Fifth Edition

Inclusive and Special Recreation

Opportunities for Persons with Disabilities

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CHAPTER

4 DISABLING CONDITIONS

(Courtesy of Courage Center, Golden Valley, MN)

Beginning at a very young age, people are capable of observing different objects and recognizing properties that make these objects similar. Tables, for example, are recognized as large, flat surfaces usually supported by four legs. Doors have handles and open to provide access to the outside or another room. This ability to categorize objects based on common characteristics is essential to human functioning. It not only enables us to recognize things that are essentially the same, but it also allows us to distinguish between items that have different qualities and/or functions. Failing to make such judgments could be catastrophic; that is, it is essential to recognize that a chair is for sitting and a stove is for cooking, rather than vice versa.

LABELING

Categorizing, therefore, is a useful and necessary process in everyday life. However, it also presents problems. Categorizing can result in overlooking the uniqueness of each item within a category or class of objects. This is particularly troublesome when people, rather than objects, are categorized. Each human being desires to be recognized for his or her talents and assets. However, placing a categorical label on people with similar disabilities, a process known as labeling, interferes with recognizing the unique qualities of each individual with a disability. Furthermore, stereotypes may be formed, and these generalizations accentuate the differences (real or imagined) from people without disabilities.

Rosenthal and Jacobson (1968) demonstrated that labeling not only creates expectations that a member of a group will behave in a predictable way, but also can result in a self-fulfilling prophecy. In other words, a person, once labeled, may behave in a certain way *solely* because such behavior is expected of him or her. As a consequence of a self-fulfilling prophecy, a child labeled as mentally retarded may fail to achieve according to his or her cognitive capabilities because others *expect* failure. An adult with a disability may remain physically dependent on others because he or she *expects* such behavior.

Figure 4-1 summarizes the sequence just described. Placing a categorical *label* on an individual results in the formation of a *stereotype*. This stereotype results in *expectations* regarding the individual's behavior. The labeled individual behaves as predicted because of these expectations. Thus, a *self-fulfilling prophecy* has occurred that appears to confirm the stereotype. It is a vicious cycle that many authorities feel precludes the use of labels for people with disabilities. Hutchison and Lord (1979) noted,

> The problems with a label are: 1) we tend to focus upon the person's disabilities rather than abilities, and 2) we make generalizations about the whole person based upon misconceptions regarding that label; in other words, a disability tends to have a spread effect in the minds of others. (p. 18)

Hutchison and McGill (1992) observed that a label may constitute a "life sentence" if it is viewed as a "sacred truth." Too often, people believe that labels are "something that puts all the pieces of the puzzle together; indicates what to do next for someone; and reveals what the person's life is likely

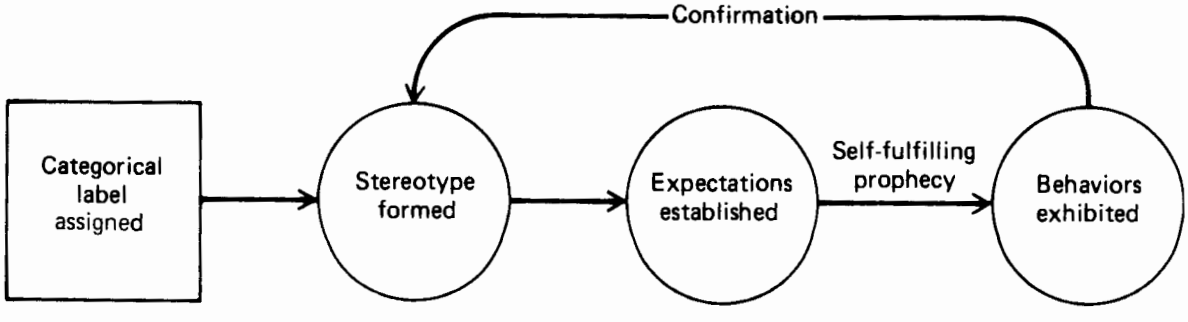

Figure 4-1 Self-fulfilling prophecy

to be like" (p. 19). Bullock and Mahon (1997) emphasized that this "rule of thumb" approach underscores the problems that can result from labeling.

Perhaps the self-fulfilling prophecy results because the *individual* focuses on the disability and makes generalizations about himself or herself. Consequently, it is sometimes difficult for a person with a disability to develop a positive self-concept. He or she may view himself or herself as different from and somehow less worthwhile than others who do not have disabilities. His or her concept of *self,* and perhaps perceptions of the entire world, are distorted by an overemphasis on the disabling condition. This overemphasis is exaggerated, if not caused, by the labeling process.

In addition to the possible consequences previously discussed, labeling someone has conceptual problems. The following questions clarify that identifying members of disability groups is not as easy as one might expect:

1. How severe does a disability or behavioral disorder have to be for a person to be classified as belonging to a disability group? For example, do people have to be legally blind before they are considered visually impaired?
2. Is it the degree of disability or the functional limitation that qualifies a person to be a member of a disability group? For example, should a person be categorized as "mentally retarded" even if he or she functions as well as most people who are not retarded?
3. Should the situation or task be taken into account in categorizing a person? For example, is a wheelchair user considered to have a disability when playing basketball, but not while eating or playing cards?
4. Does the generic term *disability* imply that people with different disabilities have common needs or problems? Should people with multiple sclerosis (who need cooler water to swim effectively) be classified under the same general term as people with cerebral palsy (who function best in warmer pool temperatures)?

The answers to these questions are not clear-cut. Rosenhan (1973) provided evidence that a person may be classified as belonging to a disability group *even if he or she has no disability or functional limitation.* In Rosenhan's study, eight subjects without disabilities admitted themselves to psychiatric hospitals and, once on the wards, behaved normally. Despite exhibiting no signs of psychological disorders, these "pseudopatients" were not detected as imposters by medical personnel. To the staff members of these institutions, Rosenhan's subjects were disabled. Ironically, a few "real" patients were the only ones to recognize that Rosenhan's subjects did not truly belong in a psychiatric facility. It is often said that beauty is in the eye of the beholder. Whether someone is classified as having a disability may likewise depend on the beholder.

The Paradox of Labels

We recognize the many shortcomings and problems of labeling individuals with disabilities. It seems paradoxical, therefore, that we find it necessary to discuss people in terms of their disabilities. When used in this textbook, the term *people with disabilities* is *not* meant to imply that all people who have disabilities are alike. On the contrary, the uniqueness of each person, whether disabled or not, is a concept that recurs throughout this text. For example, people who are classified as deaf (or hearing impaired) have similar, but not identical, limitations that may result in some common problems and needs. These same individuals, however, will have widely varied personalities, attitudes, functional behaviors, and so on. As with all other human beings, people with disabilities are alike in some ways, but in other ways they are dissimilar.

If emphasis is placed on individual differences within categories, many authorities contend that labels may prove useful. Pierce (1998), for example, indicated that labels should not be completely eliminated because they are not the cause of discrimination. Moreover, they serve as a useful, though superficial, method of classifying individuals. Bullock and Mahon (1997) have pointed

out that categorizing people with similar disabilities may enable recreation providers to be more "in tune" with appropriate services and assist with making programs accessible to everyone. Mandell and Fiscus (1981) also noted that labels can help professionals recognize and dispel negative stereotypes they may have regarding specific disabling conditions. It seems clear, therefore, that recreators must have some understanding of the nature of disabilities if they are to work effectively with *all* of their constituents. Although we fully recognize the potential problems of labeling, we do believe it is necessary to include selected information on a number of disabling conditions.

CONDITIONS AND CHARACTERISTICS

People with disabilities make up a surprisingly large percentage of the population. In the United States, about 54 million people (over 20% of the population) have some level of disability. Of these, 26 million (about 10% of the population) have a severe disability that places limits on their daily lives (McNeil, 1997). If recreation providers are going to provide appropriate services to all citizens, it is essential that they have some basic knowledge about disabling conditions.

The next portion of this chapter provides selected information about a variety of disabling conditions, as well as tips and techniques for offering recreation services to people who have these disabilities. The following disabling conditions are included: blindness and low vision, deafness and hearing loss, mental retardation and other learning impairments, motor impairments, psychological and behavioral disorders, brain injury, and AIDS. Although not disabling conditions per se, aging and at-risk youth have been included in this chapter because of the increasing importance of providing recreational opportunities for these persons.

It must be emphasized that the list in the prior paragraph does not include all possible categories of disability, nor are the statements that follow comprehensive in their content. The intent of each set of statements is to provide introductory applied information that may enhance the general understanding of recreators. Extensive definitions, etiologies (causes), prognoses (expected outcomes), and so on are *not* provided. The limited scope of this chapter does not allow for such depth; nor do most recreators who work in nonclinical settings require such detailed knowledge. Those desiring more depth on one or more disabling conditions are encouraged to refer to the references cited or to seek assistance from local volunteer health organizations, therapeutic recreation professionals, consumer groups, or information and referral sources.

Blindness and Low Vision

Selected Facts

- Millions of Americans are affected by visual impairments or blindness. According to Prevent Blindness American (2003), there are approximately 1,046,920 individuals in the United States age 40 and older who are blind, with an additional 3,406,280 others being visually impaired.
- Visual *acuity* is the precision or clearness with which one sees things in the environment. Visual *field* refers to the arc (degree) of vision that a person has when looking straight ahead.
- Legal blindness is defined as having measured visual acuity of 20/200 or less in the better eye with corrective lenses. In other words, a legally blind person is able to see at 20 feet or less what a person with average vision can see at 200 feet. A person with a visual field of less than an angle of 20 degrees is also legally blind. Persons who have significant, uncorrectable (e.g., surgery, eye glasses) visual impairments, yet are not legally blind, are considered to have *low vision.* Low vision is often defined as visual acuity between 20/70 and 20/200.
- If a person who is blind can perceive light in the environment but not perceive the direction of the light source, he or she is said to have *light perception.* If he or she can perceive the direction of the light source, the person has *light projection.*

- Most people with visual impairments have some vision. Only about 5% of people classified as legally blind have no vision or light perception (total blindness).
- Blindness or low vision are often present at birth, but people who have adventitious (after-birth) visual impairments will generally be able to create mental images of unseen objects based on prior sight.
- Language, motor, and cognitive skills are not significantly impaired by visual deficits, provided the person's environment has been structured to enhance development of these skills.
- Most people with blindness or low vision are not able to read Braille; those who do usually read much more slowly than a person with sight. Few Braille readers exceed 150 words per minute.
- Some people who are blind, particularly children, exhibit mannerisms known as "blindisms." These may be small or large body movements including head shaking, eye pressing, or body rocking.
- Diabetes, which may result in diabetic retinopathy, is one of the most common causes of low vision and blindness in North America. Other common vision-related diseases are glaucoma, cataracts, macular disease, and a hereditary condition known as retinitis pigmentosa. Macular disease causes a loss of central vision, whereas retinitis pigmentosa usually results in loss of peripheral vision (i.e., tunnel vision).

Tips and Techniques for Recreation Professionals

- Try to involve *all* senses in recreational activities; using sounds, tastes, smells, and textures of materials can be enjoyed by everyone.
- Glare and other lighting conditions may create difficulties for some people with visual impairments. Consult participants with blindness or low vision to determine the correct type and amount of lighting to provide because optimal conditions for vision vary from person to person.
- Placing information on audiotapes is preferable to Braille. Some commercial tapes offer compressed speech, which results from electronically cropping speech signals; thus, the speed of a recording is increased without distorting the sound.
- Bulletin boards and other visual displays (e.g., activity calendars) should use high-contrast (black-and-white), enlarged lettering.
- When walking with a person who has blindness or low vision and needs assistance, ask how he or she wishes to be guided. One preferred method, known as "sighted guide," is for the person with blindness or low vision to hold on to your elbow and walk to your side and slightly behind. Verbal cues can help to avoid obstacles.
- Be sure all directions are clear and concise, and demonstrate physical tasks. Allow individuals with blindness or low vision to be close enough to see or touch demonstrations. Use verbal information to create mental images for people with adventitious vision loss.
- Orientation to play and recreational areas is important. Prior to participation, encourage individuals to walk around the area with a guide so they become comfortable with their surroundings. Tactile maps and signs may also allow individuals who are blind to orient themselves to unfamiliar surroundings.
- When approaching a person who is blind, announce your presence using a calm, clear voice, and be sure to state your name. Do not shout or speak louder than necessary. If you need to walk away, let him or her know you are leaving. If the person uses a guide dog, do not touch or speak to the dog, unless you first ask permission from the dog's owner.

Selected Websites

- American Foundation for the Blind http://63.240.118.132/
- Lighthouse International http://www.lighthouse.org/
- National Federation for the Blind http://www.nfb.org/

Deafness and Hearing Loss

Selected Facts

- Hearing involves recognition of sound intensity (volume) at various frequencies (pitch). Intensity is measured by decibels (dB) and frequency is measured by Hertz (Hz).
- There is no legal definition of deafness; however, a person is considered to have profound hearing loss (i.e., deafness) if he or she is unable to hear sounds less than 90 decibles in the better ear. People are considered to be hard of hearing when hearing loss is from 25 to 90 dB.
- Hearing loss is the most common disabling condition in the United States and Canada, affecting about 10% of the population. Only a small percentage, however, have profound hearing loss. Those who have profound hearing loss are unable to understand amplified speech; they experience sound through vibrations from loud noise.
- Hearing loss occurring at birth or shortly afterward often results in delayed language development and difficulty with conceptual thinking. This is probably the greatest limitation experienced by people with hearing loss.
- Many people with hearing loss communicate by use of sign language and finger spelling. Not all people with hearing loss know and understand such communication methods, however, particularly those who lost their hearing after early childhood.
- Children with profound hearing loss often appear to be hyperactive, but their behavior frequently results from difficulty communicating with the hearing world.
- Some people with hearing loss have damage to their semicircular canals, which help control balance. Activities requiring balance, therefore, may prove difficult for these individuals.
- Many people with profound hearing loss reject the idea that deafness is a disabling condition. Rather, they consider deafness to be a cultural concept resulting from shared experiences and a unique language (i.e., sign language). People who subscribe to this interpretation of deafness may also reject the concept of inclusion in recreational and educational programs.

Tips and Techniques for Recreation Professionals

- Whenever an individual who is deaf attends a recreational event, an interpreter should be provided to facilitate communication. Sign language and finger spelling skills (see Fig. 4-2) would also prove useful for community recreational professionals. As a last resort, write messages on a pad of paper.
- When using sign language or finger spelling, wear solid, dark-colored clothing to serve as a suitable background. Also, ensure that adequate lighting is provided.
- To gain the attention of a person with profound hearing loss, tap the person on the arm or wave your hand (not arm) near his or her visual field. You may also substitute visual cues, such as flashing lights, for auditory cues.
- When using speech to communicate with a person who has hearing loss, always face him or her and do not slow or exaggerate your speech.
- Written instructions should be expressed in short, clear sentences and difficult vocabulary words should be avoided.
- Demonstrations are the most effective method for helping persons with hearing loss to develop or improve upon activity-related skills.
- When working with children who have hearing loss, have several alternative activities prepared. To maintain their interest, it is sometimes necessary to redirect attention to a new activity.
- Participants with profound hearing loss are unable to hear audible warnings of danger (e.g., traffic noise, verbal warnings), therefore, a high degree of structure and supervision is required with some activities and environments.
- To communicate by telephone with a person who has hearing loss, consider using the nationwide "relay system" established by the ADA. This system ensures that trained telephone operators are available to relay communications

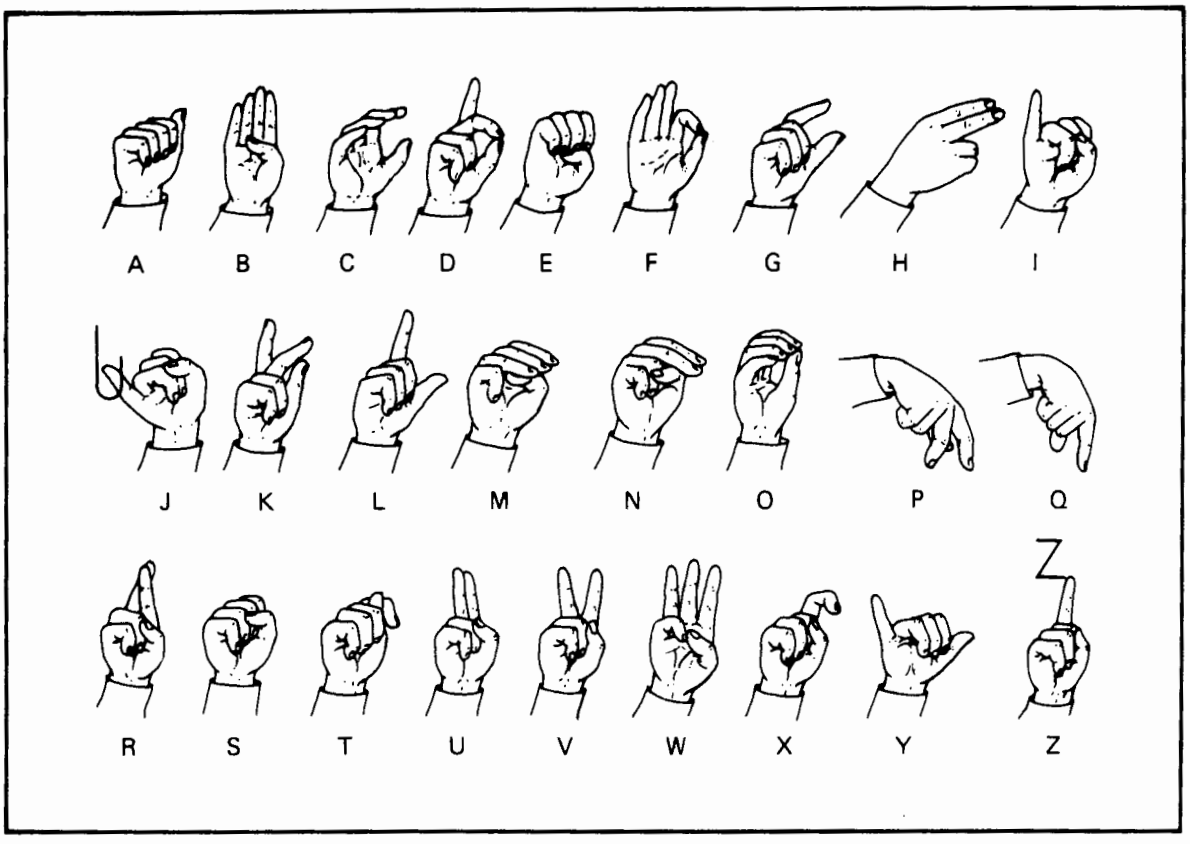

Figure 4-2 Finger spelling alphabet

between a person who is hearing and a person who is deaf or hard of hearing.

Selected Websites

- National Association for the Deaf
  http://www.nad.org/
- Alexander Graham Bell Association for the Deaf and Hard of Hearing
  http://www.agbell.org/
- National Institute for Deafness and Other Communication Disorders
  http://www.nicd.nih.gov

Mental Retardation and Other Learning Impairments

Selected Facts

- It is estimated that 2.3% to 3% of the population has mental retardation, with most (over 85%) having mild retardation. The prevalence of persons with learning disabilities is more difficult to determine, but most estimates range from 15% to 20%.
- The most frequent known causes of mental retardation are Down syndrome, fetal alcohol syndrome, and fragile X (a genetic that is the leading inherited cause of mental retardation). About one third of mental retardation cases are due to unknown causes.
- By definition, mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed by conceptual, social, and practical adaptive skills. This disability originates before age 18 (Information and Tips for Mental Retardation and Learning Impairments, 2003).
- People with mental retardation have subaverage intellectual functioning, but they are able to learn. Their rate of learning is slower than that of people without disabilities, however. Deficits in decision making and

problem solving may also accompany this delayed learning pattern.

- Mental retardation and other learning impairments encompass a wide range of cognitive and behavioral functioning. The level of functioning achieved by a person "is determined by the availability of training technology and the amount of resources society is willing to allocate . . . " (Dattilo & Guerin, 2001, p. 133). The greater the deficits in functioning, the greater the need for technological and societal assistance.
- According to the American Association of Mental Retardation (Information and Tips for Mental Retardation and Learning Impairments, 2003), leisure and recreation participation are fundamental in the development of a healthy lifestyle and contribute to a higher quality of life for individuals who have mental retardation. Some people with mental retardation, however, may need assistance and services to help develop independence skills to support their recreation and leisure involvement.
- The majority of people with mental retardation do not differ in physical appearance from their peers without retardation. In general, the higher the cognitive functioning of a person with a learning impairment, the less likely he or she is to have accompanying disabilities, motor deficits, or physical abnormalities.
- Socioeconomic conditions have been found to be associated with some learning impairments; for example, lower socioeconomic environments produce a higher-than-average percentage of people with mild mental retardation.
- Children with mental retardation usually experience delays in their physical, cognitive, and social development; they often exhibit behavior characteristic of children considerably younger in chronological age.
- Learning disabilities should not be confused with mental retardation. People with learning disabilities have average to above-average intelligence but do not function up to their cognitive potential. Sometimes learning disabilities affect specific types of information processing, like math or spelling skills.
- The signs of a learning disability vary widely. Problems in following directions, retaining information, performing paper-and-pencil tasks, and paying attention to appropriate cues are a few characteristics that may indicate the presence of a learning disability. Persons with learning disabilities sometimes also exhibit behavioral problems, such as hyperactivity, perceptual-motor deficits, emotional unpredictability, or aggression toward others (see the section on psychological and behavioral disorders). Learning disabilities are lifelong, but support and accommodations can compensate for specific difficulties.

Tips and Techniques for Recreation Professionals

- The wide range of behaviors and functional abilities of people with learning impairments necessitates careful consideration of each person's abilities. Assumptions about the individual based on a categorical designation must be avoided.
- Activities should be divided into manageable parts and carefully sequenced to offer a progression of skills. Repetition of important tasks may also facilitate learning. Whenever possible, it is helpful to provide a demonstration so participants with learning impairments can model the desired behavior. Also, avoid "multistep" commands when giving directions and consider using colors or shapes in place of numbers or written words.
- Assist participants with mental retardation in selecting activities that are age appropriate and require skills that are useful in community living. Some people with learning impairments have inaccurate perceptions of their capabilities; try to ensure that the challenges of an activity correspond with the skills of the participants.

- Small group and cooperative activities may facilitate social development for those with deficiencies in adaptive behavior. Activities should be structured to provide positive feedback when appropriate social skills are exhibited because effective social skills may be difficult to master.
- Use verbal instructions that are clear and easy to understand. Provide careful supervision of all activities, especially those in which accidents or injuries are possible. Be careful not to over-protect participants, however, and avoid treating an adult with mental retardation like a child.
- Start an activity at the participant's current skill level rather than at the lowest possible level. When leading an activity, provide opportunities for choice and "work toward people making constructive decisions where they devise their own alternatives, weigh the consequences of each, and choose one that meets their needs" (Bullock & Mahon, 1997, p. 182).
- Seek medical advice, including signed releases from doctors, parents, or guardians, before introducing strenuous physical activities or contact sports for persons with Down syndrome. Heart abnormalities and unstable vertebrae near the top of the spine are complications experienced by some people with Down syndrome.
- With individuals who have learning disabilities, it is important to reduce extraneous stimuli; the leader should limit the quantity of materials, directions, verbal suggestions, and so on. Care should be taken *not* to eliminate choices or limit opportunities for creativity.
- For most children with learning impairments, especially those with learning disabilities, activities should involve as many of the senses as possible. Abstractions are often difficult for such children to grasp, so visible evidence of success, such as certificates of achievement, should be used.

Selected Websites

- The ARC (Association for Retarded Citizens) http://www.thearc.org
- American Association of Mental Retardation http://www.aamr.org/
- National Center for Learning Disabilities http://www.ncld.org/

Motor Impairments

Selected Facts

- The diversity of motor impairments makes the use of generalizations exceedingly difficult, if not impossible. Some are easily identified and have reasonably predictable physical effects (e.g., amputations). Others, however, manifest in many ways and result in a wide range of functional limitations (e.g., cerebral palsy). Moreover, some neurological or neuromuscular disorders may cause dramatic fluctuations in performance from one session to the next.
- Some motor impairments are present at birth (congenital) and others occur after birth (adventitious). Most remain stable or improve, but a few are progressive. As a result, the person's functional abilities may decrease across time (e.g., muscular dystrophy).
- Motor impairments may affect almost the entire body or may affect one specific area, such as the lower extremities. Common terminology for partial or full loss of function in a part of the body includes *monoplegia* (one extremity), *hemiplegia* (extremities on one side of the body), *paraplegia* (both lower extremities), and *quadriplegia* (all four extremities, perhaps including head involvement).
- Some people with motor impairments may have accompanying disabling conditions such as learning impairments, speech difficulties, or seizure disorders. Most people with motor impairments do not have multiple disabilities, however.
- Some children and young adults who have motor impairments experience an overly protective home environment, which places additional limits on their physical or social functioning.
- Modern technology has improved the lives of many people with motor impairments.

Augmentative communication devices, for example, have improved social interaction for persons who have associated communication disorders. Lightweight manual and motorized wheelchairs have improved mobility for wheelchairs users.

Tips and Techniques for Recreation Professionals

- Most people with motor impairments can fully integrate into community recreational activities if an accessible environment is provided (see chapters 5 and 6). Minimize environmental barriers that limit optimal independent functioning. Adaptive equipment may help.
- Some people with motor impairments have been overprotected at home, so encourage challenging, but safe, activities. Emphasize independent functioning, allowing the person to exert control over his or her environment. During activities, keep in mind that balance difficulties are common among people with mobility limitations.
- Participation in specific activities or exposure to certain weather conditions may be inadvisable for some people with motor impairments. Try to discuss the demands of an activity with participants in advance, and consult a therapeutic recreation specialist (or another knowledgeable professional) if there are any doubts about the advisability of participation.

Selected Websites

- National Spinal Cord Injury Association http://www.spinalcord.org/
- United Cerebral Palsy http://www.ucp.org/
- Muscular Dystrophy Association http://www.mdausa.org/

Aging

Selected Facts

- In the year 2000, there were over 36 million Americans age 65 and older (approximately 1 in 8 Americans). By 2030, it is expected that there will be approximately 70 million Americans age 65 and older, more than twice the number in 2000 (Administration on Aging, 2002).
- It is accepted that old age begins at 65 years of age, but the physical, cognitive, psychological, and social functioning of people who are older varies considerably. People can be chronologically old yet exhibit few signs of advanced age. Conversely, some people display physical attributes associated with advanced age well before their 65th birthday.
- Most individuals who are older are self-sufficient in all aspects of their lives. Some, however, do experience a role-reversal situation. This happens when their offspring begin (or attempt) to make important life decisions for the person who is older. Such situations are extremely frustrating and may lead to feelings of futility and personal ineffectiveness.
- Approximately 95% of people who are older in the United States live and function within the community rather than in hospitals or nursing homes.
- Advanced age is usually accompanied by decreased visual acuity, some hearing loss (especially of higher pitched sounds), and decreased motor performances. However, these declines do not place limits on most activities until a person is well into his or her 70s or beyond.
- In metropolitan areas, fear of crime and lack of financial resources are two major factors that may limit recreation and leisure participation among individuals who are elderly. Other factors include health considerations, lack of companionship, and transportation difficulties.
- Contrary to stereotypes held by many, people who are older *are* interested in sex. They can, and frequently do, engage in satisfying sexual relationships.

Tips and Techniques for Recreation Professionals

- It is essential that people who are older be given opportunities to maintain personal control over their life activities. Citizens'

councils and other organizations should be used to provide direction for community programs with participants who are elderly.
- Put to good use the skills that people who are older possess. Provide opportunities for individuals to serve as activity leaders, and try to offer a chance for them to share their life experiences with children and with people of all ages.
- Opportunities to socialize with age cohorts (those in the same stage of life) are important; flexible programs in a relaxed atmosphere should facilitate social interaction. Activities must be age-appropriate and should encourage older participants to proceed at their own pace and desired level of involvement.
- People who are older are capable of learning new information and skills. Many welcome the chance to participate in adult education classes; identify topics, subjects, and skills of interest and provide opportunities for learning.
- Visual, hearing, or motor impairments may accompany the aging process, therefore the recreation leader should be prepared to integrate tips and techniques related to these impairments, as needed.
- To the extent possible, provide "environments that support easy access to rest rooms, have flexible climate control, do not pose undue obstacles to movement around the facility, and support diminished vision and hearing with appropriate lighting and acoustical design features" (Teague, McGhee, & Hawkins, 2001, p. 245).

Selected Websites

- National Institute on Aging http://www.nia.nih.gov/
- National Council on Aging http://www.ncoa.org
- Alzheimer's Association http://www.alz.org/

Psychological and Behavioral Disorders

Selected Facts

- Psychological disorders are classified in the Diagnostic and Statistical Manual of Mental Disorders, currently in its fourth edition. This manual includes over 300 categories of psychological disorders.
- Almost 16% of the U.S. population suffers from a major psychological disorder or substance abuse, and approximately 1 in 4 Americans will suffer a serious psychological disorder in their lifetime. Psychological disorders strike all races, incomes, and social strata and are more common than cancer, diabetes, or heart disease (National Institutes of Mental Health, 2003).
- Disruptive or abnormal behavior is manifested in a wide variety of ways and may result from one or more factors. Heredity, learning, physiological malfunctions, and environmental (situational) factors are often identified as contributing to problem behavior.
- For an individual to be considered to have a psychological or behavioral disorder, his or her behavior must be viewed in terms of degree, duration, or both. Extreme outbursts or withdrawal or consistently inappropriate behavior over time may indicate that professional intervention is necessary.
- Some prescription drugs may result in behaviors that appear to be signs of psychological or behavioral disorders. Many illegal drugs also have this effect on users.
- Of primary concern to most group leaders is the person whose actions distract other group members or disrupt group processes. Some behaviors, however, are not disruptive but may warrant similar attention, including extreme withdrawal, excessive shyness, submissiveness, frequent and prolonged daydreaming, fearfulness, and lack of interest in or response to environmental surroundings.
- The context in which abnormal behavior occurs, and the life situation of the individual, must be considered. Behavioral deviance is based on culturally defined norms and values. Much behavior that appears abnormal can be explained rationally by the heritage or life circumstances of the individual.

- Because of their atypical behaviors, people with psychological and behavioral disorders "experience some of the most significant barriers to recreation participation and the greatest prejudice from both the general public and recreation service providers . . ." (Bullock & Mahon, 1997, p. 236).

Tips and Techniques for Recreation Professionals

- Group leaders should become familiar with behavior management techniques and use them when necessary. Some specific techniques for dealing with problem behavior are included at the end of this chapter.
- No single technique of behavior management has been found effective with all people. Regardless of the technique used, consistency and empathy are essential. Be specific and firm about expected behavior, and express expectations in a clear and calm manner. Refrain from expressing negative emotions (e.g., blaming, threatening). If it becomes necessary to express displeasure, do so calmly and clarify that the *behavior,* not the person, is the concern.
- The presence of appropriate behavioral models in a warm and understanding environment may do a great deal to reduce or eliminate inappropriate behavior. Patience and acceptance of individual differences are also important.
- Learn to identify the physiological and psychological effects of popular (i.e., recreational) drugs. In addition, side effects of drugs used to treat psychological disorders should also be considered. These may include "hypersensitivity to sun exposure, fine motor tremors, weight gain, inability to eat certain foods, blurred vision, dry mouth, sedation, and stiffness of movement" (Bullock & Mahon, 1997, p. 247).
- If an individual's behavior appears to warrant outside intervention, seek the assistance of a qualified mental health professional.

Selected Websites

- American Psychological Association http://www.apa.org/
- National Association on Mental Illness http://www.nami.org
- National Institutes of Mental Health http://www.nimh.nih.gov/

Brain Injury

Selected Facts

- Brain injury (also referred to as head injury or closed head injury) is caused by trauma to the brain, usually resulting from an external blow to the head (e.g., auto accident, fall) or internal injury (e.g., embolism). The effects may be temporary or long term, and recovery is often slow. "Intellectual ability may cease to improve after a period of time, but memory, social, and behavioral functions may improve over long periods of time" (Dattilo, 2002, p. 333).
- The majority of brain injuries are caused by motor vehicle accidents. Violence and falls are also frequent causes of brain injury. Less frequent, but of particular concern to recreation providers, are brain injuries caused by participation in recreational activities.
- The extent of impairment resulting from brain injury varies according to the severity of the injury and the specific portion of the brain most affected by the injury. For example, a person whose injury is greatest to the frontal portion of the brain may have significant difficulty with planning and initiating actions. Injury that is primarily to the back portion of the brain, however, is more likely to cause difficulty with visual perception and memory.
- The effects of brain injury vary greatly from person to person and often involve more than cognitive functioning. Ineffective social skills and limitations in motor functioning may also be associated with brain injury.
- Persons with brain injury often display one or more of the following characteristics: excessive talkativeness, impulsiveness, lack of inhibition, deficits in memory, inability to interpret

situations accurately, and difficulty with time management.
- Depending on the nature and variety of the injury, a person with brain injury may be unaware of his or her limitations. In addition, the person may be unaware of the effects his or her behaviors have on others.

Tips and Techniques for Recreation Professionals

- Recreation leaders should become familiar with effective behavior management techniques. Many people who have brain injury need guidance with appropriate behavior in social situations. Such guidance should reinforce appropriate behaviors and, without being punitive, emphasize the consequences of inappropriate behaviors.
- When memory deficits are associated with brain injury, repetition of information, skills, and so on is helpful. Keep in mind that the individual with a brain injury often does not realize that he or she has recently made a statement, asked a question, or performed a task. Try to respond to each repetition as if it were the first time.
- Initially, recreational activities should be *highly* structured for participants who have brain injury. Start with relatively simple (but age-appropriate) tasks that are sequenced in small, manageable steps. Doing so will facilitate success and encourage advancement to more complex tasks.
- Give directions in clear, concise, and concrete ways, and try to supplement verbal instructions with demonstrations and visual cues. Try to avoid abstract concepts and generalizations.
- Leadership of most activities that include participants with brain injury requires highly attentive supervision. The leader must be ready to intervene in any situation that has the potential for accidents or injuries because the participant with brain injury may not recognize appropriate actions or his or her own limitations.

Selected Websites

- Brain Injury Association of America http://www.biausa.org
- Brain Injury Resource Center http://www.headinjury.com/
- National Resource Center for Traumatic Brain Injury http://www.neuro.pmr.vcu.edu/

Acquired Immunodeficiency Syndrome (AIDS)

Selected Facts

- There are approximately 800,000 to 900,000 people currently living with Human Immunodeficiency Virus (HIV) in the United States, with an estimated 40,000 new HIV infections occurring each year. As of December 2000, 774,467 AIDS cases were reported in the United States with many more cases reported among men than women and children. Since the first reported case in 1981, AIDS has claimed 448,060 lives through December 2000 (Centers for Disease Control, 2003). Projections indicate that before the disease is eliminated, everyone in North America will know at least one person with AIDS.
- HIV is *not* transmitted by casual contact, nor can one get HIV from sweat, saliva, or tears. HIV is transmitted through bodily fluids such as semen and blood. Unprotected sexual contact and sharing needles or syringes with an infected person are the most common methods of transmission. Also, a baby may be born with HIV if the mother is infected.
- At present, AIDS is a chronic disease that cannot be cured. Medical treatment, however, can prevent or postpone associated illnesses and delay the onset of AIDS after infection with HIV. Improved treatment has resulted in a greater number of individuals living with AIDS in the United States (322,865 in 2000). This growing population suggests an increased need for HIV prevention programs for HIV-infected individuals and for increased treatment and care services (Centers for Disease Control, 2003). The average length of time between

being infected with HIV and the onset of AIDS is more than 10 years. A person infected with HIV is capable of transmitting the virus even though he or she does not show any symptoms of being ill.

- Prescription drugs have enabled persons with HIV to live longer, more productive lives. However, these drugs often have side effects that have an impact upon recreation participation. These side effects may include "nausea, vomiting, abdominal discomfort and diarrhea" (Grossman & Caroleo, 2001, p. 301).
- Despite being protected by the Americans with Disabilities Act, people with HIV and AIDS often experience prejudice, discrimination, and social stigma. As a result, feelings of alienation, social isolation, and despair are frequently experienced by persons with HIV and AIDS.
- There is evidence that many recreation professionals have misconceptions about HIV and AIDS; moreover, they also have limited knowledge about high-risk behaviors and steps to reduce the risks of infection (Glenn & Dattilo, 1993; Grossman & Caroleo, 1992).
- Physical problems associated with AIDS may include loss of energy, loss of weight, bladder/bowel incontinence, and problems with coordination. Persons with AIDS also experience a wide variety of nutritional problems associated with their illness or medication (Caroleo, 1988). In addition to physical problems, most persons with AIDS will experience dementia during the latter stages of their illness. Symptoms may include impaired memory and concentration, confusion, and slowing of mental processes.

Tips and Techniques for Recreation Professionals

- Become knowledgeable about HIV and AIDS. Use that knowledge to provide appropriate environments and activities for participants with HIV or AIDS.
- Provide an atmosphere that enables participants with AIDS to feel relaxed, welcome, and supported by staff members. Friends and family members of participants with HIV or AIDS should be encouraged to attend. Enjoyable recreation-related activities that include family members have been found to boost the immune system of persons with HIV and AIDS (Goleman, 1994).
- Serve refreshments at events because reduced caloric intake may compound the severity of the disease (Grossman & Caroleo, 2001). If refreshments are provided, be sure to provide choices that are consistent with dietary requirements of persons with AIDS. For example, foods high in yeast, fat, or lactose may be prohibited for some participants with AIDS.
- Include individuals with HIV or AIDS in activities and programs *and* in the program planning process. Coping with AIDS requires discipline and necessitates adherence to physician directives; therefore, it is important to provide ample opportunities for choice and personal control during leisure. Activities that provide outlets for socialization and stress reduction are also important for persons with HIV and AIDS.
- All recreation providers should include prevention education in conjunction with programs and activities. To date, prevention (e.g., safer sex practices) is the only method of controlling the spread of HIV infection and AIDS.

Selected Websites

- AIDS.ORG http://www.aids.org/
- American Foundation for AIDS Research http://www.amfar.org/cgi-bin/iowa/index.html
- Center for Disease Control Divisions of HIV/AIDS Prevention http://www.cdc.gov/hiv/dhap.htm

Youth-at-Risk

Selected Facts

- The term *youth-at-risk* means different things to different people. As used in this textbook, it

refers to children and adolescents who, for a variety of reasons, are at risk of becoming juvenile offenders.

- Youth-at-risk often come from socially disadvantaged backgrounds, lack basic academic skills, experience feelings of alienation and futility, and have limited support from family members. Most of these young persons do not succeed in school and many fail to complete their secondary education. The number of school dropouts is particularly high among minorities and those with low socioeconomic status.
- Most youth-at-risk have low self-esteem; they experience, or have experienced, extremely stressful home environments. Family-related stressors include parental separation or divorce, physical and/or sexual abuse, alcoholism, and frequent residential moves. For many, peers (e.g., gangs) replace the family as the primary source of support, affiliation, and behavioral guidance.
- Delinquent and other behaviors that deviate from society's norms (e.g., physical aggression, disorderly conduct, destruction of property) usually occur during free time. Moreover, they may provide youth-at-risk with fun and other feelings associated with leisure experiences (Aguilar, 1991; Reimer, 1981). Substance abuse is also an issue for youth-at-risk. "The age when young people first start using alcohol and other drugs is a powerful predictor for later substance abuse, especially if use begins before age 15" (Kuntsler, 2001, p. 95).
- Many factors help create *resiliency* among youth-at-risk (i.e., they resist criminal behavior and make positive contributions to communities). Some *protective factors* that promote resiliency include knowledge of neighborhood resources, presence of caring adults, positive attitudes toward the future, and perceived competence (Allen & McGovern, 1997). Initiation of recreation programs that focus on resiliency has been found to decrease local crime rates (Witt & Crompton, 1997).

Tips and Techniques for Recreation Professionals

- Recreation leaders need to provide stimulating activities that can provide youth-at-risk with high degrees of personal challenge. Outdoor adventure programs and ropes courses are two commonly used activities that offer a progression of challenges to participants. Such activities also foster important interpersonal skills, such as acceptance of others and cooperation with group members. In addition, outdoor adventure programs assist participants to develop a more realistic view of self (Gillis, 1992).
- Programs and activities should emphasize autonomy and choice making. Youth-at-risk should be active contributors to the program planning process, and activities should be structured to optimize decision making and personal control among participants.
- Education regarding socially acceptable leisure participation should be incorporated into recreation programs. Educational activities that promote small group interaction and interdependence among group members may be particularly helpful because acceptance of peers is important to many youth who are at-risk.
- Create a positive, caring, and accepting environment for youthful participants by displaying genuine interest in them and their experiences. Providing unconditional support and universal acceptance may be the most important programming principle for youth-at-risk (Allen, Paisley, Stevens, & Harwell, 1998). Also, encourage their family members to become actively involved in recreation programs and activities. Fees for services should be kept to a minimum because financial constraints are significant for many youth-at-risk.
- Peers who are appropriate role models for youth-at-risk should be encouraged to attend programs and share how they successfully adjusted to the demands of society. Recreation leaders and adults in the

community may also serve as mentors to youth-at-risk, offering guidance, support, and understanding.
- Early intervention is vitally important; therefore, recreation programs should be available to preschool and preteen youth considered to be at-risk. The most effective way of dealing with socially deviant behavior is to prevent it before it begins.

Selected Websites

- Children, Youth and Families at-Risk Program (CYFAR)
  http://www.reeusda.gov/4h/cyfar/cyfar.htm
- National Network for Child Care
  http://www.nncc.org/
- Children, Youth and Families Education and Research Network (CYFERnet)
  http://www.cyfernet.org/

Attention Deficit Hyperactive Disorder (ADHD)

Selected Facts

- According to numerous data sources, approximately 4% to 6% of the U.S. population has ADHD.
- Adults and children diagnosed with ADHD typically display certain characteristic behaviors over a period of time (the behaviors typically are evident prior to the age of 7 and are displayed consistently for a period of time greater than 6 months).
- The most common behaviors associated with ADHD are:
  1. distractibility (inability to sustain attention to tasks),
  2. impulsivity (impaired impulse control and difficulty with delayed gratification), and
  3. hyperactivity (physically restless and excessively activity).
- According to the *DSM IV* (*Diagnostic and Statistical Manual of Mental Disorders*), specific behaviors associated with ADHD include difficulty attending to tasks; making careless mistakes or failing to attend to details; may not seem to be listening when spoken to, failing to follow directions; losing or forgetting important things; feeling restless and/or fidgeting with hands or feet; running, squirming, or climbing excessively; talking excessively; and having difficulty waiting a turn.
- ADHD is believed to be caused by improperly working chemicals in the brain and is believed to be a neurological disorder. It is also suggested that genetics may play a part. For example, when one family member is diagnosed with ADHD, there is a 25% to 35% probability that another family member also has ADHD. This is an increase over a 4% to 6% probability in the general population.
- ADHD is *not* believed to be caused by poor parenting, poor schools, poor teachers, or too much sugar.
- It is estimated that one half to two thirds of children with ADHD will continue to have significant problems with ADHD behaviors and symptoms as adults, which often can have an impact on their occupations, families, and social relationships.

Tips and Techniques for Recreation Professionals

Note: Although ADHD is found in both children and adults, ADHD begins at childhood. Therefore, the following tips and techniques are directed toward children in an effort that some of the approaches will have positive long-term outcomes as the children grow into adulthood.

- If a child is continuously exhibiting some of the symptoms associated with ADHD, talk to the child's parents about the behaviors that you are observing. The child may or may not have ADHD; do not assume or attempt to diagnose the child. First, learn from the parents about techniques they have successfully used to minimize the observed problem behaviors. If a child has been diagnosed with ADHD, most parents will disclose this information and provide helpful approaches to managing the behaviors associated with ADHD.

- Determine from the parents whether the child is taking any medications that may be having an impact on his or her behavior (either positive or negative). If the child is taking a medication, learn the effects and side effects associated with the medication.
- Make sure to always speak to the child in a respectful manner. "Putting down" a child can only serve to further damage a child's self-esteem and may contribute to increases in inappropriate behavior.
- Try to structure the environment to allow for social or peer support. Perhaps identify another child to serve as a "social buddy." Social buddies can be either an individual or a group of individuals who can provide assistance to the child with ADHD in difficult situations. The buddies can prompt and reinforce appropriate behavior by demonstrating such behaviors for the child with ADHD when appropriate. Critical selection and training of "buddies" is paramount to the success of this approach (Asher & Gordon, 1998, p. 45).
- Try to help the child plan ahead. Before engaging the child in an activity or program, review with the child what he or she might expect and "troubleshoot" any obstacles that the child might encounter (Asher & Gordon, 1998, p. 44). Give the child an opportunity to think ahead of time how he or she might handle a situation that may cause problems *before* they arise (e.g., what to do if the child is teased or is rejected). This approach empowers children to act for themselves without authoritative intervention, and thus serves to boost confidence and self-esteem.
- Finally, praise the child for any positive behavior and any small successes. Praise and recognition of positive behaviors usually result in repeated positive behaviors over time.

Autism Spectrum Disorder (ASD)

Selected Facts

- ASD typically appears during a child's first three years. It is a neurological disorder that affects brain functioning impacting the normal development of the brain in the areas of communication and social interaction.
- Children and adults who have ASD most often have problems in both verbal and nonverbal communication resulting in secondary problems in social interaction and leisure or play activity.
- ASD affects approximately 1.5 million Americans, both children and adults. According to the Centers for Disease Control and Prevention, it is estimated that 2 to 6 per 1,000 individuals are affected by some form of ASD.
- The number of cases of ASD is increasing each year at a rate of 10% to 17%. At this rate, the ASD Society of America estimates that the prevalence of ASD could reach 4 million Americans within the next decade.
- Boys are four times more likely to be diagnosed with ASD than girls. There is no difference in ASD rates across race, ethnicity, social boundaries, income, lifestyle, and educational levels.
- The cause for ASD is largely unknown, although it is generally believed to be caused by abnormalities in brain structure or function.
- ASD is *not* caused by poor parenting and is not considered a mental illness. No psychological factors have been found to contribute to the development of ASD.
- ASD is generally diagnosed by ruling out all other potentially contributing causes for the exhibited behaviors. Diagnosis is based on observation of the individual's behavior, communication, and developmental progress. Early diagnosis typically results in better long-term outcomes.
- In addition to communication and social interaction difficulties, many children with ASD have sensory difficulties. The child may be hypersensitive or hyposensitive to stimuli or materials and/or may have difficulty integrating senses.
- Some individuals with ASD exhibit repetitive and/or dangerous inappropriate behaviors. These behaviors might include hand flapping,

rocking, finger snapping, headbanging, and self-mutilation. Many of these behaviors are thought to be the result of problems with sensory integration.

Tips and Techniques for Recreation Professionals

- As with ADHD, take some time to talk to the individual's parents or guardian about your observations. Learn about the individual's interests, his or her abilities, and what have been traditionally successful approaches to working with the individual.
- Consult the parents/guardians when inappropriate behaviors arise. Learn what approaches have been most successful when attempting to minimize or eliminate the behavior. Consult an appropriate ASD professional, if needed. The goal is for the person and any other participants to have a safe environment in which to participate.
- If the person has an augmented communication system that he or she uses, learn how to use the system. Example systems include using pictures to identify needs/desires and computers for audible communication.
- Provide activities that are appropriate to the age and abilities of the person. Modify and adapt activities as needed.
- If appropriate, provide art and music activities to aid in sensory integration. These activities provide tactile, visual, and auditory stimulation.
- Utilize songs to aid in speech development and language comprehension.
- Offer opportunities for participation in art activities to provide a nonverbal method for individuals to express themselves safely.
- If possible, provide animal therapy (i.e., therapeutic horseback riding) to improve coordination and motor development and to aid in sensory integration.

SUMMARY

The traditional approach to recreation with persons who have disabilities is to focus extensively on characteristics that distinguish people with special needs from the general population. Medical terminology, facts and figures, and therapeutic interventions are often stressed. We feel, however, that this traditional approach overlooks the uniqueness of each person with a disability. Rather than give detailed characteristics and data for all disabling conditions, we have presented selected information that should be useful to any recreational professional. Readers interested in additional information regarding data, characteristics, techniques, and terminology associated with specific disabling conditions are encouraged to visit the selected Websites at the end of sections in this chapter. Additional print resources include:

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SUGGESTED LEARNING ACTIVITIES

1. Explain the concept of a self-fulfilling prophecy. How do you think expectations could cause behavior?
2. Write a two-page paper that gives your opinion on the topic "Should Labels Be Used to Identify People with Disabilities?"
3. Learn the finger spelling alphabet pictured in Figure 4-2. Practice this alphabet by finger spelling a message to friends (they can use Figure 4-2 to interpret your message).
4. Use the Web to research one disabling condition and
   a. Add two facts to the "Selected Facts" listed in the chapter;
   b. Add two suggestions to the "Tips and Techniques" provided in the chapter.

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