dimension of Dunn’s wellness model.

Environmental sensitivity concerns an individual's ability to balance personal and business demands, as well as to evaluate his or her impact on or contribution to nature and/or community resources (Roscoe, 2009). According to this model, an individual can create an environment, which facilitates his or her efforts to attain high-level wellness.

Illness-wellness continuum model. The illness-wellness continuum is the first of three wellness models developed by Dr. John Travis beginning in 1972. This is a comparative model used to examine the relationship between dimensions of wellness and treatment. Health and high-level wellness reside on an illness/wellness continuum with premature death at one end and high-level wellness at the other (Travis, 1975). According to this model, an individual who moves to the left of center is in a progressively worsening state of health, whereas an individual moving to the right is improving his or her levels of health and wellness. Travis (1975) defined wellness as a dimension of health, which involves a process of awareness, education, and growth. He believed the treatment approach to be one that might require an individual to take medication, have surgery, or receive psychotherapy in order to alleviate any signs and symptoms of disease and/or disability and reach the point of neutrality. The wellness dimension directs an individual to move beyond the mid or neutral point and encourages him or her to move as far toward high-level wellness as possible. According to Travis (1975) wellness does not preclude periods of illness and weakness or ignore that death is a part of life. The idea is not to replace the treatment dimension, but to work in conjunction with it instead.

Iceberg model. The iceberg model of wellness is the second of three key wellness concepts developed by Travis. According to this model there are four levels of wellness.

The first is an individual's current state of health, which is what is visible above the surface and is considered to be the tip of the iceberg. Travis (1981) believed that in order for a person to achieve true wellness, he or she must delve below the surface and explore deeper levels of personal wellness.

The first level includes lifestyle and behavioral patterns, which are located at the shallowest point. The second level addresses cultural, psychological, and motivational factors of wellness, which can be found at the midpoint where individuals might discover the strength of their cultural norms and what motivates particular lifestyle choices. Finally, there is the spiritual, being, and meaning realm of wellness, which resides at the bottom of the iceberg and addresses everything in the unconscious mind as well as an individual's reason for being (Travis, 1981).

Wellness energy system. The wellness energy system is the last of the three models developed by Travis. According to this model, a human being is seen as an open energy system, taking in energy from all sources, organizing it, transforming it, and returning it to the environment at various points along the way. The premise is that an efficient energy flow is essential for obtaining wellness and that disease occurs as a result of any interference with the flow.

An individual's condition, be it physical, emotional, mental, or spiritual, determines the amount of energy he or she absorbs, what the energy feels like internally, and how it moves into the environment (Travis, 1977). When the energy flow is balanced and smooth, a person is said to be well. Conversely, when there is interference at any point - the input, the output, or in between - an individual may feel empty, confused, pressured, or blocked, resulting in an illness (Travis, 1977). Input is measured via

considerations such as one's education level and beliefs, previous experience, nervous system activity, strength, emotional development, and general state of health. The building and repairing of one's body takes place while the individual is engaged in the sleeping (internal output) stage while the outside world (external output) will be affected by the ways in which individuals transform energy. For example, all individuals radiate heat and eliminate waste products, as well as affect others through touch, work and play, laughter, and tears (www.thewellspring.com). As human beings we learn about ourselves and allow others to learn about us via communication, shared intellectual pursuits, and the expression of creativity. This wellness model was founded on the idea that one cannot help but to make an impact on the planet through his or her interaction with the environment.

Six-dimensional wellness model. Bill Hettler (1980), who is considered to be the father of the modern wellness movement, defined wellness as "an active process through which people become aware of, and make choices toward a more successful existence" (p. 14). This model is meant to assess the wellness of college students as well as promote healthy lifestyles (Hettler, 1980).

The six dimensions of Hettler's model include occupational, physical, social, intellectual, emotional, and spiritual factors. According to Hettler (1980) the occupational dimension recognizes personal satisfaction in life as a result of one's work. The physical dimension recognizes the need for regular physical activity and personal responsibility. For example, taking care of minor illnesses, including knowing when to seek professional medical attention is important according to this model. Next, the social factor is one that encourages community involvement, emphasizing the relationship between man and

nature. The intellectual aspect of this model recognizes one's creativity. A well person, according to this model "expands his or her knowledge and skills while discovering the potential for sharing their gifts with others" (National Wellness Organization, n.d.) The spiritual factor recognizes one's search for meaning and purpose in life including an appreciation for natural forces that exist in the universe. Emotional wellness, according to this model, includes "the degree to which one feels positive and enthusiastic about his or her self and life (National Wellness Organization, n.d.)." It also includes the capacity to manage one's limitations, development of autonomy, and ability to manage stress. Further, a well person maintains satisfying relationships with others. In addition to serving as the structural framework for the National Wellness Institute and various public and university level wellness programs, the overall purpose of this model is to provide a visual representation of the concept of wellness and the idea of balanced living (Hettler, 1984).

Perceived wellness model. Adams, Benzer, and Steinhardt (1997) conceptualized wellness as being relative, subjective, and perceptual with a multidimensional health focus. This model emphasizes the importance of factors such as physical and psychological wellness as well as cultural, social, intellectual, and environmental influences from a systems perspective in which all subsystems are seen to contain their own elements and contribute to a larger whole. Additionally, Adams, Benzer and Steinhardt (1997) considered wellness to be about balance and believed that research and practice should be focused on identifying causes of wellness rather than illness. This model is different from others in that it was constructed using cognitive behavioral concepts as its framework. For example, Adams, Bezner, Drabbs, Steinhardt, and

Zambarano (2000) supported the idea that that if you can change perceptions, you can change attitudes and ultimately behaviors. According to this model, change in any dimension of wellness affects the other dimensions; therefore, increasing wellness in one dimension might have a positive effect on the other dimensions, whereas disease or illness might cause a rippling negative effect on the other dimensions. In addition, they considered general health perceptions to be among the best predictors of numerous health outcomes.

The wheel of wellness and indivisible self model of wellness. The wheel of wellness model (WoW), developed by Witmer & Sweeney (1992), was the first integrative model of wellness to incorporate Adlerian psychology as an organizing principle (Witmer & Sweeney, 1992). Encompassing the individual in the wheel of wellness are five interrelated life forces, which impact personal wellness, including: spirituality, self-direction, work and leisure, friendship, and love. This model supports and builds upon previous research such as Dunn's (1977) conceptualization of individual wellness, Ardell's (1977) perception of self-responsibility, and Hettler's (1980) definition of occupational wellness (Roscoe, 2009).

The indivisible self model of wellness (IS-Wel) was created as a result of several studies conducted using the WoW (1992). According to Myers and Sweeney (2005), this model "provides a foundation for evidence-based practice for mental health and counseling practitioners" (p. 277). It is a strength-based choice oriented model also grounded in psychological theory and based on characteristics of healthy, independent people who can make their own decisions. Like the WoW (1992), this model is based on five factors, including the essential self, creative self, coping self, social self, and physical

self, which together provide a comprehensive wellness score (Hattie, Myers, & Sweeney, 2004). The essential self is composed of four factors: spirituality, gender identity, cultural identity, and self-care. According to Mansager (2000), spirituality interjects one's sense of meaning, purpose, and hopefulness into life whereas factors such as gender and cultural identity are filters through which life experiences are seen. Self-care, according to this model, involves making proactive efforts to live long and well. The creative self is viewed as a combination of attributes, which assist an individual in establishing a unique place among others in his or her social circle (Adler, 1954; Myers & Sweeney, 2004). There are five components to this factor: thinking, emotions, control, positive humor, and work, each of which has the potential to enhance one's ability to live life to the fullest (Bennett, 1998; Myers & Sweeney, 2004). The coping self consists of four different components, which include: realistic beliefs, stress management, self-worth, and leisure. According to Myers and Sweeney (2004), this part of the self regulates one's responses to life events and provides the necessary tools for an individual to be able to move beyond their occasionally negative affects. The social self includes two components, friendship and love, which can be thought of as existing on a continuum and, as a consequence, are not clearly distinguishable in practice. The physical self is comprised of exercise and nutrition, both of which are widely promoted. The purpose of this model is to help clients understand the components of wellness, their interaction, and the way in which positive change can occur if one focuses on his or her strengths rather than weaknesses (Myers and Sweeney, 2004).

As evidenced by the descriptions of wellness presented in the models above, the concept of wellness is addressed using a holistic approach, which is often regarded as the

quintessence of nursing practice (Ellis, 1999). However, this is not the case when it comes to caring for individuals with mobility impairments or a disability. In these cases, patient care tends to be focused on one's compromised physical condition rather than individual needs. Little attention is given to total care as a result (Ellis, 1999; Price, 2006).

Disabled Population

Currently, models specific to persons living with a disability attempt to operationalize health and wellness within the disability experience (Putnam, Geenen, Powers, Saxton, Finney, & Dautel, 2003). However, none, to the present researcher's knowledge, address wellness using a holistic approach. Instead, the different understandings of the relationship of impairment to well being, reproductive decisions, medical interventions, and social policy have produced the three most commonly referenced models of disability, known as the medical, social, and biopsychosocial models of disability (Altman, 2001).

Medical model of disability. According to the medical model of disability, a disability is perceived as an abnormal characteristic of an individual occurring as a result of a disease, trauma, or other health condition affecting one's mind or body which needs to be changed, fixed, or cured (Forhan, 2009). Treatment approaches, then, are directed at the disease or impairment in an effort to eliminate the cause of the disability within the individual (Forhan, 2009) and are often stereotypical, with a standard menu of treatment options existing for any particular mobility impairment (Fregly, Boninger, & Reinkensmeyer, 2012). Further, the individual with the disability rather than the disability itself is viewed as the problem and he or she should adapt to fit into the world

as it is. For example, if a person in a wheelchair cannot fit through a doorway, the problem is *not* that the doorway is too narrow and inaccessible, but rather that the wheelchair is too wide. According to this model, if it is not possible for an individual to adapt to his or her environment, then he or she should be hospitalized, institutionalized, or isolated, where only most basic needs are met (Thomas, 2004b). Additionally, the individual's experience of living with a mobility impairment, along with their values and beliefs about being disabled, are not often considered within the scope of the medical model nor does it provide a means to explore the social causes of disability experienced by persons with a disability (Landsman, 1997). As a result, the majority of individuals with a disability have rejected the medical model, recognizing that it perpetuates disability stereotypes (e.g. low self esteem, undeveloped life skills, poor education, and high unemployment rates) within their local communities as well as society as a whole (Forhan, 2009).

Social model of disability. The social model of disability was created in response to the medical model of disability. It is based on a distinction between the terms impairment and disability. Disability is viewed as a socially constructed problem versus an intrinsic characteristic of an individual that must be fixed or cured in an attempt to meet societal norms. From this perspective, it is systemic barriers, negative attitudes, and exclusion by society that are responsible for disabling people (Paley, 2002). A fundamental aspect of the social model concerns equality. In an attempt to help level the playing field for individuals with disabilities, the Americans with Disabilities Act (ADA) of 1990 was established. The ADA is a wide-ranging civil rights law, which prohibits discrimination on the basis of disability. It affords similar protections against

discrimination to Americans with disabilities as the Civil Rights Act of 1964, which made discrimination based on race, religion, sex, national origin, and other characteristics illegal. A phrase often used by disability rights campaigners is "Nothing About Us Without Us" (Charlton, 2000). Further, the social model of disability implies that attempts to change, fix, or cure individuals, especially without their input, can be discriminatory and prejudiced, and can potentially harm the self-esteem and social inclusion of those constantly subjected to it (Paley, 2002).

Biopsychosocial model of disability. This model is based in part on social cognitive theory, which supports the idea that the survival of humanity is dependent upon the replication of the actions of others (Halligan & Aylward, 2006). Additionally, this model recognizes that the interaction between biological, psychological, and social factors can influence the course and outcome of one's health and wellness. According to Santrock (2007), the biological component of the biopsychosocial model attempts to understand how an illness develops within an individual's body, the psychological component looks for potential causes of mental instability such as anxiety, depression, and addiction, and the social component investigates how different social factors including socioeconomic status, culture, and religion impact an individual's health and wellness. Researchers suggest that perceptions of health and the threat of disease impact the likelihood that an individual will seek treatment and/or promote healthy behaviors such as taking medication, engaging in physical activity, and joining a support or social group of some type (Di Matteo, Haskard, & Williams, 2007). This model serves the general framework used to guide theoretical and empirical exploration since 1977 (Armitage & Conner, 2000).

Wellness Interventions for Children and the Elderly with Mobility

Impairments

Though it can be challenging for those who have disabilities to lead healthy lives, health and wellness is important for everyone, including those with mobility impairments. While it seems that there is a lack of attention paid to the wellness needs of those with mobility impairments who are between the ages of nineteen and sixty-five, there is an abundance of research available which is focused on addressing wellness concerns such as support networks, physical activity, psychological wellness, and self-esteem for both disabled children and the elderly. However, this research is not concerned with wellness as a specific construct for people with disabilities. Rather, it is discussed in terms of elements that are considered components of wellness when applied to the general population. Further, entire hospitals have been established for the sole purpose of conducting research and servicing the physical wellness needs of crippled children across the county.

Mobility Impaired Children

Education and support networks. Reliable and trustworthy education and support is essential in order to create a lifestyle, which promotes the overall health, wellness, and personal growth for any child and his or her family living day to day with a disability (Grassman, Whitaker, & Larsson, 2009). It is likely that at some point, families may need information and assistance obtaining recreational and medical or health related supports, respite care, financial support, and parent-to-parent support as well as assistance with meeting basic needs such as food, water, and shelter (Bradley, Knoll, & Agosta, 1992; De Fosset, 1999).

Physical activity and adaptive sports. According to a study conducted by Rimmer and Rowland (2008), the recommended amount of daily physical activity for youth is 60 minutes a day, several times a week. Disabled children are not meeting this goal and are typically heavier and less active than their non-disabled peers. As a result, the children are at a high risk for developing health problems such as obesity (Rose & McGill, 2005; Wiley & Damiano, 1998). However, participation in activities such as adaptive sports has been shown to enhance the physical health and emotional wellbeing of children with physical disabilities as evidenced by increased fitness levels, improved coordination and mobility, and greater muscle strength (Aitchison, 2000; Taub & Greer 2000). The existence of special fitness programs and adaptive equipment make it possible for mobility impaired children to participate in sports such as swimming, cycling, and horseback riding.

Swimming. According to the National Center on Physical Activity and Disability, (2011), swimming is an activity that is both recreational and therapeutic for everyone, including children with disabilities. Swimming provides resistance training, is easy on the joints, and can improve coordination. Water is especially beneficial as being buoyant allows for easier movement, muscle relaxation, and a reduction in spasticity, and/or muscle spasms or pain, which can result in an increased range of motion. For mobility impaired children and adults alike, it is one of the most practical means of maintaining activity and preventing further physical deterioration because being in the water takes the stress of weight off of the joints (Kelly & Darrah, 2005).

Cycling. In the past, exercise and activities such as cycling to promote physical fitness and strengthening were discouraged for children with Cerebral Palsy and other

forms of spasticity, because of the idea that cycling would enhance it. Researchers have indicated however, that resistive exercise such as cycling actually improves strength and function for children with CP (Dodd, Taylor, & Damiano, 2002; Fowler, Ho, Nwigwe, & Dorey, 2001). As a result, families and physical therapists have come to value adaptive tricycles for both recreational and therapeutic reasons.

Horseback riding. Hippotherapy literally means “treatment with the help of the horse” (Sterba, Rogers, France, & Vokes, 2002, p. 202). Similar to that of a person, a horse’s pelvis has three-dimensional movement while walking. This type of rhythmic and repetitive movement provides a sort of sensory stimulation, which is beneficial to mobility impaired children in that it can improve balance, coordination, and muscle tone over time (Sterba, Rogers, France, & Vokes, 2002). For children with mobility impairments such as cerebral palsy, hippotherapy (also known as equine-assisted therapy, or horseback riding) has proven to be a popular and exciting alternative way to engage in physical therapy. For some, riding a horse might be the first time they experience moving and getting around without the assistance of adaptive equipment.

Social activity. Disabled children value the social aspect of taking part in positive activities, which enable them to maintain existing friendships and develop new ones (Aitchison, 2000). Whether artistic, creative, cultural, playful, or skill-based, participation in social activities allows children to acquire the physical and social competencies needed to function both at home and within their communities (Mahoney, Larson, & Eccles, 2005) In addition to cycling, horseback riding, and swimming, attending a special needs summer camp is a very popular social activity among disabled children. Being at camp with people whom they can identify with provides children and adolescents with the

opportunity to further explore the world through the outdoors, sports, art, and music while increasing their independence, confidence, and social skills at the same time. Regardless of the type of activity a child chooses to engage in, it is important to remember that accessible, socially supportive, non-discriminatory, family members, friends, and environments are key to promoting participation in social activities (Lyons, 1993; Mahoney, Larson, & Eccles, 2005).

Well being and self-esteem. Studies examining the well being of disabled children have revealed that accessibility, participation in activities, and independence are common factors associated with well being (Colver, 2005; Kirk, 2006) Additionally, the emotional and/or psychological benefits of children participating in adaptive sports and other physical activities include feeling better about their outward appearance and gaining a sense of self-identity (Groff & Kleiber, 2001) and experiencing an increase in self-confidence (Kristen, Patriksson, & Fridlund, 2003; Taub & Greer 2000).

When considering self-esteem, children with physical disabilities are born into a world focused more on outward appearances, beauty, and attraction than anything else (Lewis, Parsons, & Robertson, 2007) As a result, they tend to face even more challenges because they do not see others in the community who look like them. Additionally, surgeries and other medical interventions intended to improve the quality of life for children with disabilities can actually lower his or her self-esteem via inadvertently sending a message that the child's body needs major reconstruction. According to Dyer (2001), positive imagery is a powerful tool that can be used to help children feel and become more capable, healthy, and vibrant. Through the use of visualization children can be taught to imagine themselves as being whole, radiantly healthy, individuals who can

actively participate in whatever activities they want to. Further, children can also use visualization to help move their bodies along through the healing process. According to Dyer (2001), happiness and success is tied to a positive body image and healthy self-esteem.

Mobility Impaired Elderly

The elderly, over time, often develop various disabilities, including mobility impairments, even when they have not had them before. So efforts here are not for people who are disabled and then become elderly, but are elderly and become disabled. The number of older adults over the age of 65 is increasing, and many of them live alone without support from a caregiver (Eaton et al., 1999). As a result, promoting physical, social, emotional, spiritual, intellectual, and occupational wellness is important for independent living. When professionals interact with the elderly and perceive them as a whole-person versus an illness alone, opportunities to focus on their strengths and capabilities, rather than on deficits and decline, which support negative stereotypes of aging, are created (Hettler, 1980; Miller, 2004).

Physical activity. Activity is believed to promote successful aging (Menec, 2003). Researchers have identified the importance of physical activity in reducing the risk of debilitating conditions such as depression, arthritis, and stroke (Hurley & Roth, 2000). The benefits of physical activity include: increased mobility, flexibility, and strength (Carlson et al., 1999). Researchers have also discovered that more active participants had better diets and functionality, resulting in lower rates of health problems such as heart disease (Hurley & Roth, 2000). Some of the most common activities discussed in the literature that the elderly can participate in to help them maintain

personal wellness are swimming, tai chi, yoga, and walking (Mazzeo & Tanaka, 2001; Ravaglia & Forti, 2007).

Swimming. Swimming allows people to move their bodies in ways that are fundamentally different than allowed by other types of activities (Mazzeo & Tanaka, 2001). It provides the opportunity for older people to tone and strengthen their bodies without stressing the bones and joints as they exercise (Neid & Franklin, 2002). For example, the warmth, buoyancy, and resistance of the water challenge the body while easing strain on problematic areas. The benefits of swimming for the elderly population can include a decrease in pain and blood pressure, an increase in flexibility, and improvements in balance and posture (Di Carlo, Sparling, Millard-Stafford, & Rupp, 1991; Mazzeo & Tanaka, 2001).

Tai chi. Tai Chi consists of a series of strength building movements and breathing exercises meant to restore balance, and increase flexibility while helping a person achieve a heightened state of being (Kutner, Barnhart, Wolf, McNeely, & Xu, 1997). According to Miszko and Cress, (2000), this form of exercise is especially popular with the elderly population because it is low impact. Benefits of tai chi for older adults include alleviating joint pain and increasing strength, flexibility and balance (Busing, 2006; Kutner, Barnhart, Wolf, McNeely, & Xu, 1997; Miszko & Cress, 2000; Wu, Liu, Hitt, & Millon, 2004).

Walking. All systems within our bodies change as we age. According to the Cleveland Clinic Health Extra (2004) walking is essential for the health and wellbeing of seniors. The benefits of walking include the reduction of stress as well as health problems such as heart disease, diabetes, and osteoporosis. Walking programs including chi

walking can be done alone or in a group. This unique approach to walking was created combines walking with the basics of the ancient Chinese practice of tai chi. Another form of walking includes elements of yoga and meditation, forcing walkers to concentrate on their breathing and to focus their attention on each step (Chi Walking, 2007).

Yoga. Yoga has been shown to help alleviate or reduce many of the health concerns faced by the elderly (Krishnamurthy & Telles, 2007), making it an increasingly popular exercise choice for this population. If an instructor is knowledgeable about medical conditions common among the elderly and has the ability to accommodate each person's health issues, a well-informed Yoga instructor may help these individuals lower blood pressure (Turner, Ersek & Kemp, 2005), lose weight (Yang et al., 2011), and reduce chronic pain levels (Hansen & Streltzer, 2005).

Social activity. The lack of social ties can make elderly people more susceptible to disease, illness and ultimately death. According to Raub (1992), social ties significantly affect the wellness and mortality rate of the elderly. Attending community or adult day care centers and participating in games such as bingo, dominos, cards, and puzzles enhances an elderly person's wellness. Additionally, attending parties/gatherings for family and friends is also aimed at helping the elderly create and maintain healthy relationships (Kang & Russ, 2008; Shellman, 2000).

Emotional wellness. Researchers have discovered over time, that living life alone feeling unnoticed, unappreciated or ignored by others is one of the most unfavorable situations for people of any age (Dixon, 2007). According to Arehart-Treichel (2002), negative emotions reduce quality of life, wellbeing and longevity. Therefore, helping them develop positive attitude about aging is important (Ostir & Kyriakos, et al., 2000).

For example, when working with older adults who exhibit negative emotions, the ability of professionals to provide emotional support, and motivate the elderly to focus on their own capabilities and possibilities, is key (Miller, 2004). Emotional wellness requires a balance between feelings of happiness, purpose, self-acceptance and hope; and stress management (Penninx, Tilburg, & Kriegsman et al., 1997). Forming meaningful relationships with others is also a key component of achieving emotional wellness (Kang and Russ, 2008).

Spiritual wellness. Spirituality is important to the psychological wellness of aging adults. According to Miller (2004), it involves personal growth and the strengthening of the mind-body connection at all ages. Moberg (2001) believes it is particularly important to assess spiritual needs when addressing quality of life issues, including transition periods involving such changes as illness, relocation, widow-hood, and retirement.

Intellectual wellness. Many adults worry about losing their ability to mentally function as they age. Those who engage in stimulating activities are at a lower risk for developing disorders such as dementia and Parkinson's disease. According to Levine (2004) and Cohen (2005), intellectual wellness involves broadening one's horizons, keeping an open mind, and using available resources to discover the world around us. Playing games, solving crossword puzzles, reading, surfing the internet, and dancing are a few of the activities which promote intellectual wellness for the elderly. Staying mentally sharp excited, and happy is key (Miller, 2004).

Occupational wellness. Despite the fact that many older workers look forward to having the time to pursue new opportunities/hobbies as they retire, the transition can be a

difficult one, which may compromise one's wellness (Butler, 2002). According to Hettler (1980) occupational/ vocational wellness involves using one's unique skills/talents doing meaningful and rewarding work while contributing to the wellbeing of the community as well. Additional activities include painting, dancing, or writing, gardening, woodworking, raising grandchildren and/or engaging in political action.

Barriers to Health and Wellness

Individuals with disabilities have more problems accessing health and wellness programs than those without (Beatty & Dhont, 2001; Coughlin, Long, & Kendall, 2002). According to Kroll and Neri (2003), problems arise when trying to fit the proper wellness interventions with the needs of individuals with disabilities. As a result, these people face a variety of personal and cultural, as well as environmental and social, barriers related to health care and wellness resources (Stuifbergen, Becker, & Sands, 1990).

Personal and Cultural Barriers

Some individuals with disabilities may not be ready personally to participate in health promoting activities (Ford, 1992). Further, barriers can develop as a result of high stress levels and feelings of depression as well as a negative frame of mind and/or attitude (Pratt, 1995; Sallis & Hovel, 1990). In their study regarding cross-disability experiences of barriers to health-care access, Drainoni et al. (2006) found that regardless of disability type, participants spoke about similar barriers. For example, mounting frustration with providers' preconceived ideas about their disabilities as well as lack of respect created a set of barriers to surmount when individuals attempted to access health and wellness services. Insufficient knowledge about disabilities and the failure to be

taken seriously by providers also contributed to the personal barriers experienced by participants when trying to obtain health care.

Cultural barriers for individuals with disabilities also exist. Foremost among these types of barriers is insufficient knowledge on behalf of a provider about how to help individuals with disabilities enjoy and maintain full, healthy lives (Pierce, 1998). For example, insufficient promotion of health care and wellness services adapted for persons with disabilities as well as a lack of creative approaches to enhance the health and wellness of persons with disabilities contribute to the barriers experienced by individuals with disabilities (Drainoni et al. 2006; Neri & Kroll, 2003).

Environmental and Social Barriers

Some experts believe that disability is the result of the interaction between the individual and his or her environment (Field & Jette, 2007; Neri & Kroll, 2003; Pierce, 1998). Places such as health care facilities are often inaccessible to people with disabilities (Stuifbergen, Becker, Incase, & Sands, 1990). Nosek (1992) and Pierce (1998), found that people with mobility impairments (e.g. spinal cord injuries, CP, MS, and arthritis) faced health care obstacles related to the physical accessibility of their doctors' offices; establishing a trusting relationship with their physicians; and the physicians' level of knowledge, skills, and awareness concerning disabilities. In a similar study regarding health promotion practices and what helps or hinders people with disabilities in maintaining healthy lives, Putnam, Geenen, Powers, Saxton, Finney and Dautel (2003) conducted 19 focus groups and asked participants about how health and wellness is different for people living with disabilities when compared to their non-disabled peers. The participants suggested that people with disabilities have to be resilient

in the face of environmental or social barriers, and promote and/or maintain their health and wellness on a daily basis. In addition to having to overcome barriers related to accessibility, Iezzoni, McCarthy, Davis, and Siebens (2000) and Kroll, Jones, Kehn, and Neri (2006) and revealed that issues such as shortened appointment times and inadequate equipment might also deter individuals with mobility impairments from seeking preventive health care and/or wellness services.

Other environmental problems with accessibility to health and wellness promoting services are evident in the construction of outdoor recreational areas. Non-disabled individuals access to activity settings such as neighborhood streets, parks, and walking/ jogging trails, while walking for people with various mobility impairments is limited. For example, damaged sidewalks may create a higher risk of falling and impassability for wheelchairs, while other sidewalks or walking trails may be too narrow for use by someone in a chair. Additional problems include a lack of wheelchair ramps, or not having enough benches for people who need frequent rest periods, poorly designated signage, no accessible bathrooms and no handicapped parking spaces near the entrance of these outdoor recreational areas (Neri & Kroll, 2003).

Despite the passage of the Americans with Disabilities Act (ADA) , access to health care is still a struggle for people with disabilities (Rimmer & Rowland, 2008). Providing accessible health care to individuals with disabilities is imperative as a matter of equity (Braveman, 2006; Neri, & Kroll, 2003; Rimmer & Rowland, 2008) Furthermore, because people with disabilities utilize a wide range of services across the span of their lives, their experiences may in some respects provide some insight as to how to improve

the overall performance of the healthcare system (Burns, Batavia, Smith, & DeJong, 1990; Fouts, Andersen, & Hagglund, 2000; Rimmer & Rowland, 2008).

Ethics and Multicultural Competency

Individuals who do not currently have a disability have about a 20 percent chance of becoming disabled at some point during their work lives (English, 1997). People with disabilities cross all racial, gender, educational, socioeconomic, and organizational lines and are the nation's largest minority, as this is the only group that any person can join at any time (Counsel for Disability Awareness, n.d.), yet discussions regarding diversity have often been limited to gender and race. As a result, there has been minimal attention given to people with disabilities as the world's largest minority group.

In an effort to provide guidance and set the proper expectation within societal organizations when addressing diversity or multicultural issues, many professions such as counseling, psychology, and social work have adopted formally written ethical codes which reinforce the moral principles and commitments of an organization by clearly defining what is considered acceptable and responsible in terms of behavior (Neukrug, Milliken, & Walden, 2011). For example, the ACA Code of Ethics (2005) states that counselors will respect diversity and differences including age, color, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, or socioeconomic status as well as learn how his or her own cultural, ethic, and racial identity impacts his or her values and beliefs about the counseling process. Similarly, psychologists and social workers are expected to exercise reasonable judgment and take precautions to ensure that their potential biases do not lead to, or condone unjust practices. It is also the responsibility of the psychologist and social worker to be aware of, and respect cultural,

individual, and role differences, including those related to disability (APA Ethical Principles and Code of Conduct, 2003; NASW Code of Ethics, 2008).

Disability Culture and Counseling

While a new focus on disability culture has emerged over the past two decades, the first recorded disability can be traced as far back as 3500 B.C., in which the Rig-Veda, an ancient sacred poem of India is said to be the first written record of a prosthesis (www.disabilityhistory.org). Since then, individuals with various types/degrees of disabilities have come together and forged a group identity, sharing a common history of oppression, language, and resiliency (www.disabilityhistory.org). For example, Brown (1996) believed that disability culture (also known as *crip culture*) could be defined in a multitude of ways, addressing different themes, and diverse aspects of disability.

Despite their anger or frustration about societal assumptions and stereotypes, individuals with disabilities may or may not enter into counseling with issues related to their disability. However, as our society continues to grow in diversity, it is important that mental health professionals work toward becoming *multiculturally competent* providers (Sue & Sue, 2007) and incorporate multiculturalism into each counseling interaction. Competent counselors are aware of the client's culture as well as their own, and are willing to bring it into the discussion during interactions with clients (Sue, Arredondo, & McDavis, 1994). Additionally, culturally competent counselors are open to listening and assisting clients in determining and/or achieving goals without imposing personal cultural values on clients. Further, culturally sensitive counselors are respectful of the client's uniqueness, and work to meet clients where they are. They refrain from

being judgmental, and are willing to engage in a journey with their clients, while providing support along the way.

Chapter Three: Methods

Some misperceptions exist regarding the positive role that wellness can and does play for people with mobility impairments. For these individuals, having a mobility impairment is just one aspect of life and should not be seen as a master status, limiting whom the person is or what they can become. As seen via the literature review in the previous chapter, there is limited research available which examines the perceptions of wellness from individuals who have a mobility impairment. Several researchers including health organizations recognize and acknowledge the fact that more efforts need to be made to include these perceptions in the literature (Welner & Temple, 2004). As Krahn (2003) affirms, health and wellness are of the utmost importance for people with mobility impairments and the lack of focus on the perceptions of wellness for this population is keeping them from being fully acknowledged as healthy and well members of society. Understanding what it means to be well for members of this population is the first step in promoting change in this arena.

This chapter provides an explanation of the phenomenological heuristic research design utilized in the present qualitative study. The purpose of this study was to describe the experience of wellness from adults with mobility impairments. The heuristic data collection and analysis methods revealed core themes surrounding the participant's detailed experiences of wellness.

Design Rationale

Qualitative research is concerned with developing explanations for a particular social phenomenon. It is often aimed at examining one's lived experience via examining theories and patterns developed from subjective data. This type of research places an

emphasis on collaboration, participation, and research methods which promote relationships (Creswell, 2003). A major strength associated with the use of qualitative research is the support of complex textual descriptions of how people experience a given research issue (Marshall & Rossman, 1998). The purpose of conducting qualitative research is to assist researchers in gaining a better understanding of the world in which people live and why things are the way they are (Lindlof & Taylor, 2002). Additionally, it seeks to answer questions about the differences between social groups, and how people are affected by the events that go on around them (Creswell, 2005; Denzin & Lincoln, 2005). Through exploration and identifying themes, qualitative research is designed to closely examine lived experiences and provide rich, useful information about a particular phenomenon (Holliday, 2007). Consider qualitative research to be a jigsaw puzzle composed of many unique shapes and various blends of color. No two pieces are exactly alike. Despite their differences, when all of the individual pieces of the puzzle are put together, a larger, clearer, and picture is revealed. Because an individual's unique circumstances define for him or her what it means to be well and because a complex detailed understanding of wellness was needed, the present study explored and described perceptions of wellness from individuals with mobility impairments utilizing a qualitative research design.

Design Methodology

In the present study the researcher sought to explore and describe how individuals with mobility impairments including the researcher, perceive their own wellness as it relates to physical activity, psychological wellbeing, and social connectedness. The researcher entered fully, through written description, into the situations of the participants

as well as her own. The researcher empathically joined with participants in their lived situations, sharing the experience of wellness, and later reflecting on its meanings.

According to Patton (2002), it is by attending to perceptions and meanings that people can awaken their conscious awareness. Thus, phenomenological-heuristic methods were used to collect and analyze data in the present study.

Phenomenology

Phenomenology is a type of qualitative methodology used to examine the human experience in order to discover the underlying aspects of experiences and to understand how things are lived and interpreted (Creswell, 2003; Sokolowski, 2000)

Phenomenological research stems from the philosophical beliefs of Husserl (1970).

According to Patton (2002), the focus of phenomenological research is on life situations and what people see as significant versus cause and effect. Phenomenology may be considered an analytical social science perspective, an interpretive theory, a philosophy, or a research method. Researchers employing this methodology operate on the assumption that perceptions provide evidence of the world and that phenomena can be understood once preconceived ideas and beliefs have been put aside (Creswell, 2005).

The goal of a phenomenologist is to describe participant commonalities in such a way that will “grasp the very nature of the thing”(Van Manen, 1990, p.177), while exposing assumptions often taken for granted (Sokolowski, 2000). The phenomenological approach as applied to the present study allowed the researcher to uncover what is being taken for granted as well as to understand the perception and meaning of wellness that participants attached to it in their everyday lives.

Heuristic Inquiry

Heuristic inquiry is a type of phenomenology, which describes the personal insights of the researcher (Patton, 2002). It is an autobiographical process that begins with a question or problem, which the researcher seeks to answer. The heuristic method is a way of being informed, a way of knowing. This method is demanding, involving high levels of self-commitment, self-searching and reflection, self-dialogue, self-discovery, and an ultimate surrender to the process on behalf of the researcher (Moustakas, 1990; Patton, 2002) as the initial data lies within the researcher. During the heuristic process the researcher may challenge, confront, or even doubt his or her experience. The purpose is to focus on the meaning, experience, and transformation of the researcher as related to the research question (Moustakas, 1994). The dawning of awareness may be refreshing and peaceful, or disturbing and even jarring (Moustakas, 1990). In regard to the present study, the use of heuristic inquiry allowed the researcher to critically examine her personal perception of wellness. Additionally, remaining immersed in the process with other participants assisted in the researcher's ability to remain open and flexible as well as uncover her personal bias as related to wellness.

Role of the Researcher

The qualitative researcher's perspective is perhaps a contradictory one. It is expected that the researcher will be fully tuned-in to the experiences and meaning systems of others on one hand, while maintaining an awareness of how his or her own biases and preconceptions may be influencing what is trying to be understood, on the other (Maykut & Morehouse, 1994). I remember the day I sat in my chair's office and reluctantly decided on the topic for this dissertation. Not only was it going to be about

wellness, which was not at all my favorite subject at the time, *but* it was also going to be qualitative in nature, *and* I was going to participate in my own study. Needless to say, I was uncomfortable with both the topic and the method. Anyone who knows me knows two things for certain: One is that I love quantitative research methods and statistics, and the second is that I'm not a big fan of hanging out in the messy, emotionally charged, gray areas of life. I admit that even as a counselor in training, I much prefer black and white to gray, and even though I have a mobility impairment (CP) myself, it's not something that I talk about at length or in depth with many people, much less strangers. I didn't want to write a dissertation related to disability in any way, because in my mind doing so would've been expected, would only reinforce the societal idea that "different means deficit," and that because I have a mobility impairment, I must live a sheltered "comfortably miserable" life, counting down my days feeling "less than" and alone. I can only imagine the look on my face as my chair began to explain the phenomenological-heristic research method and how it was going to relate to my study.

Surprisingly, because she has this superwoman way about her, I left my chair's office feeling somewhat hopeful about writing on this subject. She was right, I did have things to say; I was tired of reading about myself—about how hopeless or inspirational I am because I have CP—from the perspective of nondisabled people. My chair's biggest job at that point was to constantly remind me to watch my mouth outside of her office. If I was going to ask people with mobility impairments to share their stories with me, I felt it only fair to experience this process with them, so from that day forward I was "all in" and began my own wellness journey, which got off to a very rocky start.

Part of the inspiration for writing this dissertation came from my experience in a required wellness class that I had to take during the 2010 fall semester. Here I was in this class being asked to participate in activities that were both difficult and painful for me as a person with CP—activities like yoga and progressive relaxation. The class frustrated me from week to week and I made sure on a couple of occasions that the professor, and everyone else in my cohort for that matter, knew it. I went to another professor, (who was then my LPC supervisor and soon to be my chair) and let it all out, telling her very matter of factly that I didn't feel like I was going to get anything out of the class and had no idea why I had to take it under the circumstances. Very calmly she asked, "Have you talked to your professor about this, I wasn't even aware of some of those things in regard to CP." "Not exactly," I told her. Truth be told, I hadn't been very nice to him at all, so I left her office to make an appointment to meet with him. The other part of my wanting to write a dissertation on this topic came from the fact that there are no wellness programs or activities on campus for students with disabilities, and nothing beyond physical therapy really, within the local community that I could find. So I was now on a mission. "How can someone ask me to take part in a wellness program if the resources aren't available for me to do so?" I thought.

The first step in this process was making the decision to change my attitude from one of being angry and frustrated to one of being open minded and determined. That didn't exactly happen over-night, and I think it's still happening, but I'm in a much better place than I was a year ago. Secondly, I had to "get right" with the idea of becoming part of my research process and figure out with my chair exactly how I was going to do that. Again, I knew I couldn't ask something of my participants that I wasn't willing to give of

myself or do in return, so given the lack of wellness programs available on campus, I set out that summer to find a trainer at a local gym who had the knowledge, skills, and willingness to work with me. Doing this meant that I was going to have to overcome my insecurities and uncomfortableness about working out in front of other people. It didn't take long. I found the trainer and the gym in July of 2011, I've been there ever since, and I love it!

Personal growth and development is a lifelong process. As I wrote in my journal and reflected on the often-unexpected stories that my participants shared with me during the course of this study, I realized how much we had helped each other and how grateful they were that I had decided to conduct this study. "Thanks for putting this information out there, Joy. I hope something good comes of it for us for a change," said one participant as I was leaving an interview. It was at that moment, as reluctant as I was to be "all in" in the beginning, that I knew that my soon to be chair was right, conducting a phenomenological-heuristic study was in fact the right choice under the circumstances. People are counting on me and believe that I will do good things with what I've learned from them during this process.

Participants

Individuals with various physical mobility impairments were solicited to participate in the present study via flyers and face-to-face contact. Participants were from both a South Texas university setting and physical therapy programs within the local community. Students from the university campus were solicited via flyers placed in the disability services office. Additionally, both the director and assistant director were provided flyers for specific distribution to appropriate candidates in the university

community. The researcher also placed flyers in community and hospital physical therapy locations. Directors and/or physical therapists in those settings were also provided with flyers for specific distribution to appropriate candidates in their programs. Interested candidates contacted the researcher via telephone or email at which time the researcher explained the nature and the purpose of the study, answered any questions, and provided interested candidates with informed consent forms to be signed before individual interviews took place. Interviews were conducted in locations that were comfortable and convenient for each participant and pseudonyms were chosen to protect their identities. Participants in this study ranged in age from twenty-two to seventy-two. Three self-identified as white, two as Hispanic, and three as black. Two were male and six were female. Two of the participants were married and all but one participant was unemployed. People who had disabilities other than a mobility impairment were excluded from this study.

Data Collection Methods

After approval was granted from The Institutional Review Board (IRB) at a South Texas university, prospective participants were invited to participate in the present study. There were two screening criteria. First, participants had to be at least 18 years old. Second, participants had to be enrolled in disability services on the university campus and/or enrolled in a physical therapy program within the local community. The participants contacted me via telephone and email based on information in the flyers. Each participant completed an informed consent form, which described the purpose of the study, the procedures, and potential risks involved, with an understanding that participation in the study was voluntary. The interviews consisted of one session, which

were conducted at locations that were comfortable and convenient for each individual participant. I kept a reflective journal throughout the process and updated it after each participant interview. Once saturation of data was achieved no additional participants were interviewed. Interviews were transcribed by a professional transcription service and were returned to each participant for editing and/or verification purposes. Once I received the corrected transcripts from the participants, I began the data analysis process, developing a synthesis of each participant's experience of wellness including my own.

Semi-structured Interviews

After reviewing the informed consent form and answering questions, each participant was interviewed face-to-face for anywhere from 30 to 60 minutes. The interviews were audio taped with the consent of participants. The interviews consisted of asking participants to discuss the following questions:

1. What does wellness mean to you?
2. What do you do to manage stress?
3. What role does physical activity play in your life?
4. What contributes to your sense of psychological health?
5. In what ways are social relationships important to you? With whom?
6. Tell me about any wellness program that you are currently involved in. How could that be supported or enhanced?

These questions were used to build rapport and gain a better understanding of the participant's perception of wellness. Each interview was audio-recorded and transcribed by a professional transcription service. I immersed myself in the data and got to know the participants by listening to their audio recordings and reviewing individual

transcripts for accuracy. Doing this allowed me to reflect on my original impressions and feelings experienced during each interview. After verifying transcripts each participant was given a copy of their transcribed interview and asked to review and verify the information as well.

Once I received the transcripts I highlighted units of meaning relevant to each participants' perception of wellness (Seidman, 2006) and made notes in the margin. After reviewing the transcripts, I retreated from the data for approximately a week to allow time for the incubation process (Moustakas, 1990). This "time away" was an invaluable part of my research process as it allowed time to absorb information and formulate ideas. Upon return to the data a second and third time, I reviewed original highlights and notes, and then edited the information as needed, making additional highlights and placing a checkmark by previously identified units that I still "agreed with" or a line through those I didn't. After three rounds, I was able to identify what I considered to be the most significant units of meaning concerning each participant's perception of wellness.

After identifying the units of meaning, I printed a second set of transcripts for a peer reviewer. Because I was a participant in my own research, it was important that I submit my work for review in an attempt to minimize bias. Having a reviewer with a fresh eye also helped me identify additional units of meaning and/or themes, correct mistakes, and improve my work overall. When the peer reviewer was finished reviewing and coding, leaving comments in the margins of the transcripts, I assigned a color and created separate files for each participant. After that I wrote the identified statements on an index card for every participant in their assigned color and attached a formulated

meaning (Moustakas, 1990) of the statements to each stack of index cards and continued this process for each participant. The immersion process coupled with periods of incubation facilitated the illumination (Moustakas, 1990) of themes relative to the perception of wellness for the individual participants. I was especially conscientious during that phase as I wanted to make every effort to connect the dots between what the participants said and what they meant, while maintaining the original context of the statement, as accurately as possible. After attaching a meaning to each statement, the peer reviewer and I collaborated in organizing the meanings into theme clusters for each participant and assigning an emergent theme label representative of the clusters associated with each participant's perception of wellness.

Individual narratives were composed during the explication phase in an attempt to accurately capture each participant's perception of wellness based on the emergent themes and theme clusters previously formulated for each participant. The participants were (e)mailed a second time including their individual depictions for verification purposes. After approximately two weeks, I received communication from participants via phone, email, or in person, confirming my interpretation of their perception of wellness.

Trustworthiness

Because the researcher was a participant in her own phenomenological-heuristic study, it was important to triangulate the data and ensure that the research findings were trustworthy. Measures such as member checking, utilizing a peer reviewer, and keeping a reflective journal throughout the study were employed in

order to safeguard the credibility of the study as well as to establish rigor and consistency of the data in the present study.

Member Checking

Member checking is a process by which the researcher solicits participant's views of the credibility of the findings and interpretations of data (Creswell, 2003). In addition to providing transcripts to each participant for review for accuracy prior to identifying units of meaning, results from the analysis of data were provided to all participants. Participants were asked to respond to the results presented to them via telephone, (e)mail, or in person depending on each participant's preference. Once data from the initial interview was corrected (if necessary), the preliminary results of the study were mailed to all participants who were asked to respond about the accuracy of the themes and subthemes via phone, email, or in person depending on the participant's preference.

Peer Reviewer

In order to enhance its credibility, this study utilized a peer reviewer who analyzed interview transcripts and offered additional feedback. The peer reviewer was a colleague with a master's degree who had previous experience with phenomenological research methods. Upon completion of his review and analysis of unmarked transcripts, we compared our thoughts as well as our notes in order to confirm the emerging themes.

Reflective Journal

After each participant interview I updated my reflective journal, where I recorded the thoughts, feelings, and reactions that resonated with me upon the completion of each

interview. My reflections were either recorded directly after the interview or at the end of each interview day when I could adequately reflect upon the experience. In the journal I also recorded my thoughts, feelings, and reactions regarding my own wellness journey (i.e. working out and the gym, putting down cigarettes for good, eating right and losing weight, and any interactions with doctors) in an effort to provide a more balanced and clearer picture of my experience throughout my wellness/dissertation process.

Data Analysis

Phenomenological-hermeneutic methods were used to analyze the data and identify themes. The first step in this process involved gathering data from each participant through conducting interviews, reviewing transcripts and notes. Secondly, I immersed myself in the data in order to gain a clear understanding of the participant's experience. The third step involved setting aside and returning to the data repeatedly and with fresh eyes in order to identify themes and construct individual depictions of wellness. Steps four and five consisted of me returning to the original data to ensure depictions contained themes or examples essential to each of the eight participants' experience of wellness. Next, individual depictions representing each participant were gathered together in order to create a vivid and accurate composite depiction, representative of the entire group. During step six I utilized individual portraits rather than interview transcripts to enter into the immersion process with intervals of rest until I understood and was able to embrace the participants' experiences of wellness. During step seven I chose two participants who exemplified the group as a whole and constructed their individual portraits, which included all of the core meanings of wellness as identified by the group. The final step in the process involved creating a synthesis based on my experience personal as the

researcher, exposing the peaks and valleys of my experiences. As previously stated, this type of analysis involves examining the human experience from the inside out in order to gain a clearer view of the bigger picture. According to Moustakas (1990), by trying to enrich oneself through gaining an understanding of the phenomenon in question and creating a new avenue for research, new realities may be reached. Themes arrived from the data analysis will be discussed in the following chapter.

Chapter Four: Results

Maintaining health and wellness is important for both disabled and nondisabled individuals. However, those individuals with mobility impairments often encounter professionals who are unable to fully address their wellness needs. The purpose of this qualitative research study was to examine the perceptions of wellness from adults with mobility impairments. This chapter begins with the presentation of each participant's depiction of wellness followed by the composite depiction for the group. Next, the core themes are revealed and finally, the researcher developed a creative synthesis written in the form of a narrative to represent the core themes revealed during the course of this study.

Individual Depictions of Wellness

Brenda

Her commitment to exercise, her support system of friends, and pain management are the factors, which most significantly influence Brenda's perception of wellness. As a woman in her 70s, she is an avid participant in Pilates. Brenda's exercise routine coupled with medication is an essential component of her wellness because it physically and psychologically assists her in managing pain resulting from neuropathy and a knee replacement. Getting through the day with enjoyment is a typical goal for her. Brenda's daily schedule includes two to three hours of exercise per day and/or going to the beach. Solving crossword puzzles, playing computer games, and cooking are also things she likes to do on her own to maintain her psychological wellness.

In addition to her exercise routine, Brenda's relationship with her local group of German friends is a key component of her perception of wellness. This tightly knit

group provides the social and emotional support Brenda needs as they meet regularly throughout the week at the gym, for dinner and/or coffee, and an occasional movie or concert. The friends often discuss their individual travel plans, play games, exchange recipes, and celebrate various events together. Brenda described herself as someone who likes to be with people.

At present, Brenda is satisfied with her wellness program and does not feel as though anything is missing. According to Brenda, everyone she works with on a daily basis is doing the best they can to help her and as a result, she is determined not to allow her pain and disability to get the best of her, especially at night when, “it’s bad.” Currently Brenda works closely with her doctors and does her best to maintain a positive attitude. “I mean I cannot change it, so why complain about it,” she stated at the end of our interview. According to her, “Everyone needs to do something to have wellness in their lives.”

Dana

Dana’s wellness is focused on the importance of “being able to function.” “Healthy living and clean eating” as she put it, is her only option as far as managing her weight. As a quadriplegic woman in her 40s, eating nutritious, balanced, meals are essential to her wellness. “The only thing I can move is my mouth, and I’m pretty good at that,” she stated. Dana’s only source of physical activity takes place during weekly visits with a physical therapist, who works with her to help minimize the painful effects of (muscle) atrophy. To cope with the stress of completing her kinesiology degree combined with the stress of keeping up with all of her medical and social appointments,

Dana relies on prayer and her faith in God to keep her centered, and motivated to balance her multiple responsibilities.

Maintaining close relationships with her ex-husband and her two children is also significant to Dana's wellness as they, in addition to her nurse, provide the support she needs to get through the “day to day of it all.” “I can complete any goals I have. I still do a lot of things, I just do them differently now,” she told me. Her friends and her work as a youth leader continuously offer Dana encouragement throughout her week as well. She emphasized that if she had to have an injury that she could not have been injured any better way. “I have the opportunity to be an influence on people, care, and be a role model for people around me.”

While Dana stated that she is satisfied with her personal wellness routine, she did express some frustration toward people who unnecessarily park in handicapped spaces. “It’s so aggravating to see a whole family come out and they’re using grandma’s hanger,” she said. Other sources of her frustration stem from the inaccessibility of some buildings as well as people’s lack of education and flexibility where disabled people are concerned. Despite these things, Dana is optimistic about her future and is particularly interested in seeing how the use of stem cells might enhance her overall wellness as advancements are made in that area of research.

Eric

Physical fitness is an essential component of Eric’s perception of wellness. As a male in his early 20s, he exercises regularly to improve his mood, the functioning and mobility of the right side of his body, as well as manage the stress and frustration he feels as a result of being paralyzed after surviving a gunshot wound. Since experiencing a

traumatic brain injury, Eric has “stopped partying” and refocused his energy on living a healthy and active drug free lifestyle.

The relationship with his parents, especially his mother, is an important source of emotional and social support for Eric. “She slept with me day and night in the hospital, she did not leave my side, not for one second” he stated. If not for his parents, Eric feels like he probably would not be alive. Also important to him are his relationships with his girlfriend and his friends. They spend time together at his house playing video games and shooting hoops. Occasionally he and his girlfriend like to go out to dinner and a movie. Eric is especially grateful that his relationships with them have remained unchanged since his accident and intact since junior high.

Eric described his spiritual wellness as being positively impacted by his dad who is a bible teacher, since his accident. Reading the bible and “praying, praying, praying” with his dad gives Eric the structure and support he feels he needs to stay mentally stable and motivated to improve physically, as he considers God to be his mentor. Another component of wellness for Eric involves taking medication for pain management and depression as well as attending doctor’s appointments. “I get headaches a lot because of the metal plate in my head and have muscle spasms that I can’t control without medicine,” he told me. Eric is thankful for the team of doctors who have helped him improve as much as he has over the past three years and acknowledged that they are another reason why he is still alive.

Support groups, social activities, and even sports teams for disabled people are some of the things that Eric would like to see in the local community. “Sometimes I get tired of being the only different one in the group, and I wish I didn’t have to be,” he

stated. He expressed being frustrated with always feeling like he has to “teach people about this” and does not think he would feel this way if there was a place he could go to “hang out and have fun” with other disabled people.

Leslie

For Leslie, a woman in her mid 40s and a survivor of a closed head injury, an important source of wellness is taking care of her mind and body. To do this she enjoys walking in the park regularly despite the fact that some people stare at her because of her paralysis. She also likes to go to the gym to exercise at least two or three times a week to keep up the strength in the left side of her body and manage the frustration she experiences because of a speech impediment. Leslie wants people to understand that, “We can come out and do things like normal people can, we just do them differently.” “Walking it off” whether at the park or at the gym, makes it easier for Leslie to go back and retry things that she finds difficult to accomplish throughout the day. “Sometimes I just get frustrated because I know I wasn’t like this,” she told me.

The relationship with her dogs and two close friends, contributes to Leslie’s sense of emotional and social wellness. Leslie talked about several stressful events over the past few years in which her friends and her dogs have helped her get through since the loss of her mother to breast cancer eight years ago. Leslie acknowledged occasionally going to a movie with her sister and attending family gatherings but said that she prefers being at home spending time with, and having fun with her dogs. “I am happy to live on my own now even though my grandma is down the street if I do need help. I want to do it on my own, I can do it on my own,” she said.

Spirituality is another factor that contributes to Leslie's perception of wellness. "There is a God up there and if he didn't want me in this world I think he would have taken me out in the beginning," she stated. Leslie stressed feeling blessed in spite of her injury, which occurred twenty years ago. "I am still here and I am going to keep going, and going, and going."

In addition to her relationship with God, Leslie relies on physical therapy and her physician to help her manage her pain. She has frequent headaches and experiences muscle spasms and back pain as a result of her head injury. When asked if her wellness program could be improved in any way, she said that she wishes things were easier to use in the community for people who are handicapped. "For me I hate it when I see there is only railing on one side or not at all. I can fall easily because of that." She expressed a desire for things to be more adaptable in the community in general, not just for herself. Independence is definitely a key contributor to her overall perception of wellness. Feeling and/or being helpless and allowing people to have "Oh, poor girl" syndrome as she calls it, are not options for Leslie.

Monica

Essential to Monica's perception of wellness is attending physical, occupational, and speech therapy. Without help from her therapists and her doctors, Monica would not be able to talk or walk at all. As a woman in her late 60s and a survivor of a domestic violence attack, a good day for her is a day without falling and/or pain. She uses a walker to make things easier and to minimize her chances of falling. The walker also helps Monica manage her stress and frustration because it provides her with a sense of security and stability as well as some independence.

Faith in God has gotten Monica through the hardest, darkest times of her life and she does her best to keep looking forward to a time when she will be even better than she is now. Monica believes that God is in control and that he does not make mistakes. In addition to God, her relationship with her family is vital to Monica's wellness. She lives with one of her daughters who takes care of her and she attends family gatherings very frequently. Sunday dinners are especially meaningful to her.

When asked if she felt like anything could be done to improve her wellness, Monica's daughter told me that Monica wishes the doctors and therapists would have taken more time in the beginning to show her how to use her voice box equipment so that communicating would be easier for her now. Despite her inability to talk very well, laughing and smiling is something Monica did do a lot of, and did very well during our interview. Her family recognizes her as their own "personal little miracle."

Paul

Most important to Paul's wellness is the support he receives from his family, his dog Lola, managing his pain and diet, and his faith. According to Paul, a male in his mid 60s, he believes he is able to get through rough days because of the support from his wife as well as spending time with his children and grandchildren. He is especially thankful to his wife for her emotional and financial support since he is not able to work anymore. Paul is now an amputee as a result of complications associated with diabetes. He considers family time, "a welcome distraction from his pain and boredom," where he can direct his attention to his family. An additional source of social and emotional support is his dog Lola, whom Paul considers a friend. He recognizes his relationship with his dog as a typical when compared to his relationships with his cats or even other

people. “Lola is a good dog, she takes care of me, and is there for me to talk to when no one else is around during the day.” Paul is grateful for the companionship and sense of security Lola provides for him on a daily basis.

Paul is committed to making it to his doctor appointments despite the transportation issues that arise sometimes from only having one vehicle. He wakes up most mornings and experiences “screaming pain from head to toe” as a result of his many health problems stemming from his birth injury, diabetes, and hepatitis c. Paul feels that maintaining open and clear communication with his doctor, eating heart healthy and diabetic friendly meals, taking his medication, and “staying on top of his pain” are all key to remaining physically active and enjoying his life.

Faith continuously recharges Paul’s energy and keeps him motivated. “My faith helps me not get too depressed. I’m not saying I don’t, I do, but my faith gives me hope that things will get better and I try to focus on that.” “Better” for Paul is still in the future.

Paul mentioned that he spends a lot of time at home alone with his dog Lola while his wife is working and would like to see programs in the community “for people like him” that offers transportation. “I would like to get together and talk about stuff whether it be what’s going on physically or not...I’m sure there is other people out there like myself that would love to have someone to talk to,” he told me.

Tanya

Tanya discussed the influence of her family, occupational therapy, and spirituality on her perception of wellness. Since having a stroke at the age of 30, less than a year ago, her family is essential to her social and emotional wellness because of their ability to demonstrate empathy (her step mother and grandmother are also disabled)

regarding her stroke. They visit with each other at least four times a week and spend some of that time discussing Tanya's progress and recovery. They laugh a lot, and love to eat. Sunday dinners with her family are especially important to Tanya. At this point she still finds it difficult to socialize outside of her family as she is having to relearn to bathe, dress, walk, and even talk to some degree, and is experiencing some confusion about things that came simply to her before her stroke.

Physical and occupational therapy are vital to Tanya's wellness. She works closely with her doctors and therapists to improve her ability to walk and talk as well as manage her pain. Going from her everyday work life to a life involving so many doctors and scheduled appointments has been a humbling experience for Tanya. "Having to depend on people a little bit more changes a lot of things in your life."

Her relationship with God plays a major role in Tanya's life. She told me that if not for God she doesn't think she would be here right now. Once she left the hospital the reality of her situation set in and she continuously asked herself, "why me?" Prayer and going to church has really helped her cope and has given Tanya the strength and motivation she needs to continue her rehabilitation process. "I know God is going to heal me," she stated at the end of our interview.

Wendy

As a woman in her 40s, significant to Wendy's perception of wellness is "feeling whole." Stress management, her support network of friends and family, staying physically strong, and spirituality are all factors, which influence Wendy's wellness. While experiencing a spinal cord infarction and having to live the rest of her life in a wheelchair was unexpected and unwanted, the chair did not "stress her out." According

to Wendy, she has always stayed in “good spirits” about it and has been able to “deal with it.” Meditation and deep breathing exercises are helpful stress management techniques that she practices a lot. The most significant way she manages stress is to set goals for herself in three month increments. “I know that when I’m dealing with something that’s difficult like physical pain, that three months from then things are going to be different or better for me, and if they’re still not where I want them to be, I just set another three month goal for myself... I just keep looking to the future where things will be better, and it works,” she told me.

Socializing is something that is important to Wendy despite a wheelchair coming into her life. She has a lot of friends and gets out of the house everyday and feels fortunate in that being in the chair has actually provided her with the opportunity to go back to school and improve her life as well as make friends. “My social life is pretty much the same way it was before the chair...I love people and feel very, very blessed that the only thing this chair has taken from me is my ability to walk.” In addition to her friends, spending time with her family is important to Wendy. She is especially close to her stepdaughter, sister, and former mother in law. “My house is full of a lot of laughter when my family is here, we love spending time together. Sitting around the table for Sunday dinners after church are what I always look forward to.” Additionally, Wendy appreciates the ability to be a role model and source of strength for her stepdaughter and former mother-in-law, who are also disabled. They go to doctor appointments together, encourage, and motivate each other to be the best possible versions of themselves.

Staying physically strong is a key component of wellness for Wendy. She has learned to do with her arms, what she used to do with her legs. “I can still do a lot of the

things I used to do, I just do them differently now”, she told me. Her balance is good and working out has helped her improve her ability to climb up on things when she needs to, transfer in and out of her chair on her own, and complete household chores like laundry and doing the dishes. Eating healthy is another way Wendy tries to stay in good physical shape. “I could exercise more but I just haven’t taken the time to do so. I’ve also tried to do yoga, but I can’t sit still that long,” she said as she laughed.

Spirituality plays a major role in Wendy’s wellness. She “stands on” three scriptures so that no matter what happens in her life, the scriptures are able to carry her through. She firmly believes that, “God is in control, he does not make mistakes, and he is not a man that he should lie.” Wendy's involvement with her church community helps keep things in perspective and her priorities in order. “God promised me that he wouldn’t give me more than I can bear. He didn’t say that I would like it, but he said that I’d be able to bear it and if I can’t, he will take care of it.”

Composite Depiction of Wellness

Individual interview transcripts and lists of emergent themes experienced by each participant were utilized to construct a composite depiction in the present study. I combined similar emergent themes and attached a new name to reflect the combination of the similar themes. At that point I retreated from the data for a week to allow time for ideas to emerge during the incubation period.

After combining the similar emergent themes, 17 remained. From there, the peer reviewer and I returned to the interview transcripts to confirm that each of them were reflective of the participant’s described experiences. Of those themes remaining, 11 were combined with other themes or discarded altogether. In the end there were a total of

6 themes, which the peer reviewer and I considered to be representative of the most common characteristics to emerge when considering the eight participant's perceptions of wellness.

Theme 1: Overcoming barriers

All of the eight participants described the challenges they face regularly in relation to overcoming barriers as a way to make progress toward, and maintain their wellness. Some of the barriers mentioned by the participants were personal, while others were attitudinal, physical, and community related. For example, all but one participant is experiencing a financial hardship, a few do not have transportation, some have trouble sleeping, some have experienced being embarrassed by nondisabled people because of speech impediments and paralysis, and most reported feeling like there is no place for them to go to participate in a wellness program or social activities. For some, the barriers they face negatively impact their wellness by increasing their stress and anxiety. For others, they do what they can and let go of the rest.

One participant stated:

For me I am always under stress, but when I do my exercise, I don't think about all this. I just do my stuff and I don't have time to think about anything. But that's why I cannot sleep. I'm up at 3 o'clock sharp.

Another participant talked about her levels of stress and frustration in relation to her interactions with some people in the community:

I really think everybody should be treated respectfully and be able to do the same as everybody else and we should not be looked at as somebody that there is something wrong with us...I wish they could give us an equal opportunity like we

do them. We don't discourage them to go walking at the park or from being able to use the stairs or from talking because of the way they are. That's the way I feel. They shouldn't do that to us.

Other participants discussed being frustrated with barriers such as a lack of social activities and transportation services for disabled people:

I wish there was more community resources for disabled people. I really feel like we don't have as many options to do things or to get together with other people like nondisabled people do. They have the access and an easier time with transportation means than we do. I feel like sometimes there's no place to go and no way to get there unless you can walk.

Theme 2: Pain management

All of the participants emphasized the importance and necessity of pain management and keeping scheduled doctor appointments as part of their perceptions of wellness. Without the ability to manage their physical and/or emotional pain, being able to function and accomplish daily activities becomes impossible and negatively impacts their moods and even their relationships with others as a result.

One participant stated:

It takes everything I can to get out of bed...the minute I stand up I am hurting from head to toe. It's just screaming pain you know, and it's like if I thought it would do any good to lay back down again I would, but I just have to get up so I may as well take my meds and tough it out.

Another participant talked about the importance of exercise as pain management:

See, for me, I like doing pilates for instance. I really like it but for me it's getting harder and harder because I'm really handicapped and not like the other people. For my knee, it's so painful I have to put something underneath. Balance, because of my neuropathy, I don't have balance so I have to hold on to get on my toes because there are poses you get on your toes. It's so painful, but I still do it. I don't know for how long I can do it, how much longer, but I still do it. And I mean all this physical activity, except [being in] water, for me it's really painful but I do it. Because if I wouldn't do it, then, gosh, I could give up.

While another discussed the use of medical devices to help manage her pain:

I have been given a lot of things to manage my pain and make life easier now, like a pacemaker to move my diaphragm, which I can hook up beneath the bed when I want to breathe, when I don't want to be hooked up to the other tubes, and I have a Baclofen pump too.

Theme 3: Psychological wellness

All of the participants described the various ways in which their disability influences their psychological wellness and vice versa. However, the majority of the focus for each of them centered around their recovery periods, whether from the original injury or onset of illness, or subsequent medical procedures, which ranged in time from four months to four years. A few of the participants talked about the amount of time and the psychological and emotional toll it took to learn how to do things that were at one point simple (dressing, eating, talking, walking) for them, but are now more difficult and problematic, all over again. Most of them said they didn't think much about their psychological wellness before becoming disabled but that becoming disabled made

them realize how much they took for granted. When discussing her mobility impairment and her psychological well being, one participant said, “All I could think about when this first happened, was ‘why me?’ The work comes in accepting it and then adjusting to it.” I was surprised when another participant told me, “I couldn’t have gotten injured any better way...I have the opportunity to be an influence on people, I’m fortunate.” Another participant shared a similar perspective and stated, “My greatest and most humbling lesson is to ask people to do things for me and then being forced to depend on them. I do not necessarily like that, but I am going to be okay.”

Theme 4: Physical activity and nutrition

Maintaining some type of physical activity as well as a healthy diet was a theme present among most of the participants as a means of coping with their stress, improving physical fitness, and enhancing their social connectedness.

One participant stated:

I try very hard every day to go to the mall and do two laps around, that’s about two and a half miles. If I don’t have the truck or the gas I will take my dog on a walk if we can get it in, my dog is actually part of my wellness too. I have diabetes so I have to be sure that I watch what I eat and manage my weight too.

Another discussed the importance of exercise in her life and said:

Wellness for me is exercise and I have to do it in order to be well. If I wouldn’t do it I think I couldn’t walk...I do my water jogging because I don’t have to be on my feet. For yoga and Pilates we do a lot of standing up and it’s painful, but I see this 85-year-old man and he does pilates with me and as long as he comes, I go too. And there’s this 86-year-old woman in yoga, Clare. She’s good. She comes

or she swims with me and she swims good and gosh, as long as they come, I go, too.

In addition to exercise some participants expressed the importance of weight management in relation to their wellness:

To stay physically well I'm not supposed to gain weight. I eat healthy, but heart healthy, and I take a lot of vitamins. I take Omega 3's, that sort of thing to try and keep my body at a healthy weight...I also have physical therapy, but my mouth is my only thing I can move on my own and I'm pretty good at that.

Theme 5: Social connectedness and family support

All of the participants acknowledged that the social support they receive(d) helps facilitate their wellness and their motivation to improve. Social support for the participants comes in various forms including emotional support, encouragement, and friendship, with the most recognized source of support stemming from family members. For some participants, their relationships with their friends and animals are just as important as their relationships with family members.

One participant shared that her preference in terms of social connectedness, is to spend time with her dogs:

I don't associate with too many people. I have a friend that I have over 15-20 years which is about the only one that I talk to and then I have another one that lives down the street. I go over there and I only associate with those two because I'm not a person that goes out. I go to the movies once in a while but... with my sister. I go to family gatherings too. Most of the time I like to be at home with my two dogs. We are there all day long by ourselves and we have fun.

Another participant talked about the importance of his parents in his life:

Socially maybe I have just my family and I have just a couple of friends that are really important. Other than that, I would not say too much. Friends change so now I just keep the close ones that were there for me since day one, out of the hospital, and that never left my side... My parents, they have been there since day one and they mean the world to me and without them, I probably wouldn't be here. My mom, she slept with me day and night in the hospital. She did not leave my side not for one second.

Another participant talked about her relationship with her two best friends and "hanging out" with her kids:

Well socially, I have a very good friend, he's a musician but he's also a math teacher; and he has his Master's degree in Technology and then my ex-husband, he's my best friend ever. He comes over and spends time with me too. I have two men in my life, and my kids, they're wonderful. They are my support, and they worry about me too much, way too much. They were very good about curfews, I just have great kids, I don't know how it happened. My ex and I were both horrible teenagers. But they were not, they never gave me a hard time, my daughter never yelled at me, never raised her voice once to me. As adults they're awesome both of them. And if they want me not to talk they'll tell me. I tend to push the limits sometimes with them. They're both very modest and conservative as far as how they joke around. I can embarrass my children very quickly.

Theme 6: Spirituality

Seven of the eight participants emphasized the importance of their relationship with God and the impact it has on his or her perception of wellness. Additionally, they acknowledged that their spirituality gives them a sense of inner strength and peacefulness, especially during their recovery process from various medical procedures, via prayer and meditation, attending church, and reading the Bible.

One participant said:

Spirituality plays a major, major role in my wellness. First off, I think back to when I first got in the chair, and I remember when I was in rehab, they called in a Psychiatrist to come and talk to me because I wasn't tripping. I wasn't upset, I wasn't depressed, I was in good spirit, I was just looking forward to three months from now, because I knew things were going to be better.

Another stated:

My relationship with God has a lot to do with my wellness, I've never let little things get to me, I just can't. I never did that even before the car accident, so I'm fortunate. It was kind of hard growing up, but you learn to adapt it's just what you have to do. I went through a lot of turmoil; I fooled around a lot more than I should have. It started in high school, I drank and smoked pot, but I don't do anything like that anymore. Eventually, I just realized that you can't look back over time; you've got to look forward.

Another replied:

I did see a counselor at first, but I just... with the bible and everything else, I just put in my trust into God which is really what I need to be mentally stable and just

to pray, pray, and pray. I see God as my mentor. So...the first couple of years after I shot myself were rough. They were really rough. I was all on antidepressants and suddenly I couldn't accept it, but now three years later, I've come to conclusion that it is what it is and I just gotta accept it and move on.

Exemplary Portraits

After retreating from the data analysis process for two weeks, I came back to it and reviewed both the individual and composite depictions in order to create the exemplary portraits using condensed versions of interview transcripts (Moustakus, 1990). The purpose in doing this is to uncover the nature of the phenomenon being investigated, which in the present study is the perception of wellness from adults with mobility impairments. I selected the following two profiles, as they were the most representative of the group's experience of wellness including the core themes revealed from the individual interviews.

Dana

For me wellness means a few things like being able to manage my pain, taking meds so I can function at my best, keeping my nurse and my kids close by, I know I'm not supposed to gain weight. I eat healthy, but heart healthy and I take a lot of vitamins. I take omega 3 that sort of thing and I try to keep my body at a healthy weight. Going to school to finish my degree, trying not to lose my patience with people who aren't flexible is also part of wellness for me. I've had some great professors in that way, and I've had others who were not flexible at all. That happens, I know. It is difficult and it's a little frustrating that things are not more adaptable for us.

In terms of overcoming barriers, I would like to see people that park in handicap parking spots get tickets. It's so aggravating to see a whole family come out and they're using Grandma's hanger. I also wish places were more accessible and that some people were a little more educated and flexible about disabled people. I hope what you're writing will really help people understand us better and not feel sorry for us. That would be nice, right? On the other hand, I'm very blessed I'm telling you. If I had to have an injury I couldn't have gotten injured any better way. I have the opportunity to be an influence on people, care and be a role model for people around me, and I now have the financial means and I'm not having to worry about work, or spending money. And I can complete any goals I have. I still do a lot of things; I just do them differently now.

In relation to my pain management, I have been given a lot of things to make life easier now, like a pacemaker to move my diaphragm, which I can hook up beneath the bed when I want to, when I don't want to be hooked up to the other tubes, and I have a Baclofen pump too...I've had mine like 10, 11 years, but I've had to go up. It doesn't last all that long. Mine lasts about six weeks. I also take Alltrium. That's what my doctor gives me, which really helps a lot with the nerve pain. I have become curved because of the spinal cord change, so I've been doing a lot of research on all this stem cell stuff. Maybe something will develop in the future. For now I spend a lot of time going to and from doctor's appointments. My relationship with God contributes to my psychological and obviously my spiritual health. I've never let little things get to me, I just can't. I never did that even before the car accident, so I'm fortunate. It was kind of hard growing up, but

you learn to adapt, it's just what you have to do. I went through a lot of turmoil; I fooled around a lot more than I should have. It started in high school, I drank and smoked pot, but I don't do anything like that anymore. Eventually, I just realized that you can't look back over time; you've got to look forward... You get better the best that you can and get on with your life. I know of a lot of the community of quadriplegics, they have no life, they just don't care anymore, they don't care about their appearance, they don't care about anything. It's very, very few people that can get past a spinal cord injury, I don't know why. Something else that helps me is that I run a youth group here on Wednesday nights, for teenagers and college kids and we really enjoy that. I stay busy; I have a lot of business.

I have physical therapy once a week at my house for my physical activity. I try to be up out of bed everyday at about 2:30 or 3:00 and in my chair. I've hardly been up in the air, I'd probably pass out now. I used to have this stander where I'd stand up in that thing; but I'd fight every time they got me up there. I'd rather be able to walk a little bit than not be able to walk at all. I used to be able to move more but now I have so much atrophy the only thing I can move is my mouth, and I do that a lot...I just don't sweat the small stuff, I just shake it off, and what can you do?

Socially I am very busy too. I have a very good friend. His name is David. He's a musician but he's also a math teacher; and he has his Master's degree in Tech and then my ex-husband, he's my best friend ever. He comes over and spends time with me too. I have two men in my life. Then there's also my mom and my two kids and the kids from the youth group and all of my caretakers. My house is

always full of people and I like that. My kids are wonderful, they are my support, and they worry about me too much, way too much. They were very good about curfews. I just have great kids; I don't know how it happened. Mike and I were both horrible teenagers. And as adults they're awesome both of them. If they want me not to talk they'll tell me. I tend to push the limits sometimes with them. They're both very modest and conservative as far as how they joke around. I can embarrass my children very quickly.

Wendy

Wellness to me means feeling whole because...being whole, since I've been in the chair for 12 years now. Actually, it'll be 13 years next month on the 24th, the 26th, I'm sorry. And I've always considered myself very healthy. Mentally, I'm very stable, I had a very difficult past year, but outside of that, I've always been able to handle stresses, things of that nature. The chair didn't stress me out. It was new and unexpected and unwanted but I was able to deal with it. When I think of wellness, I think of physical abilities, which of course do not include walking anymore, but I'm still able to do a lot of things I did before the chair, just differently. Before, I had strong legs, now I have strong upper body. Socializing, my social life is pretty much the way it was before the chair. I have a lot of friends, I love people and in return, people tend to love me. I feel very, very blessed that this chair didn't...the only thing it took from me was my ability to walk. It provided me the opportunity to go back to school, something I always wanted to do. So when I think of wellness, I think of the overall me, the total package. I feel like I am as well as I would have been in all aspects except maybe

my stomach is not as flat as I would like it to be because I can't do sit ups. But outside of that, I feel I'm as well as I would have been if I were walking, if I were still walking.

Some of the barriers I feel like I have to overcome in order to get along and get through life come from people's attitudes and assumptions about me as a person and my abilities, and access to or from some buildings, especially on campus. My goal in these situations is to just stay positive and "kill them with kindness." It doesn't happen too often but it does sometimes, so I just do my best to "roll with it," no pun intended. I actually do a lot of laughing, which cures a lot of things. To manage my pain and stress I just do a lot of meditation and deep breathing exercises. Sometimes I take medicine for my back and an occasional leg spasm, but most of my pain came when I was in the hospital. Like I said, it's been 12 or 13 years now so I'm pretty well adapted. One time for exercise and pain management I did try yoga, but I just couldn't sit still that long as funny as that sounds.

I think for me, physical activity is more of a challenge. I have to remind myself that I do things differently sometimes and things take a little longer. I still try to get out of the house in the morning the way I did when I was walking. I used to have strong legs, and now I have a strong upper body. I'm a multi-tasker, I get up in the morning and I put to wash two or three loads of clothes and clean off a shelf, and fold up some clothes, and before you know it, it's ten minutes before I need to be where I'm going and it takes me that amount of time just to get in the car. So when I think of wellness, as a whole, it is different because I can't go to

the gym like I used to and I've always had a gym membership. Actually I recently cancelled it because there was no adaptive equipment that I could operate on my own. I'm very able-bodied. I have a strong upper body, and my balance is good, and I'm good at moving myself around transferring, climbing up on things and the sort which it makes them uncomfortable to see me climbing on and off my chair without anybody there of course because they're afraid of a lawsuit or whatever. There are some things that they can use, but one of the things I've come to realize is, they don't feel our pain, they don't know what we need because they don't feel it. The only people who can tell them what we need are us. There's some challenges but for me, it's just another means for me to grow.

I have a very broad social network. I have of course, my fellow students that I went through school with, I've been in school the past 12 years; I've just completed my master's, amen, hallelujah! I've met and made a lot of close friends through school. And then I have my Christian women's groups whom I've connected with through the MAS community, and through the Journey community where I sometimes give talks to women groups and so I have that community and then I have my church family, where I'm very active in church. And last but not the least, I have my family who... I took a trip one day. One weekend, I went to Houston and I took my 7-year old granddaughter, and my 5-year old son. The three of us got in the car and drove to Houston. My family was upset with me because they felt like I needed a chaperone, like an adult person to go with me. But I had it under control and it was an awesome.

My mental stability is tied to my spirituality, which plays a major, major role in my wellness. First off, I think back to when I first got in the chair, and I remember when I was in rehab, they called in a psychiatrist to come and talk to me because I wasn't tripping. I wasn't upset, I wasn't depressed, I was in good spirit, I was just looking forward to three months from now, because I knew things were going to be better. I didn't know what better was, but I knew it was going to be better. The reason I knew that is because before I had any problems in my life, I was a member at this church, it was a new church for me and my family, and the pastor told us to find 3 things to stand on, so that no matter what happen in your life, it'll be able to carry you through. The three scriptures that I stood on, I found to stand on was, God does not make mistakes. He is in control. He's not a man that he should lie. He promised that he would not give me more than I can bear, he didn't say I would like it, but he said I'd be able to bear it. And if I couldn't bear it, he'd take care of it. The other scripture was that I could cast my burdens in him, and he would carry it for me. I knew that no matter what happened I was going to be okay. I would not necessarily like it, but I was going to be okay. All I could think was, 'three months from now, the pain that I feel right now, is going to be lessened. It isn't going to be as bad.' I've been so blessed, God gifted me to be able to do anything I set my mind to, and if it's something I couldn't so, I could do without it. It wasn't anything I needed that God didn't enable me to provide for myself. And when I got in this chair, I found myself in a position where there were some things, there were some things that I could not do for myself. Twelve years in now, I could do a whole lot more than I could do then but in the

beginning, it was humbling to have to ask, and I think that's been one of my greatest lessons too, is to ask people to do things for you.

Creative Synthesis

The last step of the heuristic data analysis process involves what Moustakas (1990) called creative synthesis. During this phase of analysis the researcher is given free reign of thought and develops a summary of his or her personal and/or professional experiences, exposing the peaks and valleys through the use of narratives, stories, poems, art, metaphors, analogies or tales. The following is a narrative I composed in an attempt to describe my own perception of wellness as well as this experience.

“Awww.” “What’s wrong with you?” “What happened to you?” “How did you hurt yourself?” “My heart goes out to you.” “Can I help you with something?” “You look like you’re doing a great job getting around...” these are a few of the things that I hear from random well-intentioned people throughout my day now that I use a wheelchair a lot to get around outside of my apartment. Talking about myself in relation to having CP isn’t something I do, or at least it wasn’t until I started this dissertation process. Honestly, it’s never been the focal point of my life until now, nor have I allowed it to become my master status. My mom would say that Cerebral Palsy has had moments of running my life, specifically during times of surgery and recovery, but that I, or should I say she, never put the “i” in run and let it ruin our lives. I was born with Cerebral Palsy in 1973, so the fact that I am disabled, handicapped, crippled, differently-abled or whatever the politically correct term is that society is calling me this week, is not a new, tragic, or traumatic event that Lifetime movies are made of at all. It just is. Just as simply as a baby can be born with dark hair and blue eyes, I was born with Cerebral Palsy. It’s my normal.

When compared to my participants I don't know any different, and I'm certainly not suffering because of it. When I was 11 years old I had major surgery, the kind that left me in casts up to my waist with a bar between my legs and out of school away from my friends for months. After I got the casts off and was recovered, my dad asked me what I wanted to do so I told him that I wanted to play soccer...and I did. It wasn't until a few years ago that he told me the story behind what it took to make that happen. In addition to soccer, I spent many years in and out of ballet, and I was even a Brownie. My parents were cool like that, as were the rest of my family members, and even my friends. I can count one hand the number of times I was teased and made fun of as a kid for having CP. I can count on the other how many times I went to the principal's office for remedying those situations on my own. I did (and still do) everything that I wanted to (with the exception of surfing and riding a bike, but I'm working on those as we speak). For all intent and purposes, I was "Little Miss Sunshine" growing up.

The new and different part of all of this for me is that I have been using a wheelchair for the past year to get around outside of my house if I have to walk long distances. My left knee is a mess and I can't straighten it to bear weight on it and walk for long at this point. So, while the participants who helped me write this dissertation all have mobility impairments of some sort and have adapted to and even accepted them, I am still trying to get used to being in a wheelchair for now, hoping beyond hope that my knee can be fixed, and that the chair is not going to be a permanent fixture in my life. I have to admit, I feel crippled for the first time in my adult life. It's almost as if I'm newly disabled. I've come to realize that life in a wheelchair is so much different than it is out

of one, so that's part of the reason why I chose to write my dissertation about the perceptions of wellness for people mobility impairments.

My wellness journey got off to a very rocky start about two years ago as part of a required wellness class that I had to take in my doctoral program. My first problem was that the class was not originally designed to “meet the needs” of people with mobility impairments. I didn't understand why a class of that nature was required in a doctoral program. I felt like I was being set up for failure and was angry that a cookie cutter approach was being implemented to teach the class when it was obvious that there were two of us in the room who were not like the rest. I didn't feel like our cultural differences were being taken into consideration at the time and I wasn't happy about it to say the least. The second problem arose when we were asked to implement some type of wellness program for the semester. I was happy about this assignment given that I was smoking almost a pack of cigarettes a day and had been for about a year prior to that and I was overweight. The professor asked us to be “all in” so I exchanged my terrible attitude for a slightly better one, and called the wellness center on campus to get a schedule of adaptive exercise or water aerobics classes. There were no such classes *and* there was only *one* piece of adaptive equipment in the wellness center available for use by people who are wheelchair bound. I was really upset at that point. The post on the disability services website of the university stated that students with a disability had access to all of the same types of programs and services that non-disabled students did, so it never occurred to me that that wouldn't be the case. Not only were there no available classes, but also there were no staff members available in the wellness center who were qualified or interested in working with people with mobility impairments at the time. I

called the director of the wellness center, who informed me that while they were in process of developing such programs, she was unsure as to when the classes might actually start. Call me naïve, but I was a bit shocked. “How am I supposed to complete this assignment for the semester if the tools I need to do it aren’t available to me on campus,” I thought. I knew I wasn’t the only mobility impaired and/or disabled student so I couldn’t believe that this was an issue. Naively, I thought a university setting would be one of the last places where I would have to ask or fight for a level playing field, especially considering that I attend a university that frequently puts out memos written by the university president himself about embracing diversity on our campus. For years I had been paying for this wellness center on campus via my student fees and when I finally decided to take advantage of what I’d been paying for, I couldn’t. I was mad and on a mission at that point, so I started looking in the community for what I needed. Short of physical therapy, which is not the same as what I was looking for (though some might mistakenly think so), there weren’t any adaptive wellness programs in the local community to speak of, either. I continued to go to class but I was discouraged and definitely not happy about having to be there. I’m definitely not one for masking my emotions or my opinions about things, never have been. I have no doubt that comes from being raised in hospitals and having no choice but to allow people, doctors or otherwise, to constantly put their hands all over me for one reason or another. Anyway, I walked into my soon-to-be-dissertation chair’s office one day, venting about how I didn’t understand why or how a wellness class went from being an elective in the master’s program to a requirement in the doctoral program. I also told her that some of the relaxation exercises were stressing me out because they were actually calling my

attention to or causing me pain and anxiety. Her question in response to my “fit” was calm and simple: “Have you talked to your professor about any of this that you’ve just told me?” she asked. My answer was no. I didn’t think that I could and the thought of educating my professor was a bit intimidating at the time, especially after being so unpleasant in class. But I took her advice and with her voice in the back of my head in true Yoda fashion, I called my wellness professor to set an appointment and he graciously agreed to meet with me. During our meeting, I apologized to him for my behavior and we were able to formulate a plan to be carried out for the rest of the semester. Thankfully, I didn’t give up on my mission to find a wellness program in the community either. After going through a terrible eight-month experience with a couple of unknowingly under-qualified trainers, I found a gym and a trainer who had the knowledge, skills, awareness, and more importantly, the willingness and the patience to work with me. Together we have developed an adaptive workout program that meets my physical activity abilities and wellness goals.

The last thing in the world I wanted to do was write a dissertation about disabilities or being disabled. I didn’t want to be seen as a poster child for people with disabilities and I definitely didn’t want to do what was expected. I was afraid of perpetuating the stereotypical ideas that:

1. Because I have a disability I’m angry and have to “get up on a soapbox” and tell the world about it.
2. I have nothing else to talk about. I dislike that some people see me as the perfect subject for an after school special on NBC or an inspirational interviewee for Oprah’s next special on OWN.

3. I live a life of solitude and am a super cripp because I go to the gym and Work out or because I go to the grocery store and load and unload a cart by myself.

Honestly, I didn't know much about having Cerebral Palsy or being disabled in any other capacity other than my own experience. I had no outside knowledge at all, never cracked a book or read an article about disabilities at all. Believe it or not, I felt much more qualified to discuss and write about other subjects. No part of me wanted to write a qualitative dissertation and force myself to hang out in the gray mucky emotional areas of life. Despite the fact that I am a counselor, I tend to be more comfortable with a black and white way of seeing, thinking about, and doing things in my personal life.

I learned a lot about myself in relation to being disabled and otherwise in a short period of time, which was sometimes overwhelming. There's so much I have to say that it's difficult to know where to begin. What I know is that I set out on this journey and agreed to be "all in" because I realized there was a need for the various people around me in my day-to-day life to be educated about, and given the opportunity to understand individuals with disabilities. I also knew that conducting a study of this magnitude was a good place to start putting an end to the stereotypical attitudes concerning individuals with disabilities. There was nothing more depressing during this process than reading about the miserable state of my life concerning my social, sexual, and intimate relationships with others, my employment status, health, and overall life satisfaction, from a nondisabled person's perspective. I can empathize with celebrities and how they must feel every time they read some half-baked story or see some photo-shopped picture of themselves splashed across the cover of the *National Enquirer* below a ridiculous

headline. On one hand, I wish I could have remained ignorant about all of that. On the other hand, reading all of that hopeless “stuff” about myself presented me (and the participants in this study) with the opportunity to set the record straight and offer perspectives as individuals who are actually living with disabilities.

I was nervous about interviewing my participants. I had no idea what to expect from the experience. Would I say or do the right things? Would they be comfortable enough to open up to a complete stranger about their wellness experiences? How would I handle tears? These are all questions that I asked myself before the interviews began. As it turned out, each participant was very honest and open with me, and actually all of them were very happy to share their stories. It was easier for me to engage in these individual interviews and conversations with them than I thought it would be. From illness to surviving self inflicted injuries and domestic violence, the origins of our disabilities are all different, but our desire to be respected and treated as equals is not.

My dissertation chair was good at reminding me about treating my participants as equals when we would meet to talk about how things were going. For example, I remember sitting in her office after more than one of the interviews telling her how I needed to get over myself and how lucky I was to be born this way versus being able bodied and then experiencing some traumatic or dramatic accident that changed my life forever. I shared with her how hard it was to hear some of the stories and how shocked I was when one of the participants who went from being a rock climber to breathing into a straw in order to get around in her wheelchair said to me, “If I had to be disabled, this is the best possible way it could’ve happened.” I couldn’t believe the terrible things these people survived and then, in true superwoman fashion, my chair reminded me that I was

looking at and feeling about them the same way that I *didn't* want other people looking at or feeling about me. As usual, she was right and helped me realize during that particular conversation that all of my participants have accepted their disabilities and I, despite the fact I was born with CP, feel newly disabled, and have not. I talk about *their* culture, *their* language and things *they* do, still feeling like I am that 11-year-old girl who thought her disability went away after she had surgery and was able to walk, play soccer, and take ballet lessons without help from an assistive device or a person. I want to believe my knee will be fixed and that I will go back to “my normal.”

Much like our experiences concerning our mobility impairments, our perceptions of wellness share similarities and differences as well. For example, some of us can and do engage in physical activity such as working out at a gym, playing basketball, or walking on the beach while others achieve physical fitness through maintaining a balanced diet. In terms of maintaining mental stability we all engage in activities that we find enjoyable whether it's alone or with another person. When considering social connectedness, we are all very close to our families and agree that without their love, support, patience, tolerance, and understanding, we might be in very different places in our lives. I honestly and truly could not make it through some of the day-to-day struggles I face without my mom. She is my set of legs and provides my balance (figuratively and literally speaking) when I can't use my own. In addition to family support, most participants, including myself, have one or two very close friends, while a couple of the participants enjoy spending time with large groups of people. As I previously mentioned, I'm fortunate to have never had to experience the teasing and tormenting that I know other people with disabilities have. My speech, my facial features, my hands, and my cognitive abilities are

not affected by CP, which makes communicating, socializing, and dating easier for me in comparison to others with CP. My friends have been a significant source of strength and support for as long as I can remember. Most of them, now that I think about it, have been around for decades. Spirituality was another factor that came up during our conversations about support. The majority of participants expressed having faith and/or a strong belief in God. One participant in particular looked me straight in the eyes, placed her hand on top of mine and said, "God is in control Joy, God doesn't make mistakes, so I'm gonna be ok." The way she said that while she looked at me with such intensity and conviction in her eyes and voice gave me goosebumps. It was very matter of fact, yet peaceful at the same time. I'll never forget it. Several of them talked about how important their conversations with God had become as an additional source of support as well as a way of managing pain. Attending doctor's appointments and taking medications regularly were also important aspects of pain management of course, but faith and praying really helped them cope when their anger and/or frustration towards their doctors, the side effects from medication, and even themselves when they were struggling to do something like feed themselves. One participant described what it was like to be an amputee, saying:

I have days where I am screaming with pain from head to toe from the time I wake up in the morning until I go to bed at night from a combination of phantom pains and having to wear a prosthesis ten hours a day. It's not fun, and I get depressed sometimes, but I've dealt with pain from the word go, so I just take my medication, pray everyday if not every hour, and push through because I know for me, better is still in the future.

This participant's physical and emotional pain was evident during the interview, as was the fact that he spent so much time alone. He was talking so much and so fast, fumbling over his words it was as if he was trying to beat the clock. At one point I touched his leg and told him that we didn't need to rush, that he could take his time. That seemed to help. When the interview was over about an hour later, he hugged me and thanked me for listening.

During this process I became much more aware of my own thoughts, feelings, and actions (both generally speaking and in relation to my mobility impairment) than I have ever been before. Some of the major lessons I've learned are:

- Wellness exists on a continuum and requires a balance among factors for mobility impaired individuals the same way it does for nondisabled individuals. Additionally, when compared to models for the nondisabled, the same wellness factors (i.e. physical activity/nutrition, mental stability, social connectedness, and spirituality) that are important to them are also valued by individuals with mobility impairments, with the added factors of overcoming barriers and pain management.
- Being observant and listening to others and myself is important *all* of the time, not just in select situations.
- Going through life sitting down is much different than going through it standing up. People react to me differently now than they did before I needed to use a wheelchair.
- My ability to empathize with others who are not mobility impaired is improving. I'm more willing and able to think about what might motivate

people to say or do certain things in regard to my mobility impairment than I was before, even when it confuses me or makes me mad.

- I've learned that saying thank you is important and empowering, especially when it's difficult.
- Gratitude for what I can do, what I do have, and what I can change, is something that I've gained more of as a result of this process as well.

My participants taught me some valuable lessons about grace and acceptance, reminding me how resilient the human spirit can truly be. I was shocked (to say the least) to hear about the amount of pain and suffering, and even the humiliation, that each of the participants had to endure. I found myself reacting to some of them and their experiences *exactly* the same way (e.g. "That's terribly sad, I can't imagine...") I *don't* want nondisabled people reacting to me. I suspect I fell into that hole because their experiences of becoming disabled are so different from mine and I wasn't really prepared for that. Thankfully, none of them held my reactions against me, and reminded me that "terrible" was a subjective term or way of looking at things. "I did what I had to do at the time, it was hard, but I can't change it, so I just have to keep moving forward," stated one of the participants.

What I (we) hope is that reading this provides individuals working in the helping professions, including counselor educators, with clear, honest information about the perceptions of wellness from adults with mobility impairments in an attempt to address the shortcomings of current wellness models and attitudes toward individuals with mobility impairments. In my experience I think that people sometimes forget that different means different, not deficit. We are not sick or hurt. We are healthy individuals

living with injuries. In the absence of some functions, we have gained other abilities. We can and want to do the same things (e.g. participate in wellness classes and wellness programs etc.) that nondisabled people do but we need a level playing field to do them. We are not extraordinary or miserable because we have mobility impairments. We put our pants on one leg at a time and do the best we can to function in our day-to-day lives just like nondisabled individuals. There is always a way. Understanding these things from the perspective of those who experience them is a significant part of multicultural competence.

Chapter Five: Discussion and Conclusion

This chapter includes a reflective summary of my experience throughout this process as the researcher, followed by a discussion based on the patterns and core themes revealed in chapter four as they relate to the wellness and mobility impairment literature reviewed in chapter two. Lastly, implications for counselors and counselor educators and recommendations for future research are also presented.

Data from eight participants were analyzed to answer the following research question: How do mobility impaired adults perceive wellness? Individual depictions were developed in order to capture each participant's experience as it related to wellness. From there, a composite depiction representing the emergent themes as experienced by each individual as well as by the group as a whole, was constructed.

The researcher identified six core themes, which illuminated the individual perceptions of wellness:

1. Overcoming barriers
2. Pain management
3. Psychological wellness
4. Physical activity and nutrition
5. Social connectedness and family support
6. Spirituality

Two individual profiles represented many of the themes experienced by all eight participants. Finally, I completed the creative synthesis process by sharing my perception and experiences surrounding wellness, via a narrative.

Reflective Summary

Utilizing a phenomenological-heuristic approach to complete this dissertation allowed me as the researcher to be an active participant in my study so that I might be better able to contemplate and understand my own personal experience of wellness during this time. In order to keep everything checked and balanced along the way, I started journaling about my wellness experiences beginning in the fall of 2010, and continued throughout my dissertation process. I used the notes from my reflective journal to construct the following narrative based my personal wellness experiences as well as those of my participants.

My frustration with various situations at the time, most of them revolving around wellness, served as my motivation to write this dissertation. I didn't know what to expect upon meeting and interviewing my participants. I was nervous about conducting the interviews because I was talking about things I had never talked about with many people and I didn't know what they would share with me in return. To my surprise, talking to the participants was much easier than I anticipated.

As I went back and forth between the different phases of the heuristic data collection and analyses process, I struggled, especially with making sure that I did my best to capture the essence of the participants' perceptions of wellness. I reviewed the interview transcripts repeatedly and relied on a peer reviewer, who assisted me with the data analysis process. Additionally, I set my data aside several times for clarity, allowing things to ferment. During that time away I continued my work on campus at the Counseling and Training Clinic and on my weight loss as well. Emotional support from my family and a few friends, allowed me to focus on the data with clear eyes.

During the illumination phase, once again my peer reviewer and I verified my interpretations by reviewing the transcripts. At that point I was starting to feel more comfortable with the qualitative research process in general. I worked on my dissertation for a total of 18 months. My motivation to keep moving forward re-surfaced during the explication phase once I began constructing the participants' individual depictions of wellness. Completing the explication and creative synthesis phases were the most difficult and time consuming steps in the heuristic research process for me. Figuring out how to present their perceptions of wellness as well as my own in just the right way was nerve wracking at times. I wanted to make sure that I honored their words as well as the heuristic analysis process, and presented their experiences in just the right way. It was rewarding to see how all of the detailed pieces of the heuristic data analysis process fit together in order to display the bigger picture as the end result.

Discussion of Core Themes Related to the Literature

Overcoming Barriers

The first theme, overcoming barriers, recognizes the challenges and importance of individuals with mobility impairments working to overcome barriers associated with their ability to achieve and/or maintain personal wellness. As previously discussed in chapter two, several studies examine the impact of personal, cultural, (Drainoni et al., 2006; Stuijbergen, Becker, & Sands, 1990), environmental, and social (Stuijbergen, Becker, Incase, & Sands, 1990) barriers to wellness. According to Rimmer (2005), these environmental barriers and the lack of information on how to overcome them make it difficult for people with disabilities to engage in health promoting behaviors and participate in wellness programs.

According to the participants in this study, participating in wellness programs is difficult because of a lack of community resources and accessibility. However, they do their best to maintain their health and wellness as doing so “keeps things from getting worse” and helps them “at least keep what they have.” They expressed that there is always a way, and that more than anything they want to be taken seriously, accepted for who they are, and allowed access to the same playing field as non-disabled individuals.

Pain Management

The second theme revealed by the participants during the study was pain management and its influence on their wellness. The participants’ mobility impairments and accompanying pain (due to injury or disease in these cases) have had a significant impact on their quality of life, functioning, and overall wellness. As pointed out in chapter two, it is because patients are often treated by doctors via a standard set of options rather than individually, that the development of effective treatments to restore or replace lost function is an important societal challenge (Fregly, Bonniger, & Reinkensmeyer, 2012).

All eight participants in this study acknowledged that pain management is an essential *part* of, but not *the* main focus of their perception of wellness. They identified a number of factors which help them manage their pain and “get through the day to day of it all,” including: attending regular doctor visits, taking medication, engaging in meditation practices, the use of assistive devices, family support, their own personal motivation to “push through” their pain and finally, their sheer determination to “get on with their lives.” The refusal of these participants to allow their mobility impairment to become their master status or allow their pain to get the better of them serves as an

example of the participants' ability to keep their wellness in perspective. According to them, engaging in pain management has improved their quality of life by fostering functionality, self-care, and independence. Additionally, it has facilitated mental, emotional, and social wellness and has allowed for academic success (for some) participants as well.

Psychological Wellness

Psychological wellness was the next theme that emerged from the data. A majority of the participants described moving through stages of grief in regard to adjusting to their mobility impairment. Denial in which they refused to accept the facts of their injuries was a frequent response among the participants. One participant in particular said that she lay around a lot in the beginning, constantly asking herself, "Why me?" Some participants expressed feeling as though they were in a dream, that their injuries were only temporary and that they were going to "be the one to prove the doctors wrong and make a full recovery."

Two participants stated that anger was a common emotion in the beginning also. They were angry to the point of being difficult to take care of and pushed people away, refusing to listen, especially because of spending long periods of time "stuck" in the hospital. Today, their feelings of anger and frustration are not so much about their mobility impairment, but rather how society views and treats them because of it. That people in the community often operate on assumptions about things they can and cannot do is what is most frustrating to the participants at this point.

All but one of them discussed experiencing periods of depression and/or anxiety, especially during the beginning stages of their recovery as they settled into their "new,

normal bodies and lives.” Some talked about wanting to stay isolated so that no one could “see them like that.” Others talked about being embarrassed because they could not speak, feed, bathe, or dress themselves on their own for several months. Having to rely on someone else to help them do such intimate things was a first for all but one of the participants.

The injury dates for the participants range from approximately one year ago to twenty years ago, so for most of them feeling sad about being disabled is no longer an issue. To date, the participants are all thankful to have “gotten through the worst of it” and to have reached some level of acceptance in terms of their mobility impairment. “I can’t change it, so I just have to do the best I can and keep moving forward,” is a statement that was expressed during the interviews most often in terms of acceptance. All of the participants maintain a positive attitude about their level of impairment. To the researcher’s surprise, one participant expressed gratefulness for her injury, while another indicated that while her injury was unexpected and unwanted, it did not impact her life in much of a negative way at all.

As pointed out in chapter two, Myers and Sweeney (2004) stated that factors such as physical activity, social connectedness, and spirituality also contribute to an (nondisabled) individual’s overall sense of mental wellness. According to them, the factors overlap and cannot be separated. Similar overlapping patterns were found in the present study as well. For example, the participants did agree that in times of stress and wanting to get away, they enjoy going to the gym, taking a walk, reading the Bible, or spending time with friends and family. For most, their family members are now the most significant source of mental and emotional support just as they were during the

participants' recovery period. Two participants in particular acknowledged that without help from their mothers in "keeping it all together," they might not be here today and "definitely wouldn't be as well off" as they are now. As pointed out by the participants in this study, it is with an attitude of acceptance of their mobility impairment, determination, and motivation that they function in the world today.

Physical Activity and Nutrition

In support of addressing the pressing need to establish successful intervention strategies that keep persons with disabilities involved in physical activity (Kailes, 2004), the fourth theme acknowledges the role of physical activity and nutrition, and the impact of each on the participant's wellness. Regardless of the fact that they are not able to perform some exercises or engage in maintaining their physical wellness the way they used to, most participants in this study reported that exercising is a way to manage stress, "get out of their heads," and to increase or maintain physical fitness and mobility is important to them, and in some cases, vital.

Since many individuals who have spinal cord injuries or a chronic disease do not consider themselves candidates for an exercise program, they often do not make an effort to become involved in community-based fitness programs (Kailes, 2004). However, in an attempt to counteract their inactivity, some individuals, including some of the participants in this study, recognize that nutrition can and does have a major impact on their health and wellness. Three of the eight participants in this study revealed that making smart food choices helps them prevent the worsening of their secondary conditions such as asthma, diabetes, heart problems, and weight gain. They also reported that their physical health status and health behaviors tend to change as their level of impairment changes

over time. For example, factors such as blood pressure and cholesterol levels, hair loss, sleeping patterns, weight gain, and eating habits all have the tendency to fluctuate with other wellness factors such as their degrees of mobility and pain management.

Social Connectedness and Family Support

The fifth theme supports the importance of social support and family connectedness as discussed in the literature. The participants in this study believe the social support they receive from their friends and family facilitates their wellness. They reported their primary source of support as coming from their mothers, siblings, and a few close friends. For some, just knowing someone was there to provide emotional support, especially during the rehabilitation process, made all the difference.

Similar to research findings addressed in the literature (Seybold, Fritz, & MacPhee 1991), the participants in this study also acknowledged the importance of the support they receive from their doctors, nurses, physical therapists, and trainers as well. Despite some frustration with their doctors, participants recognized the contribution these professionals make to their lives that enable them to be better equipped physically and emotionally to fulfill their personal needs.

Spirituality

Finally, the sixth theme of this study, spirituality is an essential component of wellness for the majority of the participants in the present study. Most participants held a belief in God and remained committed to their spiritual practices because it was something they practiced prior to, and throughout, their rehabilitation process. However, one participant in particular stated that religion and reading the Bible was not something he took an interest in or started to believe in until a couple of years after his injury. At

present the majority of the participants believe that activities such as meditation, prayer, scripture readings, and participating in religious services minimizes their stress; provides them with a sense of inner strength, guidance, and stability; and assists them in keeping their mobility impairments in perspective as well.

The results of this study indicate that individuals with mobility impairments share both similar and unique views of wellness when compared to the nondisabled population. For example, physical activity, mental and emotional stability, social connectedness, and spirituality are important factors of wellness for both the mobility impaired and non-impaired populations. It is the what and the how of doing things that is different between these two populations, especially when taking physical activity into account as mobility impaired individuals may not be able to engage in the same types of physical and cardiovascular activities as nondisabled individuals. Factors of wellness unique to the mobility impaired population include overcoming accessibility and attitudinal barriers and pain management. Accessing a building or some type of wellness program and being able to receive assistance in doing so is more difficult for a mobility impaired individual. In terms of pain management, maintaining a relationship with his or her doctor is key to a mobility impaired individual's ability to function on a daily basis. Without access to the proper medical care and pain management, some of these participants would lose their ability to talk, walk, eat, or sleep properly.

Implications for Counselors and Counselor Educators

The number of people with mobility impairments is. As a result, counselors and counselor educators regardless of their fields will be asked to provide services and/or educational instruction to clients and students with various types of disabilities at some

point during their careers (Smart & Smart, 2006). The problem here is that information about disability culture is not available via most university curricula (Bauman & Drake, 1997; Hogben & Waterman, 1997). Students in counseling training programs are not typically required to facilitate multicultural or diversity discussions about the disabled population. Because having a disability has been regarded as a medical issue up to this point (Smart & Smart, 2006; Thomas, 2004a), it is typically medical schools that offer courses and rotations, which focus on disability culture (Smart & Smart, 2006).

This research may provide useful information to guide policy and practice with the diverse population of clients diagnosed with disabilities. According to Myers and Sweeney (2005), understanding wellness and the meaning it holds for these clients is an essential component of building effective wellness models and programs, and designing new and effective intervention strategies for adults with disabilities and may contribute to the development of best practice recommendations. As revealed in chapter four, results of this study may also provide information that indirectly strengthens the support systems utilized by these clients via supplying parents, spouses, caretakers, educators, physicians, friends, and the community at large with valuable data about wellness in the context of disabilities, thus enabling them to incorporate this understanding into their clinical and/or everyday practices. The Code of Ethics of the American Counseling Association (ACA, 2005) and the accreditation standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) indicate that it is important for counselors to possess an understanding of the cultural contexts of working with individuals who have a developmental crises or a disability so that they may assist in leveling the playing field for these individuals.

Limitations of the Study

As with any research, there are limitations, which must be kept in mind when considering the results of this study. First, heuristic inquiry allows much latitude with regard to procedures (Djuraskovic & Arthur, 2010). In an attempt to address the potential for laxity in methodology, I carefully followed Moustakas' (1990) explication of phases and data analysis in qualitative research. Second, by its nature, heuristic research emphasizes subjective experience and may increase the researcher's bias. Synthesis depends on the researcher's interpretation, and since the researcher also experiences the phenomenon being studied, interpretation of findings can be influenced by the researcher's experience (Djuraskovic & Arthur, 2010). Similarly, because heuristic inquiry encourages the researcher to explore his or her personal feelings via embarking on a journey of internal discovery alongside the participants, it was sometimes difficult to stay focused on the phenomenon of wellness rather than on social justice or advocacy issues, or on participants' particular stories. There were definitely times during the interviews where my own thoughts and feelings about my participants' experiences took precedence over remaining focused on what was being said in the moment. In order to address these sources of potential bias, I kept a researcher's journal throughout the process, used an unbiased peer reviewer, and verified themes and subthemes with participants. I also made sure to disclose biases and struggles both in my reflective journal and to my dissertation chair.

Third, the present study included the restriction of the population to university and physical therapy office locations. Individuals participating in university life or physical therapy may hold views or practice behaviors that are not representative of the

population of persons with disabilities as a whole. Additionally, those with disabilities other than physical mobility impairments were not included in this study. Because I was present while gathering data via semi-structured interviews, limitations such as social desirability bias may have caused participants to self-censor their actual views. Despite these limitations, however, utilizing this type of qualitative approach allowed me to capture the depth of participants' perceptions of wellness as well as my own and relay experiences associated with this phenomenon in a way that would not have otherwise been possible.

Recommendations for Future Research

Future research geared toward gaining a better understanding of the experiences of the disabled may offer new insights into wellness. For example, individuals who were born with a disability might perceive and experience wellness differently than those who were not. Additional studies could look at the impact of being born with a disability versus acquiring a disability on perceptions of wellness. Also, future studies revealing the effect of disabilities such as being blind or deaf on perceptions of wellness and wellness practices may be of interest to counselors and counselor educators.

Examining additional characteristics of the disabled population such as race and ethnicity and gender may yield different results as well. A study that investigates the possible impact of these factors in combination with disability could provide helpful information about cultural influences and practices affecting an individual's perception and/or physical activity. For example, since many of the factors from newer wellness models, such as Myers and Sweeney's IS-Wel model (2004) were found to be important to individuals with mobility impairments, current wellness models could be expanded to

explicitly discuss the various aspects of wellness that are unique to individuals with mobility impairments, such as barriers, pain management, and adaptive physical activities. Individual differences are important, and being able to listen to what works and does not work is just as significant when working with disabled individuals around wellness as it is when working with persons from other cultural or racial or ethnic backgrounds. Future studies exploring the impact of wellness practices on resilience and recovery from trauma would be beneficial to the field as well. It is important to note that not all individuals with mobility impairments are alike, any more than members of other groups are alike. A one-size fits all approach will not work with this population.

A vital advocacy consideration for counselors and counselor educators is that of accessibility. Given that access was one of the two most commonly reported changes that the participants in the present study would like to see more of in the community, additional cross-discipline research involving the collaborative efforts of counselor educators, kinesiology educators, and nurse educators may prove helpful in examining programs that enhance wellness for those who cannot participate in “traditional” fitness activities.

Conclusion

There is limited information available in the literature concerning the perception of wellness from adults with mobility impairments. The purpose of the present qualitative study was to describe the perceptions of wellness from adults with mobility impairments utilizing a phenomenological-heuristic approach. Using this type of approach allowed me to uncover what is being taken for granted via sympathetically joining with the participants in their lived situations, sharing the experience of wellness, and later reflecting on its meanings. The results of this study indicate that wellness is just

as important to adults with mobility impairments as it is to nondisabled adults. It is simply the what and the how that are different between the two, specifically in terms of engaging in physical activity. Further, mobility impaired adults perceive wellness to include factors that are both similar and unique when compared to nondisabled perceptions of wellness. For example, overcoming barriers, pain management, psychological wellness, physical activity and nutrition, social connectedness and family support, and spirituality are all important factors to consider when promoting health and wellness among these mobility impaired participants.

When asked during the interview process how their current wellness program could be supported or enhanced, participants offered concrete suggestions as to how to make their experience of wellness and wellness programs more fulfilling. Having physical access to buildings and the availability of programs and/or groups is a critical change if wellness for mobility impaired individuals is to be supported. It is not acceptable that wellness programs and the staff to work with mobility impaired adults do not exist on college campuses which claim to embrace diversity and multiculturalism and which collect student fees for services they cannot use. Networks to include other mobility impaired individuals via adaptive physical activity programs, support groups, and social gatherings need to be established on both university campuses and within communities as well.

As pointed out by Welner and Temple (2004), when society as a whole takes the time to explore and understand the meaning of wellness for mobility impaired individuals, the misconceptions surrounding this population regarding health and wellness may be eliminated altogether. Despite their frustration about societal

assumptions and stereotypes, individuals with disabilities may or may not enter into counseling with issues related to their disability. As members of society, counselors and counselor educators also play a vital role in helping individuals identify their needs and develop and/or enhance their coping skills, assertiveness levels, self-advocacy skills, and education levels. Through gaining a better understanding of the unique wellness needs facing the mobility impaired population, counselors and counselor educators may be better prepared to develop valid wellness models and assessments as well as advocate for and facilitate the psychological and/or emotional, physical, and social wellness needs specific to this population.

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