

The lived body – experiences from adults with cerebral palsy

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Objective: To get a deeper understanding into how adults with cerebral palsy experience living with a disability and how they manage daily life.

Design: Interviews with open-ended questions were carried out. They were analysed by one person according to the Empirical Phenomenological Psychological method (EPP).

Setting and subjects: Twenty-two community-living adults (35–68 years) with cerebral palsy from five counties in Sweden participated. All had mobility problems and all had cognitive abilities making it possible to carry on a conversation.

Results: The varied experiences resulted in themes including (1) perceptions of living with a disability and (2) strategies used for managing the described perceptions. The perceptions were: a dys-appearing body, a not-appearing body, difference, being in-between, normality, restricted autonomy and autonomy. The strategies were: to fight one's way, to plan, to get used to it, to hide and to give one's all.

Conclusion: These interviews expressed heterogeneity in lived experiences showing the importance for professionals to meet people with cerebral palsy as individual subjects in relation to functional problems, self-image and autonomy together with seeing the consequences of different coping strategies.

Introduction

Cerebral palsy is a lifelong disability that is due to an injury in the immature brain and has been described as a non-progressive disorder.¹ In spite of this, many adults with cerebral palsy report a decrease in activities and body functions.^{2–8} Secondary conditions such as pain, musculoskeletal problems, fatigue, bladder and bowel problems are common and can lead to decreased activities in daily living.^{9–12} Normal ageing also contributes to these conditions, but in people

living with a disability these impairments often emerge earlier in life.^{6,7,13} Many of those conditions are due to consequences of abnormal movements and straining oneself in order to manage daily life.^{3,10} Studies have also shown that life satisfaction is similar to the average population⁴ and that well-being and self-perceived health are related to pain and deteriorating function, but are not related to the level of functioning in itself.^{7,14} However, a search in medical databases found no studies that focused on narratives from the people's own experiences of living with cerebral palsy.

Feelings, thoughts and actions express lived experience according to the phenomenological tradition.¹⁵ It is based on the person's interpretation and valuation of life situation and is based on everyday life. In everyday life, the body is essential as we *are* our body

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in feeling and actions, but we also *have* a body and can observe and talk about it. This means that the body is both a subject and an object and this is expressed by the concept of ‘the lived body’, a concept developed by the French philosopher Merleau-Ponty.¹⁶ It is through our body that we exist, act and understand the world. The lived body is intentional and gives access to the world and there is no perceived separation between body and self.^{16,17}

Adults with cerebral palsy, living with a disabled body, have their personal experiences of the lived body. To describe this from an insight perspective can give further and deeper knowledge for professionals and thus have an impact on rehabilitation. This was a starting point for this study where the aim was to get a deeper understanding into how adults with cerebral palsy experience living with a disability and how they manage daily life.

Method

Data collection

To explore experiences of the lived body, interviews with open-ended questions were used to collect data. An interview guide was used containing questions about functioning, activity, interaction, participation and self-image. The interview addressed the informants’ experiences, focusing on daily life activities. The informants were also asked to describe their experiences in relation to past, present and future concerns. To clarify answers and identify examples, the interviewer rephrased the questions and asked follow-up questions.¹⁸ Each interview lasted between 45 and 90 minutes and except the described aim for this paper, the interviews contained other content areas about physical training and physiotherapy, which will be presented in another paper.

Participants

To catch lived experiences the participants were required to meet a minimum age limit of 35 years, but no maximum age limit was set. In total 22 individuals participated, 12 men and 10 women. Mean age was 47 years (range 35–68 years). People with functional level II–IV according to the Gross Motor Function Classification System (GMFCS)¹⁹ were included. The GMFCS consists of five levels and is meant for chil-

dren up to 12 years. Recently, the GMFCS has been used in the adult population and is considered reliable for describing gross motor function in adults with cerebral palsy.²⁰ There were seven participants from GMFCS level II, seven from level III and eight from level IV. All had their own housing and six received some sort of personal assistance. Seventeen participants were employed (or had a daily occupation) in varying degrees, and two of those were on sick leave. Four participants were pensioned (because of disability or age) and one was searching for work. There was no person with mental retardation.

Procedure and ethical considerations

The study population was collected from five counties, in the middle and south part of Sweden, with help from professionals in rehabilitation who had knowledge of the population. They verbally informed each person about the study and if the person permitted he or she received a letter with further information. After this, the researcher/interviewer called the person. If they chose to participate they also signed a paper that gave permission for the interview to be taped and transcribed verbatim. The interviewer, a physiotherapist, had no treatment connections with the informants. The study was approved by an ethics committee.

Analysis

This study explores life world experiences using a phenomenological approach. Phenomenology is above all a philosophy, but it can also be a method for describing and elucidating individual experiences.²¹ The method used in this study was the Empirical Phenomenological Psychological method (EPP).²¹ Five analytic steps were followed. The first step was listening and reading the transcribed material. In the second step the transcribed data was divided into meaning units, discernible parts dealing with the aims of the study. In the third step, each meaning unit was condensed and transformed to codes, which were understood in light of the whole interview. In the fourth step, each interview was synthesized and presented in a form of synopsis. In the fifth step, the 22 synopses were compared to find meaning structures that were found in all interviews. These structures revealed different themes. The analysis was carried out by one person (KS). As a validation the result of the analysis was presented to nine of the interviewed people on two

occasions (five participants and four participants on each occasion). They provided feedback that indicated that the result of the analysis agreed with their narratives. A physiotherapist with long experience of rehabilitation read the interviews. She compared her perceptions of the content in the interviews to the analysis (made by KS) and the correspondence was good.

Results

The varied experiences described through the 22 interviews resulted in themes illustrating both perceptions of living with a disabled body and strategies used for managing the described perceptions (Figure 1).

The themes are illustrated by quotations, in which ‘...’ indicates a pause and () indicates removed information because the information was not relevant. The number in brackets after a quotation is a specified subject. Words that the person stressed are in bold>.

A) Perceptions

Perceptions represent different aspects of the lived body and have emerged from all the material. They are presented by the following themes:

Perceptions of a dys-appearing body

When the body was present in an unpleasant way it was perceived as a dys-appearing body. Pain, stiffness, and fatigue were aspects of dys-appearance that were

prominent in this group. Pain above all was musculoskeletal. Although pain had increased, it often had appeared both in childhood and youth. To be used to pain as a child (for example, in connection with orthopaedic operations or intense physiotherapy) was a factor that sometimes contributed to neglecting pain, but when new pain areas appeared or intensity of pain increased it became a disturbing factor. Stiffness was also familiar for many; especially for those living with a muscular hyper tone, but in perspective of change it also became more obvious. Fatigue, on the other hand, often was a new experience that drained all energy. It sometimes was related to pain and stiffness and was a sense of both physical and mental fatigue:

You just don't have the initiative to do anything. You just sit there; you don't even have the strength to go to bed. (17)

Pain, stiffness and fatigue could alternate and have different simultaneity. They represented body perceptions that had increased over the years. Often it took time until this dys-appearance was noticed because the process was slow and imperceptible, but eventually it became obvious:

Well, you discover after a while that well now, it's a little worse than it was a few years ago. (20)

The changing perspective was clear especially when the dys-appearance interacted with daily living. An often-perceived contributing factor to deterioration was the fast pace of society, which created stress because they had to exert themselves to their physical and mental limits. There also was a vicious circle: an uneasiness and dysfunction that influenced activity and a counteract response to maintain activities which created more problems with dys-appearance:

If I do things ... when I get angry and it doesn't work ... well, then I have to pay for it for a month, because then I've tensed up my entire body. (10)

Highlighting physical defects in various situations could create a perception of dys-appearance. Another example was excessive reactions, which are typical in cerebral palsy and either can decrease or increase during life. In adulthood, however, there was a great awareness that emotions- such as stress, anger, or happiness- caused exaggerated body expressions:

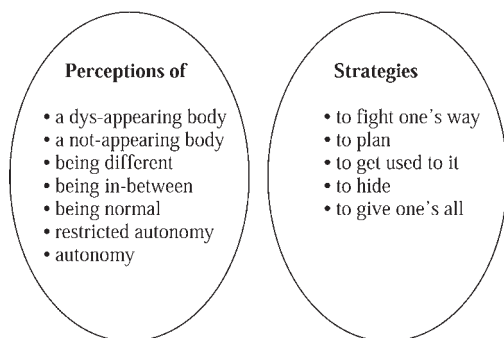


Figure 1 Themes illustrating perceptions and strategies as experienced by adults with cerebral palsy.

Did you know that cerebral palsy is so much more of everything? () We are so exaggerated. If we're happy, then we're happy ... it gets exaggerated and if we are sad, we are exaggeratedly sad. (11)

The changes with body dys-appearance and deteriorated function created uneasiness about the future and also questions about what cerebral palsy is and its impact on ageing:

Somehow it feels like everyone takes it for granted that it's the cerebral palsy that's causing problems, but you know ... yes it's really easy to blame it in one way, but which is which, no one can answer that either () ...where is it, you know, in your head? (10)

Perceptions of a not-appearing body

When the body was in the background, supporting and enabling daily activities in a silent way, it acted as a not-appearing body. One important factor in not taking notice of the body was the absence of physical problems such as pain. That is, when the body could be physically used without interfering in daily activities, the person did not notice his or her body. This could occur often or infrequently:

... then there are days when you feel that there's no limit to what you can do. (2)

Sitting with friends and relatives could be situations when the body was temporarily absent as it was not used in physical activities. There were also activities, such as riding, swimming and meditation, which in a way put focus on the body, but resulted in relief and well-being, where the body was not a disturbing factor. Not noticing bodily deteriorations was also a sort of not-appearance that could be negative as they did not take care of the body. Inversely, a consciousness of the body, resulting in a care taking with a balance in moving and resting also could contribute to feelings of a body that was in the background supporting daily activities:

My body feels much better if I do things everyday. My muscles become calmer. (18)

Perceptions of being different

Perceptions of being different were primarily connected with feelings of special treatment from other people or feelings of difference in the eyes of others.

Overprotection and lack of demands from both parents and professionals could, during years of growth, be experienced as a sort of special treatment that had created a false sense of security. In the meeting with the 'normal' world, the difference then had become obvious. Being educated in a class with only disabled children could result in a shock when they had to face new school situations or when beginning a work as the only disabled person. The feelings of difference were thus created by new situations and the way other people treated them and could also be obvious when professionals highlighted the disability through different acts:

... then they were going to record my speech ... and since then I didn't talk () I got a shock ... I thought it was okay. (11)

Different treatment could hurt and lead to low self-confidence, but sometimes it could also give an opposite reaction increasing one's sense of self-worth and confidence. Adolescence was a critical period when differences could become obvious especially in contacts with the other sex, leading to many questions about identity. Later in adulthood perceptions of difference were above all experienced through the attitudes of and treatment by strangers, sometimes leading to feelings of indignity. This could happen when meeting new people while for example searching for a job and could also occur in health care situations:

In my experience, you come to some authority and are treated tactlessly; it's awful, quite simply, because it happens often. I feel like I have to work so hard to convince people that I need help. (22)

Perceptions of difference were often caused by strangers who did not understand that a person with a disability could be competent; however, a sort of reverse discrimination was sometimes experienced and the attitudes of others could contain an unnecessary diligence and an astonishment of how capable the person was despite a handicap:

*... and then they become so surprised about that I have a girlfriend too ... it's just **great**. Either people don't say anything or they say how **great** everything is that I have succeeded, but somehow it's so overblown. (3)*

The wheelchair could be a symbol of a handicap and people alternating between walking and sitting in

wheelchair had an experience of worse treatment when they were using their chair:

Well. Especially when you wind up in a wheelchair they want to talk over your shoulder () ... but I felt that clear difference when I wound up here than when I walked with my canes. (9)

Not being able to carry out certain activities and to follow the high tempo in the society also created feelings of difference. A significant hindrance for feeling 'normal' was that everything takes more time, making it impossible to follow another person's pace. Already as a child there could be a perception of being different, especially when keeping up with friends, but as a grown-up it above all was the deteriorations in body functions that made a consciousness of difference and influenced self-image:

When I started to walk slowly ... that was when I felt disabled for the first time. It was driving me crazy. (6)

Perceptions of being in-between

Belonging to a group where the handicap is the focus sometimes created the self-image. In other contexts, without connections to a special group, another self-image could dominate. This feeling of living in different worlds was sometimes predominant:

I've always been somewhere in-between. (5)

There were different thoughts about being affiliated to the cerebral palsy group. The 'handicap world' sometimes could give a higher status since being disabled could be seen as bestowing importance:

I mean in the ordinary world, where I do everything to fit in ... move with the flow and stand out (). In the world of disabilities, that's another rank () you get status there much faster than what you get in the ordinary world. (10)

Being among other people with disability could contribute to a positive self-image in the sense of not being alone with the disability; however sometimes it also produced negative feelings. Ways of feeling in-between were sometimes expressed in acknowledging the disability in certain situations, but in other situations act and pretend to be as normal as possible because it created better self-confidence and

well-being. Some people could use the disability to gain an advantage in different situations, but in other situations it was important not to be stigmatized as a disabled person. Also in relation to society services there were perceptions of being in-between:

... your condition is too good to get help but not good enough to be able to manage completely on your own, so somehow you get caught in the somewhere in the middle. (17)

Perceptions of being normal

Managing daily life with work and family duties contributed to a perception of normality. Also being the person you are, including the cerebral palsy, supported those perceptions. The disability in this way was integrated in self-image of normality:

Well, I've had it all my life and I don't know anything else. (20)

Other people's positive attitudes towards the disability were important, but also their own ability to meet the surrounding world without focusing on the disability with a believing in your self. A supportive family and schoolfriends were stressed as facilitating factors for feelings of normality and in adulthood managing a daily job was important. Perceptions of normality also could contain dissociation to other people with disabilities:

I never have any contact with them. I'm friendly when I speak to them and I can help them, but that's all, nothing more. (6)

Perceptions of restricted autonomy

The ability to control and steer the intended activities was sometimes restricted. The perceptions of restricted autonomy could be associated to different levels of dependency and also to different situations:

I couldn't get out on my own and just that feeling of not being able to run out and say I'm leaving now. (12)

Time-consuming, everyday life was an often-mentioned limiting factor that could diminish the possibilities for making choices. Another factor influencing autonomy was dependence on other people

when it intruded on decisions and activities. Excessive protection and loss of decision-making authority were often stressed as restrictions in autonomy in childhood and adolescence. In adulthood, dependence on relatives and friends produced negative feelings. Sometimes this dependence, as a remnant from childhood, could create a false security, but gradually it became a hindering factor especially in relation to other people:

I feel like I'm a burden to so many people. (16)

To depend on personal assistance was a new experience for some, creating a sense of restricted autonomy. One disturbing factor was that other people come very close to your body, but also that you cannot choose when you want to be alone:

You see, my assistants actually are not supposed to leave me during their working hours, which I sometimes think is really tedious. (15)

Obstacles in society structure with inaccessible places, non-functioning technical aids and an inflexible support from society could negatively influence autonomy. Many people need short and irregular help and the system for support is often very rigid:

*I could get **time** from them and then I could decide myself what they would do with the time () I'd like to get a number of hours and then I **would like to decide** ... today I don't want you to hover, I want you to do this instead. (5)*

Perceptions of autonomy

Perceptions of autonomy could mean having a body that functions in daily life with no need for help in daily activities:

There is nothing in every day life that slows me down or makes things difficult for me. (19)

On the other hand, this could also mean that assistance from other people was experienced as a support leading to autonomy. Likewise, technical aids and other society resources could be experienced helpful in taking part in activities. Losing this support would be the same as losing autonomy. Perceptions of autonomy could involve deciding to accept

time-consuming daily chores to ensure being able to make one's own decisions:

I can take care of just everything, as long as I have time. (12)

B) Strategies

Strategies for daily life differed and the same person could vary strategies depending on the situation. The following themes represent strategies for managing the described perceptions.

To fight one's way

Stubbornness was a characteristic for many in this group. They were fighting to manage activities and showing others and themselves that things were possible, striving for normality and autonomy. They also wanted to project themselves as competent people who could handle a variety of situations:

When people have said to me 'you can't do that' ... you shouldn't say that to me because then by golly, I'm going to make it work. (5)

Fighting spirit was a way of having control and experiencing the satisfaction of being competent and self-confident:

It's really worth the fight, because I can say straight out that if I hadn't fought ... if I had done what others wanted and thought, then I wouldn't be sitting here. (2)

For some people, physical training was a way of fighting to maintain body functions. A fighting spirit was often expressed in relation to ageing. As a 37-year-old man stated:

The reason that I struggle the way I do is that I don't want to sit in a wheelchair when I'm 45–50 () I've decided to give age a fight. (19)

In the fight to maintain activities, they often noted they ignored the management of their condition, resulting in negative bodily reactions with pain and decreased function:

You can do it if you're stubborn ... but it all goes to hell if you're stubborn. (11)

To plan

Planning daily life could mean adapting, prioritizing or redistributing. Time-consuming activities led to different kinds of planning strategies:

I've become some kind of planning addict. I get totally caught up in planning ... now I'm going to do this and now this has to be finished and then ... (21)

Planning strategies could also give a structure for limiting stress and chaotic situations. One way of planning was to drop certain activities, usually leisure activities, in order to manage work and family. On the other hand, priorities could be the opposite and focus more on choosing family and leisure before work. This strategy made it possible to avoid undue stress on the body or the need for assistance:

I've been working part-time so that my body can handle it. Quite a few people have worked full-time and had to back off and are now on disability. (4)

To get used to it

Growing use to one's condition was connected with accepting life situation. Living with a disability and gradual deterioration was something incorporated in daily life and a way of seeing the possibilities in life:

I have accepted it. For the most part I feel that I have nothing to gain from becoming irritated and annoyed about it. (15)

This was also a consequence of the inability to initiate certain activities or control different problems:

Well, you always have pain in your toes, but you have to live with it. () Yes, you have to ... you get used to it, too. (6)

To hide

Hiding the disability by 'pretending' to be normal sometimes created a better self-image. Driving away unpleasant feelings or daily problems was another way of hiding. The deterioration of body functions could consciously be hidden and was a strategy for managing daily life:

The body's signals, nooo, I mostly ignore them. Well, that ... when I've made up my mind, then I ignore them. (10)

Hiding was a way to avoid situations where for example excessive physical reactions or other disabilities in joining different activities could be obvious for others. Hiding protected oneself from another person's insight through keeping distance. That sometimes originated in feelings of causing trouble for other people:

I haven't let ordinary people get close to me either (). I've been petrified that they will think that I'm forcing myself on them or that they will help out (). I've pulled away a bit, it isn't fun to be invited out and never be able to reciprocate. (5)

To give one's all

There was also a strategy that encouraged others. An open attitude towards non-disabled people was important in creating a good atmosphere. An understanding of one's own feelings and also other people's insecurity was necessary for this strategy. Being open to non-disabled people reduced their frustration and insecurity and avoided hurting the other person's feelings:

I think it has to do with how you are, in other words, a person who opens up to others gets something back in return () So I probably believe often ... or have always tried to be as straightforward as possible. (13)

Discussion

This study shows that there is heterogeneity in life experiences in adults with cerebral palsy. In this way the results were global, showing that people with cerebral palsy have the same perceptions and strategies as anyone else. On the other hand, this study points to certain problems that influence life for this group: negative perceptions of the physical body, perceptions of difference and restricted autonomy. Different coping strategies in striving for normality and autonomy could give both positive and negative consequences in managing daily life problems.

Musculoskeletal problems and fatigue are common issues for many adults with cerebral palsy. These problems have been documented in other studies ^{2,9,10,12,13}

and the experiences of pain are also described among people living with a disability.^{22,23} These problems were confirmed in the interviews, and the subtle progress of the symptoms did not make the condition explicit until it really interfered with daily life. The ‘dys-appearing body’, a concept created by the philosopher Drew Leder,²⁴ was a way to label these experiences of an unpleasant and disturbing body.

The results in this study showed that when you have a congenital disability the body and its limitations are often taken for granted. A disability acquired as an adult has been described as a ‘biographical disruption’ and involves theories about coming back to one’s pre-disability state.²⁵ In living with cerebral palsy there is no coming back, but there are changes that focus on new problems in life situation. When changes occurred, it drew attention to the body, especially when changes emerged in an unpleasant and disturbing way. The dys-appearing eventually led to a dysfunction and in this way it was more objectified as it influenced daily activities and participation.

The excessive body reactions caused by different stimuli, especially strong emotions, became a dys-appearance in an awareness of the abnormality. This also included awareness that their thoughts and feelings became evident for others, which in a way was a loss of privacy. Professionals often see these excessive reactions, but it is also important to have knowledge of the person’s own feelings to help one choose strategies.

The concept of a ‘not-appearing’ body²⁴ was used to describe the body when it was in the background, living in interaction with others and doing activities without being reminded to them. This response could occur when physical problems were absent and was often temporally. Professionals need to support the people to promote this condition, but it is argued that we still have limited knowledge about the relation between overuse and inactivity and that follow-up rehabilitation programmes must motivate and understand a lifelong balanced use of the body.¹³

Perceptions of being different could be obvious in limitations managing daily activities, but also in special treatment and discrimination of different kinds. The difference in the eyes of others appeared in many different situations and influenced self-image. Interesting thoughts about professionals’ contribution to discrimination through their actions were stressed. It is argued that the ideology of ‘normality’ underpins

the process of rehabilitation²⁶ and in this way professionals, in trying to normalize, contribute to feelings of difference.

Interviewees pointed out the wheelchair as a symbol for difference and emphasized walking as an important factor for normality. The upright posture can be described as a crucial element in the constitution of lived body and verticality is directly related to autonomy.¹⁷ Standing face to face with another person is incorporated in many social interactions and a sitting posture also causes others to assign the dependent role to the sitting person.¹⁷ This dilemma was thoroughly expressed in the interviews by those who had experience of both walking and wheelchair sitting. This must be considered and incorporated in rehabilitation situations and it is also important to discuss appropriate means of locomotion in relation to the impact on self-image.

The perceptions of being in-between showed a conflict in a double identity, where the disability status often was stressed in health care situations or in belonging to a certain group in society, but in other situations they could pass as non-disabled. There was an obvious feeling of being in-between in the relation to social services and it also must be a duty for rehabilitation professionals to influence municipalities to provide more flexible service systems.

A congenital disability is an essential part of self and in this way it represents a state of normality. The informants also stressed the importance of support from parents, relatives and friends in promoting feelings of normality and a positive self-image. This agrees with other studies, which also point out that social support is a strong predictor of self-worth.^{27,28}

Autonomy, the ability to control life, depends on many factors. It could be both promoted and restricted according to personal and environmental factors. A factor that both supports and restricts autonomy is the presence of personal assistants and there were many thoughts about their influence on personal autonomy and privacy. A study among adults with cerebral palsy showed that self-efficacy, a concept also dealing with ability, was high in people who depend on mechanical assistance, but low when they depend on personal assistants.²⁹ These are interesting aspects that need further investigation. Understanding of the correlation between goals in life and physical capacities is also pointed out as an important factor in acquiring

autonomy³⁰ and rehabilitation professionals can play a supportive role in this process.

The strategies described in the results can probably be applied to many individuals with or without disability, but the consequences differ according to life situation. Different strategies were used to attain autonomy or normality, sometimes at the expense of deteriorated body functions. For clinicians it must be important to see the relationship between different coping strategies and their influence on body function, self-perception and activities in daily life.

Cognitive or perceptual limitations were not highlighted as problematic issues. This may be the case because the interviewer was a physiotherapist and the interviewees thought that they were expected to talk about mobility problems. In addition, in this selected group these were not primary problems and there had been no changes to these functions. Another study noted that there is a decline in ambulation in adults with cerebral palsy, but not in many other skills, such as speech.⁸ Physical appearance was also not considered as problematic or was not mentioned in the interviews. This, however was pointed out in another study about body image and disability,³¹ a study that also noted that there was a bodily acceptance over time and perhaps as an adult with cerebral palsy the focus is on other issues. Instead, questions about cerebral palsy and its impact on ageing were stressed. Some people felt they knew too little and also that there are too few arenas where these questions can be answered. This also must be an important task for rehabilitation settings to address.

The main limitation in this study is that the analysis of the interviews was carried out by one person. Another physiotherapist read the interviews and the result was presented to a group of interviewed people. There was an agreement in their perceptions and the result as presented from the analysis, but still it is a weakness that only one person did the analysis. Another limitation is that the selected group of people lived in Sweden and represented community-living adults; no one was totally dependent or had mental retardation. Other content areas in the interviews dealt with physical training and that could also influence the results. Therefore caution must be taken in generalizing from the results.

This was an exploratory study giving some aspects with implication for rehabilitation professionals. First, cerebral palsy is a congenital disability and there is no

'before' to compare with as with an acquired disability. This underlines the importance for rehabilitation professionals to find intervention strategies promoting good health in a life perspective, including appropriate information about cerebral palsy and ageing. Second, rehabilitation professionals must be active in influencing society structures to become a more flexible system where each person can be met as an individual and get appropriate support. Finally, professionals in rehabilitation have a huge challenge in meeting different needs in relation to functional problems such as body deterioration, but also in relation to self-image and aspects of autonomy. This is an important aspect because many disabled people feel that they are treated as a collective group and not as individuals. This requires attentiveness and perhaps we have much to learn both from sociologists and from psychologists, especially in the phenomenological traditions, when it comes to focusing on life experiences.

Clinical messages

- Deterioration in body functions are often part of a slow and imperceptible process and may not be evident until they begin to affect daily activities.
- Feelings of being different are often the result of how others react to you or if you are limited in taking part in activities.
- The ability to select among choices and to make decisions over your daily life plays an important role in providing a sense of autonomy.

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