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Original Article

Toward the development of a training program that promotes a "social model of disability" for physical therapists: a discussion on experiential learning surrounding the use of "acceptance of disability" by physical therapists

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Abstract. [Purpose] This study aimed to extract knowledge for the development of a training program for creating a social model of disability for physical therapists, focusing on the experiential learning of those physical therapists who did not use acceptance of disability according to their subjective judgment. [Participants and Methods] The study included 11 physical therapists who were interviewed about their use of acceptance of disability and the circumstances leading to its non-use. [Results] The study identified the past and current use of acceptance of disability, as well as cases and reasons for its discontinuation, along with changes in clinical content. [Conclusion] The study extracted knowledge for the development of training programs in line with the components of the experiential learning model.

Key words: Social model of disability, Acceptance of disability, Experiential learning

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INTRODUCTION

Acceptance of disability is a concept generally known in the field of rehabilitation, and refers to the "acceptance of one's own disability" by a person with a disability caused by illness or accident[1)]. Acceptance of disability is attained through the stages of shock, denial, confusion, striving for resolution, and acceptance, as well as a shift to positive values 'about one's own disability'[1)]. However, critical views have emerged regarding the usage of acceptance of disability by supporters[2, 3)]. For example, there are situations in which a supporter expresses that the person with disabilities "has not accepted their disability" in response to the person's insistence on returning to work[3)]. The issue is that such statements connote the imposition of one's expertise.

Rehabilitation has been the subject of criticism in disability studies, an academic field that has been developed by people with disabilities. Oliver[4)] pointed out this problem—disability is perceived to "[belong] to persons with disabilities and they are responsible for [the] social disadvantages that occur". Such a view can be glimpsed in the use of the term "acceptance

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of disability" mentioned above. In contrast, disability studies proposed the social model of disability as a way of looking at disability. The social model of disability is "a concept of disability that sees disability as a disadvantage that society brings to people with disabilities and emphasizes the positive aspects of disability and the diversity of society"[4]. In Japan, this model is adopted as the concept of disability in the Convention on the Rights of Persons with Disabilities[5], which was ratified in 2014. The Law on Elimination of Discrimination against Persons with Disabilities subsequently came into effect in 2016. The implementation of rehabilitation that emphasizes such a model rooted in human rights will lead not only to the elimination of social disadvantages caused by illness and disability but also to medical communication between persons with disabilities and rehabilitation workers[6] and foster an ethical perspective that reconsiders how such communication should be conducted.

Based on this background, Tajima[7] conducted an interview survey of occupational therapists' clinical use of acceptance of disability in 2005 and 2020. The number of occupational therapists who refrain from using this term increased in 2020. In their interactions with persons with disabilities, they were introduced to many narratives that emphasized dialogue for shared goals and implementation of treatment in accordance with the patient's wishes, with an awareness of the diversity of life. Meanwhile, Tajima[7] also noted an increase in the number of occupational therapists who felt that the refusal to use acceptance of disability conflicted with medical ethics. Such changes were cultivated through a continuous process of reflection on how occupational therapists themselves made sense of their clinical experiences and applied them in practice. Among occupational therapists who had an abundance of clinical content and experience, many narratives were seen where clinical content changed through such reflection. However, the details of the use of acceptance of disability among physical therapists have yet to be clarified.

Experiential learning is a concept that is emphasized in human resource development and training[8]. In the field of health care, research on experiential learning processes has been conducted in recent years with the aim of developing human resources capable of self-growth in clinical practice, and the visualization of knowledge and skills for practical knowledge is gradually progressing[9, 10]. Although there are various theories on experiential learning, two points are common: the emphasis on experience and practice in learning and reflection on experience. The most well-known is Kolb's Experiential Learning Model[8]. Kolb formulated a cycle of experiential learning by creating a four-quadrant model based on the two axes of "activity–reflection" and "abstraction–experience"[8]. The experiential learning model has the potential to be applicable to changes in physical therapists regarding acceptance of disability. We believe that physical therapists who focus on the individual model of disability can become introspectively aware of the nature of medical communication, learn positively from the person's experience of disability, and work to create a society with positive disability and diversity, where not only the person with disability can be transformed but also society can be encouraged to transform itself in accordance with disability. In other words, we aimed to obtain knowledge and insights for developing a training program that enables rehabilitation highlighting a social model of disability be put into practice.

Hence, this study aimed to conduct an interview survey on the use of acceptance of disability by physical therapists and extract knowledge for the development of a training program that will promote a social model of disability, based on the narratives of physical therapists who do not use acceptance of disability based on their own judgment and who are oriented toward a social model of disability.

PARTICIPANTS AND METHODS

We recruited two physical therapy facilities through social media and offered to cooperate with one of the current authors who delivered a lecture on acceptance of disability. Facility A provided day-care and home-visit rehabilitation, whereas Facility B mainly provided employment support and day-care rehabilitation for recovery rehabilitation. We secured four physical therapists at Facility A and five physical therapists at Facility B as research collaborators.

For data collection, we used an individualized semi-constructive interview survey. All interviews were conducted by the first author. The location was either at the participant's workplace or in a quiet space near their residence where privacy was protected. Interviews were conducted between December 2019 and February 2020, and lasted from one hour to one and a half hours per person. The interview items were on the use of acceptance of disability and the support provided for and manner of interaction with persons with disabilities. The interviews were recorded with permission and transcribed as qualitative data.

The analysis procedure was as follows. First, we conduced Fisher's exact probability test on those who chose to use acceptance of disability based on their own independent judgment and those who did not choose to use it, categorizing the participants by years of experience. The categories of years of experience were 1–5 years, 6–10 years, and 11 or more years[9]. We used IBM SPSS Statistics for Windows, Version 28 (Chicago, IL, USA), and the statistical significance level was set at $p<0.05$.

Focusing on qualitative research data from physical therapists who no longer used acceptance of disability as a proactive decision, we organized the data based on each step of Kolb's experiential learning cycle. In Kolb's experiential learning, "activity" indicates interaction with the environment based on the learner's experience, "reflection" indicates making sense of one's own actions from a bird's-eye view, "abstraction" represents the conceptualization of experience after "activity" and "reflection," and "experience" represents new actions after "activity", "reflection", and "abstraction".

In the development of training programs, the perspective of an experiential learning process, in which the use of acceptance of disability is made nullified by independent decision, is important. Hence, we focused on the following four concepts:

"activity" during the use of acceptance of disability, "reflection" and "abstraction" that show the inner transformation process (opportunity and awareness) from use to non-use, and "experience" that leads to the use of the social model of disability. We conducted a qualitative content analysis[11], focusing on these four concepts. Specifically, we read the qualitative data of five physical therapists and paid attention to, first, their previous use of acceptance of disability as an "activity"; second, cases and reasons for no longer using acceptance of disability as "reflection" and "abstraction" (i.e., opportunities for reflection and their contents [awareness through abstraction, gaining knowledge]); and third, current use of acceptance of disability as "experience". Contexts and sentences that were considered important for each item were coded and categorized. Finally, we coded and categorized the changes in clinical content with respect to going from use of acceptance of disability based on subjective judgment to use of the social model of disability. Thus, we expected to clarify the process of transformation from the use of acceptance of disability to that of the social model of disability and the accompanying changes in clinical content.

Generative coding and categorization in qualitative content analysis were conducted by the first author, who has experience in qualitative research, and conceptualization was discussed with the co-authors to ensure the rigor of the results. Finally, all authors extracted the findings considered important for planning training programs and creating formative evaluations. Ethical considerations included approval by the Ethics Committee of Seirei Christopher University (ethics certificate no. 19060). Regarding Facility B, the study was conducted after obtaining approval from the Ethics Review Committee of Facility B.

RESULTS

The years of experience, gender, research request method, and work details of the collaborators are shown in Table 1. The minimum number of years of experience was 1 year and the maximum was 17 years, with an average of 7.4 years. The work details varied, but those with more years of experience were more likely to have multiple work contents. Table 2 shows a crosstabulation of the use of acceptance of disability and years of experience. Fisher's exact probability test was conducted because more than 20% of the total cells had an expected frequency of less than 5.

Regarding the notations for analysis results, codes are indicated by {} and categories by []. Table 3 shows the narratives of the five physical therapists who stopped using acceptance of disability based on their own judgment on their previous use of the concept. With the exception of Case No. 3, the five physiotherapists used acceptance of disability without questioning its use in clinical settings at the time. In Case No. 3, the therapist felt uncomfortable with the use of the term while she was still a newcomer and stopped using it herself.

Table 1. Basic information on research collaborators

Case no.	Years of experience	Gender	Research request methodology	All work experience
1	16	Female	Individual	Recovery, geriatric health care facility, home-visit rehabilitation
2	17	Male	Facility A	Recovery and home-visit rehabilitation
3	17	Male	Individual	Recovery, convalescent, day-care, and home-visit rehabilitation, and labor management for rehabilitation staff
4	7	Male	Facility A	Acute, recovery, day-care, and home-visit rehabilitation
5	9	Female	Facility A	Recovery, day-care, and home-visit rehabilitation
6	1	Male	Facility A	Day-care service for older adults
7	1	Male	Facility B	Recovery
8	1	Male	Facility B	Recovery
9	8	Male	Facility B	Recovery, facility providing services and support for persons with disabilities
10	1	Female	Facility B	Recovery
11	4	Male	Facility B	Recovery

Table 2. Association of acceptance of disability use with years of experience

	Use of acceptance of disability			p-value[a]
	By proactive decision making	No	Total	
1–5 years	0	5	5	0.015
6–10 years	2	1	3	
>11 years	3	0	3	
Total	5	6	11	

[a] Fisher's exact probability test.

Table 3. Previous use of acceptance of disability

Case no.	Narrative
1	I was using it, or I think I was using it. I don't feel that I was consciously using it, nor do I feel that I didn't consciously use it, so I probably did.
2	I think I was using it. I think a lot of things came out. There were things they couldn't do but they couldn't admit it. I think it was nuanced in that way.
3	It was right after I joined the company, the first or second year, that I became very reluctant to use the term "acceptance of disability". I really didn't like the way the term was used in the context of hospitalization. I think that by attaching a name to that status [acceptance of disability], it becomes a sort of label, but I really think there are a lot of small changes. I just feel like the changes there would be invisible with that sort of labeling.
5	When patients are in the hospital, they are still in a state of shock after becoming disabled from an injury they received. I have to sugarcoat it a little bit, behaving very cautiously around them. But I did talk with the nurses and other staff about the fact that some patients were not able to accept their disability very well.
9	Q Before you went [to a support facility for the disabled], did you use it a lot when you were there [at the recovery-phase hospital]? A Yes, I did. The level of acceptance of disability among the patients was often a topic of discussion among the team members. There were even some study sessions on such topics in the hospital.

Table 4 summarizes the cases and reasons for no longer using acceptance of disability and the opportunities for reflection for the five physical therapists who stopped using acceptance of disability based on their own judgment. Regarding opportunities for reflection, we identified the categories of [use of acceptance of disability by other professionals and surroundings], [guidance and comments by senior staff], and [exposure to the disabled person's commitment to life and diversity]. The cases/reasons were commonplace clinical situations. In addition, as abstractions (realizations and knowledge gained), the following were categorized as the content of reflection: [Recognition of the importance of capturing the disabled person's changes and life], [Reconsideration of the meaning and significance of rehabilitation], and [Reconsideration of the values learned and cultivated as a therapist].

The narratives and coded content surrounding the current use of acceptance of disability by five physical therapists are shown in Table 5. Since the narratives of the five therapists included negative content regarding the use of acceptance of disability and positive content based on independent judgment, we added the coding and categorization of each person's narrative as positive and negative contexts. In the positive context, we identified the categories of [knowing the disabled person's thoughts], [attending to the disabled person's needs], and [imagining the actual life]; in the negative context, we clarified the categories of [not facing the disabled person's thoughts and needs], [gap between acceptance of disability theory and reality], and [perceiving the disabled person from the disease name].

Table 6 summarizes the narratives of change in clinical content resulting from not using acceptance of disability among five physical therapists. We extracted seven codes for narratives of change in clinical content, which were categorized in two ways: one was single underlined and included {do not jump to conclusions}, {do not assume that the person with disabilities will not change again}, and {provide appropriate information on the person with disabilities to collaborating agencies}, categorized as [Believing in the possibility of change in the disabled person over time]. The other, double underlined, included {believe in the possibility of change and try various intervention methods}, {build a relationship with the person with disabilities so that they trust and accept the therapist's suggestions}, and {understand the disabled person's true needs and try to make them possible within a limited period of time}, categorized as [Aiming at building a trusting relationship that allows the disabled person's true feelings to be heard and becoming more proficient in their interventions].

DISCUSSION

We observed that for the physical therapists who made the proactive decision to stop using the acceptance of disability concept, this change occurred after five or more years of clinical experience, and by the 11th year or later, had stopped using it altogether. Thus, the therapists required more than five years of experience to realize the importance of the social model of disability. In addition, qualitative data on the use of acceptance of disability as an "activity" among physical therapists with less than five years of experience showed that four used it without question and one felt uncomfortable with its use by others, leading to non-use of the concept. Therefore, in the promotion and practice of rehabilitation that emphasizes the ideal social model of disability, it is necessary to make practitioners feel some kind of doubt or discomfort about acceptance of disability. This can be considered to suggest the need for training programs that promote the social model of disability and that are targeted specifically at those with less than five years of clinical experience.

On observing the opportunities for reflection that led to independent judgment as "reflection" and "abstraction", we found that the participants themselves found opportunities for reflection in situations that any clinical physical therapist would

Table 4. Cases and reasons for no longer using acceptance of disability and opportunities for and content of reflection

Case no.	Narrative	Opportunity for reflection	Details of reflection
1	The nurses and counselors at the conference said that the patient was not able to accept her disability. It's not that I was in the patient's shoes, but I felt that they had no idea what was going on. I felt at the time that we are the ones who have one-on-one interactions with patients, so I really thought that their statements were wrong. During my first year of experience in the recovery-phase hospital, there was a patient who was transferred from the recovery-phase hospital to the geriatric care center, and the senior doctor who was in charge of the patient told me that he really wanted to see the patient's life or evaluate the patient in a totality of 24 hours a day, which made me realize how important it was for me to do so.	Use of acceptance of disability in other professions Guidance from senior staff	Awareness of the importance of capturing the lives of persons with disabilities
2	The instructor of Therapy A said, "Think about it, do you think this person can walk? No, but I wonder if he could. If that's the case, what's the purpose of gait training? I think it's really more about the gait training. But the doctor's way of doing Therapy A was really like adjusting the tone and saying, "Yes, you can stand lightly now" or "You stood once, and that's it." (Author note: The therapist thought he wanted to get to the bottom of things with the patient's progress.)	Comments from senior personnel	Significance and meaning of rehabilitation
3	It was right after I started working here that I thought I didn't like using acceptance of disability very much. I think that by attaching a name to that status, it becomes a sort of label, but I really think there are a lot of small changes. I feel that such changes become invisible with that sort of labeling. Even in a state of acceptance, I don't think they are ever really accepting, though it is difficult to even define acceptance. Somewhere in their heart, they want to get better, and I don't think we can express all of such feeling with just one word. By using this word, I felt that I would not be able to express small changes in patients' mind. This is why I didn't want to use it.	Usage of acceptance of disability in one's surroundings	One loses sight of the changes in persons with disabilities that one should be capturing as a therapist
5	There are people who feel that because they can't hold chopsticks in their dominant hand well, they don't feel like eating with a fork, and if that is the case, they would rather not eat. Is that because they don't like it because they can't accept it? They are the ones who cannot do it in terms of ability. They can't make that transition, because they are stuck with the preconceived idea that udon has to be eaten with chopsticks. It's the person's way of thinking, their sense of values. They want to eat udon with chopsticks, and they think that udon should be eaten with chopsticks. I think it's missing the mark to tell such people, "No, but it tastes good with a fork, too."	Touching on the disabled person's commitment to life	Value learned and cultivated as a therapist
9	After working in a recovery-phase hospital for four years, I worked in a day service and outpatient department for one year and in a facility for people with disabilities for two years. I was stationed at a facility where people with disabilities lived, and I assisted them in their daily lives. I think it was because I spent time with people with disabilities and came into contact with the variations of their disabilities in a very natural way.	Exposure to the diversity of real life of people with disabilities	Value learned and cultivated as a therapist

The main points of the narrative are underlined.

experience, such as [use of acceptance of disability by other professionals and surroundings], [guidance and comments by senior staff], and [exposure to the disabled person's commitment to life and diversity]. Therefore, training programs must create opportunities to come into contact with [the use of acceptance of disability by other professions and surroundings], [guidance and comments by senior staff], and [exposure to the disabled person's commitment to life and diversity], and incorporate the content of what they learn. Creating these opportunities through lectures and exercises will promote reflection on acceptance of disability. Tajima[7] conducted an interview survey on the use of acceptance of disability by occupational therapists, and found that "learning experiences outside clinical practice", such as lectures by the people concerned, related books, and study groups at work, also provided opportunities for reflection. Therefore, we believe that it is possible to utilize both of these as opportunities for reflection. Hence, in addition to individual clinical experiences, the training program aimed to be developed by the authors can be expected to increase and promote opportunities for reflection by individual physical

Table 5. Narratives and coding of current use of acceptance of disability by five therapists

Case no.	Narrative	Coding details	
		Positive context	Negative context
1	I would like to see if the patient is dealing with their illness, and if they are or are not, but when I hear from people in other professions that the patient is not doing so well, it makes me feel angry. In such situations, I consciously avoid using such words or deny them.	Know how the disabled person perceives their own disability or illness	(Non-) use of acceptance of disability
2	It's someone that I'd like to care for... I feel that I'd like to take care of all kinds of people. We can try one method, then another, then we find some other method, so we get it. Wouldn't it be better if we did this? Well, this was not really feasible, so we'll try some other method, things like that. Then, the task may change to something other than this one. As I provide care for them, people who change on their own will change. I don't think I wanted to provide care for patients in this way before, when I was working at a hospital. That's probably why I don't think about acceptance.	Attend to the disabled person's needs to the fullest	Does not interact with the disabled person based on acceptance of disability (not done) as a criterion
3	I had an image in my mind of the general stages of acceptance of disability, but when I actually dealt with them, the reality was different, and I felt like, "What is this?" I think that at that time, I did not have a clear image of what the life of a disabled person would be like. I think I was only thinking of the person being in a wheelchair at the hospital or moving around by themselves in a wheelchair. I think I stopped using the process of acceptance about a month after I started working in this profession.	Imagining actual life	Gap between acceptance of disability theory and reality
5	It's not that I consciously stopped using it. It just came naturally. I guess I don't really look at it with a disability in mind anymore. I think more about what the patient themselves think and what they want to do. In the end, I think that the disability doesn't seem to have such a drastic impact on the person's life. In rehabilitation, we have to look at various things, such as the name of the disease, but at the base, I think we have to look at the person. If we start from the name of the disease or the name of the disability, I think it will be difficult to see the person.	Knowing the disabled person's thoughts and feelings	Perceiving the disabled person from the disease name
9	I am beginning to feel that it is difficult to draw a line between acceptance of disability and not accepting disability, and that it is difficult to say that "disability has been accepted" once the person has really reached a certain point. I feel that we don't have to care too much about whether disability has been accepted or not. It is easier to get into specifics by talking about how the person really feels, such as what is bothering them, what is troubling them, or what is still a shock to them.	Knowing the disabled person's thoughts and feelings	Gap between acceptance of disability theory and reality

The main points of the narrative are underlined.

therapists.

The narratives on the physical therapists' current use of acceptance of disability as "experience" suggested that the physical therapists' own basis for judgment over the use of the term was generated. Specifically, the negative contexts for the use of acceptance of disability were [unwillingness to face the disabled person's thoughts and needs], [gap between acceptance of disability theory and reality], and [perceiving the disabled person from the disease name], which were consistent with the principles of medical ethics. These principles are respect for autonomy, non-maleficence, beneficence, and justice. In their 1979 book *Principles of Biomedical Ethics*, Beauchamp and Childress added the principle of non-maleficence to the three principles proposed in the 1978 "Belmont Report: Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research"[12]. Since categories extracted in the positive context were [knowing the disabled person's thoughts], [attending to the disabled person's needs], and [imagining the disabled person's actual life], then the physical therapists focused on the principles of respect for autonomy, non-maleficence, and beneficence during therapeutic interventions, and thus acquired the perspective to realize them in the clinical thinking process regarding the use of acceptance of disability. It will be necessary to generate the basis for one's own judgment of use in acceptance of disability by encouraging reflection in training programs as well. Incorporating innovations for this purpose is considered a challenge for program development.

Regarding changes in clinical content caused by not using acceptance of disability, the following were suggested: [Believing in the possibility of change in the disabled person over time] and [aiming at building a trusting relationship that allows the disabled person's true feelings to be heard and becoming more proficient in interventions]. In a report by occupational

Table 6. Changes in clinical content resulting from not using acceptance of disability

Case no.	Narrative	Narrative coding of changes in clinical content
1	In fact, it would be good if we could help them find ways to improve their lives, rather than forcing them to work hard to overcome difficulties in their own lives. In the recovery period, the therapist is involved with the patient for three to six months, during which time they try to achieve some kind of result or to reach a certain point. If the patient does not reach that point, it is said that the patient has not accepted their disability, or they tend to stick to the rehabilitation. However, it is usual that the person with disabilities is involved in rehabilitation for two or three years, especially at a geriatric health care facility. I think they are jumping to conclusions too quickly. I think that is probably a big problem on our side. I sometimes wonder if time is also necessary.	Not jumping to conclusions
2	I was told by the care manager that the patient was no longer in a stage appropriate for a home visit, and I could understand that. However, I also think that some things will change if they continue rehabilitation. I don't think they should be judgmental like that. There is a care manager who says that I should just accept it and move on to the next patient. However, I think that if they really engage in rehabilitation, there will be some change. If there is something we can do, or even if there is not, I will try various things, and if they continue to like it, I will keep it in my mind. Well, I'm totally willing to go along with the patient.	Don't assume that there will be no change any more, Believe in the possibility of change and try various intervention methods
3	If I go to a maintenance care facility, I often hear things like, "it would have been better if they did this more in the recovery phase", or If I go to the recovery phase, they say things like, "why didn't they do this in the acute phase?" There was no point in complaining about it, so I became very careful about the way I wrote patient referral documents and so on. I don't remember exactly now, but I think that when expressing the patient's current condition, rather than focusing on the patient's acceptance of disability, I started to give specific examples and write about how this happened and how the patient responded to my efforts.	Provide appropriate information on the person with disabilities to collaborating agencies
5	After all, you can't take the disabled person out of their house unless you get close to them. If I say yes, it's like I'm selling something to them. Even if I tell them it's good and they don't want it, then they still don't want it. First of all, you have to build a relationship of trust with them, or at least a relationship that says, "I'm looking at this from the same point of view" or "I understand, but would you like to try something like this once?" But, even if it's just once, I'd like to see them try something like this. It still takes a little time. I think we need to dig a little deeper into the background of why the patient doesn't want to give it a go.	Build a relationship with the person with disabilities to gain their trust so that they would accept the therapist's suggestions
9	I think it is not only about acceptance of disability but I used to be very enthusiastic about the idea of being close to the patient, to say the least. However, now, it is considered fruitless if therapy ends at just getting close to the patient; the emphasis has shifted to the need to move on to the treatment that can be acquired in a set period of time. When acceptance of disability was not going well, I focused on what I could do, or rather, on what I could do first, or on what was realistic, and I think it was true that I became self-righteous, but if possible, I hope to hear from the patient what they really think, what they actually need and want to do.	Do not place too much focus on being close to the person with disabilities, Identify the actual needs of the person with disabilities and try to make them possible within a limited period of time

The main points of the narrative are underlined.

therapists[7]), "changes in the relationship with the disabled person" include "presentation of options", "emphasis on dialogue to share goals", "implementation of treatment in accordance with the disabled person's wishes", and "collaboration and support for the disabled person's life in the community". The content may differ slightly between physical and occupational therapists. In addition, the definition and theory of acceptance of disability are often explained in the educational courses of training schools for physical therapists. For one, acceptance of disability is an easy-to-use term for physical therapists[3]). However, not choosing to use acceptance of disability because they feel that it is not the only value that physical therapists have can be considered an important opportunity to change the content of their clinical practice. Specifically, by refraining from the use of acceptance of disability, then a change is taking place that does not set the limits of intervention too early but rather opens up to an orientation that emphasizes the disabled person's feelings, diversity of interventions, and collaboration with other agencies and departments that are not limited to their own organization. Here, we can see the significance and role of training programs that step away from acceptance of disability and promote a social model of disability.

From the above, the training program should target physical therapists with less than five years of clinical experience who use acceptance of disability without question (including those who lack years of experience). The program content should provide opportunities for reflection, specifically incorporating [use of acceptance of disability in other professions and surroundings], [guidance and comments from senior staff], and [exposure to the disabled person's commitment to life

and diversity]. To confirm the effectiveness of the training program, program facilitators should ask the participants to provide evidence for their own judgments on the use of acceptance of disability. Ultimately, it is necessary to have a system to formatively evaluate whether the physical therapists themselves have grown in terms of [believing in the possibility of change in the disabled person over time] and [aiming at building a trusting relationship that allows the disabled person's true feelings to be heard and becoming more proficient in their interventions]. In particular, since such a training program places importance on the physical therapist's inner prompting, developing and implementing formative evaluation methods are considered crucial to success.

Regarding the limitations and challenges of this study, the possibility that the target population was biased cannot be ruled out because sampling was conducted through social media and lectures out of the need to obtain in-depth narratives on the clinical experiences of physical therapists. In the future, we would like to work on the content of the training program and formative evaluation methods based on the results of this qualitative survey, and verify the effectiveness of the training program.

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