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Accessible tourism and its benefits for coping with stress

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ABSTRACT

The present study had two main objectives: (i) to understand the relationship between tourism and stress-coping for individuals with disabilities, and (ii) to develop an empirical basis for therapeutic purposes and for improving new tourism products and policies, in a biopsychosocial framework. An empirical study was conducted using participants with disabilities ($N=306$) who were assessed with the Leisure Coping Scale adapted to the Accessible Tourism context. The positive influence of tourism on these individuals' biopsychosocial dimensions of stress-coping is identified and discussed. Results suggest that accessible tourism should be recognized as a new stress-coping resource for disabled people, supporting the rebalancing of their personal and social resources, positively contributing to their health and well-being. These findings provide further evidence for the development of new tourism products targeted to a population with special needs, and for accurate policies of alternative therapeutic interventions in the context of their rehabilitation.

RESUMEN

El estudio tiene como objetivos principales los siguientes puntos: (i) para comprender la relación entre turismo y estrés coping para personas con discapacidad y para desarrollar una base empírica para propuestas terapéuticas para el desarrollo de nuevos productos de turismo. Un estudio empírico fue conducido en pacientes con discapacidad ($N=306$) que han tenido acceso a la Escala Leisure Coping adaptada en un contexto de turismo accesible. La influencia positiva del turismo en estos individuos a nivel psicosocial fue identificada y discutida. Los resultados sugieren que el turismo accesible puede ser una nueva herramienta de estrés-coping para personas discapacitadas soportando el reequilibrio de sus vidas personales y sociales, contribuyendo para la salud y bienestar. Estos resultados pueden garantizar descubiertas para el desarrollo de nuevos productos para poblaciones específicas con necesidades especiales y aún

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MOTS-CLÉS

Tourisme accessible; stress-coping; handicap

关键词

可进入旅游; 压力处理; 残疾

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para nuevas y alternativas políticas terapéuticas en contextos de rehabilitación.

RÉSUMÉ

Cette étude vise deux objectifs principaux: (i) comprendre la relation entre le tourisme et l'adaptation au stress pour les personnes handicapées, et (ii) développer une base empirique à des fins thérapeutiques et à l'amélioration de nouveaux produits touristiques dans un cadre biopsychosocial. Une étude empirique a été menée auprès des participants ayant un handicap ($N = 306$) qui ont été évalués à l'aide de l'échelle de loisir adaptée au contexte du tourisme accessible. L'influence positive du tourisme sur les dimensions biopsychosociales de l'adaptation au stress de ces personnes est identifiée et discutée. Les résultats suggèrent que le tourisme accessible devrait être reconnu comme une nouvelle ressource pour les personnes handicapées qui résistent au stress, en soutenant le rééquilibrage de leurs ressources personnelles et sociales, contribuant positivement à leur santé et à leur bien-être. Ces résultats fournissent des preuves pour le développement de nouveaux produits touristiques focalisé sur une population ayant des besoins spéciaux et pour une politique précise des interventions thérapeutiques alternatives dans le contexte de leur réadaptation.

摘要

这个研究有两个主要的目的：(1) 了解旅游和残疾人士压力处理之间的关系，(2) 基于治疗目的以及改进新旅游产品和政策，用一个生物心理社会框架去建立一个实证的基础。此实证研究的对象是 306 名残疾人士，研究使用经调整适用于可进入旅游情景的休闲处理测量 *Leisure Coping Scale (LCS)* 来对这些调研对象进行评估。研究识别出以及讨论了旅游对这些人士处理压力的生物心理社会方面的正面影响。研究结果显示，可进入旅游应该被视为残疾人士的一个新的压力处理方法和资源，支撑着他们的个人和社会资源间的重新平衡，正面地促进了他们的身心健康和幸福。研究的这些发现为针对有特殊需求的人士的新旅游产品的发展提供了进一步的实证证据，也为在这些人士的复原时期的另类的治疗型方法的正确政策提出进一步的数据证明。

Introduction

The interaction between stress, coping and leisure or recreation was consistently studied, theoretically and empirically, by the prolific research of Lazarus and Folkman (1984). However, only a few authors have contributed to the increase of knowledge in the leisure field (Schneider & Iwasaki, 2003) and none, in particular, in the field of tourism.

The literature proved the importance of leisure for health benefits and overall well-being and particularly for the recovery and rehabilitation of individuals in extreme cases of loss or negative life events, such as the emergence of a disability (Kleiber, Reel, & Hutchinson, 2008). Moreover, tourism is a recognized Human Right and an important social activity (McCabe & Diekmann, 2015), increasingly related to what people do in their free time and within recreational activities (Mannell & Kleiber, 1997). It thus seems that social tourism is the appropriate framework for this research, as it refers to initiatives that

include individuals who would otherwise be excluded in tourism activities (Assipova & Minnaert, 2014). These include people living on a low income (McCabe, Minnaert, & Diekmann, 2012) or those socially disadvantaged, as is frequently the case of the disabled or the elderly (Walton, 2013).

So, in this study, we will analyse tourism as an activity developed in leisure time, whose intrinsic features and specific benefits are very important in coping, arousing feelings of freedom, autonomy and personal development, particularly relevant in minimizing and controlling stress (Folkman & Moskowitz, 2004). Our aim and research innovation objective is to fill this gap in knowledge, perceiving tourism as a coping resource for people with disabilities, one of the target groups of social tourism most frequently mentioned in the literature (Carneiro, Eusébio, Kastenholz, & Alvelos, 2013).

Regarding a more frequently studied type of disability – mobility impairment – and the fact that there is less-empirical evidence on other kinds of disability, the present paper also aims to eliminate part of this limitation, based on the empirical object established: people with physical and sensory disability, i.e. with mobility, visual and hearing impairments. The sampling limits also exclude the population with intellectual or mental disability, considering the complexity of the subject and its evaluation tools (Bramston & Fogarty, 1995), as it would not ensure reliable data and information collection (if they were themselves to answer the questions) or anything comparable to that (if it were their caregivers to respond).

Empirical evidence shows that leisure arouses positive feelings of freedom and personal development, which illustrates its potential to reduce and control stress by promoting social interaction, positive emotions and coping in the context of stressful situations (Folkman & Moskowitz, 2004). Since tourism is recognized as a source of positive impacts or benefits for an individual's overall well-being and long-term quality of life (La Placa & Corlyon, 2014; Neal, Uysal, & Sirgy, 2007), it can also be associated with stress reduction, which is why we decided to study the intrinsic aspects of this activity to minimize stress, from the perspective of people with disabilities.

This potential involvement of people with physical and sensory disability in tourism as a coping resource, is to be analysed, allowing us to establish two major research objectives. The first one, yielding a contribution to theory in the fields of tourism and psychology, namely in the domain of stress-coping, is to better understand the dynamic relationship between tourism and stress-coping amongst individuals with a disability. The second, more focused on practical implications, aims at an empirical basis for the development of relevant guidelines, not only for therapeutic purposes, but also for developing new, more inclusive tourism policies and products, rooted in a biopsychosocial approach. As suggested by the WTO Global Code of Ethics for World Tourism, 'Social Tourism and "Social Equity" is not a mere will of the wisp of idealists and marginalized pressure groups, but an aspiration shared at the highest levels of industry and governments' (Ryan, 2002, p. 19).

We will proceed by first presenting the literature review leading to the conceptual model proposed here. The methodology of data collection and analysis to then validate the model's hypotheses is presented as well as results of the empirical study. The final section is devoted to conclusions and a debate on the implications of results, some limitations of our approach as well as future avenues of research.

Literature review and conceptual model

Stress negatively affects peoples' lives in modern society, causing sickness and disease, diminishing daily performance and decreasing quality of life. The population with disabilities is probably more exposed to disadvantaged situations (Walton, 2013) or to different and more intense stress-inducing circumstances, which may cause instability – even more severe when affecting the individual's mental, psychological, emotional and even physical resources.

Accessible leisure tourism, adopted as the main focus of this research, induces positive effects on the development of its participants at various levels, which are even more intense for people with disabilities (Shaw & Coles, 2004). It may enhance positive emotions, thus serving the functions identified above, and may correspondingly be considered a stress-coping tool or a stress-control method, with particular relevance to the disabled population.

Research gaps in this area are evident, explaining the relevance of this study for the pursuit of knowledge and development of strategies to deal with stress for individuals with disabilities, with the potential of thereby contributing to health and quality of life of this population group (Mactavish & Iwasaki, 2005). Additionally, the involvement of people with disabilities in accessible tourism should enhance their social inclusion and permit the enjoyment of benefits that greatly affect their physical, social and mental well-being, thus positively contributing to their overall rehabilitation (Kastenholz, Eusébio, Moura, & Figueiredo, 2010).

Consequently, the relevance of this investigation is clear from (a) a scientific point of view, since it corresponds to a new area of knowledge in psychology, leisure and tourism, where research has given little attention to the role of leisure or recreational activities as stress-coping mechanism, particularly relevant for the disabled population (Iwasaki & Mannell, 2000; Kleiber, Hutchinson, & Williams, 2002; Lazarus, 1993; Zuzanek, Robinson, & Iwasaki, 1998), (b) a social perspective, as it promotes the inclusion of a population frequently affected by discrimination and prejudice, (c) a therapeutic angle, since it reveals means of enhancing the overall well-being of individuals with disability and (d) an economic standpoint, since it seeks to add arguments in favour of a new management paradigm in the tourism industry, namely 'accessible tourism' or 'tourism for all', stimulating loyal tourism demand.

Constructs established and selected were based on the studies of Lazarus and Folkman (1984), Iwasaki and Mannell (2000) and Mactavish and Iwasaki (2005), considering the population with disabilities as the research population (see Figure 1).

Through the presented conceptual model, it is possible to link the main topics under study, showing how it is suggested they interrelate and affect each other. What are the effects of tourism on people with disabilities? What are the benefits that tourism can provide to individuals with disabilities, so that they can cope with stress successfully? Do the individuals' type of disability and the socio-demographic profile influence the way they deal with stress through tourism? These questions served as a starting point for the methodological construction.

Based on the literature review, it can be assumed that stress-inducing circumstances are different for the individual with disability, when compared with the rest of the population. So, the way this individual will handle stress may also be different. Iwasaki and Mannell

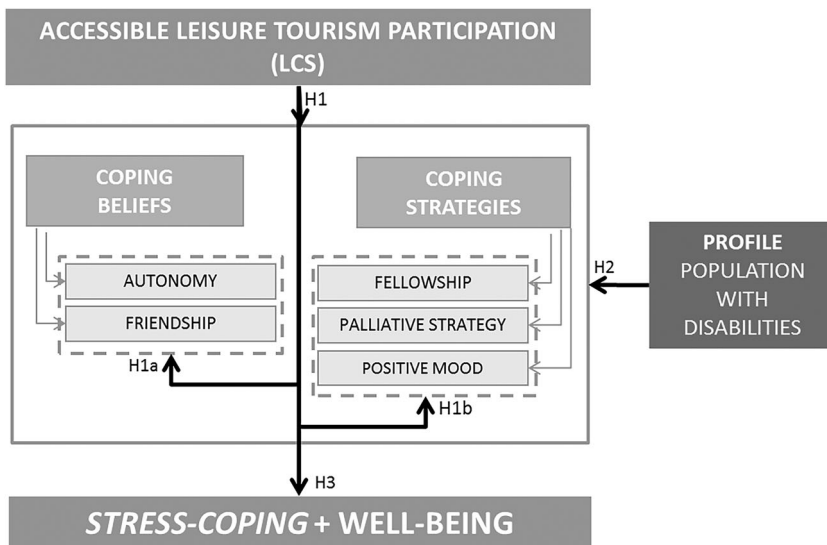


Figure 1. Conceptual model and research hypotheses.

(2000) proposed a hierarchical sub-dimension analysis of stress-coping through leisure, assessed through the Leisure Coping Scales (LCS). Its applicability to the population with disability is the first aim of the present study.

The benefits resulting from participation in accessible leisure tourism will be subject of coping beliefs and strategies, as also suggested and empirically confirmed by Iwasaki and Mannell (2000). Knowing that coping beliefs through leisure provide feelings of autonomy and the promotion of friendship and that coping strategies through leisure promote fellowship, palliative strategies and positive mood, it would be reasonable to think that both beliefs and strategies could have an impact on the stress-coping of individuals with disabilities.

Additionally, this positive effect or feeling of ‘inner power’ provided by participation in accessible leisure tourism activities leads to the possibility of considering tourism as an effective stress-coping resource for people with disabilities. Thus, it is important to understand the intrinsic and distinctive features of this special population and to understand how tourism can lead to overall well-being (Brown & Hall, 2005; Coleman & IsoAhola, 1993; IsoAhola & Park, 1996; Mannell & Kleiber, 1997; Mueller & Kaufmann, 2001). In this case, we suggest the following hypotheses:

H1- Participation in accessible leisure tourism activities positively affects various biopsychosocial stress-coping dimensions of the individual with physical and sensory disability:

H1a – Participation in accessible leisure tourism activities has a positive effect on the coping of people with physical and sensory disabilities, through coping beliefs;

H1b - Participation in accessible leisure tourism activities has a positive effect on the coping of people with physical and sensory disabilities, through the development of coping strategies;

H2- Coping beliefs and strategies through tourism vary, depending on the type of disability and the socio-demographic and economic profile of individuals;

H3- Stress-coping through tourism rebalances and harmonizes the resources of people with physical and sensory disability, positively influencing their overall well-being.

This conceptual model and hypotheses suggested will be validated with data collected from an empirical study, as explained in the following section.

Methodology

We opted for a multidimensional and interdisciplinary strategy, in order to understand the beliefs and coping strategies of individuals with disabilities in a specific leisure context – tourism – trying to simultaneously measure the impact of leisure activities in the context of accessible tourism in the control and management of stress for these individuals. Tourism and especially stress-coping are social phenomena, as they imply contact, interaction and social support (Coleman & IsoAhola, 1993; Hood & Carruthers, 2007; IsoAhola & Park, 1996; Iwasaki, 2001; Iwasaki & Mannell, 2000; Kleiber et al., 2002). Simultaneously, they may be considered individual phenomena, requiring intimate psychological processes, making their study most complex (Jennings & Nickerson, 2006; Kastenholz, Eusébio, Figueiredo, & Lima, 2012). A full understanding of this reality requires both introspection and interpretation, through a phenomenological approach, as suggested by Cohen (1979) and Elands and Lengkeek (2000).

Concerning research design, a transversal, correlational and quantitative study method was used, as detailed next.

Sample

The survey took place in Portugal, over a period of 4 months, from June to September 2013, in person or electronically, according to the convenience of the respondents (people with mobility, visual and hearing impairments). This application period was chosen so as to obtain answers in which the tourist experience had been recent. Additionally, respondents were asked to indicate how long ago the last tourist experience had been, and all those who indicated ‘more than one year’ were excluded. A ‘snowball’ sampling technique was used, consisting of the initial contact with some elements of the target population, who indicated other possible participants with the same characteristics or characteristics required by the study, thereby fostering networks of formal and informal contacts relevant to this study.

A total sample of responses from 306 individuals with physical and sensory disability was obtained. This sample consists mainly of individuals between 25 and 44 years of age (60.6%), distributed almost equally by gender (56.4% male, 43.6% female). Out of these respondents, 66.2% present a motor disability, 15.7% a hearing disability and 14.4% a visual disability, and only 3.6% have another sort of incapacity, a category that includes the combination of any of the above (see Figure 2).

When asked about the severity of their disability, survey participants state they have a serious problem (83.7%) and only a few consider that their disability is not a problem (2.9%) (Table 1). This information collection was inspired by the International Classification of Functioning, Disabilities and Health (ICF), whose codes require the use of one or more qualifiers (Functions and Body Structures, Activities and Participation and Environmental Factors) that indicate the magnitude of health or the severity of disability:

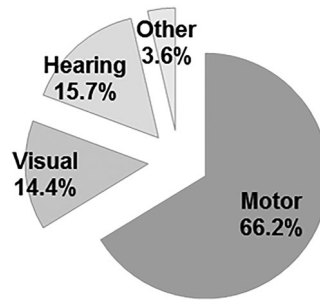


Figure 2. Type of disability.

Table 1. Severity of disability.

Severity of disability	Frequency (No.)	Percentage (%)
Not a problem	9	2.9
Slight problem	2	0.7
Moderate problem	3	1.0
Serious problem	256	83.7
Severe problem	20	6.5
Did not answer	16	5.2
Total	306	100.0

(i) .0 Not a problem (none, absent, insignificant); (ii) .1 Slight problem (light, small); (iii) .2 Moderate problem (medium, regular); (iv) .3 Serious problem (large, extreme); (v) .4 Severe problem (total); (vi) .8 Not specified; (vii) .9 Not applicable (WHO, 2004). As might be expected, 63.2% need some kind of mobility aid, and out of those, 41.7% refer to a wheelchair (manual or electric) as the main technical assistance, followed by crutches (8.1%) and guide dogs for assistance (2.3%).

As far as socio-demographics are concerned (see also summary in Table 2), the respondents' family situation is shaped by most being unmarried (58.9%), while 33.0% are married or have a partner, with a large majority not having any children (71.4%). Interestingly, 44.6% of the respondents are employed and only 14.3% are unemployed (see Figure 3), with the majority showing a high-educational level (39.6% with a higher education degree and 37.6% having completed secondary education), contrary to what was found in previous research concerning this target population in Portugal (Casas, 2005; Centro de Reabilitação Profissional de Gaia, 2007; Gonçalves, 2003).

Table 2. Summary of socio-demographic profile of the sample.

	Variables	Mode
Socio-demographic characteristics	Age group	[25–44] (<i>N</i> = 186)
	Gender	Male (<i>N</i> = 172)
	Type of disability	Motor (<i>N</i> = 202)
	Severity of disability	Serious problem (<i>N</i> = 256)
	Family situation/Marital status	Single (<i>N</i> = 179)
	Parenthood	No children (<i>N</i> = 217)
	Professional situation	Employed (<i>N</i> = 137)
	Qualifications	Higher education (<i>N</i> = 120)
	Income	[€240–€480] (<i>N</i> = 60)



Figure 3. Employment status.

Finally, discretionary monthly income is mostly under €960, and it should be stressed that 19.6% of respondents earn between €240 and €480, 17.3% from €480 to €720, 13.7% from €720 to €960, and 11.1% less than €240.

Considering that the present research focuses on tourism, it was also relevant to understand tourism preferences of the individuals in the study. Thus, 44% of respondents showed a preference for sun and sea activities during their holidays, followed by cultural and nature tourism activities, with respectively 16% and 15% of the preferences. Results also highlight the fact that the level of satisfaction with these activities is quite high, ranging from satisfied (27%) to very satisfied (33%), considering a single-item, 5-point Likert-type scale (1, 'Not satisfied, at all'; 5, 'Very satisfied'). Finally, it is noteworthy that respondents refer to the habit of travelling mostly with family and friends (80%).

Measures

The questionnaire consisted of the adaptation of two scales already tested and validated by Iwasaki and Mannell (2000) and translated into Portuguese by Santos, Ribeiro, and Guimarães (2003) – the Leisure Coping Beliefs Scale (LCBS) and Leisure Coping Strategies Scale (LCSS), introducing two innovations: its application to people with physical and sensory disability in the context of leisure tourism. These scales included, essentially, closed-ended questions, i.e. questions demanding answer choices to be chosen by respondents, depending on their situation, opinion or preferences, particularly measuring behaviour choices and emotions through Likert scale graduations (1, 'Disagree'; 5, 'Strongly Agree').

Based on Iwasaki and Mannell's (2000) model, the adequacy and adjustment of scales applied was initially inspected firstly by calculating the Spearman correlation coefficient between the various stress-coping dimensions, and then the Cronbach's Alpha coefficients.

In this research, the adapted assessment instruments were first validated as to their adjustment and legitimacy. Secondly, results of the adapted scales, appropriate to the context and population in study, were analysed. So, we started with a confirmatory factor analysis rather than with an exploratory factor analysis as the scales adopted were an adjustment of the original LCS, assessing the constructs of the proposed interpretation model. Some variables did not show satisfactory values, requiring the elimination of some items of the original structures of the LCS, resulting in new scales adjusted to accessible leisure tourism, labelled here Leisure Coping Scales in the context of Accessible Leisure Tourism (LCS-ALT – see Appendix I). The results obtained demonstrate the

feasibility of the biopsychosocial stress-coping dimensions suggested in the LCS-ALT for a subsequent analysis of the proposed model, contributing to a better understanding of the phenomena under study.

Procedure and data analysis

Descriptive statistics permit sample characterization and specification of general information about biopsychosocial stress-coping dimensions, hierarchically organized by beliefs and strategies within leisure tourism for people with disabilities. Inter-relationships between different variables influencing these coping mechanisms (beliefs and strategies) were assessed by correlational analysis and variable association tests (correlations). Finally, the association between types of disability and socio-demographic characteristics of respondents and the coping beliefs and strategies was checked using bivariate analysis, namely the non-parametric Mann–Whitney U test (when variables did not meet the assumptions of the *t-test*).

Descriptive statistics, normality tests and bivariate analyses were performed using SPSS software, while the confirmatory factor analysis was achieved with LISREL computer software. In short, analysis of the data collected through the questionnaire-based survey helped validate hypotheses H1, H2 and H3.

Results and discussion

The statistical analysis allowed us to understand the relationships suggested in the research model and respective hypotheses, firstly through univariate data analysis by determining absolute frequencies and average values, then through a correlation analysis between constructs, culminating in bivariate analysis, through inferential tests (Mann–Whitney U test and Kruskal–Wallis).

Note that results are generally presented for the whole sample ($N = 306$) and, when appropriate to the research objectives, separated according to three subsamples, corresponding to the three types of disability analysed: motor, hearing and visual.

Leisure coping scales in the context of accessible leisure tourism

Following Iwasaki and Mannell (2000), the Leisure Coping Beliefs Scale, **LCBS-ALT**, may be split into two relevant coping dimensions: **Autonomy** and **Friendship**. Autonomy can be divided into the sub-dimensions of Self-Determination and Empowerment, while Friendship includes the sub-dimensions of Emotional Support, Self-Esteem, Tangible Aid and Information Support.

In a global perspective, descriptive results indicate mean, median and mode values mostly above 3, except for item 29, 'I lack emotional support from my travel companions', averaging 1.91 ($SD = 1.16$), and median and mode averaging 1 point, but this is an inverted item. Moreover, item 11 stands out: 'what I do within tourism allows me to feel good about myself, with the highest mean (4.40, $SD = 0.72$), mode (5) and median (5) values.

Results for the sub-dimensions (Self-Determination, Empowerment for Autonomy; Emotional Support, Self-Esteem, Tangible Aid and Information Support for Friendship) are detailed next.

Regarding **Self-determination**, there is a mean of 4.33 (SD = 0.81), which is above average for item 2: ‘tourism provides opportunities to regain a sense of freedom’. In the **Empowerment** sub-dimension, the above-cited item 11 is emphasized, but items 4 (‘I gain feelings of personal control in tourism’) and 19 (‘things I do within tourism help me to gain confidence’) also have a mean around 4 points. In the case of **Emotional Support**, we highlight item 28 (‘I feel emotionally supported by my travel companions’), with a mean of 4.05 (SD = 0.93). Considering **Self-Esteem**, we highlight the top results obtained in every item, emphasizing item 1: ‘my travel companions help me feel good about myself’ (mean 4.29, SD = 0.90), item 10: ‘my travel companions hold me in high esteem’ (mean 4.26, SD = 0.83), and item 21: ‘I am respected by my travel companions’ (mean 4.39; SD = 0.80). In **Tangible Aid**, item 25 (‘most of my travel companions are happy to take care of my house (apartment), children or pets when I am away’) stands out negatively, with a mean of only 2.83 (SD = 1.26). This result, as mentioned in the study of Santos et al. (2003, p. 444), using the same scale, ‘may be related to the possible lack of application to the Portuguese context’, since most respondents show disability situations that cause physical dependence on others, which explains the fact that many of them live with their families, not having their own residence or pets. Finally, under **Information Support**, all items reach medians above 4 points, except for item 3, ‘my travel companions assist me in deciding what to do’, with a mean of 3.38 (SD = 1.07).

In short, it appears that both large dimensions have very high degrees of agreement, while the **Empowerment** sub-dimension within the larger dimension **Autonomy** stands out with item 11 (feeling good about oneself through tourism), and sub-dimension **Self-Esteem** standing out in the dimension **Friendship**, with the globally most significant average values.

As far as leisure coping strategies are concerned, the **LCSS-ALT** measures three major dimensions: **Companionship**, **Palliative Strategy** and **Positive Mood**. Results show that all items reach a median of 3 and 4 points, which means that the majority of the respondents ‘agree moderately’ (3) or ‘strongly’ (4) with the statements related to coping strategies through leisure tourism, as is observable in Table 3.

Within the dimension **Companionship**, item 18 stands out: ‘one of my strategies to deal with stress was participation in social tourism’ (mean = 3.23, SD = 1.23); lower than the other items, with modes of 4 points and means above 3.30, in particular item 5, ‘socializing in tourism was a means of managing stress’ (mean = 3.51, SD = 1.18). In the **Palliative Strategy** dimension, item 3 – ‘I engaged in a tourism activity to temporarily

Table 3. Descriptive results of the dimensions and sub-dimensions of LCS-ALT.

	Mean	Median	Standard deviation (SD)	Min.	Max.	Skewness	Kurtosis
LCBS-ALT	3.85	3.86	0.53	2.17	5.00	-0.37	-0.02
Autonomy							
Self-determination	4.10	4.00	0.78	1.00	5.00	-0.99	0.98
Empowerment	3.98	4.00	0.70	1.33	5.00	-0.70	0.79
Friendship							
Emotional support	3.28	3.33	0.54	1.67	5.00	0.09	0.99
Self-esteem	4.23	4.25	0.68	1.50	5.00	-0.91	0.69
Tangible aid	3.66	3.69	0.82	1.25	5.00	-0.34	-0.30
Information support	3.74	3.75	0.71	1.25	5.00	-0.51	0.32
LCSS-ALT	3.51	3.57	0.72	1.00	5.00	-0.33	0.04
Companionship	3.38	3.50	0.99	1.00	5.00	-0.45	-0.30
Palliative strategy	3.21	3.33	0.82	1.00	5.00	-0.26	-0.05
Positive mood	4.09	4.00	0.67	1.00	5.00	-0.73	1.17

get away from the problem’ – stands out with lower agreement values. Items 4 – ‘escape through tourism was a way of coping with stress’ – and 9 – ‘tourism was an important means of keeping myself busy’ show relatively high agreement values. Finally, items associated with **Positive Mood** present the highest mode (5 points) as well as the higher mean values, above 4.20, more specifically, items 6 – ‘I gained a positive feeling from tourism’ (mean of 4.20, SD = 0.89) and 10 – ‘I maintained a good mood within tourism’ (mean of 4.28, SD = 0.79).

In general, the dimension that gets lowest agreement values is the descriptive **Palliative strategy**, with means that vary from 2.50 to 3.50, followed by **Companionship**, averaging from 3.00 to 3.50 approximately, as compared with more positive evaluations of the dimension **Positive Mood** with averages above 3.50.

So, taking some adjustments into account, we worked with an instrument named the LCS-ALT, as shown in Appendix 1. The adaptation of the LCS for the particular context of accessible leisure tourism, considering the special features of a population with motor and sensory disability, proved to be an appropriate procedure for the objectives of this investigation.

Therefore, results of the application of LCS-ALT allow us to draw conclusions about the impacts or benefits of accessible leisure tourism in the management and control of stressful situations, as suggested in hypothesis H1 (Participation in accessible leisure tourism positively affects various biopsychosocial stress-coping dimensions of the individual with physical and sensory disability). Considering both H1a and H1b, a ‘positive effect’ is assumed when agreement levels are equal to or greater than 2 points, based on the 5-point Likert scale used. Results obtained by descriptive analysis thus confirm hypotheses H1a and H1b, showing that the average values (mean, median and mode) for both scales, LCBS-ALT and LCSS-ALT, are in general above 3 points, proving that participation in accessible leisure tourism activities has a positive effect on coping for people with disabilities, either through the beliefs associated with such participation, or through strategies developed during participation. Similar to other studies in social tourism, disabled people revealed a strong interest in leisure tourism activities, with these activities being considered of utmost importance for self-development (socially, physically and intellectually), self-esteem (becoming proficient in challenge management), life satisfaction and overall quality of life (Kastenholz, Eusébio, & Figueiredo, 2015). The above-mentioned authors argue that these effects are particularly relevant for supporting social tourism policies yielding social inclusion of this underprivileged group of individuals.

For testing the hypothesis regarding coping beliefs and strategies through accessible leisure tourism, correlations with Spearman’s coefficient (ρ) were calculated.

LCBS-ALT shows very strong association values with the sub-dimensions **Information Support** ($\rho = 0.83$), **Self-Esteem** ($\rho = 0.82$), **Empowerment** ($\rho = 0.79$), and **Tangible Aid** ($\rho = 0.77$) (see Table 4). These sub-dimensions referring to the same main construct of Coping through Leisure may sometimes be associated, as can be seen through statistical correlational tests (see Table 4). For example, Self-Determination is closely related to Empowerment ($\rho = 0.70$), both belonging to the same sub-dimension ‘Autonomy’. Self-Esteem is also correlated with Tangible Aid ($\rho = 0.66$) and Information Support ($\rho = 0.67$), although these last two relations are not as strong as that previously reported.

Results thus highlight Empowerment within Autonomy and Self-Esteem, Tangible Aid and Information Support in the context of Friendship, making it clear that these are the

Table 4. Correlations between LCBS-ALT dimensions and sub-dimensions.

<i>Spearman</i> coefficient			Autonomy			Friendship			
			LCBS-ALT	Self-determination	<i>Empowerment</i>	Emotional support	Self-esteem	Tangible aid	Information support
ρ	LCSB-ALT		1.000	0.570**	0.789**	0.540**	0.821**	0.769**	0.832**
	AUTONOMY	Self-determination	0.570**	1.000	0.700**	0.147*	0.350**	0.233**	0.291**
		<i>empowerment</i>	0.789**	0.700**	1.000	0.266**	0.529**	0.408**	0.503**
	FRIENDSHIP	Emotional support	0.540**	0.147*	0.266**	1.000	0.421**	0.339**	0.500**
		Self-esteem	0.821**	0.350**	0.529**	0.421**	1.000	0.664**	0.671**
		Tangible aid	0.769**	0.233**	0.408**	0.339**	0.664**	1.000	0.658**
		Information support	0.832**	0.291**	0.503**	0.500**	0.671**	0.658**	1.000

** Correlation is significant at 0.01 (2-tailed).

* Correlation is significant at 0.05 (2-tailed).

biopsychosocial dimensions which are most associated with beliefs which individuals with disabilities hold when participating in accessible tourism.

Also, for the domain of **LCSS-ALT**, all dimensions are highly correlated (Table 5). Interestingly, **Companionship** and **Palliative Strategy** show a robust association in statistical terms, with $\rho = 0.73$. Results suggest that when people with disabilities participate in tourism activities, they develop coping strategies that are perfectly connected to each other, including Companionship, Palliative and Positive Mood strategies.

Correlational analysis of both scales (LCBS-ALT and LCSS-ALT) confirm the validity of the adjustments made, with strong associations between multiple selected items and between different dimensions and sub-dimensions assessing stress-coping.

Specifically, it was possible to confirm hypothesis H1 and thereby specify additional benefits of participation in leisure tourism for individuals with a disability, since tourism participation showed a clearly positive effect on all biopsychosocial dimensions analysed in the LCS (regarding both beliefs and strategies), considering univariate and correlational analysis results. Of note are the results of the correlation analysis, indicating a strong and robust relationship between all sub-dimensions of LCBS-ALT, except for slightly weaker correlations for the Self-Determination and Emotional Support sub-dimensions and all dimensions of LCSS-ALT, only slightly weaker in the case of Palliative Strategy, suggesting the reinforcement of its measurement (e.g. by increasing the number of items related to each).

The results described above and Iwasaki and Mannell's (2000) theoretical framework allow us to conclude that accessible leisure activities positively influence coping beliefs and strategies (H1a and H1b), which in turn positively affect the various biopsychosocial dimensions of individuals with disabilities (H1). As suggested by Bos, McCabe, and Johnson (2015), experiential learning occurring in a holiday environment stands out in the acquisition of knowledge and skills. Thus, the capacity of coping may be learnt through leisure tourism experiences, which should be accessible to as many people as possible. Given that this group of individuals still reveals serious financial and societal constraints, and that social tourism represents millions of people and is one of the most relevant and promising niches (Bélanger & Jolin, 2011), the implications of these findings for social tourism policies are undeniable.

On the whole, these results reinforce the validity of the LCS-ALT measurement instrument proposed here, and also confirm the significance of tourism for the disabled population in the domain of stress-coping. This suggests a call for corresponding social tourism action yielding the health and social inclusion benefits so urgently needed by this oft-neglected and clearly disadvantaged population group.

Besides, bearing in mind that the focus of this research is a population with very specific intrinsic characteristics, it is imperative to assess the variation of coping beliefs and

Table 5. Correlation between LCSS-ALT dimensions.

Spearman coefficient		LCSS-ALT	Companionship	Palliative strategy	Positive mood
ρ	LCSS-ALT	1.000	0.902**	0.912**	0.712**
	Companionship	0.902**	1.000	0.730**	0.540**
	Palliative strategy	0.912**	0.730**	1.000	0.508**
	Positive mood	0.712**	0.540**	0.508**	1.000

** Correlation is significant at 0.01 (2-tailed).

* Correlation is significant at 0.05 (2-tailed).

strategies depending on the type of disability and the socio-demographic and economic profile of the case study population. Thus, through bivariate analyses relating dimensions and sub-dimensions of LCBS-ALT and LCSS-ALT with the variables (a) type of disability, (b) gender, (c) marital status, (d) parenthood, (e) qualifications and (f) income, it was possible to confirm hypothesis H2.

Factors conditioning the impact of coping beliefs and strategies through tourism for persons with disability

In order to assess the impact of a series of profiling variables on responses to the LCBS-ALT and LCSS-ALT variables, we initially tested ANOVA assumptions of normal distribution and homoscedasticity. As none of the assumptions were verified, we opted for the non-parametric alternatives: Kruskal–Wallis and Mann–Whitney *U* test for verifying the relationship between a dichotomous variable (if two categories, Mann–Whitney *U*, if more, Kruskal–Wallis) and the scale variables, i.e. to compare two or more independent samples regarding the ordinal scale variable. For purposes of interpretation, only results with a 5% significance level are considered.

In the following sub-sections, Mann–Whitney *U* and Kruskal–Wallis test values are presented, with significance values and, finally, global means of ranks revealing the level of agreement (in brackets), for analysing the relationship between the coping belief and strategy scales and: (a) type of disability, (b) gender, (c) marital status, (d) parenthood, (e) qualifications and (f) income.

(a) Type of disability

The Kruskal–Wallis test showed that LCBS-ALT is influenced by respondents' type of disability ($X_{KW2} (2) = 21.45$; $p = 0.00$), in its sub-dimensions of Information Support ($X_{KW2} (2) = 8.72$; $p = 0.01$), Self-Determination ($X_{KW2} (2) = 13.13$; $p = 0.00$), Empowerment ($X_{KW2} (2) = 14.43$; $p = 0.00$), Self-Esteem ($X_{KW2} (2) = 30.53$; $p = 0.00$) and Tangible Aid ($X_{KW2} (2) = 38.94$; $p = 0.00$).

The Dunn test for non-parametric pairwise multiple comparisons based on rank sums permitted the identification of the exact position of significant differences (Marôco, 2010). The Dunn tests for **LCBS-ALT** as a whole indicate significant statistical differences ($p < 0.05$) between hearing and visual impairment and between hearing and motor impairment. No significant differences between visual and motor impairment were found. Specifically, for both **Autonomy** sub-dimensions (Self-Determination and Empowerment) individuals with motor disability show a higher Mean Rank value (159.14 for **Self-Determination**, 159.40 for **Empowerment**), meaning that they are the ones who agree most with achieving higher levels of autonomy through accessible leisure tourism, when compared to those with hearing impairment. Considering the sub-dimensions Emotional Support, Self-esteem, Tangible Aid and Information Support, all within the **Friendship** dimension, the Dunn test shows that there are differences in the sub-dimension **Self-Esteem**, where individuals with a motor disability show higher levels of agreement (162.37), when compared to those with hearing impairment. In the sub-dimensions **Tangible Aid** and **Information Support**, people with visual impairment show higher Mean Rank values (162.27 for Tangible Aid, 160.69 for Information Support) when compared to those with hearing impairment (Mean rank of 77.76 and

115.25, respectively), revealing higher levels of agreement to the corresponding support received from travel mates by those with visual impairment.

LCSS-ALT is also influenced by disability typology ($X_{KW2} (2) = 18.43, p < 0.001$), but Dunn tests only present significant statistical differences ($p < 0.05$) between motor and hearing impairments in the sub-dimension **Positive Mood**. As indicated by the mean rank values, individuals with motor impairment are those showing stronger agreement with the positive effects associated with mood (161.18 versus 159.10).

(b) Gender

As far as gender is concerned, it was found that neither **LCBS-ALT** nor its dimensions show any significant statistical difference. Thus, gender apparently does not impact leisure coping beliefs.

Leisure coping strategies assessed by **LCSS-ALT**, on the contrary, reveal higher mean values for women ($M = 3.61$; $SD = 0.69$) compared with their male peers ($M = 3.43$; $SD = 0.74$) and differences were statistically significant ($U = 9894.00$; $MW = 24772.00$; $p = 0.04$). Results demonstrated significant differences for the dimensions of **Companionship** ($U = 9546.50$; $W = 24424.50$; $p = 0.01$) and **Palliative Strategy** ($U = 9932.00$; $W = 24810.00$; $p = 0.05$), where women apparently perceive more benefits in stress-coping through accessible leisure tourism than men.

(c) Marital status

The variable 'marital status' only affects the **Information Support** sub-dimension in **LCBS-ALT** ($X_{KW2} (3) = 10.03$; $p = 0.02$). Dunn tests reveal significant statistical differences ($p < 0.05$) between married and single respondents, with single individuals agreeing the most with the effects provided by the Information Support sub-dimension (Mean Rank = 163.42 versus 130.27 for married individuals). Single individuals with disabilities may lack the consistent support of a partner, therefore feeling the need of information support more intensely when considering stress reduction through leisure tourism.

Likewise, **LCSS-ALT** is also influenced by the marital status of respondents: $X_{KW2} (3) = 25.34$; $p < 0.001$. Results pointed out statistically significant differences ($p < 0.001$) in **LCSS-ALT** between the categories 'single' and 'married', with unmarried individuals again presenting a higher Mean Rank value (168.35) when compared to married respondents (111.99). They correspondingly agree most with the effects associated with coping strategies through leisure tourism, particularly in terms of **Companionship** (Mean Rank = 166.99) and **Palliative Strategy** (Mean Rank = 169.68).

(d) Parenthood

On average, **LCBS-ALT** shows statistically significant differences ($U = 7297.00$; $W = 11125.00$; $p = 0.00$) between respondents without children ($M = 3.91$; $SD = 0.51$) and those with children ($M = 2.69$; $SD = 0.56$), in its sub-dimensions: **Empowerment** ($U = 7721.50$; $W = 11549.50$; $p = 0.05$), **Self-Esteem** ($U = 8103.50$; $W = 12068.50$; $p = 0.00$) and **Information Support** ($U = 6451.50$; $W = 10279.50$; $p = 0.01$) all revealing the same direction. That is, those without children perceive more benefits from accessible tourism in the mentioned dimensions, particularly regarding enhancement of autonomy as well as the role of travel mates presenting information support to these respondents.

Similarly, **LCSS-ALT** reveals higher mean values among respondents without children ($M = 3.60$; $SD = 0.70$) compared to respondents with children ($M = 3.28$; $SD = 0.72$) and differences were statistically significant ($U = 6935.50$; $W = 10763.50$; $p < 0.001$), especially in the dimensions of **Companionship** and **Palliative Strategy** ($U = 7042.00$; $W = 10870.00$; $p < 0.001$ and $U = 6909.50$; $W = 10737.50$; $p < 0.001$, respectively), with no relevant difference visible for the Positive Mood dimension.

Results of this analysis may be related to the previous results regarding marital status, with an active role in both marriage and parenthood suggesting a distinct general structure of daily life together with the partner and rest of close family. This probably also impacts on daily leisure and the consequent increased meaning of leisure tourism for those lacking such a daily family structure.

(e) Qualifications

No statistically significant differences in terms of education level could be found either for **LCBS-ALT** or for **LCSS-ALT** and respective sub-dimensions.

(f) Income

Income influences **LCBS-ALT** ($X_{KW2}(8) = 18.34$, $p = 0.02$) i.e. in at least one of the salary levels the scale distribution is statistically different in a significant way. Income also significantly influences the **Information Support** and **Empowerment** sub-dimensions $X_{KW2}(8) = 19.30$, $p = 0.01$ and $X_{KW2}(8) = 22.74$, $p = 0.00$, respectively.

Dunn tests confirm the statistically significant inequalities ($p < 0.05$) in **LCBS-ALT** (globally) and show specifically that individuals with the lowest level of income (those within wage category 'Less than 240 €') present a higher mean rank value for the whole **LCBS-ALT** ($p = 158.41$) and for the two mentioned sub-dimensions (Mean Rank = 162.69 for **Information Support**; Mean Rank = 157.74 for **Empowerment**). This means that respondents with lower incomes agree the most with the general beneficial effects suggested by **LCBS-ALT**, particularly regarding the effects of the sub-dimensions **Information Support** and **Empowerment**.

LCSS-ALT is also influenced by income $X_{KW2}(8) = 24.76$, $p = 0.00$, particularly for the **Companionship** and **Palliative Strategy** dimensions. Results show that individuals with the lowest incomes (<240 €) are those with higher mean rank values considering the whole **LCSS-ALT** (158.41), as well as the **Companionship** (161.99) and **Palliative Strategy** (169.57) dimensions. These individuals again show most agreement with the general effects of coping strategies through leisure tourism reflected in **LCSS-ALT** and specifically regarding its sub-dimensions **Companionship** and **Palliative Strategy**.

Zenko and Sardi (2014) claim the usual research approach to people with special needs in the context of social tourism is too one-sided and recommend a more substantial and holistic methodology to uncover this population groups' particular needs, benefits derived from and attitudes towards participation in tourism. Accordingly, results showed that coping beliefs of individuals with disabilities in accessible leisure tourism contexts vary according to the type of disability, marital status, parenthood and income, while neither gender nor educational background influence this category (coping beliefs) as a whole.

As far as the sub-dimensions of Autonomy (Self-Determination and Empowerment) are concerned, which vary between hearing and motor impairment, it was found that individuals with physical disability were those who agreed most with the positive effects

suggested in this dimension. These results are justified, as people with mobility difficulties tend to be subject to greater physical accessibility constraints and dependence on others to perform daily life activities, unlike deaf people, who face mainly communication barriers. Hence, Autonomy is a factor of greater importance for individuals with physical disabilities. Considering the Friendship sub-dimension, it is important to highlight Self-esteem, Tangible Aid and Information Support, with variations among individuals with hearing and motor impairments and between individuals with hearing and visual impairment. Self-esteem is more valued by people with motor disability, and the Tangible Aid and Information Support is more relevant for individuals with visual impairment. This variation is also understandable, as individuals with motor impairment will be those, whose disability is more visible, and therefore tend to be the ones who need to work on Self-Esteem the most. In turn, Tangible Aid and Information Support will be particularly relevant for blind people, as the simple impossibility of assessing visual cues from surroundings in an unfamiliar environment may trigger a stressful situation.

Marital status only influences the sub-dimension Information Support among single versus married people and is more significant for single individuals, while married individuals apparently do not value this aspect so much or are less concerned about it, possibly due to confidence in their partner. Similarly, and probably related to marital status, parenthood (having children or not) affects coping beliefs in general and, in particular, the Empowerment, Self-Esteem and Information Support sub-dimensions, since individuals without children may be more concerned with these leisure coping beliefs, as they are less integrated in a family structure and therefore more exposed to corresponding travel challenges.

Finally, considering income, it appears that those with lower incomes (less than 240€ per month) are the ones that agree the most with the effects of coping beliefs in the accessible leisure tourism context, especially regarding the Empowerment and Information Support sub-dimensions. This result is consistent with other studies suggesting that people from lower social classes would have greater willingness to participate in and be likely to derive greater benefits from leisure activities (Iwasaki, 2006; Mannell & Kleiber, 1997). This should be even more true for leisure in a tourism context, which is less available and thus more valued by poorer population groups, as found for low-income families (Lima, 2017) and also for many Portuguese individuals with disability, subject to social exclusion in diverse life spheres (Kastenholz et al., 2015).

Results also reveal that coping *strategies* for people with disabilities in the accessible leisure tourism context, as opposed to coping *beliefs*, vary within all defined socio-demographic categories, suggesting more heterogeneity of responses to the scales reporting actual travel challenges and how people coped with them in contrast to more general beliefs and attitudes regarding travel and tourism.

In general, results suggest that the proposed stress-coping model is valid in the leisure tourism context for people with physical and sensory disability. Therefore, also confirming other studies, there is strong evidence for assuming that individuals with disabilities develop coping beliefs and strategies through leisure tourism, reorganizing and reinforcing their internal resources, which allows them to handle, control and manage stressful situations, with obvious positive impacts on their overall well-being (Iwasaki & Schneider, 2003; Iwasaki, MacTavish, & MacKay, 2005; Zuzanek et al., 1998). These results also suggest the close link between accessible leisure tourism and social tourism, since

tourism was identified as an important tool for health, rehabilitation and social inclusion of persons with a disability, a generally marginalized group (Kastenholz et al., 2015). In this context, tourism may boost health benefits within combined tourism-rehabilitation programmes, as rehabilitation aims to enhance and restore functional ability and quality of life to those with impairments or disabilities, maximizing independence in activities of daily living (Kleiber et al., 2008; Mactavish & Iwasaki, 2005). Also, Carneiro et al. (2013) stress the potential of social tourism for generating important social benefits for persons with disabilities. Several other studies corroborate the potential of social tourism for enhancing social inclusion, health and well-being, as in the case of social tourism programmes directed to the elderly (Eusébio, Carneiro, Kastenholz, & Alvelos, 2016, 2017) or to young people (Foster & McCabe, 2015), with positive effects shown between tourist experiences and individual as well as social outcomes. Thus, considering both the social and therapeutic perspectives, one may suggest personal and social well-being as a final goal, summarizing the interpretations given to coping beliefs or strategies used by people with disabilities, within a social and leisure tourism context. Consequently, hypothesis H3 is confirmed, since stress-coping rebalances and harmonizes resources of people with physical and sensory disability, positively influencing their overall well-being.

Conclusions

Briefly, our results from both the literature review and empirical research respond to the proposed conceptual model and research objectives, as follows:

1. The LCS can be used in the context of accessible leisure tourism with the necessary adaptations, serving as a basis for assessing and interpreting the biopsychosocial dimensions of stress-coping developed by people with disabilities.
2. Coping beliefs associated with accessible leisure tourism are strongly related to biopsychosocial dimensions such as Autonomy, especially in its Empowerment sub-dimension, and Friendship, with proven emphasis on Self-Esteem in all types of disability;
3. Coping strategies developed during participation in accessible leisure tourism promote several biopsychosocial dimensions: Companionship, Palliative Strategy and Positive Humour, underlining Positive Mood as the dimension most valued by all individuals, regardless of their type of disability;
4. Coping beliefs and strategies associated with accessible leisure tourism apparently strengthens skills and capabilities of individuals with motor and sensory disability to handle, control and manage stress, supporting the rebalancing and harmonization of their personal and social resources, positively contributing to their health and global well-being.

These final conclusions suggest theoretical and practical implications for social inclusion-enhancing policies, specifically through accessible social tourism programmes, so as to enhance the opportunity of the disabled population of gaining new sources of stress-coping, empowerment and social inclusion through means of accessible leisure tourism. Social tourism initiatives thus seem desirable, increasing disadvantaged groups' participation in tourism activities (Eusébio et al., 2016, 2017; Kastenholz

et al., 2015). The theoretical evolution of the concepts involved in this debate as well as empirical evidence is as necessary here as progress of social awareness and corresponding social policies leading to increased accessible leisure tourism opportunities in practice (Kastenholz et al., 2015).

The main theoretical implications of the present study are: (i) clarification of the stress-coping phenomenon in the accessible leisure tourism context, particularly in terms of benefits or positive impacts on the development of biopsychosocial resources for individuals with motor and sensory disability; (ii) identification of social benefits as one of the main benefits of accessible leisure tourism; (iii) recognition of accessible leisure tourism as the preferred coping response for people with physical and sensory disability, through social dimensions, such as enhancement of Friendship and Companionship.

Some practical contributions of the present research project are: (i) enhanced awareness of the universal right to participation in tourism, including people with disabilities; (ii) increased general awareness of the added value and benefits of accessible leisure tourism for social inclusion; (iii) systematization of the biopsychosocial dimensions that are positively influenced by accessible leisure tourism, which could serve as a basis for planning new therapeutic interventions for the rehabilitation of individuals with physical and sensory disability; (iv) understanding accessible leisure tourism as a management model for the development of innovative social tourism products, based on social integration and promotion of health and well-being, in order to improve the destination's differentiation and competitiveness (Kastenholz et al., 2012). Accessible leisure tourism as a social tourism activity was shown to improve not only participants' health but also to promote positive effects for socio-economic development of destinations (Eusébio, et al., 2016; Vinogradova, Larionova, Suslova, Povorina, & Korsunova, 2015). Overall benefits resulting from social tourism are definitely of utmost importance for consequent policy development (Eusébio et al., 2016, 2017; Kastenholz et al., 2015).

Despite the relevance and timeliness of this paper to the progress of knowledge in tourism, some limitations and constraints of this study must be acknowledged. Firstly, the type of population studied here implies sample access constraints, since people with disabilities are a niche population in Portugal, relatively excluded from social life (Kastenholz et al., 2015), with relatively few qualifications, imposing difficulties in accessing a large number of respondents and implementing complex survey instruments with a certain level of abstraction. Secondly, constraints regarding the types of disability made data collection (frequently dependent on the availability of helpful intermediaries) difficult, involving delays in the survey process. Lastly, the variety of disabilities still leads to obstacles related to the need to adapt investigation techniques and tools, ideally requiring adapted research approaches.

Being conscious that limitations may turn into challenges to enhance knowledge and understanding of the investigated theme, we suggest the creation and validation of tools suited to different types of disability, which promote more a robust, consistent and proper assessment of the impact of tourism in relieving stress and consequently in promoting well-being and quality of life for the population with disabilities, in accordance with the heterogeneity of the group of individuals with disabilities (Figueiredo, Eusébio, & Kastenholz, 2012).

The results presented also alert us to the need for further studies to more clearly examine cultural, contextual and disability-based differences of the group of individuals studied here. Moreover, it would be of utmost interest to understand the differences between disabled individuals experiencing leisure tourism in the context of social tourism programmes and the general population. Also, the role of therapeutic intervention policies for individuals with disabilities in the context of rehabilitation deserves further study, so as to better understand and stimulate the potential of concerted action of all those involved in decision-making processes, either in tourism, social or health sectors. According to Diekmann and McCabe (2011), a strong European policy for social tourism could be the answer, through the implementation of an inclusive system, beyond the economic framework mainstream. We subscribe to Minnaert, Maitland, and Miller's (2006, 2009, 2011) contention that social tourism will not provide benefits spontaneously, since welfare agents need to be aware of their role in the process and to know exactly how they may encourage the desired outcomes. Continuous research enhancing our understanding and providing action-relevant orientation in the field is still needed.

Today, accessible tourism organizations depend on state intervention together with the voluntary sector, with its conception of 'social tourism' supported by taxes and/or enabled by charities and volunteers (Walton, 2013, p. 48). However, in order to reach the required level of social tourism development, structural, legislative, institutional and strategic aspects of public decision-making need to be considered (Vinogradova et al., 2015). In this context, La Placa and Corlyon (2014) suggest an interesting bottom-up development approach, through the introduction of social tourism at the local and community level, where local stakeholders and communities collaborate in social tourism partnerships and networks. In conclusion, independently of the political and destination context, this research paves the way to a new area of interest in the field of accessible tourism: the role of accessible leisure tourism in stress-coping of individuals with a physical and sensory disability. Emphasizing the potential of tourism as an effective means to promote social inclusion, health and well-being of individuals with disabilities, we argue that this potential should be implemented for every age group from childhood to old age. Thereby, accessible leisure tourism can contribute to primary prevention, avoidance of stress, anxiety, depression, health problems in general, and to secondary prevention, promoting rehabilitation. All these benefits should be understood as relevant for both the disabled individual's personal well-being and that of society overall.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Appendix 1

LCS-ALT: Leisure Coping Scales in the context of Accessible Leisure Tourism

LCBS-ALT: Leisure Coping Beliefs Scale in the context of Accessible Leisure Tourism

		LCBS-ALT	
		Number	Item
Autonomy	Self-Determination	lcbs2	Tourism provides opportunities to regain a sense of freedom
		lcbs5	Tourism is a self-determined activity for me
	Empowerment	lcbs 4	I gain feelings of personal control in tourism
		lcbs11	What I do within tourism allows me to feel good about myself
		lcbs15	I am able to openly express who I am in my tourism time
		lcbs19	The things I do within tourism help me gain confidence
		lcbs26	My tourism participation enhances my self-concept
		eccl30	Opportunities to express myself in tourism activities enhance my self-concept
	Friendship	lcbs7	My travel companions listen to my private feelings
		lcbs28	I feel emotionally supported by my travel companions
		lcbs29	I lack emotional support from my travel companions
	Self-Esteem	lcbs1	My travel companions help me feel good about myself
		lcbs10	My travel companions hold me in high esteem
		lcbs21	I'm respected by my travel companions
		lcbs24	I feel that I'm valued by my travel companions
	Tangible aid	lcbs12	When I need to borrow something, my travel companions will lend it to me
		lcbs14	If I need extra hands for doing tasks, I can turn to my travel companions
		lcbs16	My travel companions would lend me money if necessary
	Information Support	eccl25	Most of my travel companions are happy to take care of my house (apartment), children, or pets when I am away
		lcbs3	My travel companions assist me in deciding what to do
		lcbs18	My travel companions give me advice when I am in trouble
		lcbs20	My travel companions often provide me with useful information
		lcbs23	I can talk to my travel companions when I am not sure what to do

LCSS-ALT: Leisure Coping Strategies Scale in the context of Accessible Leisure Tourism

LCSS-ALT		
	Number	Item
Companionship	lcss5	Socializing in tourism was a means of managing stress
	lcss7	I dealt with stress through spending tourism time with my friends
	lcss8	Engaging in social tourism was a stress-coping strategy for me
	lcss18	One of my strategies to deal with stress was participation in social tourism
Palliative strategy	lcss3	I engaged in a tourism activity to temporarily get away from the problem
	lcss4	Escape through tourism was a way of coping with stress
	lcss9	Tourism was an important means of keeping myself busy
	lcss11	Engagement in tourism allowed me to gain a fresh perspective on my problem(s)
	lcss14	By escaping from the problem through tourism, I was able to tackle my problem(s) with renewed energy
Positive mood	lcss17	I took a brief break through tourism to deal with the stress
	lcss1	Tourism helped me feel better
	lcss6	I gained a positive feeling from tourism
	lcss10	I maintained a good mood within tourism
	lcss16	Tourism helped me manage my negative feeling