PARTICIPANTS' PERSPECTIVES OF AN

ADAPTED PHYSICAL EDUCATION

CLINICAL FIELD EXPERIENCE

by

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(Under the Direction of Michael Horvat)

ABSTRACT

The purpose of this study was to analyze the perspectives of a university-based adapted physical education clinical field experience through the eyes of the participants. The participants are the children with disabilities, parents of children with disabilities, and undergraduate students (UGs) teaching in the Pediatric Exercise and Motor Development Clinic (PEMDC).

Children were selected according to their ability to understand and respond to questions regarding the clinic while parents and undergraduates were randomly selected. Data collection consisted of interviews, observations, and artifacts (i.e. undergraduates' self- teaching evaluations and parents' clinic applications). The qualitative data were analyzed using analytic induction which led to the researcher's final interpretations.

The findings revealed three themes: (a) connections between the practical teaching experiences were accompanied by content knowledge learned in the classroom; (b) fostering an ethic of care which encompassed individualized contact between the triad of participants and relationships between the clinic itself and real life settings; and (c) time and its relevance for UGs to make significant progress with some children. Participants spoke of the training gained

by the UGs, the unique instruction received by the children enabling them to learn and practice life skills as well as fitness and health habits, and the many facets of learning and assistance provided to the parents by the UGs and staff.

Through examination and final analysis of the interviews, observations, and artifacts, three recommendations were made for the design of a similar experience: increase UGs contact time with a diversity of children with disabilities, help parents form a more formal advocacy group, and continue research regarding PETE and APE practicums. Practicums, or clinics, provided most participants with unique and individualized learning experiences that included valuable teaching experience for the UGs and increased functional tasks and skills for the children.

INDEX WORDS: Adapted Physical Education (APE), Disability, Inclusion, Individualized Education Program (IEP), Individuals with Disabilities Act (IDEA), Individuals with Disabilities Improvement Act (IDIEA), Least Restrictive Environment (LRE), No Child Left Behind (NCLB), Pediatric Exercise and Motor Development Clinic (PEMDC), Physical Education Teacher Education (PETE), Undergraduates (UGs)

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DEDICATION

With love to my husband, Randall, and children, Neal and Josh. I could not have done it without you!

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CHAPTER 1

INTRODUCTION

Children with disabilities face many challenges as they adapt to life at school, and these challenges are made even more difficult because these children have not yet learned strategies that ensure that their unique needs be met (Goodwin & Watkinson, 2000; Seaman, 1999). This problem is particularly acute in the field of physical education, where such advocacy requires children to be aware of their own abilities and parents expect that such adaptations will be made. Also, educators need to be aware of which adaptations are most likely to meet the needs of the children (Horvat, Eichstaedt, Kalakian, & Croce, 2003).

Individuals with disabilities may feel the desire for friendship, peer acceptance, and approval more keenly than others because they may already consider themselves different (Wessel & Zittel, 1995). Many times, observers primarily see the disability with the wheelchair or the crutches rather than the personality of the child; therefore, it is important for children with disabilities to learn how to become self-advocates. In Goodwin and Watkinson's study (2000), children with disabilities shared that inclusion physical education classes did not always meet their personal needs. When left out of skill games, children felt isolated and incompetent and perceived a loss of self-esteem and self-worth.

Children with disabilities are also learning how to manage and interact with children without disabilities. Goodwin (2001) noted that children with disabilities perceived help from other children as either supporting or threatening. Many times, if other children asked if they could help, they were perceived as caring and aware of the feelings and needs of children with

disabilities. On the other hand, either by ignoring the needs of an individual or overwhelming the individual with inappropriate offers of help, children with disabilities often perceived others as uncaring or as threatening to the independence of the child. In either case, children with disabilities frequently felt shunned and incompetent, which led to a loss of self-confidence and self-esteem.

Parents of children with disabilities stated that class size was the number one factor in their child's successful integration into the physical education setting, followed by "teacher support, parent/teacher interest, parental support, health and well-being, motivation, and administrative support" (Downing & Rebollo, 1999, p. 155). Ultimately, parents felt that if support by the school system was in place, children with disabilities would learn and have appropriate accommodations for physical education; thus educators provide for the learning of life skills. Results of the Downing and Rebollo study were similar to findings reported by Seaman (1999) in that the role of physical education for the individual with disabilities is no longer defined by functions to be learned, but by life skills such as the mobility needed to go grocery shopping, by having enough stamina to complete a full day at work, and by efficient ambulation in public.

In a quantitative study of 100 parents, Downing and Rebollo (1999) found that even though the Education of All Handicapped Children Act, passed in 1975, determined the least restrictive environment for children with disabilities, that providing students with least restrictive environments has continued to be problematic. The purpose of their study was to determine parents' perspectives of factors necessary for integrated physical education programs. Downing and Rebollo reported that shortages of qualified adapted physical educators and undergraduate adapted physical education programs, rising attrition rates of physical educators, and child

misplacement according to diagnosis were the primary hurdles faced by children with disabilities, their parents, and educators.

Since adapted physical education programs are designed to accommodate a smaller group of children compared to regular physical education classes, teachers have a greater opportunity to become more aware of individual needs, likes, dislikes, attitudes, and behavior. Smaller groups assist teachers in making informed decisions regarding activities, teaching strategies, and the appropriate timing of teachable moments (Seaman, Morton, DePauw, & Omoto, 2003). It is important that the adapted physical education curriculum adapts to the children instead of forcing children to adapt to the curriculum (Horvat, Eichstaedt, Kalakian, & Croce, 2003; Kowalski, Lieberman, Pucci & Mulawka, 2005; Wessel & Zittel, 1995). One way to accomplish this goal is to provide practical experiences in adapted physical education. In this manner, prospective teachers become more aware of personal needs of children with disabilities and usually form more desirable attitudes toward children with disabilities (Nolan, Duncan, & Hatton, 2000).

This practical experience will enable prospective teachers to overcome their insecurities while teaching children with disabilities (Gerber, 2005; Goodwin, Thurmeier & Gustafson, 2004; Kudlick, 2003; Verstraete, 2005). Through education and experience children with disabilities are now regarded as similar to their peers and can be empowered to become functional and successful in life (Goodwin et al., 2004). In this manner, children can manage or transcend their disabilities to determine how others perceive them. Moreover, since individuals with disabilities do not come from families defined by disability, they are expected to participate in mainstream society and regular education settings.

Purpose of the Study

The purpose of this study was to analyze a university-based adapted physical education clinical field experience through the perspectives of the participants. Results will provide and assist future educators in their preparation for demands of an inclusive school environment.

Multiple issues and parties must connect to create a viable adapted physical education teacher education program. This study investigated the effectiveness of an adapted physical education program from the perspectives peculiar to children with disabilities, parents with children with disabilities, and undergraduate physical education majors. Children with disabilities must learn to adapt, modify, and advocate for themselves in order to achieve and function in an inclusive school and society. Parents or guardians must learn to adapt and modify in an ever-changing society. Undergraduate physical education majors must learn how to adapt, modify, advocate, counsel, direct, sponsor, and continue research in physical education and adapted physical education (Horvat et al., 2003). Thus, to create an optimal adapted physical education experience for all involved, researchers should investigate the various perspectives of the adapted physical education experience of all concerned parties: (a) children with disabilities, (b) parents/guardians of children with disabilities, and (c) teachers. Undergraduates teaching in the clinic are hereafter referred to as the UGs in this research. The questions guiding the research were:

1. What practices and experiences are beneficial in teaching children with disabilities?
2. What practices are not effective in teaching children with disabilities?
3. What facilities and equipment have been essential to the effectiveness in teaching children with disabilities?

4. What parameters are necessary for a good adapted physical education training program?
5. What are the values of clinical experiences and classroom instruction?

Contributions of the Study

According to Wilhite, Mushett, Goldenberg, and Trader (1997), inclusion of children with disabilities is problematic for physical education teachers. Lytle and Hutchinson (2004) stated that the role of adapted physical educators has changed from being merely a teacher to include being an advocate, courier, supporter, helper, and resource coordinator. Demands on adapted physical educators have expanded from simply providing instruction to children with disabilities to providing instruction to regular educators. Many times, adapted physical educators act as consultants and do not actively teach a child or a group of children.

Adapted physical educators must know how to negotiate and circumvent structural and instructional barriers along with attitudinal barriers exhibited by children without disabilities, teachers, and administrators. Future adapted physical educators must be trained and able to satisfy the expectations of the children, parents, teachers, and administrators and deal with experiences associated with disabilities. Because of the expanded role of the adapted physical educator, a critical need exists to examine the way in which these teachers are prepared. Communication skills, the ability to work with children and adults, and strategies for adult interactions along with psychology, counseling, special education training, and continued research in adapted physical education are integral functions of an effective adapted physical educator.

However, it must be noted that most children with disabilities are placed in regular physical education classes and only those whose disabilities prevent them from participating in

regular education classes are served in adapted physical education classes. Teachers in regular physical education classes must be prepared to provide modifications and teach those children with disabilities in a regular physical education setting (Hovat et al., 2003).

Results of this study may lead to new strategies for developing adapted physical education programs to enhance and incorporate daily living skills in the public school setting while also providing teachers with specific knowledge and experience with children with disabilities to future teachers. Current educational trends of inclusion (Block & Krebs, 1992; Block, 1996; Block & Zeman, 1996; Connolly, 1994; DePauw & Karp, 1994; Horvat, Eichstaedt, Kalakian & Croce, 2003; Hutzler, Fliess, Chacham, & Van den Anweele, 2002; La Morte, 2005; Place & Hodge, 2001; Reid, Dunn, & McClements, 1993) require that children adapt to the regular structure of school and societal settings; the adapted physical education class could provide an instructional training setting for meeting some of these demands and prepare children for inclusion in the regular physical education setting.

Overview of Succeeding Chapters

Chapter two contains a review of literature that is specific to adapted physical education (APE) and physical education teacher education (PETE): legislation, theoretical frameworks, and research that are unique to individuals with disabilities and those who teach them. Chapter three includes a design of the study; a description of the participants and how they were selected; an explanation of the way in which the researcher gained entry into an adapted physical education clinic; the method by which the data analysis was conducted; a defense of the objectivity of the research and researcher; the pilot tests; and the timeline for the study. Chapter four defines the themes of the research and chapters five, six, and seven reflect on the themes as expressed by the triad of participants: children with disabilities, parents of children with

disabilities, and UGs. Chapter eight summarizes the themes and addresses how these data can improve teacher training and practices.

Glossary of Terms

Adapted Physical Education (APE): Physical education that is adapted according to the child's needs, "with or without supportive services or equipment" (Horvat,Eichstaedt, Kalakian, & Croce, 2003, p. 55).

Disability: H.R. 1350, Section 602, Definitions of Individuals with Disabilities Education Improvement Act of 2004, disability is categorized as "mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance (referred to in this title as 'emotional disturbance') orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities."

Inclusion: Instruction for children with disabilities is provided in a regular or general education setting. (Horvat, Eichstaedt, Kalakian, & Croce, 2003).

Individualized Education Program (IEP): "… a written statement for each child with a disability that is developed, reviewed, and revised in accordance with IDEA requirements" (La Morte, 2005, p. 334).

Individuals with Disabilities Education Act (IDEA): Public Law 105-17, Amendment of 1997, "designed to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepares them for employment and independent living."

Individuals with Disabilities Education Improvement Act (IDEIA) of 2004: Public Law 108-446. A school system no longer has to wait until children are significantly behind their peers before academic intervention begins. Also, teachers must be highly qualified in their field and meet state and local requirements.

Least Restrictive Environment (LRE): IDEA mandates "to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are not disabled, and special classes, separate schooling, or other removal or children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily" (Public Law 108-446).

No Child Left Behind (NCLB): The goal is to make every public school child proficient in reading and math by the year 2014. Schools are required to make adequate yearly progress (AYP). (Public Law 107-110 revised 2001).

Pediatric Exercise and Motor Development Clinic (PEMDC): Clinical experience in Physical and Motor Development Clinic (Horvat, course outline, Fall 2006, Appendix H).

PETE: Physical Education Teacher Education.

UGs: The undergraduates teaching the children with disabilities in the adapted physical education clinic.

CHAPTER 2

REVIEW OF RELATED LITERATURE

This chapter contains a description of the legislation specific to children with disabilities. Legislation has enabled children with disabilities to attend public school and become involved in school activities. Adapted physical education is just one of several services provided through legislation. Also found in this chapter is an overview of the current theoretical framework used by most adapted physical educators. Research in this chapter includes topics that directly affect children with disabilities and their teachers: Physical Education Teacher Education (PETE), Adapted Physical education (APE), peers, inclusion, self-advocacy, and personal health.

Physical education teachers who have often taken only one introductory adapted physical education class with or without a practicum experience are teaching children with disabilities (Folsom-Meek & Rizzo, 2002). Hardy's (1999) study found that practicum experience encouraged favorable teaching experiences that contributed to the pre-service teachers' acquisition of practical, positive classroom experiences and knowledge. The quality of teacher mentors and frequent visits by university professors also contributed to the overall learning experience of the pre-service teachers. Finally, peer coaches (Jenkins & Veal, 2002), also helped develop positive teaching feedback between the teacher and peer coach.

Legislation

By the 1970s, supporters of special education were pushing changes that resulted in rigorous legislation that required modifications for children with special needs (Cratty, 1980). Three distinct pieces of legislation at this time caused changes that would require the states to

serve the needs of children with disabilities: Section 504 of the Rehabilitation Act, the Education for All Handicapped Children Act, and the Vocational Education Act. Other important legislations pertinent to children with disabilities are the Individuals with Disabilities Education Act (IDEA), and No Child Left Behind (NCLB).

In 1975, approximately fifteen percent of the population had specific disabilities (Reid, Dunn, & McClements, 1993). LaMorte (2005) stated that when the Education of All Handicapped Children Act was enacted, it was estimated that a million school-aged children were being excluded from the public school setting. And, over one-half of children with disabilities were being denied appropriate educational services. Between 1976-1977 and 1989-1990, the number of children served under IDEA and Chapter 1 of the Elementary and Secondary Education Act increased by 23% (Goodwin, Thurmeier, Gustafson, 2004). The number of children with disabilities has risen from 4,907,400 in 1995 to the current count of 6,813,656 in 2005 as computed from IDEA statistics (http://www.census.gov/). The disabilities of these children include specific learning, speech impairments, mental retardation, emotional disturbance, multiple, hearing impairments, orthopedic impairments, other health impairments, visually impaired, autism, deaf-blind, traumatic brain injury, and developmental delay.

Table 1

Overview of Legislation

Year Enacted	Title	Purpose
1973	Rehabilitation Act of 1973 Section 504, Public Law 93-112	Nondiscrimination under Federal Grants and Programs.
1975	The Education for All Handicapped Children Act (EHA) Public Law 94-142	Guaranteed opportunities for children with disabilities. Utilized individualized education program (IEP) and least restrictive environment (LRE).
1984	Vocational Education Act (Carl D. Perkins Act) Public Law 98-524	Authorized federal funds to augment vocational programs in public schools and institutions.
1990	Individuals with Disabilities Act (IDEA) Reauthorization of EHA Public Law 105-17	Ensures that all children with disabilities have a free and appropriate education. Emphasizes special education and related services.
2001	No Child Left Behind (NCLB) Public Law 107-110	Accountability for all children. Least Restrictive Environment (LRE) Individualized Education Program (IEP) Transition Plan (included in IEP)

Rehabilitation Act

Public Law 93-112, Section 504 of the Rehabilitation Act of 1973 was the first piece of federal legislation that dealt specifically with disability. Under its section on nondiscrimination under federal grants and programs, the following statement is found:

> No otherwise qualified individual with a disability in the United States, as defined in section 7(20), shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits or, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service (Public Law 93-112).

Section 504 states that those agencies that receive any kind of federal funding may not discriminate or deny services to children with disabilities. Through this enactment, public schools, colleges, universities, or vocational programs could not exclude a child based upon disability. Section 504 of the Rehabilitation Act of 1973 was composed using the Civil Rights Act of 1964 as its model (Cratty, 1980). The rights of individuals with disabilities became federally regulated just as minority rights became federally mandated. Advocates for special education used the same measures that were used in the Civil Rights movement to help bring about federal legislation in support of people with disabilities; to protect against discrimination; and to receive federal assistance (La Morte, 2005).

Often called the nondiscriminatory clause, Section 504 states that children with disabilities must be given equal access to public school programs such as clubs, intramurals, and interscholastic athletics. If a child is qualified to participate in the events, then accommodations must be made by the school to allow that child to participate (Kelly & Melagrano, 2004). If a

child requires adapted measures for their inclusion in school athletics or clubs, the adaptation must be met. The disability must not limit the child in "one or more major life activities" (Public Law 93-112, Section 504). Section 504 considers major life activities as the functions normally carried out by an individual: "caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working" (Public Law 93-112, Section 504).

Education for All Handicapped Children Act (EHA)

Public Law 94-142, The Education for All Handicapped Children Act (EHA), 1975, was the second piece of legislation that guaranteed opportunities for children with disabilities. This law was passed in 1975 and declared that states and school regions were able to receive federal funding to assist in the education of children with disabilities. In order to qualify for funding, the states had to (1) offer free and appropriate education based on the specific needs of the child; (2) provide an individualized education program (IEP) including parents and guardians in the decision making process; (3) provide a due process procedure to allow parents to challenge and appeal any decision related to identification, evaluation and placement of their children, and (4) provide an education in the least restrictive environment (LRE) (Public Law 94-142).

Adapted physical education became a requirement for some children under the Education of All Handicapped Children Act. Either regular physical education or adapted physical education must be made available to those children whose counterparts receive physical education. In section 121a.4 of this same law, the components of physical education for children with disabilities include "special physical education, adapted physical education, and motor development, means for development of physical and motor fitness, fundamental skills and patterns, body mechanics, individual and group games and sports, skills to include intramural and lifetime sports, and dance and movement education" (Public Law 94-142).

Vocational Education Act

The third distinct piece of legislation that complemented the enactments of Section 504 and the Education of All Handicapped Children was Public Law 98-524, the Vocational Education Act of 1984. This law, often referred to as the Carl D. Perkins Act or simply the Perkins Act, authorized federal funds to augment vocational programs in public schools and institutions. The Perkins Act targeted children with disabilities, children who were disadvantaged and children who had limited English proficiency. This legislation was later reauthorized and is referred to as the Carl D. Perkins Vocational and Applied Technology Education Act of 1990 (Public Law 101-392).

Individuals with Disabilities Education Act (IDEA)

Also in 1990, Public Law 94-142, the Education for all Handicapped Children Act (EHA) was reauthorized as the Individuals with Disabilities Education Act, commonly known as IDEA, and was "designed to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepares them for employment and independent living" (Public Law 105-17, Amendment 1997). IDEA also encompassed public law 99-457, passed in 1986, which was a reauthorization of the Education of All Handicapped Children Act, to ensure and provide consistent, nationwide facilitation for special education in the pre-school years (birth through 4 years of age) (Horvat et al., 2003). IDEA includes a number of services rendered or related to children with disabilities:

> Transportation, and such developmental, corrective, and other supportive services (including speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic

> recreation, social work services, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children. (Public Law 105-17)

IDEA allows special services such as adapted physical education to be provided for a child with disabilities in order to assist in the education of the child.

The Individuals with Disabilities Education Improvement Act was reauthorized in 2004, and is closely aligned with the No Child Left Behind Act to ensure an appropriate education for children with disabilities. Tourette's syndrome and attention deficit hyperactivity disorder (ADHD) were added to the other health impairment (OHI) listing and those children diagnosed as developmentally delayed also became subject to certain requirements as long as the child meets special education requirements. Also, the Act stated that all teachers must be highly qualified and meet local and state requirements (Public Law 108-446).

No Child Left Behind (NCLB)

The No Child Left Behind Act was preceded by the Elementary and Secondary Education Act of 1965 which provided schools with large concentrations of children from low income families with federal funding to assist with the education of children whose academic progress was unsatisfactory or at risk. These funds helped schools hire teachers in order to reduce class size, provide trained tutors, develop computer facilities, initiate community intervention with parents and guardians, provide professional development of teachers and staff, purchase learning materials, offer pre-kindergarten classes, and hire and train teaching assistants or

paraprofessionals. The schools that accepted these federal funds became classified as Title I schools (Public Law 89-10).

Providing further support to children, The No Child Left Behind Act of 2001 (NCLB) provides an opportunity for children to transfer from a failing Title I school in order to attend a school that is deemed successful. Teachers, curriculum, instructional materials, student achievement, high and low performance of students, academic alternatives, resources, accountability, improved instructional time, reform, coordinating student services, and providing opportunities for parents to participate in their children's education are just a few of the standards that are taken into account in the new legislation (Public Law 107-110). Through examination and documentation of accountability for children with disabilities and other children, public schools are required by law to provide a quality education to all children.

Children with disabilities are placed in classroom settings where they are most likely to be successful and are also considered the least restrictive environment (LRE). These environments include a regular education setting, an inclusion setting, or a special education setting. Those children with disabilities that are placed in regular education settings may require modifications or accommodations in order to be successful. Inclusion settings often include a regular education teacher and a special education teacher or paraprofessional. Special education settings vary according to the needs and disabilities of the children. Per IDEA, children are only removed from regular education class settings when the needs of the child can not be achieved (http://www.ed.gov/parents/needs/speced/iepguide/index.html#introduction).

Also included in IDEA, children are assessed yearly or on an as needed basis and an individualized education program (IEP) is developed. This program is written according to that child's specific needs which specify appropriate and required modifications and

accommodations. Though IEPs vary from state to state, they must be based upon a child's individual needs and accepted by the child with the disability, the parents or guardians of that child, teachers, administrators, and support personnel (i.e. therapists, etc.).

IEPs also may include a transition plan that is developed to aid that child in moving from the public school setting to the private sector. Whether they obtain a job or are assigned a work placement, children must be physically able to complete a standard work day. Physical fitness becomes a necessary element in that child's success on the job. Washing dishes, lifting boxes, and carrying groceries require a fitness level and is necessary in order to complete those tasks on a daily basis. Also, lifetime fitness and enjoyment of fitness activities should be considered in a child's transition plan (Folsom-Meek, Nearing, & Bock, 2007). The regular physical educator or the adapted physical educator should always be included in the development of the IEP and the transition plan.

Summary

Legislation provided the impetus that required schools and organizations to include adapted physical education for children with disabilities. The value of adapted physical education to the triad of participants in this research is an integral part of this research. However, many children with disabilities are able to function and learn in the regular physical education setting provided appropriate modifications and accommodations are available. Thus, teacher training and clinical experience is a necessary requirement for successfully preparing physical educators to teach children with disabilities in all types of settings.

Theoretical Frameworks

Maria Montessori wrote in 1963 that "Education is a natural process spontaneously carried out by the human individual, and is acquired not by listening but by experiences upon the

environment" (Gagnon & Collay, 2006, p. 1). Simply put, a constructivist view states that children construct meaning out of learning experiences and meaning is construed through previous experiences. Individuals have different views and come from different environments. Although they may share an experience, the perspective of that experience may be very different for each participant (Fosnot, 1996; Marlowe & Page, 1998). Just as children learn to construct knowledge, teachers must learn how to teach children with different abilities. Learning to teach children with disabilities requires a teacher to construct knowledge about the child and that child's disability.

Dyson, Griffin, & Hastie (2004) discussed the framework of constructivism and its composition of elements: the active learner, the social learner, and the creative learner. The learning is not constructed by the teacher but actively engaged in by the learner. The teacher is the facilitator who guides the learner through the maze of learning to achieve the end result – acquisition of knowledge. As outlined by Brooks & Brooks (1999), at some point in the learning process, the child is constructing active, social, and creative learning.

Maina, Griffin, & McCurdy (2002) discussed the actions of a teacher in the physical education class or adapted physical education class and compared them to a teacher in a classroom who can pick up a pencil and help a child work through a problem as would be done in a math class. The focus is not on the physical education teacher's actions, but on the children and how they must learn how to actively merge thinking and movement processes to achieve higher-level movements and strategies. Children must also learn to critique a movement or skill and then manipulate their body to achieve a more efficient physical response.

One of the skills used in constructivism is critical thinking, which according to Davies (2002) should happen not only in the classroom; rather, critical thinking should follow children

throughout their educational careers and beyond. The teacher essentially becomes the facilitator, just as a boss is a worker's facilitator. Tinning (2002) stated that physical education was not just a physical activity class where children learned, practiced, and refined skills, but was also a class where equality of gender and opportunity along with the discouragement of sport elitism should be practiced. By practicing social justice in the physical education setting, teachers can help their children take critical thinking outside of the classroom and into society.

Through empowerment of the disabled, children with disabilities are developing critical thinking, problem solving, self-efficacy, self-respect, social competence, leadership, active learning, and commitment (Hutzler, Fliess, Chacham & vanden Auweele, 2002). In their study, Hutzler et al. (2002) noted that over half of the comments made by children with disabilities related to the experience of failure during physical education. Through overcoming these failures, the children became empowered because the physical education setting became a practice setting for real-life. Through trial and error, potential and future success promoted an individual's sense of empowerment. By limiting experiences of failure, teachers are limiting children's empowerment. The instructor is teaching fatalist reactions, helplessness, and reliance on external conditions for learning, coping, and decision-making.

Similarly, Hutzler et al. (2002) discussed the empowerment of the disabled. By empowering the individual, teachers help that person learn to construct knowledge in all facets of his or her life – socially, physically, and psychologically. Through this empowerment process, the child with disabilities learns to think critically, solve problems, advance self-efficacy and self-respect, and learn social competence and leadership. These advances are critical to self-learning and the decision making process. Through critical thinking, the children are putting together lessons learned through trial and error.

Contact Theory

Teachers will become more comfortable in the inclusion setting through the practice of contact theory, the experience of working with disabled children over periods of time and gaining experience with different disabilities (Block & Zeman, 1996). In "Attitudes toward the Participation of Individuals with Disabilities in Physical Activity: A Review", Hutzler (2003) stated that contact theory had become the most popular and most used theoretical foundation when working with individuals with disabilities. By becoming familiar with individuals with disabilities, the teacher is learning not just about the disability, but also about the child as an individual. Common misconceptions about persons with disabilities seem to fade as the instructor and other children get to know the child with disabilities as a person.

Experience with children with disabilities provided classroom teachers a higher level of comfort in their teaching abilities of those children. The teachers became more self-confident in relation to the amount of experience they gained in practical settings. By having previous experiences with individuals with disabilities, more teachers perceived a higher level of competence in their own teaching and felt more academically prepared for their career. They had a more positive attitude and could go into the classroom with a positive outlook (Theodorakis, Bagiatis & Goudas, 1995).

In another study, Nolan and Duncan (2000) conducted a study of attitudes before and after an adapted physical education course. They found that those individuals who completed field experience had higher positive attitudinal changes toward children with disabilities. As a corollary, children without disabilities, who completed an adapted physical education course, became more motivated to develop and refine their motor skills. Nolan and Duncan's study

supported field experience as a valuable addition in prospective physical education teacher education.

Summary

Contact theory allows a teacher to build knowledge not only about specific disabilities, but also about children and their individual perspectives of their disabilities. Children and teachers become part of a constructivist classroom allowing each participant to develop knowledge and skill necessary for learning to occur. Teachers have a unique opportunity in adapted physical education to help children with disabilities learn about themselves and acquire life skills necessary for success both in and out of the classroom.

Research

Current research of adapted physical education has revealed five main topics of concern for children with disabilities: inclusion, self-advocacy, peers, personal health, and teachers. These concerns can have positive and negative effects on the children with disabilities as they became immersed in the educational system. Also, this section includes a review of current methods in physical education teacher education (PETE) with regard to adapted physical education (APE) and its role in how we prepare future adapted physical education teachers.

Physical Education Teacher Education (PETE)

The literature regarding disabilities (Gretchell, McMenamin, & Whitall, 2005; Polastri & Barela, 2005; Sandt & Frey, 2005) indicates the presence of children with disabilities being in every public school classroom is likely. Autistic children were often placed in restrictive environments due to their disability, and they subsequently lost accessibility to physical education or playground time (Sandt & Frey, 2005). Those children were also more likely to go home and participate in sedentary, technology oriented activities. When observed in physical

activity classes, children with autism were active only 41% of the time. And, children with Down syndrome required early intervention and extended practice to initiate, respond, and complete a motor task (Polastri & Barela, 2005). Many of the children in the clinic with Down syndrome had been served through early intervention programs that provided early physical and speech therapy opportunities.

Often, children with disabilities were relegated to the back table in a classroom or instructed to leave the classroom to receive individual instruction from a paraprofessional. Davis, Kotecki, Harvey, and Oliver's (2007) study found that 86% of paraprofessionals escorted children with disabilities throughout the school day, 59% worked individually with children with disabilities, and only 31% assisted all children in the classroom. Paraprofessionals increased separation rather than inclusion of the children; this relationship resulted in the paraprofessionals acceptance of a "mothering" role for the children with disabilities.

Based on the statistical data available, it would be naive of teachers to expect there to be no children with disabilities in regular physical education classes and substantiates the need for having practical experience with children with disabilities. As stated by Rovegna (1989), regular physical education teachers had to learn to transfer theoretical knowledge gained in the university setting to actual practice in the public school classroom to become successful. This is supported by DePauw and Karp (1994), who indicated that teacher preparations were minimal in regard to disabilities. One pre-service elementary teacher learning to teach physical education stated that they simply did not have enough time to acquire the needed skills in a methods class and that the class itself had little to do with practices employed by pre-service teachers in the classroom (Curtner-Smith, 2007). Without practical experience, the likelihood of pre-service teachers being successful in the classroom became minimal.

In 1992, it was decided in England and Wales that pre-service teachers should spend two-thirds of their teacher education program in community schools (Hardy, 1999). Accompanying the field experience was supporting professional studies in physical education and subsidiary subjects. After graduation, 62 pre-service teachers completed questionnaires and participated in interviews about their experiences in the school systems. Questions about the actual experience showed that the pre-service teachers felt the school experience was positive because they were able to learn educational theory in the classroom and then apply that knowledge in the classroom in the community school. Also, the pre-service teachers were able to experiment with different teaching styles and strategies in the classroom. Pre-service teachers felt the experience was a prelude to professional teaching with its assorted pressures, unexpected occurrences, and responsibilities.

One finding of Hardy's (1999) study was the apathy or disinterests some of the mentor teachers showed toward the pre-service teachers. Some pre-service teachers felt their mentors wanted them to succeed, and others felt their mentors wanted them to function independently with little or no guidance. Several pre-service teachers felt children and teachers did not view them as professional teachers - just people who came in and taught a random lesson. Of course, having a more effective mentor, critical and informative visits made by the professor, and little time dealing with behavioral issues brought about a higher level of satisfaction in the field experience. Being students for 13 years in the public school sector before becoming pre-service teachers certainly had an impact on the additional 4 or 5 years of education received in a university setting in teacher education (Hardy, 1999; Jenkins & Veal, 2002). Three contributors that heightened the PETE experience in conjunction with the field experience were: reflection of

the teaching experience by the pre-service teachers, collaboration between the schools and universities, and thinking and problem solving.

In contrast to PETE trained teachers, some states require that elementary teachers also teach physical education (Xiang, Lowy, & McBride, 2002). While the practice may be practical, not all teachers enjoy or want to teach physical education. In the study, "The Impact of a Field-Based Elementary Physical Education Methods Course on Pre-Service Classroom Teachers' Beliefs," 97 elementary education majors took part in an elementary methods class that consisted of a classroom and an instruction practicum. The practicum experience was for 2 hours one day per week for 10 weeks. The pre-service teachers were expected to assist the elementary physical education teacher and then plan activities and teach during weeks 8 and 10. Xiang et al. found that pre-service classroom teachers had similar views of physical education as their physical education counterparts after the practicum experience, not before.

Based on the data analysis, major themes that were benefited included the whole child, fitness, healthy lifestyles, personal and social skills, and increased motor skills. Though the pre-service classroom teachers recognized that physical education was not just a fun break from the academic school day, fewer were willing to teach physical education after the practicum experience. Comments gathered through journal reflections revealed that one of the negative factors influencing the pre-service classroom teachers was the management skills necessary in a gymnasium's "no desks" environment (Xiang et al., 2002, p. 157). Pre-service teachers gained an understanding of how hard it was to manage behavior where movement was expected but had to be controlled at the same time. However, the experience gave prospective classroom teachers a sense of physical education and what the class meant to the children. Physical educators

contribute more to children's overall health and well-being than classroom teachers who may not have adequate skills or knowledge regarding physical education.

Adapted Physical Education (APE)

Hodge, Tannehill, & Kluge (2003) conducted their study at Ohio State University's inclusion adapted physical education clinic, called Unified Physical Activity Program. Contact theory was the theoretical foundation of the inclusion clinic. Children who participated in the clinic were divided into four groups of similar ages and children with disabilities were divided among those groups. For example, group one had 13 children without disabilities, 1 child with attention deficit hyperactivity disorder (ADHD), 2 children with autism, 4 children that were developmentally delayed, and 4 children with speech and language impairments. The remaining 3 groups had similar divisions of children. PETE students chose which group they preferred and were assigned to either their first or second choice.

On the basis of journals and debriefings after teaching sessions, 11 themes were reflected, but disability, inclusion, and support were unique to this study. The research showed that "students' attitudes and perceived competency were favorably influenced by what they viewed as challenging, rewarding, and meaningful practicum experiences" (Hodge et al., p. 396). PETE teachers felt apprehensive about working with children with disabilities at the beginning of the clinic, but they felt the experience was rewarding and meaningful at the end of the practicum experience. The main conclusion from this study was that the PETE teachers found the practicum worthwhile, and that it provided experience they could transfer to a physical education setting in a school. Organization, class management, small group structures, cooperation, non-elimination games, and positive reinforcement were just some of the strategies the PETE teachers felt were important. They also felt that knowledge would transfer to other physical

education settings. Reflective journaling created a method for the PETE students to analyze their experiences and determine what benefits they gained professionally from the inclusive clinic setting.

In another study, it was found that negative experiences brought about through lack of support or lack of equipment to help modify lessons limited the effectiveness of an inclusive program (Houston-Wilson, Dunn, van der Mars & McCubbin, 1997). One teacher commented that it was hard to juggle the demands of a regular physical education class to also include children with disabilities. The inclusion class could seemingly become two or three classes held at the same time because the different groups and individuals with disabilities had different lessons or activities due to adaptations or modifications (LaMaster, Gall, Kinchin, & Siedentop, 1998). Also, if a teacher was not educated in special education or adapted physical education, that teacher was easily overwhelmed (Heikinaro-Johansson, Sherrill, French & Huuhka, 1995). When an unqualified teacher was in an inclusion class with a qualified teacher, the qualified teacher had to teach or assist the unqualified teacher in the class.

However, Connolly (1994) gave an alternative perspective of adapted physical education by examining the journals of pre-service teachers who worked with children with disabilities. She chose teachers' journals that gave rich descriptions of their experiences with their assigned children with disabilities. The intent of the physical education course at Brock University, "physical education for the exceptional individual," was for the physical education pre-service teachers to focus on the movement approach and in turn learn to understand the individual and differing needs of children with disabilities. The pre-service teachers visited schools and institutions to gain practical experience working with children with disabilities.

In Connelly's (1994) study, three of the participants were Kevin, Jeff, and Julia. Kevin learned that he could not group children with cognitive disabilities into one lump because they were all unique. His relationship with his assigned child John developed into a friendship that continued after the conclusion of the class. Jeff stated that his child was not very attractive physically, but that once he got to know him, Jeff thought he was one of the happiest and most adorable individuals he had ever met. He continued with the description of the individual's child-like behavior and how much he (Jeff) gained personally from the relationship. Jeff felt that, "These children with disabilities are like everybody else, they are individual, and they should be treated with the same kind of respect as an able-bodied person" (p. 321). When Julia asked her assigned child if he could be granted one wish, she really believed that his response would be that he wanted to be "normal" - rid of his disability. She stated her surprise when he responded that he wanted to attend a rock concert. He was happy with himself and comfortable with his disability.

One participant made the observation that he knew what books stated about cerebral palsy, but he really didn't notice the disability when he worked with his child Michael. They became friends, and the one thing that he really liked about Michael was that he liked to have a good time. Michael was very social and liked sports, music, and being outdoors. He did not walk well and was slow with his speech, but they forged a friendship and relationship with each other. In retrospect, the student noted,

> Maybe I should have focused on the disability, but at this point, I'm glad I didn't because I gained more out of this than I ever thought . . . I've made the observation that those with disabilities are never looked at as a normal (person) if the focus is always on the disability (Connolly, 1994, p. 320).

By getting to know Michael as a person first and then recognizing the disability, the student was able to address the issue of being accepted as an individual with a disability.

Peers

In a study on the interactions between children with disabilities and peers without disabilities, Goodwin (2001) found that children could be placed in two categories, self-supporting or self-threatening. Self-supporting actions were caring and consensual and became instruments in the learning process – the children with disabilities wanted and needed help. The interactions that were considered self-threatening by the children with disabilities contributed to a loss of independence, lowered self-esteem, and restricted participation. Sometimes, assistance from a peer was perceived as interference and children with disabilities wanted to try first to succeed on their own. Offers of help from children without disabilities were regarded as a lack of respect from the peer tutor for the child with a disability. As noted by the comment, "Helpfulness gets to be annoying sometimes" (p. 296). Trained peer tutors were more effective if they were trained in appropriate cueing, feedback and task analysis and in knowing or interpreting when a child with a disability actually wanted help (Houston-Wilson, et al, 1997).

Inclusion

Place & Hodge (2001) focused on three females with disabilities placed in an inclusion physical education class. The performance and attitudes of these females were evaluated through video, observation, interviews, Analysis of Inclusion Practices in Physical Education, form S (AIPE-S), and Academic Learning Time for Physical Education (ALT-PE). The females described self-segregated inclusion and felt socially isolated from their classmates. They felt that they were perceived as objects of curiosity and felt very awkward with their peers. Due to those

feelings, the children purposefully separated themselves from the rest of the class. They practiced self-segregation due to their perceptions of their classmates' attitudes.

Three examples substantiated those feelings. First, the female children with disabilities were not included on any field trips due to lack of appropriate transportation (handicapped access). Second, the ALT-PE method recorded that the children with disabilities had 29% wait time compared to 13% wait time for the regular physical education children. At one point, a female in a wheelchair had to ask the instructor if she could have a turn at bat. The children stated that they usually went last in any type of skills practice. Third, the females with disabilities gained entry to the gymnasium through a hallway, while the other children went through the locker room. Structurally, perhaps the females with disabilities could not pass through the doorway; however, this requirement compounded their feelings of social isolation and difference.

As the females were in other classes together, it was natural for them to associate with each other in the physical education class. Children in regular education rarely interacted with the females with disabilities. Because the females with disabilities had already established personal relationships with each other, this connection may have discouraged the regular education children from trying to interact or forge a relationship with them (Place & Hodge, 2001). By not providing appropriate transportation for field trips, placing them last in skill practices, and having them enter the gymnasium through an alternate route, the females felt isolated and ostracized because of their disabilities. Also, these occurrences separated them physically and emotionally from their peers with no disabilities.

Another study of inclusion indicated that "exclusion or removal of a student from the general education program sent the message that belonging is not a basic human right but

something that must be earned" (Tripp, Rizzo, & Webbert, 2007). Losing that sense of belonging may also cause a child to lose motivation for learning. Tripp et al. (2007) explained two types of exclusion: complete exclusion which meant segregation from a child's peers and functional exclusion, which is what the females experienced during their physical education class in the previous study. Though they were in the class, they were excluded from activities and relegated to the back of the line.

According to Tripp et al. (2007) through inclusion, interdependence is practiced along with independence; children learn how to work together in a nonthreatening environment where the teacher observes and guides children through the learning process. Peer tutors and paraprofessionals may be included according to the needs of children with disabilities in the class. Inclusion allowed children to develop a sense of belonging and established accountability and responsibility among the children.

Self-Advocacy

> Self advocacy has been defined by Pennel as:
>
> The ability to stand up for oneself and to help other people with disabilities stand up for themselves by speaking up, speaking out and speaking loud. It means having the opportunity to know your rights and responsibilities, to stand up for yourself, and to make choices about your own life (Macdonald & Block, 2005, p. 46).

Macdonald & Block (2005) investigated self-advocacy in the inclusion setting. Catherine, a child with a disability, changed her shirt in order to meet the requirements for "dressing out" in physical education. She also used a smaller basketball for easier handling. By becoming a self-advocate and learning to modify and make adjustments for herself, Catherine had a very positive

experience in physical education. She had learned to compare herself with her own previous personal scores rather than comparing herself to the other children in physical education. Catherine attended her own Individualized Education Program (IEP) meetings and gave input as to what she wanted to accomplish and achieve. By becoming a self-advocate, Catherine was able to direct her own experiences rather than having them dictated to her by others.

Though hearing impaired, Lisa did not consider herself as disabled. Lisa progressed early from special education classes to general education classes, and finished sixth in her high school class. She learned to read lips, wore hearing aids in both ears, and stated that most people did not realize she had a severe hearing impairment. Assistance from note takers in classes and professors who were accommodating to her disability enabled her to become a successful university student (Gabel, 2001).

Lisa may have been labeled as disabled, but she did not include herself in that grouping. "Lisa differentiates between disability and impairment and, in doing so, agrees with many disability studies scholar who make a distinction between an impairment, or loss of function, and a disability" (Gabel, 2001, p. 38). She learned to use accommodations and modifications to became a successful self-advocate. Her life skills were not related to physical education, but the fact that she learned to become a self-advocate as many of the children in the clinic had enabled her to stand up for herself and her personal rights.

In addition, Goodwin and Staples (2005) related three viable themes regarding children with disabilities when they attended camps: not alone, independence, and a chance to discover. The experience of being away from home and being independent at a camp provided children with the opportunity to be around others with disabilities. "Camp experiences provided a reprieve from perceptions of disability isolation often felt in home communities" (p. 160). In

camps and away from the home environment, children with disabilities were able to experience self-reliance, independence, a new sense of physical potential and develop physical skills and peer relations.

Also, camps provided an environment in which children with disabilities could share feelings of anger, loneliness, and frustration. Through personal explorations, children with disabilities found that they were not alone in their feelings and experiences and could explore "identity options" (Goodwin & Staples, 2005, p. 163) away from family, friends, and classmates. Goodwin and Staples related that many children with disabilities wanted to disassociate from other children with disabilities. They felt that a stigma was attached to children because of their disabilities and wanted a physical distance from other children with disabilities. Camps for children with different levels of disability are becoming common with offerings of mainstreaming, modified mainstreaming, and segregating.

Personal Health

Many children with disabilities stated that with increased physical activity they had more energy, better agility, greater strength, more flexibility, increased muscle tone, better coordination, and decreased physical deterioration (Blinde & McClung, 1997). Physical activity, outside their usual environment gave children with disabilities the opportunity to experience their bodies in new ways, enhance their perceptions of physical attributes, redefine physical capabilities, and increase their perceived confidence to pursue new physical activities. Also, through these experiences the individuals were increasing their social interactions and experiencing social activities in new contexts. Through recreational activities such as horseback riding, swimming, fitness, weightlifting, racquetball, bowling, tennis, fishing, walking, and tai chi, individuals with disabilities were able to experience less restricted environments. One

person interviewed remarked how "free" she felt going from a wheelchair to the top of a horse. It was a physical experience that gave her a whole new perspective of physical activity and of what her body could accomplish.

Summary

Self-advocacy can be practiced in a regular education classroom or an inclusive classroom where children with disabilities learn to deal with their peers, personal health issues, and possibly teachers who may be insufficiently prepared to instruct them. As teachers learn more about children with disabilities, their perception of being self-assured and confident begins to rise. Contact theory practiced in clinics and practicums enables pre-service teachers to expand their knowledge of disabilities and develop professionally. Through ongoing physical education teacher education and support from professors, teachers are able to make the link between classroom theory and practical experience.

Summary of Literature Review

There are multiple areas of concern connected with adapted physical education. Each child with a disability must be considered on an individual basis before a curriculum for adapted physical education can be developed (Horvat et al., 2003). Legislation beginning with the Rehabilitation Act and including the current No Child Left Behind has provided guidelines for society to ensure personal and public rights are maintained for individuals with disabilities (Cratty, 1980).

Contact theory practiced through field experience has been noted as a valuable addition to prospective physical education teacher education programs (Nolan and Duncan, 2000). Teachers and children without disabilities became more comfortable and had a more positive attitude when allowed the experience of working with children with disabilities (Block & Zeman,

1996; Connolly, 1994; Hodge, Tannehill & Kluge, 2003; Theodorakis, Bagiatis & Goudas, 1995). Children without disabilities learned how to become supportive rather than threatening with their actions toward children with disabilities (Godwin, 2001). Children with disabilities learned to become self advocates and maintain a sense of individuality (Macdonald & Block, 2005). Teachers and children benefited from a classroom setting grounded in constructivism. The classroom became a setting for real-life experiences which allowed the child to experience failure in a protective environment (Hutzler et al., 2002). Teachers became facilitators for children, but were also constructing their own learning according to the individuality of children with disabilities.

Children with disabilities become empowered through education. Through inclusion, children are acknowledged and recognized for who they are, not their disability, and accepted as full and contributing members of society. But the greatest benefit of infusion will be a fully inclusive society and the affirming environment provided by that society (DePauw & Karp, 1994). Through the examination of the legislation, theoretical framework, and research of children with disabilities, parents of children with disabilities, and teachers, teachers became aware of each child's individual needs and abilities. As Weikart and Carlton (1995, p.3) stated, "If our civilization is to continue to be both dynamic and nurturing, its success will ultimately depend on how well we develop the capacities of our children, not only to earn a living in a vastly complex world, but to live a life rich in meaning."

All children benefit from models of healthy lifestyles, an increased perception of self-worth, a sense of belonging to a group, learning and developing new skills and knowledge, and maximizing of their development (Wessel & Zittle, 1995). Ideally, this new knowledge and skill would be used every day. Experiences each day is an example of inclusion (Goodwin et al.,

2004). Children must learn to become self-advocates, who use modifications and accommodations in order to be successful in life situations.

In this study, the researcher is analyzing a university-based adapted physical education clinical field experience through the perspectives of the participants. Providing a positive, rich practicum experience for pre-service teachers to become comfortable working with children with disabilities will help to provide that necessary link between children, school, and community. Physical education teacher education (PETE) and adapted physical education (APE) must examine how teachers are educated, prepare teachers for future challenges, and develop appropriate programs to prepare teachers for future success (Connolly, 1994). As outlined in chapter one, communication skills, the ability to work with children with disabilities and strategies for adult interactions along with psychology, counseling, special education training, and continued research in adapted physical education are integral functions of an effective adapted physical educator (Lytle and Hutchinson (2004).

CHAPTER 3

METHODS AND PROCEDURES

The purpose of this study was to analyze a university-based adapted physical education clinical field experience through the perspectives of the participants. Children with disabilities must learn to become self-advocates, parents expect adaptations to be made for their children with disabilities, and educators need to make accommodations according to the children's individual needs. To create an optimal adapted physical education experience for all participants, researchers should investigate the perspectives of the adapted physical education experience of the participants: children with disabilities, parents of children with disabilities, and teachers (UGs). According to Horvat et al. (2003), the child needs physical education to develop and refine physical, cognitive, or affective behaviors or limitations in order to develop life skills. The parent must learn to adapt and modify for that child, not just in physical activities, but also in everyday life experiences. The UG must make the adaptations to the lesson, the equipment, and the environment to make the child successful in physical education.

Setting

In order to provide a mix of theoretical and practical experiences for UGs teaching children with disabilities, a practicum experience is provided at the University of Georgia. The Pediatric Exercise and Motor Development Clinic (PEMDC) is focused totally on the needs of children with disabilities and the undergraduates (UGs) who are provided their first experience with children who have disabilities. The clinic has been active for over 30 years evolving from a program in the 1980's originally designed for young adults and developing into the current

program that focuses on teacher education in adapted physical education. The UGs are undergraduate students majoring in physical education or related majors such as therapeutic recreation, health promotion or special education. Adapted Physical Education is a required course for undergraduate physical education majors and an elective for other majors. In the Fall 2006 semester, there were 24 children, 42 UGs, 4 graduate teaching assistants, and the program director.

Children are directed to the clinic through area doctors, hospitals, schools, or other organizations. Several weeks of orientation are used for the UGs prior to the start of the program to provide specific instructional time which include class lectures and presentations. The PEMDC is a one hour program that is 9 weeks in duration for each semester. In the clinic itself, the children concentrate on physical and motor skills designed to increase upper/lower body strength, or increase functional tasks such as walking up stairs or sitting upright without assistance. Children work on individual skills such as balance, locomotion, strength, or coordination while aquatic instruction is used to facilitate flexibility, joint and limb movement, respiratory control, upper and lower body strength, and swimming techniques. For the most part, children experience time in motor and physical development as well as the aquatic setting.

Gaining Entry

The researcher's professional foray into participants' perspectives of adapted physical education was during her transition from master's program to doctoral program. One of the elements that the researcher would like to emulate in her educational setting is the experiences that are presented in the clinic itself. It can provide some additional perspective to a quality physical education experience from observation of the PEDMC. APE is a rarity in most public schools. After observing the clinic, discussing the clinic with participants (parents and UGs), and

conducting literature searches, the researcher found no research with the combination of all participants' perspectives.

As a professional educator it is also essential to determine why some teachers remain in the profession and why others find employment in other areas. This was evident from interactions with graduate students in adapted physical education; their comments of feeling worthwhile and making a contribution to someone's life became an emerging factor regarding attrition. This led to the question of how we prepare future teachers for physical education and adapted physical education.

Completing and gaining approval from the University of Georgia's Individual Review Board (IRB) was necessary before initiating this study as it involved human subjects. And, as minors with disabilities are considered a vulnerable population (deMarrais & Lapan, 2004), the writing and approval of the consent forms, permission forms, potential interview questions, audio taping, and promise of confidentiality had to be assured and documented. All appropriate steps were taken before the initiation of the study in August 2006.

Subjectivity

Qualitative research requires that researchers be aware of their personal views and biases regarding the researched subject. According to Merriam (1998), when conducting qualitative analysis, the investigator is the "primary instrument" (p. 20) of the research. The researcher is limited or influenced by the researcher's own humanity through personal experiences, education, environment, gender, race, and religion among others. Perspectives of the subjects are the "phenomenon of interest", not the perspective of the researcher. We bring to each experience our own conceptions and misconceptions: "It is assumed that meaning is embedded in people's

experiences and that this meaning is mediated through the investigator's own perceptions" (Merriam, 1998, p.6).

In the early 1970s, the researcher of this study was aware of child versus curriculum at an age when the word curriculum meant nothing. A neighbor boy, who was intellectually disabled and nonverbal, wandered the streets while other children attended school. The school system offered no special education class, and funds were not available for the boy to be sent to a private institution. The man was finally housed in an institution upon his parents' deaths and he never learned any life skills. His life consisted of random acts of kindness by neighbors, taunts by strangers, and loneliness brought about by his circumstance.

Later in life, as a newly indoctrinated educator, the researcher was required to teach a fifth grade physical education class while at the same time teach adapted physical education to a child who was nonambulatory, nonverbal, and wore a body frame that was screwed into positions (i.e., sitting, knees bent, arms straightened). The boy was brought to the gymnasium in a wheelchair, and physically manipulated according to the activity by a paraprofessional and the researcher. Due to the age of the children and the disability of the child, a professional quandary developed on the part of the researcher regarding liability, safety, and respect for all children. The boy provided cues as to personal likes and dislikes. The researcher very quickly realized that the boy was embarrassed to be moved like an object in front of his peers. His peers let it be known that the boy was either the object of youthful curiosity or provided the opportunity to engage in improper behavior while the teacher's attention was diverted. Personal experiences in life along with current legal emphasis regarding "No Child Left Behind" in public education has placed the researcher in a tenuous position of being legally compliant while maintaining personal integrity for all children.

Participants

The researcher found a clinic that was established, had a relatively large population of children necessitating adapted physical education (20-25 children), parental involvement, and was a training center for future physical educators. This setting was at the University of Georgia where children's' parents applied for openings in the Pediatric Exercise and Motor Development Clinic (PEMDC) held throughout the Fall and Spring semesters. Many children participated each semester and several had attended for over 10 years. Pseudonyms were used for all participants: children, parents, and UGs.

Children

Common disabilities are behavioral disabilities, sensory and spatial disabilities, autism, cerebral palsy, Down syndrome, spina bifida, mild and severe intellectual disabilities, and learning disabilities. In the Fall 2006 semester, there were six children with Down syndrome, three children with autism, one with Aspergers (a form of autism), four with cerebral palsy, three with delayed development, one with vision loss and reduced depth perception, one with myotonic dystrophy, one with sensory integration disabilities, one with hearing impairment, one with bipolar, one with spina bifida, and one with Williams syndrome. Nine of these children were between the ages of two and eight; seven were between the ages of eleven and fourteen; five children were between the ages of fifteen and eighteen; and three children were in their twenties. All children were Caucasian except for one who was African American and one who was Hispanic. Seven children were female and seventeen were male.

All children who participated in the clinic chose to be included in the research process and signed a consent form, or the parent signed a permission form (Appendix A, B, and C).

Interviews were conducted before or after the children' participation in the clinic and took place in a casual and open environment such as the atrium, at the end of a hallway, or in an empty classroom at the physical education facility where the clinic was held. The parents were not present during the interviews, but the children knew where their parents were during the interview process. The children were happy and willing to participate in the interview process.

Four children were purposefully selected according to their ability to understand and respond verbally to questions. The parents of each of the four children were either e-mailed a transcript of the interview or given a hard copy to review. None of the parents made changes or asked that any interview information be omitted. Each parent gave consent for the interviews to be used in the research process.

Table 2

Overview of Children Interviewed

Name	Age	Disability	Educational Setting
Diane	18 years old	Down Syndrome	Home School
David	13 years old	Spina Bifida	Public School
Seth	13 years old	Williams Syndrome	Public School
Tom	18 years old	Down Syndrome	Home School

DIANE

According to the National Down Syndrome Congress (www.ndscenter.org, 2006), 1 in every 800 to 1000 live births are babies with Down syndrome, a chromosomal anomaly in which 47 chromosomes are present in each cell rather then 46. Individuals with Down syndrome

have common facial characteristics; physical, intellectual, and language development delays; and 30% to 50% have heart defects among other physical problems. Down syndrome is found in every race, nationality, culture, religion, and socio-economic level.

Diane was an 18 year old female who was home schooled after sixth grade. Her mother removed her from the public school setting because regular education classmates were mean and called her names, plus, there was not a special education program that would enhance her daily living skills. Diane was pacer-dependent (heart pacer) and had to be careful during certain physical activities. She participated in gymnastics until the pacer was placed in her abdominal region at the age of 12. Diane had a small stature; a very athletic build; and as the clinic director stated, was capable of running the clinic on her own. She had been attending the clinic for 16 years. Beyond the clinic, Diane also participated in fitness activities with her family. She had recently started participating in rhythmic gymnastics at a local public school and bowling with the Special Olympics.

Diane's parents both attended the clinic; they usually watched her from the viewing windows that surround the gym. They both sat in the pool area when Diane would swim or dive. Her parents drove approximately 42 miles to get to the clinic, which made an 84 mile round trip. Tuesday night clinic was a family affair, with a meal at a local restaurant before the trip home. Because of the lack of special education or adapted physical education programs in their county, Diane's parents drove her similar distances to the rhythmic gymnastics and bowling programs.

DAVID

David was 13 years old, in the seventh grade at a local public school, and active in academics and band. He had been attending the clinic since the age of 3, but he missed last year due to academic demands and his dislike for the gymnasium portion of the clinic. After seeing

the clinic director at a summer workshop, the director and David's mother decided that David would participate in pool therapy for the entire session, as opposed to splitting the time between the gymnasium and the pool. Also, his academic demands became more manageable in the seventh grade. According to Goldberg (ed., 1995, p. 80),

> Spina bifida is a congenital disorder of neural tube development in which there is failure of proper neural tube closure. It occurs in 2-3:1000 live births. With spina bifida aperta, or meningomyelocele, the vertebral elements are incompletely formed at the defect site and neural elements are directly visible. The etiology of this defect is unknown, although it is felt to be multifactoral.

When asked about other physical activities, David stated that he was not allowed to participate in elementary physical education. When he would move around the gymnasium and "get in the way", the teacher would send him to the equipment room with a friend where they would throw Frisbee. David had not yet been placed in a physical education class in middle school at the time of this research (Fall semester, 2006).

SETH

Seth was 13 years old and attended seventh grade at a local public school. He and David had not developed a close friendship; however, they always spoke and seemed to enjoy seeing each other at the clinic. Seth had been attending the clinic for four years.

The Williams Syndrome Association (www.williams-syndrome.org, 2006) described those with Williams syndrome as extremely social and trusting personalities who gave the appearance of learning more than ability allowed. Persons with Williams syndrome normally have an intellectual disability and experience developmental delays. Most show strengths in

social skills, speaking, and long term memory while experiencing deficiencies in fine motor skills and the ability to focus and remain on task. Some have physical abnormalities such as weak muscular structure, contractures, and joint movement along with facial characteristics.

Seth attended public school where he was placed in inclusion classes or regular education classes. Because he was so social, his father stated that Seth was well liked by his peers and that he enjoyed the daily routine of school.

TOM

Tom also had Down syndrome and was home schooled at various times in his educational career. Currently 18, Tom had attended the clinic for around 16 years. Like Diane, he stated that because his classmates were mean and taunted him, his mother chose to remove him from public school. He did home school, returned to a private school setting for a year, and then returned to a home school setting where his mother directed his education to include life skills. Tom was very social, liked being around people, and was very aware of his surroundings and environment. He was very eloquent in manner and speech, aware of personal space, and asked the researcher if she was comfortable in the setting. The researcher was taken aback at Tom's attentiveness and manners compared to all participants.

Parents

Parents, guardians, or grandparents accompanied the children to the clinic every Tuesday of every week. One mother commented that she and her son had a ritual of eating at the same restaurant after every clinic because it was their time to be together without the other parent and the other children. Both child and mother looked forward to their "outing" together each week.

The parents were unique in that many times a father and mother would attend together even though they were no longer married. One father was remarried, but he still attended the

clinic every Tuesday with his ex-wife and son from that marriage. Another child attended with a parent and a paid caregiver. Two children attended with their grandparents while the father attended sporadically. One parent was a university professor and another parent taught in an elementary school. The parents' ages ranged from late 20's to early 60's.

All parents were randomly selected. Every parent who attended the clinic with their child agreed to participate in the research process. All consent and permission forms were signed before any observations or interviews took place. The parents were e-mailed or given a hard copy of their interviews to allow them to make corrections or add information. No parent chose to delete any information or asked for any information to be withheld from the research process. All parents consented to the use of their interview information.

Table 3

Overview of Parents Interviewed

Name	Marital Status	Age	Occupation	Children
Gary	Married	46	Fireman	4
Melba	Divorced	43	Elementary Teacher	1
Emma	Married	65	Housewife	4
Stan	Married	30	Technology Specialist	2

GARY

Gary was married, worked full time as a fireman, and had three daughters and one son. The son, Seth, was 13 years old, attended the clinic each Tuesday night and was one of the children interviewed. The only night that Gary did not attend with his son was the third Tuesday of every month when he was on duty. Gary drove from a neighboring county to allow Seth to attend the clinic.

MELBA

Melba's son, David, was also one of the children interviewed. Melba was an elementary teacher in the same county that David attended school. David's father would sometimes attend with Melba, or would bring David on his own. Melba was looking forward to getting remarried over the Christmas holidays. She also resided in a neighboring county and drove to the clinic every week.

EMMA

Emma was the longest attending parent with a child. Her daughter was now 29 years old and had been attending the clinic since she was 5 years old. The current program director was the third program director during those 24 years, and he has been the director for 20 years. Emma laughed and stated that her daughter had obtained several doctoral degrees, as they had participated in many university sponsored programs over the years.

Emma moved her family to the university area when Amy was five in order to obtain services that were not available in her county. Her son was in seventh grade, two daughters were in college, and her husband remained in a southern county to continue their family owned business. She moved her entire family except for her husband to obtain what was needed for Amy. During the interview, Emma stated that her son was "sick over the move for months" until

he finally became involved in sports and made friends. He was eventually named "Mr. Middle School". The son and daughters are grown, but Amy and her mother continue to travel "home" every weekend to be with the husband and father.

STAN

Stan was 30 years old, married, and had two children. His youngest was 2 years old and attended the clinic. His older child was almost 5 and born with club feet which were corrected surgically. After surgery, Stan said that, "he just took off!" Perhaps because of the ages and physical development, there was little socialization between the two boys. The oldest "goes full speed ahead, nonstop." His youngest, Alan, was developmentally delayed: babbled rather than talked, wore braces to aid in stability, and had poor motor skills. Alan was just starting to pick things up and feed himself. Due to Alan's delays, he did "not get much opportunity to exercise and develop his motor skills."

GROUP

After observing the clinic and casually conversing with the participants during the first weeks, it was noticed that a group of parents sat together in the atrium of the building and talked during the clinic hour every week. Some would leave at certain times to watch their child in the gymnasium or pool, but the majority would sit and wait until their child was returned by the assigned UG. The majority of this group was made up of the "old timers". Several had been attending for over twenty years and had literally watched each others children grow up. After several conversations, the group agreed to be interviewed as a group.

Some members were relatively new to the clinic, but they were close in age to the other members of the group. Emma, who was interviewed individually, was 65 and had been attending the clinic for 24 years. Sally had a boy that had been attending the clinic for 23 years.

George was in his 50's and was now raising his niece, who was 8. Sally, Mary, and Beth were in their late 50's and were grandparents. John, also in his 50's, attended with his son, who was 14.

Undergraduates (UGs)

The teachers of the clinic were undergraduates in physical education, therapeutic recreation, health promotion, special education, and those interested in learning to work with children with disabilities**.** The adapted physical education clinic is an integral part of the adapted physical education class required for a physical education degree as mandated by the state board of regents. Some students entered the class with a positive attitude and prior knowledge of children with disabilities. Other students entered the class with a negative attitude and the desire to never teach children with disabilities. For some of these students, their perspectives changed over the course of the semester. The researcher wished to investigate whether teaching experience at the clinic changed their perspectives and how the experience might change their perspectives of teaching physical education and adapted physical education.

The UGs were between the ages of 19 and 31. Twenty-four were female, eighteen were male. The UGs were Caucasian except for one male who was African American. Some students were oriented toward individual sports, while others were team oriented. Their sports orientation became apparent in their teaching strategies. Some appeared very comfortable in one-on-one situations and playing individual games while others had to be more creative and adapt team activities to make them appropriate for one or two children. UGs must converse, interact, and become receptive to just one child. There were more UGs than children, so the UGs worked in pairs with a child. Each UG was required to develop individual lesson plans, and then teach together using both plans.

Table 4

Overview of Undergraduates (UGs) Interviewed

Name	Major	Age	Gender	Class
Dennis	Exercise Science	31	Male	Senior
Beth	Exercise Science	21	Female	Junior
Connie	Exercise Science	22	Female	Senior
Matt	Physical Education	23	Male	Junior

DENNIS

Dennis was a nontraditional student. He was 31 years old, had completed four years in the military and then worked in the private sector. After working in a bank for about 5 years, he began working as a personal trainer part-time. When Dennis returned to college, he chose to major in exercise science with the intention of working as a strength and conditioning coach at the collegiate level. However, his focus became pre-med, with a strong emphasis on the sciences. He stated that he would take his exam for medical school (MCAT) in April, and then weigh his options. Dennis lived with his girlfriend in another county and commuted to the university.

BETH

Beth was a junior who was majoring in Exercise Science. She was 21 and from the southern part of the state. Beth had extensive experience with disabilities and wanted to continue her education in physical therapy. She had worked with hippo therapy, which is movement therapy on a horse, for several years during high school.

CONNIE

Connie was also an exercise science major and was completing her senior year at the university. Like Beth, she was interested in continuing her education in physical therapy and at the time of the research was in the process of sending out applications to graduate schools. Connie explained that the adapted physical education class was a major elective that was required by her department. Even though she had previous experience working with children with disabilities, she had no future interest working in adapted physical education or special education. If she did not get into physical therapy school, then teaching regular physical education was an option.

MATT

Due to the random selection of UGs interviewed, Matt was the only physical education major. He was a fifth year student and new to the physical education program. This was his third change in major and he felt that he was finally in the right field. He played football and wrestled in high school in which he placed in the state competition. After this semester, he had two semesters remaining of classes and then student teaching. Most of his relatives (mother, aunts, and uncles) were employed in education, and he stated that they had told him for years that he should be a teacher. After taking a career class, he found that teaching was one of his top options. He would like to teach and coach wrestling.

Data Collection

Data collection included interviews, observations and artifacts. Observations included casual conversations with the children with disabilities, parents of children with disabilities, and UGs. The artifacts were the UGs self-teaching evaluations and children's clinic application forms.

Interviews

As Fraenkel and Wallen (1993) explain, qualitative research is used to find out the "why's" and "how's" of an experience. When we want to know a person's perspective of a situation, we ask them. The interview questions (see Appendices E, F, & G) relate the participant's experience, behavior, opinion, values and feelings. The questions were developed through practice interviews with children with disabilities, parents of children with disabilities, and graduate physical education majors to gain optimum data while guiding each participant through their clinic experience.

Specific, open-ended questions were asked which allowed participants the opportunity to give full, descriptive answers and provide the researcher a guide. Patton (2002) called this a combining approach connecting a conversational strategy and a standardized interview format. The researcher wanted to know the children's, parents', and UGs' stories: interviews attempted to collect their best experiences and their worst experiences. Also, what experiences made the clinic worthwhile and kept the parents and children coming back week after week, year after year. Through the interviewing method, participants were able to tell the researcher their stories, histories, and thoughts.

Four children in the clinic were purposefully selected to participate in interviews based upon their ability to understand and answer the interview questions. The parents and the UGs were randomly selected and were interviewed regarding their perspectives of an adapted physical education program: strengths, weaknesses, advantages and disadvantages. The researcher wanted to learn the participants' perspectives of the clinic; therefore the interviews gave the participants a voice to communicate the positive and negative aspects of the clinic. This information might provide data to initiate change in the clinic if needed. By interviewing the

children, parents, and UGs during the course of the clinic, the researcher was able to collect and then analyze the participants' perspectives of the clinic. All interviews were assigned a number to replace names of those being interviewed to ensure confidentiality. The researcher was the only person with access to the interview log. All interviews were audio taped and transcribed.

Observations and Field Notes

Clinic observations throughout the semester were conducted along with the task of compiling field notes. Because the researcher was an active participant in the clinic in the past, many of the children and parents were familiar with the researcher. Over the past two years, many of the adults have discussed their fears and concerns, surprises and laughs. Because the researcher was a fixture in the clinic itself, the researcher was a better observer. The researcher could tell if "Sally" was happy with the class and could ask "Johnny's" mother why he was so distraught.

The researcher observed the UGs teaching children with disabilities. The way the UG talked or did not talk to the child gave indications of the UGs level of confidence in teaching ability. Some parents watched their children, others read the newspaper or did work, and some sat in the lobby and talked with the other parents. The researcher observed parent responses, and monitored how they changed throughout the semester. Also, the researcher documented how nervous energy of some UGs evolved over time into easygoing manners when working with children. Through observation, the researcher wanted to see what the actions of the participants were telling (Patton, 2002).

Because of the nature of the adapted physical education class, the researcher found it necessary to be an insider. Every adapted physical education class is structured around the children's needs. Without in-depth knowledge of the disability of the child, an outsider would

find it difficult to assess and evaluate the clinic session. Although taking an emic (insider) perspective may be more closely associated with an anthropologist studying other cultures, adapted physical education is outside most people's experiences and norms (Merriam, 1998) and has its own language and identity.

Patton (2002) described field notes as descriptive notes of everything that "has been observed" and everything "worth noting" (p. 302). The researcher wrote field notes describing participants arriving at the clinic, delivering greetings, going to the gymnasium and swimming pool, and departing the clinic at the end of the session. Over time, patterns emerged regarding these transition periods as did the activities in the clinic itself. Field notes were taken from the minute the researcher started walking to the facility until the researcher stepped into her car at the end of the session. Many times the researcher would hear conversations between children and parents or UGs and other UGs while she was walking to or from her car. Often a parent or UG would stop and ask the researcher questions about the clinic or even the progress of the research.

After leaving the clinic, the researcher transferred the field notes from rough hand-written notes to more complete, word processed documents including thoughts, feelings, and insights reflecting the evening's clinic session. The field notes documenting the observations many times included conversations with participants that reflected their feelings. It was noted on several occasions that the researcher thought that parents at times just needed someone to listen.

Artifacts

The teaching evaluation forms (Appendix H) added another dimension to the study (Atkinson, Coffey, & Delamont, 2003; Ferguson et al., 1992; Merriam, 1998; Patton, 2002). The artifact in this study was the UGs self-teaching evaluations of the lesson which included a brief

description of the lesson plan developed by them for use with their assigned child with a disability. The lesson normally consisted of 30 minutes conducted in the gymnasium or gym-like setting (i.e., racquetball court, hallway, or wherever was available and appropriate) and another 30 minutes in the swimming pool. Time in the gymnasium or pool was extended or decreased depending upon the children and their disabilities. Also, clinic application forms were examined by the researcher. Several parents made requests regarding the focus of the instruction and teaching of specific skills according to the child's needs.

The UGs were instructed to write self-teaching evaluations throughout the course of the clinic. The UGs evaluated their own lessons and explained why their lesson was successful or unsuccessful and how it could have been changed to make better use of time and equipment. The UG must learn to conduct self-evaluations in the classroom to make immediate corrections or changes before, during, and after a lesson. The UGs were describing their overall clinic experience through their self-teaching evaluations (Merriam, 1998; Patton 2002). Their experiences as the teacher are totally different from those of the student or the helper; they must make split second decisions, good or bad, and see how the lesson develops (Fraenkel & Wallen, 1993).

The clinic application forms were also previewed by the researcher. This form was completed by parents stating their child's age, diagnosis, learning limitation, physical limitation, and any special problems such as seizures, anemia, diabetes, or other conditions limiting exercise. Parents also completed a section where they listed physical skills or social behaviors that they felt should be taught during the clinic. This form provided insight to the children's disabilities and skills the parents felt needed to be stressed throughout the semester. One parent

stated during the group interview that her child, who was not interviewed, completed her own application form.

Data Analysis

According to Miles and Huberman (1994), the actual process of data analysis can be broken down into four distinct phases: 1) data collection, 2) data reduction, 3) data display, and 4) drawing and verifying conclusions. In this study, the data collection was comprised of interviews, observation, and artifacts as described in the previous section.

Data Reduction

Data reduction was the coding phase of the transcripts, field notes, and summaries of the artifacts. The researcher analyzed the data from the interviews, observations, and artifacts and identified common themes specific to each participant group. Merriam (1998) stated that "categories are abstractions derived from the data, not the data themselves . . . these categories have a life of their own apart from the data from which they came" (pp. 181-182). There were themes or strands that were related to only one participant or one particular group.

Asking questions regarding experiences, behaviors, opinions, value and perceived value, personal and observed feelings, knowledge, sensory observations, and backgrounds (Patton, 2002), the researcher analyzed data depicting experiences of the participants. Participants provided their viewpoints and perspectives of the adapted physical education experience by telling their stories. As the stories unfolded, themes became evident. Category construction and resulting theory of those constructs painted a picture of the perspectives of the participants (Merriam, 1998; Patton, 2002; Stake, 1995).

Analysis of data from the transcripts of the interviews, the field notes from the observations, notes taken from the undergraduates' self-evaluation evaluations, and correspondence between the parents and the professor were separated into dominant themes. Inconsistencies in the interviews added dimension to the research just as the varying descriptions of the observations painted a picture of the clinic itself. Themes of the interviews created an impression of the person being interviewed. Observations created an impression of the children, the parents, and the UGs. Artifacts completed the impressions by relaying themes consistent from the parents and UGs (Hollway & Jefferson, 2000).

Field notes documented comments made during casual conversations between the participants and the researcher. "Content analysis usually refers to analyzing text (interview transcripts, diaries, or documents) rather than observation-based field notes" (Patton, 2002, p. 453). However, because the researcher's observations included conversations, the researcher was able to analyze common themes that related to the discourse of the interviews.

Data Display

Data display was continuous throughout the data reduction phase, with themes and threads of the coding phase being joined and condensed visually on a chart. During the interview process and the writing of the field notes of the observations and the artifacts, the researcher coded similar comments and relationships between the participants and sequences. Also, differences and negative or positive comments were coded to give an overall summation of the research (Miles & Huberman, 1994). Continuously writing, revising, and compacting the themes using inductive analysis (Patton, 2002), the researcher found the patterns that became the basis of the research. Collection of data extended from August through November. The researcher transcribed the interviews personally in order to become immersed in the data. Field notes were

coded according to content after collection to retain insights and thoughts brought about through the process.

Drawing and Verifying Conclusions

Final drawing and verifying conclusions were consistent with the themes and patterns evolved from the data reduction and data display. The researcher analyzed all data collectively, considering the views of all participants as a whole. "The meanings emerging from the data have to be tested for their plausibility, their sturdiness, their 'confirmability' – that is, their validity. Otherwise we are left with interesting stories about what happened, of unknown truth and utility" (Miles & Huberman, 1994, p. 11). The researcher's question was: what are the participants' perspectives of a university-based adapted physical education clinical field experience? The final categories "reflect the purpose of the research" (Merriam, 1998, p. 183). The categories tell a story of the participants' throughout the experience and provide an interpretation of the data. Inferences, models, or theory (p. 187) complete the data of the participants' perceptions.

Trustworthiness and Credibility

Trustworthiness has been described as authenticity, balance, fairness, completeness, validity, generalizability, and triangulation. If the information gathered and presented can be described using some or all of those terms, it may be considered trustworthy. A complete picture with all angles and options considered would be trustworthy. Qualitative research relies on the credibility of the researcher to ensure the quality of the research. Patton explained that the researcher literally was the instrument. Life experiences may initially compromise a person's credibility, but through triangulation credibility may be proven (Patton, 2002).

Miles and Huberman (1994) state that in regard to validity and credibility, the analysis must make sense, be plausible, be well-linked to theory, identify areas of uncertainty, have findings replicated in data, and the conclusions judged to be accurate by the participants. By having the people interviewed read and discuss the analyses, the researcher provided a true source of validity and credibility. Merriam (1998) called this "member check." Also, the research questions provided a clear path to the final analyses. Peer review or examination was conducted throughout the data gathering process to guide the research process.

Patton (2002) explains that credibility is established through triangulation. By utilizing different types of research such as interviews, observation, and artifacts, we are looking for consistencies and inconsistencies. The inconsistencies offer us insight into themes that may not have been uncovered using just one method of research. Credibility was proven through the consistent themes of the various researches.

Pilot Test

The pilot study was completed in three sections. After several experiences with adapted physical education as a teacher and graduate student, the researcher obtained permission from the program director to pursue and develop a qualitative study regarding the perspectives' of participants of a university-based adapted physical education clinical field experience. The second step was to talk with and eventually interview two professional adapted physical educators. Using experiences from the onset of their careers to their current situations, they discussed how their perspectives changed from having to take a class to learn how to teach adapted physical education to realizing how important adapted physical education was for the children, the parents, the community, and even themselves.

The third and final step was to test the interview questions with parents and children. This was done with permission through a public school system with which the researcher had worked in the past. The parents and children were comfortable with the researcher as she asked them questions about their experiences. As expected, answers from the original questions brought up more questions. The researcher then asked the parents and children to expound upon statements made and give examples or support.

Time Line

Data collection began in September 2006 using the participants of the PEMDC. Parents were asked to consent to be in the study and also give permission for their children to participate in the study. The parents signed a consent form and permission form. Children were asked to consent to participate in the study and sign a consent form based upon cognitive ability to understand and answer the questions. UGs signed a consent form. All interviews and observations were conducted in the Fall semester of 2006. Analysis of the data was completed and presented in the Fall of 2007. Confidential material such as interviews, audiotapes, transcripts, field notes, and collection logs were destroyed after the final defense of the dissertation.

CHAPTER 4

FINDINGS

The American Heritage Dictionary of the English language, Fourth ed., (2000) defines perspective as:

> A mental view or outlook. The relationship of aspects of a subject to each other and to a whole: a perspective of history; a need to view the problem in the proper perspective. Subjective evaluation of relative significance; a point of view. The ability to perceive things in their actual inter-relations or comparative importance.

The purpose of this study was to analyze a university-based adapted physical education clinical field experience through the perspectives of participants: children with disabilities, parents of children with disabilities, and undergraduates (UGs). Through living with a disability, having a child with a disability, or teaching a child with a disability, one's perspective may be very different from those who have never experienced life with a disability, had a relationship with someone with a disability, or taught someone with a disability. Results of this study may lead to new strategies for developing adapted and regular physical education programs to enhance and incorporate daily living skills in the public school setting and to provide better teacher training in adapted and regular physical education.

The questions guiding the research were:

1. What practices and experiences are beneficial in teaching children with disabilities?

2. What practices and experiences are not effective in teaching children with disabilities?
3. What facilities and equipment have been essential to the effectiveness in teaching children with disabilities?
4. What parameters are necessary for a good adapted physical education training program?
5. What are the values of clinical experiences and classroom instruction?

These questions encouraged three themes to emerge from the combined data: the interviews, the observations, and the artifacts.

Themes

Three strong themes emerged from the data analysis. The first theme indicated that there was a connection between the content learned by the UGs in the classroom and the application of that knowledge in the clinic: Physical Education Teacher Education (PETE) and Adapted Physical Education (APE). The large diversity of disabilities in the clinic enabled UGs to develop a broad knowledge base for their future professions. Teaching experience in the clinic enabled UGs to fuse learning in the classroom with practical experience. Through this experience, interactions between participants became positive and conducive to the learning process.

A second theme was that an environment of caring must be fostered in the clinic experience, an ethic of care. Through caring, relationships between the clinic and real life settings developed. Individualized contact led to meaningful relationships among the triad of participants: children with disabilities, their parents, and the UGs teaching in the program. UGs became care givers outside the clinic setting (i.e., “child” sitting); UGs came in contact with children with disabilities in public settings such as grocery stores, restaurants, and summer

camps; and casual contact was experienced between the UGs, children with disabilities, and their parents outside the clinic setting.

Finally, the third theme was that contact time was essential in order to make significant progress with some children with disabilities. Several UGs were unable to make any progress with their assigned child due to lack of contact time. Many times children would inconsistently attend the clinic, or the children simply did not have enough time to sufficiently bond with their assigned UGs. Some UGs were learning to work with children with profound and multiple disabilities for the first time and became frustrated with the process due to the short 9 week schedule allotted to the PEMDC.

Summary

The perspectives of the participants were obtained through interviews, observations, and artifacts. According to Patton (2002), credibility is established through triangulation, by analyzing different means of communication and observing consistencies and inconsistencies. Children were able to express their feelings about the clinic and the UGs. Parents told their stories of frustration and triumph while learning to raise a son or daughter with a disability. And finally, the UGs, the future teachers of our public educational system, gave their perspectives of teaching in an adapted physical education clinic.

Applying contact theory, the UGs took classroom knowledge into the clinic and applied it to their lesson plans, modifications, behavior management, space and equipment management, and ultimately they learned to teach. A connection between class and clinic, an ethic of care, individualized contact, relationships between the clinic and real life settings, a large diversity of disabilities, and bonding between the participants were the positive themes throughout the data. Lack of contact time between children and their UGs and inconsistent attendance on the part of

the children were the negative themes. The data suggests that the clinic (practicum) became an opportunity for each of the participants to gain individual knowledge and experience, whether as a child with a disability, a parent of a child with a disability, or a UG. The following three chapters contain detailed findings regarding the prominent themes as supported by the data in this research.

CHAPTER 5

THEME ONE: CONNECTION BETWEEN CLASS AND CLINIC

The first theme indicated that there was a strong connection between the content learned by the UGs in the classroom and the application of that knowledge in the clinic: Physical Education Teacher Education (PETE) and Adapted Physical Education (APE). UGs were able to practice transferring knowledge learned in the classroom to actual practice with children with disabilities in the clinic. Four categories of responses made up this theme of a practical connection between class and clinic: (a) the large diversity of disabilities in the clinic enabled UGs to develop a broad knowledge base for their future professions, (b) practical teaching experience in the clinic setting allowed UGs to practice modifying and teaching lessons, (c) it provided a conducive environment for interactions between the triad of participants, and (d) peer coaching opportunities were experienced by the UGs.

These four categories were interconnected throughout the clinic experience allowing UGs to experience actual teaching situations. Diversity of disabilities partnered with lesson planning, learning how to modify according to a child's level of ability, behavior management, positive and negative reinforcement, interactions with parents, environment, and learning how to peer coach were all elements of the connection between class and clinic.

Diversity of Disabilities

In the Fall 2006 semester, there were six children with Down syndrome, three children with autism, one with Aspergers (a form of autism), four with cerebral palsy, three with delayed development, one with vision loss and reduced depth perception, one with myotonic dystrophy,

one with sensory integration disabilities, one with hearing impairment, one with bipolar, one with spina bifida, and one with Williams syndrome. Though each UG did not personally teach each child, the UGs were aware of the children in the clinic and were required to help other UGs with lessons when their assigned child did not attend a clinic session. Also, some children enjoyed playing games in small groups, such as basketball, and this also enabled UGs to come in contact with children with disabilities in addition to their assigned child.

The PEMDC appeared to make UGs more aware of individual disabilities and possible strengths and weaknesses of that individual. One student, Matt, stated that even though he initially felt that he had to be more careful and protective, he gradually learned that his assigned child was pretty tough. Matt's assigned child had cerebral palsy and very poor eye-hand coordination. However, Matt found out very quickly that his child loved to run and that running helped to improve overall coordination responses. At the end of a clinic session for a reward, they would literally run down the hallways, up the stairs, and back to the gymnasium. Matt stated during his interview:

> You'll walk over there and he has this look on his face and then you start running and you get him going and he just sticks his tongue out, it's so, he just gets really happy. It's like, I just take him for a lap around the whole place because I think he would just run forever.

Matt explained that the clinic experience helped him realize how much he needed to learn about the different types of disabilities and possible modifications for those disabilities. Through contact with the children, he became more self assured, but he felt that he needed more practice and exposure to all types of children with disabilities. Matt discussed the realization that it was just as important to know what not to do as it was to know what to do:

> It will definitely, it's helped me realize that if I have these students in my class I will have to, there are modifications you have to make and that will help me be more conscious of what I have to do to help them succeed and get better in skills that they already have. I definitely like doing this, it helps out. I would do it again to just get better at it I guess. Cause I'm sure the more you're with them the better it gets. The more you're with them the more you learn. That's a big part of it.

Matt also shared in his interview his opinion of the importance of the class and the information learned throughout the semester in the class and in the clinic.

> For me it's just showing us the reality of what it's like and what problems we could be faced with in our future. And, definitely works on our skills where, approaching situations like this where we're going to have to come into contact with kids. I haven't really been put in a situation like this and this has definitely given me some warnings about what I don't need to do, do need to do, how I should approach a situation. If I were just thrown into a situation where if I didn't have this class and I had to do some teaching with some kids that need modifications I think it would be much harder then not having any kind of experience at all at first. So I think it benefits us all. Definitely an important class.

Dennis, another UG and hopeful medical school student, felt that the class would have a residual effect throughout his life. He commented that the combined knowledge he learned through the films shown in class and the information discussed, and then working with children in the clinic with those disabilities helped him to transfer the textbook description and analysis of a disability

to an actual person. The clinic setting required him to develop patience, learn how to modify effectively for children with disabilities, and relate to parents.

Donna's assigned child, Bobby, had a very slight tremor as a result of his cerebral palsy. She found it difficult to find activities that would help with his fine motor skills and keep him interested due to his disability and high cognitive functioning. The program director did not like her idea of coloring pictures with crayons, so she taped different shapes on the wall and Bobby would roll a tennis ball along those shapes. Racquet skills along with catching and throwing helped him to improve his motor skills and provided a high skill level to keep him interested. He loved to swim, so they also worked on the elements of a freestyle stroke. His reward was to dive for pennies at the end of the session. This was enjoyable for Bobby, and again, Donna learned to be creative and incorporate fine motor skills into all parts of the lesson.

Matt stated that he would like to work with children with Down syndrome in the future. Also, he commented that he thought it would be hard to work with children who were blind, but it sounded interesting after he heard a lecturer in class describe beep baseball. Dennis had commented during his interview that he had previously worked with several people with chronic health problems and he personally dealt with teaching children with disabilities in the same manner, they just required different modifications. Connie felt comfortable working with all types of disabilities and remarked that she felt good about working with children with disabilities. She had been a peer mentor in high school with a female student who had disabilities and made friends easily with her mentee's classmates.

Combining class and clinic, UGs were able to make connections quickly regarding disabilities. Learning about a disability and then experiencing working with a child with that

disability reinforced classroom knowledge and variations in those disabilities. Bringing previous experiences to the clinic setting also provided a knowledge base for some of the UGs.

Clinical Teaching Experience

Beth stated that her view of adapted physical education had not changed over the course of the semester. She definitely knew what she was getting into, but she was worried about "being over her head and freaked out." Because she liked working with children with disabilities, she thought the combined knowledge of the classroom and the clinic setting would benefit her in the field of physical therapy.

> Learning to learn to work with different kids, different little kids, and just getting the experience through trial and error with activities. Finding out what makes them happy and just the more children the more practice. And each time you're getting better and knowing what to do with them.

Beth continued her discourse about learning to teach physical education to include pedagogy she had never been exposed to in other classes, such as making lesson plans and learning to modify those lesson plans according to the child's reaction and success in the session. Beth explained her feelings about working with children:

> It feels good to get out here and be back with kids. But also, getting to set up goals and work toward those goals. And, draw up lesson plans is not something I've really done. So that's been cool. And getting to problem solve. Having the problems that I've had with the child that I'm working with this time, we tried everything which has been somewhat frustrating, so every week we have to revise lesson plans. So after something doesn't work, we're like, hey, let's try this. And what would make reaching a goal more exciting for our student? So, whether it's

> music or lifting or . . . that's been really neat. Just learning more about PE (Physical Education) and that since it's now in my major.

The father of Beth's child commented on several occasions that the UGs had a lot of patience and that his son was starting to enjoy the clinic.

Another UG, Connie, also felt that the clinic was a benefit to those who were going to teach or deal with children with disabilities. She commented:

> I think it kind of helps them realize this is what the real world is actually going to be. It's just kind of a real world situation of what we're actually going to meet, in the school system, dealing with [children with disabilities].

One father mentioned during a conversation in the pool area that he felt that the clinic was a wonderful opportunity for the UGs to experience real world situations. He also felt that the UGs would benefit from teaching more than one semester in the clinic setting. His child loved the clinic, and so few opportunities were available for children with disabilities to participate in different types of activities.

Combining class work with clinic sessions, UGs were able to develop knowledge of a physical disability and then apply that knowledge in an actual teaching (clinic) situation. Learning how to teach and learning how to modify skills on an individual basis gave the UGs more self-confidence in their teaching and coping abilities.

After each teaching session in the clinic, the UGs were required to complete a self-teaching evaluation (Appendix H) regarding specifics of the lesson itself. Modifications were necessary for different disabilities and skill levels, but the child's readiness could also change a lesson plan. Ryan commented on his evaluation that his assigned child did not bring his bathing suit that evening, nor did he bring a baseball glove for the correct hand. Because the child

wanted to swim and learn to catch, the lesson got off to a bumpy start. However, Ryan stated that the lesson went well and the child was able to recover emotionally after the initial disappointment in the change in activities.

Positive reinforcement became a key element in many of the UGs teaching experiences. When a child would not listen or do as instructed, the UG had to become creative in getting the child back on task. One UG finally told her child that if he "participated in my activities then we could do what he wanted to do." Also, the UGs had to learn how to structure the learning environment so that the children did not become too distracted. Ryan commented on his evaluation that his child became overly stimulated in the gymnasium. "He seemed very excited to be there, but maybe just a little too excited. He really enjoys watching other children. Maybe reserve a racquetball court or use a hallway so [child] isn't so easily distracted." The partnering UG also wrote that sometimes the child's focus and concentration needed to be redirected:

> We realized that [child] has a hard time concentrating, so for one activity we faced him toward the wall so he couldn't see anyone else. I also hid all the toys/materials until it was time to use them. He gets really distracted by things lying around.

However, moving a child to a different location was not always successful. One UG explained in her personal teaching evaluation that when she and her partner moved their child, he "was unhappy about being contained at the bottom of the steps. He crawled through our legs and pushed on us." She also stated after a different session that the child "became fussy and angry when we prevented him from running around/away. He was very uninterested in everything! When [child] was taken into the pool he was very nervous and scared and taken out immediately." Her recommendations for the next session included the implementation of

simpler, less demanding tasks and just splashing in the pool while sitting on the edge in order to make the child more comfortable with the water. The UGs had to re-evaluate every lesson due to the child's behavior and responses. Through trial and error, the UGs eventually became successful with the child and the child began to enjoy the clinic. However, due to the child's age and separation anxiety, the UGs and researcher discussed that the child would probably not progress until he had attended more clinic sessions in future semesters.

For several children, the pool was not always a welcome exercise station. One UG wrote, "The pool's cold water caused crying and general anxiety. [The child] was happy to walk around to pool's perimeter and splash with hands and right leg." Matt's child with cerebral palsy did not like the pool, and his reaction prompted Matt to question the necessity of the pool environment in the child's fitness program. He expressed his frustration with the pool experience:

> We took them [student and twin] to the pool one time, and we took them, they were really excited, like they were ready to go. And they were standing outside of the pool, and I reached out to him, and he was ready to do this, and he jumped in and I was holding him like this (demonstrates) and we were just going through the water a little bit and he seemed all right and then all of a sudden he just started kicking and flailing and just started he pushed me really bad and then he just started crying really bad so, and he actually got in, his brother didn't get in with us, he was just standing like on the side of the pool. So he started crying really bad so I sat him on the side, sat him up there, and he just was terrified of going in after that. . . . we tried to lure him out with the ball, cause his grandma told us that that sometimes worked. We got him back in one time for about a second, then he

> started the same thing, so, I don't know if it's fear of being out in the water, like, but it didn't work, so, we've not really working on that. And, I don't like to see him cry.

Discussing disabilities in a classroom and then working with a child with one of those disabilities proved to be more rigorous then many UGs expected. Beyond the disability, the personality of the child, the extent of the disability, environment, and simply whether it was a good day or bad day for the child became elements of the clinic sessions. Without the clinic experience, some UGs would have no practical experience working with children with disabilities before their student teaching assignment.

Participants' Interactions

Connie (UG) explained that teaching her assigned child, who had autism, required her to extend her social skills in different ways in order to keep communication flowing. Because autistic children do not communicate well, Connie had to find subjects that would keep him engaged. She also stated that she had to find ways to remain patient throughout the sessions in order to make them successful. Her assigned child, Patrick, would sometimes come into the gymnasium, lie on the floor, and go to sleep. During other sessions, he would run around the gymnasium with no focus for her, her partner, or the lesson of the evening. The UGs found that they had to isolate the child during gym time because he was too distracted in the gymnasium environment. Patrick learned that if he did the activities during gym time then they would go to the pool where he could swim or dive. As he did not like physical contact such as high five's, the UGs would give verbal praise or allow him extra diving time. When asked for a high five, Patrick would respond with "No five". Connie talked about her sessions with Patrick:

> We played with him about 45 minutes, played basketball. Well, in the beginning he was kind of tentative, he really didn't know what was going on, but as he progressed he started to get used to us and felt comfortable with us. But, I think he improved like shooting baskets, that's what his momma wanted us to work on, so he started making more shots which was good. I think he did good, but nights he was there and some nights he just kind of fell on the floor and fell asleep and we'd say, do you want to go swimming? Come on! Get up!

In one session, Patrick's mother joined in a swimming session and they talked about Thomas the Train and Winnie the Pooh. Connie said that Patrick literally knew all of the trains' names and their individual personalities. The child's mother had supplied Connie and the partner UG with a list of the trains and their names so they could become familiar with them and talk about them with Patrick. By talking about subjects that he was familiar, Connie and her partner hoped they could start building a relationship with Patrick.

> If you talk about Thomas the Train or, his parents gave us a list of all of the trains and the numbers and where they come and stuff, so that helped out. You could have a conversation with him. Yeah, I really had a good conversation with him one night about Thomas the Train. It was great. Thomas the Train or, his Mom swam with us one night and talked about Winnie the Pooh or Barney or something like that. If you talk about something interesting to him, he is very interesting. That's the only way he would talk to you though.

Connie and her partner were able to converse and form a relationship with Patrick through collaboration with the parents in finding ways to keep Patrick interested. She also remarked that her lesson plans did not always benefit Patrick because of his mood.

> Well, you're really supposed to follow a lesson plan, but we really couldn't because it just depended upon what he wanted to do that day. So, it's really hard trying to follow our plan.

She also tried to give the parents suggestions of what Patrick could be doing or practicing to increase his fitness level. Connie felt that she could have helped the parents more with his fitness program. Still, she and her partner felt that they had made a personal connection with Patrick by the end of the semester.

Matt also had to work hard to communicate with his assigned child, Ethan, who had cerebral palsy and was almost nonverbal. During short baseball drills, Matt encouraged Ethan to name the bases and call out those names, such as red or blue, as they ran over them. This communication drill functioned in addition to learning to hit, pass, or kick the ball. Matt explained Ethan's verbal skills as, "The only verbal he has is a whine. A whine if he doesn't want to do it or a smile if he does want to do it."

While Connie stated that learning to be patient was her personal goal, Matt said that his personal obstacle was the short attention span of his child. Matt became frustrated because he would want to teach Ethan a skill and Ethan just could not focus long enough to learn the new skill.

Not part of the class work, but definitely a concern to the UGs was learning how to converse and develop a relationship with the parents of the children. Ethan's grandparents would routinely watch from the windows in the gymnasium, making Matt nervous. Matt responded, "Kind of felt intimidated with the parents watching at first. Cause you're with their kid, you don't want to mess anything up." However, as Matt became more comfortable with Ethan, and as the clinic progressed over the weeks, Matt was able to effectively talk with the

grandparents and gave them ideas of what they could do at home to help Ethan become more successful physically and verbally. Toward the end of the clinic, the grandparents asked Matt for help in preparing Ethan for a Special Olympics competition at school.

Ethan's twin, who also had cerebral palsy and was nonverbal, would communicate with his UGs with grunts, facial expressions, or simply sitting down on the floor when he did not want to do an activity. The UGs quickly learned that if they also sat down and immediately transitioned into another activity such as sit to stand to jumping jacks to stand and back to sit, they were able to get him to do the activity. Verbal praise and high five's kept him motivated throughout the sessions. Through introducing equipment only when needed, they were able to keep him focused on one activity at a time.

Dennis, a senior, remarked that the clinic was "the funnest hour of the week" for him. The class and the clinic were a good combination of information. And, he felt that he got lucky with his assigned child, Seth, and his father. Sometimes Seth would ask if his father could play with them, and they would end up with a small group of children, UGs, and parents playing basketball. The children were active and developed social skills with other children, UGs, and parents and the parents were involved in a fun activity with their child and their child's UGs. The social aspect often allowed the parents and UGs to become more comfortable with each other over the course of the clinic.

Other students also found that during the initial sessions, involvement of the parents made the session more effective until they became more familiar with their assigned child. Written in a teaching evaluation:

> [Child's] father participated in some of the activities and this was very helpful because he helped encourage her and also helped with behavior management. In

> the pool, [she] started to get kind of mad at [UG] and me for trying to get her to complete activities so we finally just had to tell her if she could do a couple more things for us, she could play with whatever she wanted to for the remaining 5-10 minutes in the pool. . . . Her father was very good at encouraging her in the gym.

The participation of a parent gave the child some latitude in the choice of activities; this variable helped the UGs teach skills, complete their lesson, and become better acquainted with the child and her parent. However, the UG noted on the bottom of the evaluation that she was worried about keeping the child's attention and getting a little more cooperation from her during the lesson. Developing relationships between participants became an integral part of successful lessons for some children, parents, and UGs.

UGs and Peer Coaching

Due to the number of UGs taking the adapted physical education class, the professor chose to pair the UGs. Through peer coaching, having two UGs work with one child, the UGs were able to brainstorm ideas, activities, and handle difficult situations. In particular, Beth thought that she would not have been able to handle her child throughout the semester without the help of a fellow UG. Beth's assigned child was 2 years of age, developmentally delayed, babbled, wore leg braces, and had never been separated from his mother. Because of his separation anxiety, the mother spent the first weeks of the clinic doing the lessons with him. When he was separated, he would cry or scream and refused any interaction with the UGs. The mother suggested music, videos, and bubbles to help develop a relationship between him and the UGs, and only as the last weeks of the clinic approached was the mother able to physically separate herself from the child. Beth stated:

> It's good to have someone to share what's going on and to know that it's not just you. But that he cries with both of us and he peed on both of us today. At different times. But I guess that's okay and we have those kind of days, and she [mother] can hold him while I try to distract him with something . . . I've tried, he cries, but I've tried to stay upbeat through it and revise my lesson plans. Like we had him blowing bubbles, popping the bubbles, and we had him sit on his mom's lap one time and he was comfortable there. . . . I've enjoyed having a partner, I guess in other semesters they haven't had one, so I think it would be a little overwhelming if it were just me. I think it's great to have a partner to work with, brainstorm ideas, and testing and refining ideas, and it's nice to have someone to work on that stuff with.

Matt agreed that being paired with a partner to brainstorm ideas and have a back-up if needed made his first time teaching a child with a disability easier:

> I heard a girl talking, I heard that last year there was one teacher with one kid and I think that would be kind of intimidating, I kind of like having a partner this time around to work with, cause, you have more control. I think it would have been more difficult. I don't think I'd change anything else. It works pretty good. . . . me and my partner work pretty good. She has her set-ups, I have my set-ups, and she tells me what I need to do and I tell her what I need her to do. I think it works better with 2, because they could, its better, you can do an activity with them and if the ball goes rolling off somewhere, that person can hold the student's attention while the other goes and gets it. So, a student, the child can't just run off, nothing will happen when you go off to retrieve the ball that he just threw away.

For many of the UGs who had never worked with children with disabilities, it was more comfortable to work in pairs. Two lessons plans, someone to try new ideas with, and just having an extra person available if needed made the UGs feel more confident and comfortable. Reassurance and reliance between the UG partners was a welcome commodity in the new teaching experience. One UG wrote that she and her partner "switched back and forth with our activities and also helped each other out."

Because the UGs had been students up to this point themselves, many had to learn how to manage their child's behavior. Many UGs found that verbal praise, high five's, clapping, or simply just saying "Good job" was enough to keep the child happy and focused. For Patrick, who did not like physical contact, the UGs had to be a little more creative and find other ways to positively reinforce his behavior such as diving and talking about Thomas the Train. One UG wrote that she and her partner had to treat their child less like a baby and demand that she do the skills. Once the child learned that the UGs were not going to listen to her whine, she became more cooperative and was able to pick what she wanted to do after completing the lesson. The children learned that to use their disability as an excuse would not work with the UGs in the clinic. One UG realized that her child complained because the child did not want to do anything physical:

> [Child] claimed that some things I asked her to do "hurt" her, such as laying on her stomach on the body board (or doing the arm presses in the pool). However, she used the body board in that position when I asked her to sit on it instead. She doesn't like to carry her things, and doesn't like physical activities.

The UG also wrote that she used "her mom was watching" as a motivator along with verbal praise, and even would time the child so that she could "beat" her own times as reinforcement.

The child did not like physical exercise and the UGs were constantly modifying games to make them more interesting and fun to the child. The UG stated that the child would yell at her and the other UGs when she did not want to do an activity. Eventually, the UGs learned that the combination of when the mother watched from the windows in the gym or sitting in the pool area and they gave constant praise kept the child on task and focused. By the end of the semester, the child was less abusive verbally and more willing to do requested activities.

Sharing experiences with a child with disabilities became a welcome practice for several UGs. Learning to teach, modify, and rethink lessons to help a child become more successful was more manageable with a partner. Brainstorming ideas and learning to laugh at situations made the PEMDC experience less threatening and stressful for many UGs learning to work with children with disabilities.

Summary

UGs learned how to teach effectively in the PEMDC. Lesson plans were developed according to a child's needs through the understanding of specific disabilities. Communication, behavior management, interactions with parents, and peer coaching all became components of a successful clinic session. Through the combination of class and clinic, the UGs were able to learn content knowledge and then apply that knowledge in a practical setting. UGs were able to ask questions and obtain assistance from either the program director or the graduate UGs helping in the clinic. The class and clinic became intertwined due to the content learned and experience gained.

CHAPTER 6

THEME TWO: FOSTERING AN ETHIC OF CARE

A second theme was an environment of caring must be fostered in the clinic experience. Through caring, relationships between the clinic and real life settings developed. To these participants, a caring environment was manifested in individualized contact which led to meaningful relationships among the triad of participants which included (a) personalized fitness instruction and goal setting, (b) informal support for parents from other parents, UGs, and program director, and (c) socialization for the children with disabilities in the clinic and casual contact outside the clinic setting in public settings such as grocery stores, restaurants, and summers camps. On occasion, UGs became care givers outside the clinic setting.

Personalized Instruction by UGs

When he remarked about the importance of the class and clinic, Dennis (UG) stated the importance of exercise for everybody. He had worked as a personal trainer and loved working with elite athletes. He found working with children with disabilities frustrating and mentioned his lack of patience during the first few weeks of clinic. However, his child Seth, who was quite social and quite athletic, helped him find a comfortable pace for the lessons. His personal statement of exercise was:

> I think its, anything with exercise with anybody is very important. I mean, for most of them, this is probably the only exercise they get, so I think it's probably the most important thing they do in a week, in my view. . . . They [the parents]

> need to [bring them to clinic]. It should be mandatory for them to get some type of physical exercise during the week.

Matt interjected his thoughts of the clinic and how it affected children with disabilities.

> Well, I think it's important because you don't know how much their parents or the school actually is helping them out with improving their skills and that's our goal here. So, it's really important for them because they keep coming here year after year. Even though, I think they should do it more often maybe if it was possible. But, longer then just 6 weeks or whatever. I think it's definitely important for these kids and their parents should keep them in something like this cause you have no clue what teachers might be doing with them at school cause they could be getting left out. But, definitely I think it improves their skills overall.

For Seth, the child with Williams syndrome, the clinic had been a pleasant mixture of social skills, physical skills, and specific sports skills. Seth's father, Gary, stated that:

> He loves it. He loves being around people, and, that's one of the things here, he gets a lot of one on one attention from whoever he's paired up with and he meets all the other people here, and he loves that too. He just loves sports. He loves baseball, football, basketball, just everything. And of course, getting in the swimming pool is something he loves to do. He's learned a lot. . . . This year, in particular, every time that we come through here in the ten weeks, they want to know what to work on, and I want him to learn to swim hand over hand. He's never been able to do that, and every year they work on that. Well, all of a sudden, he has just taken off with it. So that's one of the real big things that he has – it's taken four years, course we work on it during the summer, too, at the

> pool we go to. But it's been all of a sudden it's just clicked with him. He's swimming real good hand over hand.

Melba, a single mother, wanted David to exercise, but she also wanted the UGs to teach David good lifetime health habits. She felt that if the information came from the UGs, David would be more accepting as compared to a mother's "nagging". Melba continued to talk about David's life skills and her inability to help him physically as he got older.

> I hate to take him out of the pool, I truly do, because that is something that he loves, but maybe, outside the pool before he can get in, maybe that would be enough incentive for him to really work on this. I would like for him to learn to transfer from the floor to the chair. He, again, this would incorporate having that little talk about nutrition, and about being active and about getting exercise. Because he cannot lift his body into his chair, and I cannot continue. It hurts my back. And I'm thinking how much longer can we continue this. So, I think this is a skill that he really needs to acquire because what if he were to fall out of his chair. It would be embarrassing for me to call 911 for them to help my son to get up off of the floor. That would be silly. He needs to be able to handle himself. And, to go from the floor to the chair I think is a reasonable expectation. I'm not sure how to reach that goal right now, but that is something that he needs. I know that's a life skill that he needs. . . . If I could be shown the best way to teach him how to do that, this is certainly something I want him to learn.

Melba felt that having 2 UGs was a better combination because they were able to offer different skills and viewpoints, particularly from the male and female perspective. In her interview, Melba emphasized,

I enjoy the fact that students [UGs] are working with him. Especially, they've pretty much made sure that at least one male has been with him since he's gotten older. And it wasn't a big deal when he was younger, but now that he's older, especially since it's just me at home, that's really good. And, usually, especially this group, seems to push him, make him, I want them to push; I think that's so important that they realize that a lot of these children have to be pushed, because they have a lot of fears to overcome. And usually people don't. They want to pity them, and I don't like that. I never want someone to pity David, I want them to expect, and then if you see you expected a little too much of him, you can back off. But if you don't push, you're not going to get the best. So I do want that. And this group, Sarah and Tommy seem to be doing that real well. With David, since he's doing pool work, I want him to get as much exercise as he can during that time. I'd love for them to talk to him about his eating habits. Because, while they're working, because it's a physical thing, and, you know, I can do it all the time and I can make him eat, but then when he goes to school, he's going to eat fatty foods because that's what they serve, and he's going to trade foods and he's going to do all of those thing that I don't want him to do. When he goes to his Dad's, he's going to eat what they serve, and he's probably going to keep eating and not stopping at one helping. So I can't be there to make him make good choices. When he goes to his friends, he's going to have to start making good choices. And if everybody starts pumping it into his head that what he eats is what he'll be, or become, then maybe it will mean more to him then if I'm always

> the one policing what he eats. And, in the pool, if they know strokes, I'd like for them to work with him on the actual, correct way to do a stroke. If he can do it.

Melba voiced her concern that David had never had physical education, and he was lacking in life skills such as the simple act of getting in and out of his wheelchair by himself. At the end of the interview, Melba and the researcher went to the gymnasium where the researcher demonstrated to Melba and David how to maneuver from the floor to the wheelchair and vice versa using aerobic steps as stacking platforms. They also discussed hand weights and the possibility of wheelchair racing for exercise, not necessarily to race.

David liked having 2 UGs because they made him work harder and push himself physically. He admitted, "I mean, I would say about myself, if you don't push me I won't do it as much." He enjoyed swimming laps and playing water baseball using an aquatic bat and ball and swimming to the bases. David missed a year of clinic due to an overload of schoolwork and the fact that he just did not like the gymnasium part of the clinic. Because of his spina bifida, it was difficult for him to maneuver in the gymnasium, and the water environment provided more freedom of movement. He and his mother attended the same seminar as the clinic director last summer and they discussed David's dilemma with him. David said, "I like being in the pool cause that's more fun to me . . . . and mom said, well, you do realize that he'd rather be in the pool. So, I'm all over that, I'll do it. I like the water." When asked what he did in the pool, David replied:

> Different strokes. Going back and forth in the pool. Sometimes half the pool and then back, and then another half. We do weights. They're foam, but when you push them underwater, they get heavy! You get them and think, these are too light. It's like, there's a lot of weight on it.

Unfortunately for David, he had yet to receive physical education in his public school. David was currently in the seventh grade.

Informal Support for Parents

Several parents mentioned that because of their lack of a spouse, the UG became a role model that was not available at home. One mother remarked, "And one of the things that it's good for [child] is besides the physical activity is, I'm a single parent and he always has a male student with him, so it's just time for male bonding." Her son had multiple disabilities, and explained during the group interview that she was now attending the clinic more for herself than for her son. Her son had been attending since the age of 2 and was now 16. In addition to several organ dysfunctions, he was diabetic and legally blind.

Parents at the clinic would share information regarding camps, care givers, therapists, and specialists. In the group interview, the same parent shared her personal outlook on the clinic.

> Seeing you all and seeing your kids, I mean, I have told everybody that I thought it was more therapy for me then it was for him [child]. Even though he loves it and I know it's good for him [child], but it's fantastic for me. I wouldn't see you all! You know, you say you'd call, but you wouldn't, you know, you'd get busy. You know, we get together and talk.

One parent interrupted and said she found out about a specialist who eventually performed surgery on her son from another parent attending the clinic with her son. She commented, "And then you keep up with tidbits, and share doctors and who's had good luck with therapists or whatever." Another parent interjected and noted that they took care of each other emotionally through the years and relayed information regarding each child's various surgeries, therapists,

trials and triumphs. And finally, one parent stated, "And we take care of each other," as the other parents shook their heads in agreement.

The parents expressed that the clinic was for their children, but the clinic had become more personal over the years and was a support system for them as well. Emma declared, "We, our paths cross in other ways. Camp, the challenge league, or different camps, or . . ." The group started talking about a summer camp that the children attended over the previous summer. They had a girls' night and a boys' night that was a combination graduation and prom night. The girls wore evening dresses, the boys wore tuxedoes, and the children were escorted into the dance by the counselors of the camp. The parents explained that their paths crossed in many ways outside of the clinic because their children had similar needs.

Socialization for Children with Disabilities

According to Seth, he had been attending the clinic for "like, maybe 100 years." He said that he kept coming back because it was perfect and it was so much fun. He wanted to come more often and be paired with more UGs, sports buddies, as he called them. The facility was big, "big in people and big in – the whole thing." Agility training, basketball, football, kickball, and swimming – anything done in the clinic was big and fun and he loved it!

Gary, Seth's father, also mentioned that Seth knew several of the other children through summer sports camps and recreational activities. He mentioned that even though the children did not have a lot of time to socialize with each other during the clinic sessions, they would recognize and speak to each other. That interaction became another social outlet. Seth always spoke to another child who was autistic, even though that child would often not acknowledge the salutation. Over time, the child with autism would acknowledge Seth and smile, and, at times, he would say hello to Seth.

The clinic was a place to see old friends and meet new "sports buddies" for Tom. He had attended the clinic for 16 years and stated that he had been attending "since he could walk." He was only interested in attending the clinic on Tuesdays, as that was the scheduled day. He had a busy schedule and he would not change his schedule. Tom had played exhibition tennis when he was in public school, ran with his sisters, and enjoyed all types of physical activity. He decided that he was ready to include racquetball in his clinic sessions. When asked about racquetball, he stated that he played tennis and he thought it would be another fun racquet sport.

> I would, I know the routine from now on, and the routine is now get your buddy, talk to my Mom, going downstairs, do some little sit-ups, play basketball or football or something like that, and then swim. So, what I'm trying to change now, I want to change the routine and make it go like racquetball – first meet my buddy, racquetball, then go down to the gym and play basketball or football, and then swim.

Many children who had been attending the clinic over several years had learned to become self-advocates. Some had been prompted by parents, others just simply wanted to try something new. Tom explained to the researcher that he had been thinking about racquetball for several weeks now and was ready to approach his "sports buddy" (UG) with the proposition.

Tom was able to recall the names of several of his previous UGs. He knew that he would get a new UG every semester, and looked forward to the change. Several had introduced new activities to him and he enjoyed getting new partners. Tom demonstrated several exercises that he had learned from different UGs, plus playing tennis, basketball, football and swimming. After his demonstration, he told the researcher the name of the director of the clinic, the director's function, who helped run the clinic, and how the UGs were assigned. Tom was very

eloquent in manner and organized in thought. He previously had a girlfriend who also attended the clinic, but the father of the female child chose to separate them. Tom decided it was time for a new girlfriend, he just did not know if she should be another female in the clinic due to the previous experience.

The clinic was a place for Tom to meet his friends and enjoy their company. He said, "For me, the best part of the clinic is having fun with my friends and getting to know new people and just that." Tom had been participating in the clinic for 16 out of his 18 years. In fact, he learned to walk about the time he began attending the clinic. His assignment to a "sports buddy" was one of his highlights. Tom spoke with fondness of his previous "buddies" and he told me that one became a professional football player, one ran track for the university, and one was a doctoral student. Tom described the UGs and schedule:

> The clinic is about, you get attached to a buddy, maybe a sports person. The person that has this clinic is called [the director]. [He] decides who everybody who comes to this clinic is going to see, it might be a sports buddy, or it might not be a sports buddy but someone who goes to this campus. Football players, basketball players, anybody who comes to the University. So you have a buddy and after that you go to the gym, play some basketball or something like that and then you go swimming.

As Tom learned different skills and focused on different sports, the clinic remained interesting for him. Because the UGs changed every semester, the children were introduced to different aspects of fitness and exercise that, perhaps, they would not have been exposed if they continuously worked with the same UG.

> Well, last time I was here, I can't remember his name but one of the other buddy's that I had, and I was, it wasn't the place where we are now, but when you came into the entrance, I went over there for some fitness. You know, how much you can do and I had to do [demonstrates leg lifts] like this and stuff like that. That's the only stuff I know. . . . But I guess one of my other buddies told me when I was swimming that it was time for me to do some laps, and I said, okay, I'm ready for that. I'm ready for the challenge. And then, he teaches me to swim. He teaches me not to splash, make sure when you swim you bring your hands through the water [demonstrates a stroke] and he taught me a lot. I know how to swim pretty good.

Different UGs had different interests, which enabled the children to learn a variety of skills.

The female who was previously Tom's girlfriend was also one of the children purposefully selected to be interviewed, and the majority of her conversation during the interview was about Tom. Diane stated that she and Tom talked about movies (such as Harry Potter), played games together, and that she continued coming to the clinic to see Tom. Diane enjoyed the activities at the clinic. She was an accomplished swimmer and diver, performed rhythmic gymnastics, bowled with Special Olympics, water skied, knee boarded, water tubed, and drove a jet ski. Diane liked having an exercise partner, she said it would "be much funner" with her UG than having to exercise by herself.

One of Diane's goals that her parents wrote down every semester for the UGs to work on was for her to pay attention and listen. Her mother stated that Diane did not like to listen to instructions, and she liked to tell everyone what to do. The program director had stated to me one day that Diane was perfectly capable of running the clinic by herself and that she always had

her UGs well-trained to do what she wanted. Because Diane had been attending the clinic for 16 years, she was very comfortable with the schedule and was able to inform her new UGs every semester how the schedule worked and what they were going to do during the clinic sessions.

The UGs working with Diane quickly found that she attended clinic to play basketball and see Tom. By using those two items as motivators, she would ride the exercise bike, walk laps on the track, swim laps, and tread water. However, exercise alone became drudgery for Diane, and the UGs had to find ways of making the exercises more fun. Excerpts from her UGs teaching evaluation included:

> [Diane] was very verbal and social with us and the other children. She constantly talks about Tom and wants to talk to him. Sometimes she is more into socializing than working at the task at hand. . . . did not seem very excited to go upstairs to ride the bike. But once up there she did a great job and was very talkative. She was very excited to go to the gym to play basketball and see Tom. . . . She completed the walking without too much fighting. [Diane] was excited to play basketball and see Tom. . . . We use talking to Tom as a reinforcer. . . . The entire time we have to bribe [Diane] with playing basketball and talking with Tom. Yes, they continue to be successful when working with [Diane].

Diane lived in an area where she was isolated physically and socially; her parents drove 42 miles one way to attend the clinic. Socialization and positive reinforcement helped Diane to progress physically, make new friends, and maintain old friendships.

Connie, a UG, thought that the clinic was one of the best programs for Patrick and the other children with disabilities. Also, it helped the parents to see their children in a setting where they were successful. Connie expressed her view:

> I think it helps them a whole lot. Like with their socialization skills with other kids, interactions, it probably does, it's hard to get Patrick to do everything, but it's good for him to play with other kids, sports, in the clinic. It helps with socialization I think. . . . I think it kind of helps their (parents) view, like on what their child, other kids, how they relate with other people. It just makes them see how my kid is actually a better kid, they don't see that a whole lot. But you know, they're not at school with them. . . . I think they're much more capable then the parents realize. They don't see them in that environment.

For Emma's daughter, Amy, the clinic's UGs have taught her progressive levels of skills over the years. Amy was severely autistic and had been attending the clinic for 25 years. When she first began attending, Emma's goal was for Amy to simply quit screaming and allow her mother time to get through a grocery store. She was thrilled with Amy's swimming:

> It was just fascinating to see her [UG] work with her in the water, you know, she goes under and swims, but she can't stay under forever, because once she was under there she couldn't figure out if she was up or down, she was kind of lost. So to get her to swim above the water, she swims like Ester Williams, no splashing, not a ripple, it's beautiful, it's almost like a puppy, but in order to get her to come back up, all you have to do is just touch some spot [on her body].

Even though Emma was glad Amy was exercising and practicing fitness skills, she noted that the socialization meant the most to Amy. Due to Amy's age and the fact that she no longer attended public school, only a few programs were available for her that included people her age. Emma commented during her interview:

> Probably the main thing for Amy is socialization. Also, she exercises for them, walking and running, she's with me 24-7, she'll do something for them here than she would for me. . . . Oh, yeah, she'll be up at 3, especially the first day. I try to let it slip in so she won't know [it's clinic day], or she'll be up at 3:00 in the morning. She's so excited about it. And, that's why, thing like this, I think you can overdo it when they're little and when they get bigger there's a void, she's not ready for sitting with big kids, 40 year old, you know, she wants to be with her peers, which would be college kids. Well, she's a little bit older than college, but that's why I think she enjoys it, is, she's not ready for the 40 year olds. . . I really think it's, you know, I wrote a letter one time. I don't think anybody realizes how much this clinic means to these kids. It is, it's not like they win blue ribbons or anything, but, here they're with people that are not critical, you know, we all have a problem. You know, we're all handicapped in some way. You might hopefully do better in math then I do. But, I think, just the socialization and the exercise and that she feels good about herself. You know, that she's doing something that nobody else is doing. I think that's what is important.

As the children became older and more accustomed to working with new UGs every semester, the parents found that the UGs were great child care givers. Working with the children outside of the clinic and establishing relationships beyond the clinic setting, UGs were able to gain insights into different types of disabilities, and children were able to forge personal relationships independent of the clinic setting. One mother commented that her child's male UG worked for several years as a care giver and that he still wrote the child and came to visit. Another mother stated that, "A couple of them that I've used for babysitters or sitters, it's been years, but they've

kept in touch after class is over." Several parents mentioned that just running into a UG in a local store was a high point in their children's day. One parent stated,

> I had one guy who has continued. We run into him every once in a while. But for a while, we would see him around town and he would always come over and talk to us for a little while.

Matt related his experience of seeing one of the children who attended the clinic in a local grocery store. He walked over to her and asked if she attended clinic. She stated that she did and that she loved it there. Another child, to whom Matt was not assigned, always kidded him when she saw him, calling him "fat butt". Thankfully, Matt laughed when a child would single him out and tease him. Every time he would pass a particular female child in the gymnasium, she would throw her shoes at him. Of course, he was expected to return her shoes and play whatever game she was currently engaged in for a few minutes. The children did not necessarily know all of the UGs, but many children would recognize them and some would find ways to engage them in conversation or play. Matt had a very outgoing personality and always had a smile on his face. The children enjoyed getting to know Matt and he was able to develop a relationship with many of them over the course of the clinic:

> Actually, today, I was up at Kroger and I saw one of the girls and I thought that she was in the clinic so I asked her if she goes to the clinic and she was like, yeah, I do. It's like I recognize you. Yeah, what's your name – Oh, yeah, I've heard some kids talking about you. And she's like, yeah, I love the clinic, I go there every year. And, I had been around some, I don't even know, but a student here throws her shoes at me. When I'm walking down the steps she yells fat butt at me, so that's another one. I play basketball with a couple. We played basketball

> with a couple of them when our kids didn't show up one time. They all like to play basketball; it seems like its fun [for them].

The researcher observed first hand the unique bonding between the UGs and their assigned child. Traditionally, the last clinic session every semester was staged as a carnival. Stations were set up and children and their UGs would rotate every four minutes. The stations included bowling, balance beam, T-ball, badminton, football throw, bean bag throw, scooters, floor hockey, target Frisbee, basketball, and jump rope. As each child and UG would complete a station, the graduate UG would blow her whistle to indicate that it was time to rotate to the next station. After the last station was completed, the individual groups became two large groups and parachutes were brought out. The children would sit under the parachutes, run under to the other side, help make the parachutes go up, and play popcorn. (Parachute popcorn is making paper balls "pop" into the air when the parachute is lifted up and down.)

The closing act was always the hokey pokey song and dance. After the hokey pokey, each child was recognized and given a certificate of attendance. Some children walked to the center of the group to accept their certificates on their own while listening to yells and clapping by all of the participants, and others accepted with their UGs accompanying them to the front. The graduate teaching assistant thanked every child, UG, and parent and said good night - and no one moved. The children stayed with their UGs, the parents talked to the UGs and other participants, but no one left. Several parents had brought gifts for the UGs (for example, one brought brownies) and one UG bought his very small child a very tiny university sweatshirt. Pictures were taken, hugs were given, and the participants of the clinic began to drift out the door. The clinic was finished, the final exam would be taken, and preparation for another clinic

with children with disabilities, their parents, and UGs would be organized. As the researcher walked out the door, a child turned to her mother and asked, "I wonder who I'll get next time?"

Summary

Being recognized by the UGs outside of the clinic setting was always fun for the children. The interaction was just one more way for the children to practice their social skills. In addition, the UGs became aware of children with disabilities in the community and how those children contributed to the life and environment around the university setting. The UGs learned to think of children with disabilities as individuals, not as a group who had similar disabilities.

Beyond fitness, the clinic provided socialization opportunities for all participants not readily found in other settings. The children became friends in the clinic and maintained those friendships through summer camps and recreational activities. Parents found a place where they could exchange knowledge with each other regarding care givers and services and also were able to provide a support system for each other. Male UGs became role models for children who did not have a male influence at home and all UGs became role models for healthy and fit lifestyles. Fostering an ethic of care through personalized instruction by the UGs for the children with disabilities, establishing an informal support system for the parents, and extending socialization opportunities for children with disabilities contributed to the clinic's success.

CHAPTER 7

THEME THREE: TIME

Time was the final theme supported by the data. Several undergraduates, UGs, did not have sufficient time during the semester to make significant progress with their assigned children which led to frustration from all participants involved. Many times children would inconsistently attend the clinic, or the children simply did not bond with their assigned UGs. Some UGs were learning to work with children with profound and multiple disabilities for the first time and became frustrated with the process due to the short 9 week schedule allotted to the PEMDC.

Attendance and Bonding

Attendance and bonding was not a problem for Seth, who was 13 and in the seventh grade. He had been attending the clinic for 4 years and stated that he would come every day if possible. His father, Gary, also said that he would bring him more often if it was offered, but it would become hectic and conflict with his work and family schedule. The children who came every semester were assigned a new UG every semester. Gary felt this was just another opportunity for Seth to learn to adapt to complications in real life situations. Gary replied:

> He loved [the UG]. He was an offensive lineman for the university. Anyway, he bonded with him, and he's had other teachers that he was the same way with. You know, he likes all of them, and some of them, he likes to play football, and the other teachers, this one would always talk to Seth and Seth bonded with him.

> He wasn't the one he was paired up with, but he got to know him real well. . . . I just think that it's good that he meets different people.

Seth was aware of the UGs departures every semester and would ask his dad about them.

> I think he does [miss them] because he'll ask about some of his partners that he's had, he'll ask about them throughout the year. But, when you get here, the next 10 weeks [the PEMDC is a 9 week program] and he's got a new partner, he's just excited to meet them. I'll ask, who do you think your new partner's going to be?

Gary kept Seth's outlook positive by emphasizing the new and unknown. Rather than looking back, he taught Seth to look forward to the new possibilities of each semester.

Gary mentioned a female UG that Seth was partnered with two years ago. She was also an athlete at the university. Her assigned child had quit coming to the clinic, so she was assigned to help with Seth. This UG and Seth connected in quite a different manner, and the father eventually had to intervene in a positive and humorous way.

> They'd get in the pool and I noticed she was holding him the whole time, and I went over and told her, you know he can swim. [She stated] No, he told me he couldn't. And I said I can see why [he laughed]. Yeah, he enjoyed that.

Seth's behavior was always appropriate with every UG. Because he came to the clinic on a regular basis over a 4 year period, the graduate students who helped run the clinic with the director became very familiar with Seth. He usually had a hug for the ladies and high five's for the gentlemen. Also, he always made sure he received a hug from the female graduate student, who was the scheduling coordinator for the clinic, at the end of each clinic session. Even the researcher received a hug from Seth on several occasions. Seth always came to the clinic with a smile on his face, and he always left the clinic with a smile on his face.

Opposite to Seth's behavior, when Diane first attended the clinic at the age of two, her parents stated that the first year was absolutely horrible. The father remarked on her progress with the UGs:

> They've done a great job. When we first brought her, she was kicking and screaming, we couldn't leave her. It was horrible! [The director] told us, we've had kids like this before, they'll get better, and she was gradually getting better. Before, we had to stay in the room while they worked with us, then gradually it got where we could watch from the door, or from across the gymnasium. Then it got to where we were outside looking in, and it gradually got better, and, they've done a lot with her, she's learned a lot.

Her parents stated that Diane took close to a year to become comfortable with the separation and to be willing to work with the UGs without her parents. For Diane's parents, more sessions would be better, but travel and time might become a hardship. They drove 42 miles each way to the clinic and Diane was also involved in rhythmic gymnastics and bowling. Both activities were approximately the same distance from their home as the clinic.

Emma, a mother, commented that twice a week would be a better arrangement for herself and her daughter. She felt that her daughter, Amy, who was 29, would benefit physically and socially from 2 sessions a week and that it would not be so many that it would become drudgery. She also stated that many activity programs stopped once a child left high school and that there were really no programs available for a young adult with severe or multiple disabilities. Because Amy was with her 24 hours a day, 7 days a week, the clinic provided both with a social outlet and physical break from each other.

Tom, the young gentleman who had Down syndrome, said that once a week was all that he could fit into his schedule. Because Tom was active in church activities, ran with his sisters, played tennis with his father, and did some home schooling with his mother, more clinic sessions would become cumbersome to the family's schedule. He was happy with his schedule just the way it was!

Sporadic Attendance of Children with Disabilities

David enjoyed spending all of his time in the pool. Due to his lack of physical education, immobility, and inconsistent attendance, his progression and acquisition of skills were limited. Many times the UGs would repeat a previous lesson plan because David had not progressed enough to move to the next skill level. He listened well and understood instructions, but his skill level caused him frustration. One UG wrote:

> His swimming skills did not seem to progress this week in the pool. Last week he missed the teaching session because he was sick, therefore it has been 2 weeks since he has been in the pool. . . . At times he seems a little frustrated because he thinks he is more in shape than he is and wants to swim farther even though he is struggling and starting to swallow lots of water. He seems very driven and motivated to learn and improve.

Inconsistent attendance kept David from progressing and created a re-teaching situation for the UGs. However, his mother, Melba, stated that if the clinic were offered more times per week, she would definitely fit it into their schedule. She was concerned about his health and fitness level and worried that she was unable to lift him to get him into his wheelchair. Melba spoke highly of the current UGs and stated that she wanted them to encourage David to eat healthy and

exercise. She felt the UGs were role models for David and could provide motivation that she could not.

Another child, Alex, who was a ward of the court, was driven to and from the clinic by a state driver. The foster parent and court appointed advocate attended with the child during the first session, but the child was dropped off by a driver for the remaining sessions. Alex attended the clinic sporadically and was nonverbal. Due to his inconsistent attendance, the UGs made little progress with him over the weeks. Even though the UGs were patient and tried to help the child advance purposefully from one skill level to the next, the UGs were clearly frustrated with their progress as teachers. They wrote:

> [The child] did not come to the clinic this week. He was not at the previous session either. Therefore, we were unable to progress [child] through his lesson plan. The difficulties that are associated with this include: no direct feedback from the foster parents. They do not drop him off or pick him up from the clinic, so we do not know if our efforts are transferring to his play at home. Also, the inconsistency of his attendance makes it more difficult to progress through a program.

Because Alex was nonverbal and was accompanied by a state driver the UGs did not know if the current foster care was temporary or permanent. Alex had multiple disabilities and was unable to provide any feedback, not even grunts or smiles. The UGs and researcher discussed on several occasions the appropriate actions to pursue with the child, but the inconsistent attendance prevented any progression of skills. The UGs teaching evaluations included statements such as:

> [The child] did not come to the clinic this week. When he does resume coming to the clinic, my partner and I will most likely need to do another evaluation of his

> skills to see if anything that we had taught him in the two previous sessions was learned and is able to be recalled. . . . We will have to go back to our original goals to see if he has met those at all. With [child] being in a foster home situation, it is hard to know if he is improving at home because he is dropped off by a different person each week. This person does not have an idea of what his home life is like. . . . Once again, [child] did not come to the clinic this week. We have not heard from anyone saying that he will not be returning, so we will continue to have lesson plans ready for him. Therefore, there was no progression this week. If anything, there was probably a regression in regards to our specific goals for him.

The researcher did see progression of skills when Alex attended. The child's actions led the UGs and researcher to believe that he had been kept in a wheelchair or small restricted area due to his inability to ambulate. He eventually walked on his knees and even stood towards the end of the semester, but his movements were small and hesitant. Alex loved rough textures: carpet, walls, even the seams on balls. He liked to catch one ball in particular that had ridges over it surface area. The UGs hoped that Alex will be able to attend the clinic next semester more consistently.

Alex was described as being deaf, having no sign language skills, being responsive to textures, having limited vision (perhaps needed glasses), and liking extremes such as the cold water in the pool and the warm water in the warming pool. On several occasions, the UGs would simply roll him the large red ball and he would feel the ridges and texture of the ball. Because he could not hear them, they learned to clap (the motion caught his attention) and extend their hands to receive the ball. Many of their lesson plans were contingent on his watching them and

then he would repeat their actions. His favorite activity was to lie on the carpet in the hallway, hold the ball, and kick his legs and feet. It appeared that he was accustomed to being in a small environment, and he was unsure how to move in a large area. He loved to crawl down the hallway and slide his hand against the wall, which had a rough texture. The UGs learned to exaggerate their motions in order to focus his attention on them. Also, they would simply touch him lightly on the arm or shoulder. He did cry at various times, but, otherwise he showed no emotion.

Another child, Cory, would fail to attend for several weeks at a time. He had some sight, but was considered legally blind. Cory was only four, so the UGs worked on his balance, coordination, and development. They used a balance board, bounced balls back and forth, and helped him walk on the balance beam. He loved to play basketball with his UGs, so they usually played at the end of gym time as a reward. He was easy to work with, and his parents usually sat in the gym during clinic time. On the night of Halloween, Cory was a knight. His parents were a prince and princess, and his little brother was an M&M. The family left early so the boys could trick or treat.

One UG wrote in the teaching evaluation, "If they actually come", or "actually have them show up." Most children did attend each session, or they would miss just one session due to illness. The problem was, when a child missed a session, and only one session met per week, UGs would have to start with the beginning lessons plans when that child returned. One child was given "homework" by his UGs so that progression could be maintained by the child. However, the children who consistently failed to attend frustrated UGs, and as a result they simply "helped" other UGs with their children and lessons when their own child did not attend.

Health and Behavior of Children with Disabilities

Several of the children attended the clinic with paid care givers or court appointed care givers. Sarah attended with a paid care giver who had been her paraprofessional in primary school. She was 14, had cerebral palsy and was nonverbal except for grunts and screams; she had spent several years in a wheelchair with little physical activity. Different UGs had worked with her over the past four years to help her develop leg strength and mobility. Some sessions were negatively affected simply because she had not taken a nap that day. One UG wrote:

> She would go from normal state to extremely happy and then lie on the floor and try to go to sleep. She was getting irritable by the end because she did not get a nap today (as stated by her care taker).

Sarah had just started taking a couple of steps on her own and received no physical education through her public school to advance her skill acquisition. The care giver had worked with Sarah for several years and was able to give the UGs suggestions regarding behavior and motivation. The care giver brought squeaky toys and a CD player to the clinic sessions for motivation. The UGs would take turns helping Sarah walk; one would "squeak" the toy in front of her while the other aided her walking. She also listened to the CD player frequently during some sessions. Due to Sarah's inability to talk, her UGs had difficulty interpreting her expressions and actions. Because the care giver was no longer with her during the day, she was not always cognizant about what had transpired during the day.

In one self-teaching evaluation, Sarah's UG wrote, "We tried the squeaky noises again this week but it wasn't as successful as usual. She was visibly not herself this week. We tried fun things in the pool like bouncing and splashing but she was not amused." During the next session, Sarah had an upper respiratory infection, was irritable, and unable to do her usual

workout. The UG exclaimed, "There were a couple times when (student) would just plop on the floor and not respond to us." Again, the UG wrote that Sarah was not herself, and the different methods of reinforcement (i.e., squeaky toy, CD player) were not successful.

Of great importance to Sarah's sessions was how she was feeling. In the following session her infection was gone, and she was visibly healthier and in a happier mood. Sarah was able to walk two steps on her own without assistance and she happily listened to the CD player throughout the session. The UGs used "happy" voices as feedback and "clapped when she did good." If Sarah was not feeling well, she was not cooperative during the session. Regardless of what the UGs planned for that session, the success or failure or the session was completely dependent upon Sarah's mood and health. The UGs were eventually able to get her into the warming pool and the swimming pool, but again, Sarah would only tolerate what she could. Sometimes the pool became too loud due to the other children and she would cover her ears. Similarly, she would not respond to the UGs directions if someone else entered the warming pool. Sarah missed several sessions due to illness requiring the UGs to "work on past activities." Her progress was diminished due to her health and inconsistent attendance.

Frustration of UGs

Often, the UGs became frustrated from their work with children with disabilities. Even though Matt had previous experience with children with disabilities when he was in high school, his work with a child, who had cerebral palsy and was nonverbal, became difficult. Matt worked on several different skills with his child such as strength, eye-hand coordination, balance, and communication. He summarized his experience in the clinic:

> This whole experience has been definitely harder then I thought it was going to be. But, it's definitely a good experience, but, I don't think I would ever try to go

into that field cause I don't know if I'm good at all of that. How to take care of helping them out. . . We've been working on his balance and strength, trying to work on his leg strength some. And overall coordination like eye-hand, stuff like that, so, we've been putting him on a step, an aerobic step, and having him throw bean bags to me and then I'll try and get him to shoot them into a bucket. For strength, we've been having him go up and down the steps and then as a reward he likes to run, so, he will go down the steps and then get to run up the handicapped ramp. He really likes that and then he's ready to go again. But it works his legs because he's running up the hill, too, on the ramp. And then for eye-hand coordination, we've been working with him with hockey sticks trying to just pass the ball back and forth and move to the ball with the stick instead of just passing it straight to him, we try to put it out and that way he has to move in front of it. And, we're working on throwing and catching cause he gets hitting, like hitting at the ball, like a beach ball confused with catching sometimes. So, we've been working on both hitting the ball and catching the ball. Like bringing it into your chest and stuff. And, balance, we've been having him stand on one foot, count to 10 seconds while he's holding his other leg up, trying to get him better at balancing. We also do scooters where he pulls himself along with his feet and he follows us and chases us through turns. And also we put 2 scooters down and we've been doing like this [swimming motion demonstrated] so it works on his arm strength and leg strength. We have been working on kicking the ball, too. Like, while it's on the roll so, cause he has a problem with processes, sometimes the kick comes later. So we've been working on rolling it and kicking it and then

> running bases. The main problem is communication with him because he can't say, speak, we tried to talk and have blue base, red base, and he can go to the bases but we couldn't actually get him to say red and go to red and say kick when he kicks the ball, jumping jacks. We tried to do that, working on communication, but that never really came about.

Matt's biggest frustration was difficulty with communication. Even though he worked with his child for nine weeks, he still needed several weeks to learn to interpret the child's facial expressions and noises.

> The only verbal [behavior] he has is a whine. A whine if he doesn't want to do it or a smile if he does want to do it. Kind of a happy whine. He said bye, that's the only word I've heard him say. More just noises and whines, no actual words. But they understand commands. But their actual attention span, so, if you get him focused on one thing, and the person with the ball over there, they want to go to that ball instead of the ball we're playing with. It's all about different kinds of balls. . . . I guess the communication. You just don't really think about all that the kids and the parents have to go through. I can't imagine, they need constant attention, like one second you're looking one way and the other second he's gone and you don't even know. They can just get hurt in a second and you have to take care of them. It's really hard to communicate with them and they can't communicate, say what they want back to you. The attention span is really frustrating sometimes cause you want them to learn, you want to teach them something so bad and just, they're going somewhere else sometimes and

> sometimes they're good, but, sometimes they don't know what we're doing. I guess I just never really thought about what they have to go through all the time.

Dennis also admitted that his work with children with disabilities was difficult. The patience level and slower pacing and acquisition of skills by the child made it more difficult for him as a teacher. He explained his experience level as a personal trainer:

> Being a personal trainer, I've always wanted to work with athletes, someone that is easier to teach I guess. And, to me, I guess it's just more exciting, I don't know if I have the patience to take my time with individuals with disabilities.

Lack of Time for UGs

Beth stated that some of the UGs felt uncomfortable while learning to work with children with disabilities. But, she felt that the comfort level depended upon how much exposure that person had with children with disabilities throughout their life before the clinic experience.

> . . . my best friend is hearing impaired and we've been best friends since about sixth grade, so that's never been a problem. She has taught me about, okay, it's different, but that's okay, she's just different, but that's a good thing . . . Some people don't like working with kids with disabilities, they don't like people with special needs, they can't handle people with special needs.

Regarding the lack of time, Beth (UG) remarked that:

> I wish we could spend more time with kids. Because by the time they get here and we get downstairs and we get situated, it takes 15 minutes, and then you have about 30 minutes to work with them and then you gotta start cleaning up and then it's time to go home. So, but then again, you consider the child, maybe 30

> minutes is all they can tolerate. Maybe it would be good if we could do 2 sessions a week.

Beth's partner wrote in her teaching evaluation after a clinic session that their child was hesitant to leave his parents and did not stop crying until they returned. She commented,

> I think [child] would have responded well to the goals we wanted to accomplish, but was too sad/angry to get anything done – so we'll try similar tasks again this week. . . . clapping, verbal praise, facial expressions, calm talking were all used to try to encourage him to stop his crying – but nothing was really successful. (Although the pool did decrease amount of screaming, there was still crying).

Matt felt that he had gained practical teaching experience in the clinic, but he also felt that the children needed more time and instruction than was possible in one hour, meeting once per week over nine weeks. Because the clinic was teaching-based, the UGs had class work and materials to learn before the children attended. Therefore, there were only nine weeks of clinic. Matt felt that six weeks had flown by before he had made any noticeable impact on Ethan, and then the clinic was over. He spoke of his concern that Ethan was not getting the help or instruction necessary for continued physical gains at his public school, and he was not sure that his grandparents were capable of providing the constant instruction that he needed in order to advance physically.

Teaching Experience of UGs

One UG wrote that he had to realize that he was in charge of the environment of the session, whether it was positive or negative.

> For the next clinic, I am going to cut down on the difficulty of the activities. Sometimes I do not think of who I am working with. I will also try to start [child]

> off on a good note. We started with walking last time. I will also try to talk more with him and get answers from him. I also need to ignore his shoe throwing and loud mouth. His mother said he would stop if it is ignored.

If a UG removed distractions such as too much equipment or went to smaller rooms away from so many children and noise, the change could drastically change the atmosphere of the lesson. UGs placed their children in hallways, racquetball courts, or swam while the other children were having gym time to reduce distractions and create a more personal environment.

As beginning teachers, the UGs admitted that it was hard to adjust their personal expectations of what they as teachers wanted to achieve during a clinic session. Through this learning experience, they began to perceive the children with disabilities as individuals, and they were able to focus their teaching toward their children rather than on completion or rate of finishing lesson plans. Some lesson plans took more than one session to complete, and they discovered that was satisfactory as long as the child was successful. The teaching eventually became focused on the children, not the lesson itself. As Beth stated:

> . . . you might have to think of smaller goals, breaking things down, if you just have to start with walking with good balance and good form or breaking down playing catch and throwing. Making sure they move and get exercise and enjoy what they're doing.

On a positive note, Ryan stated on his teaching evaluation that his child was becoming more verbal and not as shy. The child was learning to trust his UGs and even became a little loud during the lesson. High five's, pool time, and verbal praise were used to help the child feel successful and comfortable. Achieving personal goals such as swimming underwater for the first time enabled the child to view his UGs in a positive manner. They taught him to swim

underwater! Trust, friendship, and bonding with the UGs took place between Ryan, his UG partner, and their assigned child with a disability.

Summary

UGs found it difficult to teach children with irregular attendance skills and maintain steady progress. If a child was ill or tired, many times modifications had to be made to the lesson to help the child finish the session successfully. Some children did not have sufficient time to bond with their UGs resulting in a lesson geared toward behavior management rather then teaching objectives. Several UGs felt that progress was thwarted by not having feedback from parents or caregivers. In many cases, nine weeks was simply not enough time for UGs to establish a relationship with a child and learn how to teach.

In the case of several children, success was achieved after years of attendance, not just one semester. Unfortunately, the UGs who taught those children in their first years of attendance were not able to enjoy the sense of accomplishment that was felt by children and parents after several years attending the clinic. The researcher was able to communicate to a pair of UGs how far their child had progressed over a four year period and that they were reaping the benefits of previous UGs.

CHAPTER 8

DISCUSSION

Perspectives are influenced by a person's experiences and relationships in life. According to Patton (2002), a holistic perspective includes the environment, personal relations, and events that relate to that person. Interdependencies such as those found between students with disabilities, their parents, and UGs contribute to the participants' perspectives. Through a holistic examination of all participants, a clearer, more accurate description of the clinic was possible.

The data in this study revealed three main themes among the participants. These themes are discussed and related to the current literature regarding adapted and physical education teacher education. Their roles influenced participants' perspectives and gave them a unique view of the university-based adapted physical education clinical field experience. This chapter provides a summary of those participants' perspectives, makes recommendations for future physical educators, and suggests future research in PETE regarding children with disabilities.

Theme One: Connection between Class and Clinic

Practical learning experience was gained through the combination of content learned by the UGs in the classroom and the application of that knowledge in the clinic. Several UGs stated that they had it "pretty easy" because their assigned child with a disability was older; had been attending the clinic for a long period of time; and was socially adept. For other UGs, the clinic was a lesson in patience and frustration. Several UGs wondered if they would have been successful if they had not been paired with another UG.

In Houston-Wilson et al.'s (1997) study, some teachers found it difficult to manage an inclusion class with many different physical levels. Only through cooperation with the UG partner and assistance from parents did some UGs successfully complete the clinic experience. Essentially, UGs were peer coaches in the clinic, with one UG teaching while the other assisted. Thus, one UG was able to provide feedback regarding the lesson, and then the UGs would switch roles. Seldom did both UGs teach a lesson at the same time unless it was physically impossible for one UG to manage their assigned child with a disability. For example, in the case of Sarah, a nonverbal child with multiple disabilities, it was necessary for both UGs to actively participate.

Jenkins and Veal (2002) found that peer coaches were able to move around activities and observe student learning while also being cognizant of the lesson plans of pre-service teachers and overall classroom management. Giving feedback to the pre-service teacher gave the peer coach time to reflect on the lesson and make necessary changes to future lessons. Their study also revealed that training pre-service teachers to be peer coaches was effective and could be accomplished in a short amount of time.

Most UGs enjoyed the clinic experience, planned to use the newfound knowledge in the future, and felt their teaching improved as a result of specific rather than general feedback. UGs collaborated on ideas and activities, and they also provided moral support in difficult situations. As Jenkins and Veal (2002) discovered, the use of a peer coach provided feedback to the pre-service teacher actually teaching and gave the pre-service teacher doing the peer coaching an opportunity to observe the lesson. This observation allowed the peer coach time to reflect on the positives and negatives of the lesson and to make adjustments in future lessons accordingly.

Several UGs explained their personal goal was to learn to be patient with children with disabilities. Through this patience came the ability to modify lesson plans, activities, and

expectations. These modifications required dissecting the desired movements into smaller pieces and breaking the skills down into more manageable parts. Alternately, they might expect more from their child with a disability and would raise the bar accordingly. One UG stated, "These kids are definitely capable; they just need a little more help. And that's what we're here for." The ability to make quick and worthwhile modifications meant that UGs were getting a preview of possibilities in a real classroom (Hutzler, 2003). When a child was tired or did not feel well, the UGs had to modify the task so that the child was still successful. Otherwise, the child might become frustrated and simply refuse to do the activity.

Many of the UGs stated that sometime during the clinic experience that keeping children interested in the activities was harder then they thought it would be, but most enjoyed the challenge and were determined to make it work. For the child Diane, the clinic became a social outlet to see her friend Tom. Using Tom as positive reinforcement, the UGs were able to encourage Diane to finish her sessions so she could talk with him. Some UGs expressed frustration, but that response allowed the researcher and graduate UGs to make suggestions and enabled the UGs to ask questions. Connie, a UG, was able to forge a relationship with her assigned child's parents who provided her with support, information, and even participated in swimming sessions to help her bond with Patrick. Another UG realized that swimming laps was not much fun for his assigned child, so he quickly switched to water basketball which required the same movement skills and cardiovascular endurance.

Through practical experience in the clinic, UGs learned to vary activities and make modifications to keep the child engaged. Several UGs used music, clapping, high five's, or even a smile to break up the session and provide motivation. Sarah's caregiver would bring a squeaky toy and Sarah's favorite music to help the UGs keep her engaged throughout the session. Hodge

et al. (2003) stated that by allowing pre-service teachers to gain experience similar to children they would probably come in contact with in classrooms, the teachers became better prepared to work with children of differing physical abilities.

Most UGs stated that the clinic experience was worthwhile and benefited them professionally and personally. Professionally, they felt more prepared as future teachers. Personally, they felt the relationship helped them to understand children with disabilities and their needs. Plus, most UGs had fun with their assigned child with a disability and became more comfortable with children with disabilities. The physical education UGs stated the value of the realization that classrooms would have children with disabilities and that those children would require modifications (Gretchell, McMenamin, & Whitall, 2005; Polastri & Barela, 2005). For the exercise science UGs who wanted to continue in physical therapy, the benefit was the actual hands-on experience working with children with disabilities and learning how movement could be adapted or modified to achieve required results. Other UGs replied that it was just nice to work with children and to build personal relationships off campus. Dennis stated during his interview that it was just a good experience and he had fun doing it.

Hodge, Davis, Woodard, and Sherrill (2002) found that positive attitudes and higher rates of competence were prevalent among pre-service teachers who participated in on-campus practicums. Hodge et al. theorized that on-campus practicums were useful because they provided more opportunities for supervision by the director. The adapted physical education class was taught by the same faculty member who also directed the clinic. What he taught in class was directly related to what occurred in the clinic. Thus, the UGs were able to ask questions in class regarding issues they might have had in the clinic. Also, there was a small child to UG ratio. Due to the large enrollment in the adapted physical education class, the child

to UG (student-teacher) ratio was 1 to 2, which made partnering (peer coaching) possible. The majority of UGs enjoyed and appreciated having someone to provide assistance and moral support. By providing a controlled environment, UGs were able to experience success while being monitored and supported by their classroom professor. UGs in the clinic were able to practice teaching skills before they became student teachers.

Because the clinic was on-campus, the director had more control over the activities and experiences of the participants in the class and clinic. Just as he was able to discourage a UG from having her child color pictures for fine motor skills practice, he was also able to make suggestions to enhance a lesson, such as a smaller environment in the hallway to help keep a child focused. UGs could then modify their lessons accordingly. The UGs benefited by having their adapted physical education professor directly involved in the clinic.

Approximately 96% of all children with disabilities are educated in general education classes in public schools (Block & Obrusnikova, 2007). For the most part, general education teachers are the primary teachers for children with disabilities. However, the research has shown that teachers often felt unprepared for teaching children with disabilities and they did not know how to make accommodations for their specific needs due to their lack of education about disabilities (Brownell, Adams, Sindelar, Waldron, & Vanhover, 2006). Through teacher training, pre-service teachers thought it important that they become acquainted with the children; learned how the children typically behaved; understood how children responded to different types of lessons; and modified plans for more skilled and less skilled children (Curtner-Smith, 2007).

For the UGs, learning to adjust to the children with disabilities and their moods predicted the success or failure of a lesson. For instance, one child who had traveled by car all day before

attending the clinic was simply too tired to do some of the planned activities, so the UGs quickly adjusted their lesson plans, modified the activities, and enabled him to be successful during the lesson. Though the child was tired, the father told the UGs that his son was glad he did not miss clinic that night and he could not wait to come back next week.

Gallego (2001) stated it was important for pre-service teachers to become fluent in content and pedagogical knowledge as well as interacting with the types of children and their communities that they were most likely to teach. That was exactly what the clinic provided, class work coupled with practical experience with the same kind of children that they were likely to encounter in physical education classes. Most UGs felt more comfortable with the children with disabilities at the conclusion of the semester and realized how much they had learned during the experience. Unfortunately, Gallego (2001) stated that for many pre-service teachers, field experience did not normally occur until they were well inducted in the teacher education program and this was also the case for many of the UGs in the clinic. Several of the UGs were student teaching the semester after this clinic experience and this was their only experience with children with disabilities; they had no prior teaching or camp counseling experience.

Allowing the UGs to peer coach, the UGs learned to observe and make changes with their assigned child when necessary. Jenkins, Garn, and Jenkins (2005) suggested that providing guided observation for pre-service teachers would benefit them in learning what they were actually observing and then learning to evaluate those observations. Peer coaching has become an accepted model in PETE as it provides experience in a supportive environment such as the clinic. UGs must learn to observe the physical education setting as a teacher rather then as a student. Completing the Self-Teaching Evaluation (Appendix H) required the UGs to reflect on the lesson and its progression of skills; verbal, emotional, and social behaviors of the assigned

child; recommendations for future lessons; modifications; and behavior management. Basically, the UG was to determine if the session was a success, failure, and what could have been done to make the session more successful.

In school settings, teachers who do not have training or experience working with children with disabilities may not be able to make appropriate accommodations for them. In this research, David, a child with spina bifida, related that his elementary school physical education experience was one of either sitting on a line on the gymnasium floor or going into the equipment closet and throwing Frisbee with his best friend. No modifications or accommodations were made to enable him to participate in the physical education class.

David's experience was similar to those reported in An and Goodwin's study (2007) in which children in wheelchairs were unable to move on the grass fields and had no basketball goals lowered to aid in their skill acquisition. Had David's teacher known how to make accommodations for him, David's experiences might have been more positive. Providing a mentoring situation between regular physical educators and adapted physical educators could provide the bridge necessary to help children like David avoid negative physical education experiences. Ayers and Griffin (2005) suggest that a mentoring mosaic, using multiple forms of mentoring, may be more beneficial in some areas.

However, providing too much help can also hinder children's learning and independence. Also in An and Goodwin's study (2007), help from paraprofessionals resulted in children's complete loss of independence. One mother attended a swimming class because the paraprofessional did not swim; however, her presence led to embarrassment because no other parents attended. As a result, the child felt diminished independence and identity. Pre-service

teachers need experience in practicums in order to learn how to effectively teach children with disabilities.

The help of the UGs was not limiting but empowering (Goodwin et al., 2004). Their expertise enabled children with disabilities to become more successful and more independent through the lessons provided. One suggestion made by An and Goodwin (2007) was that schools needed to refocus individual education programs, IEPs, from a rehabilitative model to a educational model that included realistic physical education goals. Children need to be included in physical education classes that provide modifications and opportunities for inclusive physical activity and learning, and these are the opportunities that are provided in the clinic.

Theme Two: Fostering an Ethic of Care

An environment of caring must be fostered in the clinic experience. To these participants, a caring environment was manifested in individualized contact which led to meaningful relationships among the triad of participants. This environment was characterized through (a) personalized fitness instruction and goal setting by UGs, (b) informal support for parents from other parents, UGs, and program director, and (c) socialization for children with disabilities in the clinic and casual contact in public settings such as grocery stores, restaurants, and summers camps. As one mother stated, her child enjoyed seeing the UGs outside the clinic because she thought the UGs were fun.

Owens and Ennis (2005) discussed ethic of care in teaching as being "assumed rather than nurtured or taught" (p. 392). UGs in the clinic were able to develop an atmosphere of caring in the clinic which was evident to children with disabilities and their parents. Without that element of care, it would be doubtful that effective teaching would occur. Only through

caring about the children and making necessary adaptations individually for the children were the UGs able to successfully complete a session.

When considering why children like some teachers, common traits normally associated with physical educators are being physically fit and liking physical activity. McCullick's (2001) study highlighted two other attributes necessary for future physical educators: that they should like children and people and that they should be flexible. In his study, cooperating teachers felt that, "Being gregarious was considered an excellent personality trait of PTs because it exhibits a love for people, and in turn stimulates in students a desire to learn" (McCullick, 2001, p. 41). It did not matter how much a teacher knew, without the love of people and a caring attitude, the teacher would not be effective. Likewise, in this research, Matt, a UG, cared about the child he worked with. He enjoyed being kidded by the children and seeing them outside the clinic. He was able to laugh when the female child with a disability called him "fat butt" or when another child threw her shoes at him. Matt did care about the children and wanted to develop relationships with them. He understood that they found ways to get his attention that were appropriate in that particular setting.

Although flexibility was normally not associated with caring, McCullick (2001) noted that, "Being flexible and creative also entailed the ability to understand that all students will not be the same and that the children of today are not the same as the children in the past" (p. 42). Looking beyond children with disabilities to all children, teachers are reminded that children do not always come to school to learn. A male teacher in a middle school regular physical education class revealed:

> They come because they are forced to come. They come because it is the only place they get two meals. There are some who come because if they don't come,

> they are going to jail. There are some who come for an education. So, you don't really know what they come from, and if you aren't able to recognize and adjust, you are not going to be a very good teacher (McCullick, 2001, p. 42).

In an inclusion class, which contains children of many different physical abilities, a teacher must be flexible and able to modify lessons for various physical disabilities. The teacher must also manage social and emotional situations between children as needed. Being flexible, maintaining control, caring for children and caring about children is paramount to teaching (Goldstein & Freedman, 2003). In this research, one child was unable to focus in the gymnasium, but his parents felt he needed socialization. The UGs gradually increased his time in the gym and the number of people in his area. By the end of the semester, he was able to play a game of basketball with other children and UGs. Caring about the child and understanding his need for socialization, the UGs were able to initiate him into an environment that would otherwise have been traumatic for him.

Only positive statements were made by parents regarding UGs. They felt the UGs were professional, displayed patience and cared about the children. The parents also felt the UGs learned and became accustomed to the children's individual personalities, behaviors, and disabilities. More importantly, the parents felt that the UGs were never critical and always gave the children with disabilities reasons to feel good about themselves. The UGs learned the boundaries of the children's abilities and were able to make modifications when they expected too much or too little from the children with disabilities.

The parents of the children in the clinic appeared much like the parents in Donham-Foutch's (2007) study of a pre-service gymnastics program. Those parents felt a sense of gratitude for the personal and small group instruction, yet wanted the program to be offered more

then once a week to provide more instruction and possible skills progression for their children. The parents also stated that the gymnastics program provided a good physical activity foundation and helped the children with more controlled movement.

Parent-teacher connections may initiate change that otherwise would not evolve within the school system itself. The "Yes I Can Social Inclusion Curriculum" at the University of Minnesota was developed after parents insisted upon change and help with their children with disabilities (Harrison, 2000). The program itself provides educational assistance to promote inclusion in all environments in and out of school and encourages mentoring between peers with and without disabilities. Social skills are key elements taught and practiced in the program. Another program, the Highland Friendship Club, provides summer activities for children with disabilities. However, during the school year, the agenda is to promote socialization among all students. Meetings are usually co-joined with other school clubs to encourage development of friendships and help expand all students' awareness of disabilities.

For the researcher, positive comments about the UGs and the clinic reinforced the belief that the clinic was worthwhile and beneficial to all participants. Every parent that had been interviewed and every parent who was met in the lobby, hallway, or staircase made the statement that the clinic was a worthwhile and irreplaceable experience for the children with disabilities and their parents. They were grateful for the time, the facility, and the instruction. As Emma stated,

> I don't think anybody realizes how much this clinic means to these kids. It is, it's not like they win blue ribbons or anything, but here, they're with people that are not critical, you know, we all have a problem.

Most parents felt the clinic meant a lot to the children, but the clinic also meant a lot to the parents.

For some children, caring teachers were perceived as those teachers who expected children to succeed. Price (2002) pointed out that this is an important characteristic for a teacher. "The wrong people are going into the teaching profession and that is affecting our lives . . . a good person would be a person that pushed someone to succeed" (Price, 2002, pp. 118- 119). Remembering that the disability movement copied the Civil Rights Movement and legislation, there are similarities in the classroom. Teachers are challenged with the goal of transforming "schooling to meet the needs, desires, and perspectives of many students who have been ill-served by schools" (p. 119). Like the issue of race, gender, class, the issue of disability has encouraged educators to rethink education and its impact on children's lives.

In Morris and Morris' study (2002), one of the major factors that contributed to a school's perception of being "a good school" was "caring, competent, and committed teachers (p. 121) whose care extended beyond the physicality of the school itself and into the community. For example, children often went to their teachers for personal advice and had visited their teachers' homes. Teachers and principals served as community leaders and helped children obtain scholarships and financial assistance. In the clinic, if a child was paired with a UG who seemed to care, the parent would many times ask that UG to be a care-giver. Also, some of the UGs were camp counselors at summer camps that the children attended. This extended contact on an informal basis contributed to establishing relationships beyond the clinic experience.

When a teacher's concern for a child extends beyond the classroom, it can have a real impact on a child's life. For example, in Gabel's (2001) study, Martin, an early childhood major, was a nonreader in the fourth grade and was considered learning disabled (Gabel, 2001). A

product of neglect and an alcoholic mother, he found that being a bully was a way to survive in his environment. When he reached middle school, a substitute teacher in his special education class took a personal interest in him and offered him a life in her home with her family. When asked about his change in direction, he stated:

> I found some good people that did care. I believed in them. I took their advice and got the hell out. The smartest thing I ever did. It saved my life . . . from a perpetual cycle with the alcohol and the drugs (Gabel, 2001, p. 37).

He felt that his capacity for learning had not been "tapped" (p. 37), and explained that his "mom" taught him to use accommodations, modifications, and self-advocacy to become successful. Caring went beyond the classroom and affected a young man's life, dramatically changing his future. In the present research, Sarah, a child in the clinic who was nonverbal and had multiple disabilities, a paraprofessional became her care-giver outside of the classroom. The paraprofessional was able to provide the UGs with information they otherwise would not have been able to acquire.

Vogt (2002) initiated an exploration into the notion of ethic of care and its connection with gender roles as interpreted by the primary school teachers who were the participants in the study. Societal influences and demands have typically encouraged young women to enter the profession of primary school teachers due to the perception that it is biologically "natural" for women to care for children. Men have historically been discouraged from teaching primary school because it does not lend itself to the masculine image of "professionalism, expertise and authority" (pp. 253-254). Nevertheless, Vogt defined that ethic of care not in terms of gender but as a commitment to teaching and developing professional relationships with children. By excluding gender based expectations, ethic of care becomes a humanistic trait rather then a

feminine trait and expectation (Hansen & Mulholland, 2005; Vogt, 2002). Of the 42 UGs in the study, eighteen were male. Caring was not an attribute of just the female UGs, but of all the UGs. Parents appreciated the male influence with their children, whether the children were male or female. One mother stated that it was nice for her son to have a male influence, as she was divorced and the father was not actively involved in the boy's life.

Care was also a reciprocal arrangement between teacher and child (Owens & Ennis, 2005), and that caring was evident on the last day of clinic. Children with disabilities, their parents, and UGs were hesitant to say good-bye. Relationships had been formed and many were not ready to break those bonds. According to Owens and Ennis, the ethic of care should be included in pre-service teachers' pedagogical content knowledge. The clinic encouraged an environment of caring that was fostered in the experience itself. UGs were able to obtain moral, physical, and cognitive support from parents, other UGs, graduate UGs, and program director.

Theme Three: Time

While the experience appeared to be beneficial to all parties, there was a lack of time for some UGs to make significant progress with their assigned children with disabilities. Reasons included children inconsistently attending the clinic; children not bonding with UGs; and UGs learning to work with profound and multiple disabilities. However, lack of time was experienced by the UGs enrolled in the class, not the children with disabilities. Some children had attended the clinic for years and were not restricted to attending the clinic for just one semester. The purpose of the clinic was not to replace an existing physical education program or fitness regiment for the children with disabilities; rather, the clinic was a practicum of the adapted physical education teacher education class for UGs. As described in the syllabus (Appendix H), the adapted physical education course was an:

> Introductory course in the field of Adapted Physical Education that provides an understanding of the nature, behavioral characteristics and motor limitations of various disabilities and basic skills necessary to prepare meaningful individualized movement experiences of individuals with special needs functioning in an integrated, segregated, community or home environment.

The adapted physical education course was structured to be an introduction to disabilities for physical education majors. Competency areas included legislation, assessment, concepts of exceptionally, program development, community agencies and related services, and parental involvement.

Program development consisted of UGs learning to teach children in the clinic. One of the UGs responsibilities was to exhibit their understanding of disabilities and learn to teach appropriate lessons to children with disabilities. Task analysis and behavioral intervention were included in the clinic portion of the class. The UGs were encouraged to demonstrate their knowledge of their assigned child's skill level and to make appropriate behavior modifications to encourage a successful clinic session.

Many of the children in the present research attended the clinic over long time periods. While their first visits were stressful, the clinic became an important part of their lives. Amy's mother, Emma, stated that Amy simply screamed during her initial years attending the clinic. However, Amy has now attended the clinic for 24 years. Diane's parent had the same experience, and the program director assured them that she would adjust to her separation anxiety over time. Diane has now attended the clinic for over 16 years. Beth's assigned child cried and required his mother's presence during the first several clinic sessions. However, this was his first clinic experience and he was only 2 years old. Consistent attendance during the

semester allowed him to adjust emotionally to being separated from his parents. Towards the end of the clinic sessions, Beth's assigned child had learned to enjoy the activities and UGs. The child's father, Stan, noted halfway through the sessions that his child was beginning to enjoy the clinic. Becoming familiar with the clinic and providing positive experiences have allowed children with disabilities to adjust and become active participants in the clinic.

Several of the children in the study were 18 or older and had been attending the clinic for at least 16 years or more. Parents of those children with disabilities felt that the clinic was a singular experience that was not found anywhere else. The children were taught on an individual basis according to their particular needs. Physical skills were taught and practiced and behavior modifications were made accordingly. Beyond the physical benefits of the clinic, children in the clinic became friends.

The experience in class and in the clinic enabled the UGs to develop a knowledge base of disabilities and an understanding of how to work with children with disabilities. Interviews, observations, and comments made by UGs during those observations suggested that having more clinic experience provided UGs a higher comfort level working with children with disabilities. Also, rotating between children who had different disabilities was mentioned by several UGs. Dennis stated that his child was easy to work with because that child was older and had been attending the clinic for several years. Other children who had severe or multiple disabilities may have provided Dennis with more of a teaching challenge.

In Hill and Brodin's (2004) study of physical educators, many felt that their undergraduate programs did not allow enough time or opportunity to practice teaching skills. The physical educators felt comfortable with their skill level, but some areas of concern were

discipline, special needs populations, management, and assessment. Of interest was that several of the participants surveyed did not student teach in physical education.

Few studies have been conducted regarding children's continued progress in clinic settings that serve children with disabilities. As the clinic is structured to be a PETE experience and is a component of a class, extending the time for UGs to gain more practical experience in the PEDMC may not be an option. However, requiring additional clinic experience or participation in other environments such as camps would be an option for UGs to gain more knowledge and experience instructing children with disabilities. According to Faulkner, Reeves, and Chedzoy (2004), lack of contact time is a concern in all teacher training, not just PETE or APE. Without adequate initial training time, teachers may feel unprepared to deal with children with disabilities.

Hardin's (2005) research with physical educators and their reflections on preparation for the inclusive classroom suggested that teaching experience that enabled pre-service teachers to learn through trial and error provided valuable experiences. Other physical educators were also regarded as a good source of information (mentoring) along with collaboration. But the most important factor was the time and opportunity to gain hands-on experience. Exposure to students with disabilities provided pre-service teachers with the confidence needed to teach in an inclusive physical education setting. Hardin's recommendation included the need for more than one class focusing on disabilities, early field experience, and working with students with disabilities in the student teaching experience.

Metzler and Tjeerdsma (2000) documented the progression of the traditional 4 year teacher education program to the current training which includes methods classes, early field experience, internships, and even five year programs. However, how much time is required in

each area is determined by the particular program and has no standardization. And, the question remains, is the current program effective.

Recommendations

Based on the findings of this study, three recommendations are made:

1) Increase UGs contact time with a diversity of children with disabilities,
2) Help parents form a more formal advocacy group, and
3) Continue research regarding PETE and APE practicums.

Requiring UGs to participate in more clinics or gain further experience in a school assisting the physical education teacher would enable UGs (pre-service teachers) to expand their knowledge of disabilities and practice contact theory in a viable environment. Many UGs will not have any further experiences with children of disabilities after this one required class and clinic. Folsom-Meek and Rizzo's (2002) study responded to the need for more than one introductory course in adapted physical education. Future teachers should gain instruction concerning disabilities in regular classes throughout their coursework in physical education. Physical educators must be able to meet the demands to teach those children with disabilities in the public education sector, and they also must be able to assist and educate colleagues concerning teaching and inclusion in regular education classes.

As the UGs experience with the children with disabilities increased, they were better able to achieve success in their teaching. The UGs in the clinic learned to direct their attention to the children's needs to make the lessons work. Without the personal examination of the individual children by the UGs, the lessons were not successful. Cooperation between parents and UGs allowed the most resistant children to become successful through modifications by the UGs and

suggestions by the parents. The clinic provided a cooperative learning environment that enabled most participants to succeed.

If mistakes were made or assistance was needed by UGs in the clinic, the program director, graduate teaching assistants, other UGs, and parents were available. The UGs learned how and when to modify lessons and what were appropriate expectations of children with disabilities. They had to consider all aspects of the child with a disability: personality, behavior, cognitive functioning, and social ability. The children with disabilities were not as fragile as many of the UGs had assumed.

Bishop and Driver (2007) found that service learning in APE encouraged social responsibility among pre-service teachers, created reciprocal relationships between the community and university, increased faculty involvement which fostered research opportunities, and helped pre-service teachers gain practical experience. The supervising professor was still involved in the program, but did not have as much hands-on control as would be found in a clinic setting. Requiring service learning may provide additional experience before the student teaching experience or teaching assignment. Questions that must be answered before beginning a service learning program include what the UGs need to learn and how is that learning relevant to current content offered in the class.

Parents essentially formed an informal advocacy group and should be encouraged to form a more formalized group to assist other parents with children with disabilities. The clinic provided moral support for parents by providing informal contact with other parents who may have had similar experiences raising a child with a disability. Not every child with a disability would be able to attend the clinic, but a parent advocacy group could provide guidance to other parents in need of assistance. Parents were provided a unique opportunity to request that specific

skills their children needed to learn be emphasized through personalized instruction from the UGs. Through these requests, children with disabilities developed physical skills along with increased cognitive and social aptitudes. The clinic enabled the parents to set physical, cognitive, and behavioral goals for their children not necessarily available in other private or public settings.

The clinic provides ongoing education to parents regarding their children's physical development that may not be available in any other setting. Plus, the parents learn to become advocates for their children and also teach their children to become self-advocates as a result of their involvement in the clinic. Parents also provide a valuable service to other parents through the informal relay of information. A more formal advocacy group would be a valuable asset to other parents and groups.

In summary, clinics, or practicums, allow UGs to practice contact theory and increase their understanding of disabilities and the effects on children with disabilities, parents of children with disabilities, and teachers. Increasing UGs contact time with a diversity of children with disabilities either through more clinic experience or other environments will heighten the UGs learning experience.

This research focused on one university-based adapted physical education clinical field experience. Further research must be conducted to aid and assist future physical educators and adapted physical educators to become better prepared to help children with disabilities meet the demands of an inclusive society. Also, those teachers must learn how to effectively become advocates for children with disabilities within the school and community.

Closing Thoughts

> Patton (2002, p. 431) quoted from Halcolm's "Iron Laws of Evaluation Research": The moment you turn off the tape recorder, say goodbye, and leave the interview, it will become immediately clear to you what perfect question you should have asked to tie the whole thing together . . . but didn't. . . . Analysis finally makes clear what would have been most important to study, if only we had known beforehand.

In retrospect, two very important perspectives of participants are missing – the program director's and the graduate teaching assistants. During the initial planning stages, it appeared that obtaining the perspectives of the main participants would fill a gap in the literature. However, in concluding the research, it became apparent that those missing voices would have added another valuable dimension to this research.

The clinic has been a positive and successful setting for over thirty years. It has become a practical teaching experience for UGs to work with, teach, and share experiences with children with disabilities. Not all UGs anticipated that they would work with children with disabilities in the future, but they considered the experience to be beneficial professionally and personally. With the current legislation regarding No Child Left Behind, less restrictive environments in school settings, and other special education regulations, children with disabilities may be found in many different educational settings.

As a whole, the clinic provided the UGs with a link between the knowledge and theory gained in the classroom and the application of that knowledge and theory through practical experience. Completing the cycle of knowledge from theory to working knowledge, an environment of caring was fostered in the experience. Some UGs became care givers for

children with disabilities. These relationships allowed friendships to develop outside the supervised setting of the clinic. Meeting children with disabilities in grocery stores and in the public domain provided another link between the triad of participants. Though there were problems arising from inconsistent attendance or separation anxiety on the part of the children with disabilities and their parents, overall the clinic was a positive experience that allowed UGs to learn about and work with children with many different levels and types of disabilities.

Through guided experience, a teacher learns how to develop a successful learning environment while forging positive relations with other teachers, administrators, children with disabilities, parents of children with disabilities, and the community itself. UGs (pre-service teachers) should have experience teaching before they become professional educators. "If we want teachers to be educators, then we must educate them. We must provide them with opportunities, support, and challenge to become reflective, critical, and creative thinkers, to grow intellectually, to engage in a process of constant transformation" (Hill, 2000, p. 50). Practicums provide positive experiences for UGs to learn how to teach children with disabilities.

Based on the findings of this research, the researcher found that the clinic experience was valuable for all the participants in this study. The longevity of the program was a testament to the quality and necessity of the program. The willingness of some children with disabilities and their parents to continue participation for over 20 years provided proof that the clinic was a positive and valuable experience for those participants. University-based adapted physical education clinical field experiences provide a positive and conducive atmosphere of learning for all participants involved and the personal experiences of all of the participants, and the unique teaching experience of the UGs contributed to a unique and successful adapted physical education teacher education program.

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APPENDIX A

PARENT/GUARDIAN CONSENT FORM

I give consent _____ (NAME) and agree to participate in the research study titled, "Participants' Perceptions of a University Based Adapted Physical Education Program". Cora Andrews and Dr. Michael Horvat (706) 542-4455, Department of Kinesiology, at the University of Georgia are conducting the study. I understand that this participation is entirely voluntary; I may withdraw consent at any time without penalty and have the results of the participation, to the extent that I can be identified, returned, removed from the research records, or destroyed. Refusal to take part in the research study will involve no penalty or loss of benefits in the Adapted Physical Education Clinic.

1. The following points have been explained.
    a. The reason for the research is to develop an understanding of the components of adapted physical education in special populations.
    b. The study will benefit the participants by providing knowledge for the participants, teachers, and specialists for better programs addressing specific functional and daily living issues.

2. The procedures are as follows:
    a. If selected, you will participate in an interview session to give relating your and your child's experiences in adapted physical education. Note: interview will take 10 – 30 minutes. This session will be audiotaped. All audiotapes will be destroyed at the end of the study, December 2007.
    b. The researcher will document observations of activities during the clinic time.

3. No risks are foreseen.

4. The results of this study will be confidential and will not be released in any individually identifiable form without my prior consent, unless otherwise required by law. Code numbers will be used to conceal identities. The code list identifying

names will be kept exclusive and secured. All code numbers will be destroyed at the end of the study, December 2007.

5. The researcher will answer any further questions about the research, now or during the course of the project, and can be reached by phone at 706-654-2295 (Cora Andrews) or 706-542-4455 (Dr. Horvat).

My signature below indicates that the researcher has answered all of my questions to my satisfaction and that I consent to volunteer for this study. I have been given a copy of this form.

_____

Signature of Researcher Date

cora@uga.edu
706-654-2295 or 706-542-4455

_____

Participant Date

PLEASE SIGN BOTH COPIES OF THIS FORM. KEEP ONE AND RETURN ONE TO THE RESEARCHER.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706)542-3199; E-Mail Address IRB@uga.edu.

APPENDIX B

PARENT/GUARDIAN PERMISSION FORM

I give permission _____ (NAME) for my child _____ (NAME of child) to participate in the research study titled, "Participants' Perceptions of a University Based Adapted Physical Education Program". Cora Andrews and Dr. Michael Horvat (706) 542-4455, Department of Kinesiology, at the University of Georgia are conducting the study. I understand that this participation is entirely voluntary; I may withdraw permission for my child at any time without penalty and have the results of the participation, to the extent that my child can be identified, returned, removed from the research records, or destroyed. Refusal to take part in the research study will involve no penalty or loss of benefits in the Adapted Physical Education Clinic.

1. The following points have been explained.
    a. The reason for the research is to develop an understanding of the components of adapted physical education in special populations.
    b. The study will benefit the participants by providing knowledge for the participants, teachers, and specialists for better programs addressing specific functional and daily living issues.

2. The procedures are as follows:
    a. If selected, my child will participate in an interview session. The interview will take 10 – 30 minutes. This session may be audiotaped. All audiotapes will be destroyed at the end of the study, December 2007. A parent, guardian, or teacher (undergraduate) may be present during the interview if appropriate.
    b. The researcher will document observations of activities during the clinic time.

3. No risks are foreseen.

4. The results of this study will be confidential and will not be released in any individually identifiable form without my prior consent, unless otherwise required by law. Code numbers will be used to conceal identities. The code list identifying names will be kept exclusive and secured. All code numbers will be destroyed at the end of the study, December 2007.

5. The researcher will answer any further questions about the research, now or during the course of the project, and can be reached by phone at 706-654-2295 (Cora Andrews) or 706-542-4455 (Dr. Horvat).

My signature below indicates that the researcher has answered all of my questions to my satisfaction and that I agree to allow my child to volunteer for this study. I have been given a copy of this form.

_____

Signature of Researcher Date

cora@uga.edu

706-654-2295 or 706-542-4455

_____

Parent/Guardian Date

PLEASE SIGN BOTH COPIES OF THIS FORM. KEEP ONE AND RETURN ONE TO THE RESEARCHER.

Additional questions or problems regarding your child's rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706)542-3199; E-Mail Address IRB@uga.edu.

APPENDIX C

Minor Assent Form

Dear Participant,

You are invited to participate in my research project titled, "Participants' Perceptions of a University Based Adapted Physical Education." Through this project I am learning about adapted physical education.

If you decide to be part of this, you will allow me to talk with you and watch your activities in the Adapted Physical Education Clinic. I may even ask you if it is okay if I audiotape you in an interview - your parents or teacher in the Clinic may be with you. I will not use your name in any papers that I write about this project. I hope to learn something about adapted physical education that will help other children in the future.

If you want to stop participating in this project, you are free to do so at any time. You can also choose not to answer questions that you don't want to answer. You can still participate and enjoy being in the Clinic.

If you have any questions or concerns you can always ask or call me (Cora Andrews 706-654-2295) or ask or call the Professor, Dr. Horvat at 706-542-4455.

Sincerely,

Cora Andrews
Department of Kinesiology
Ramsey Center, UGA
706-654-2295 or 706-542-4455

I understand the project described above. My questions have been answered and I agree to participate in this project. I have received a copy of this form.

_____
Signature of the Participant/Date

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu.

APPENDIX D

UNDERGRADUATE CONSENT FORM

I give consent _____ (NAME) and agree to participate in the research study titled, "Participants' Perceptions of a University Based Adapted Physical Education Program". Cora Andrews and Dr. Michael Horvat (706)542-4455, Department of Kinesiology, at the University of Georgia are conducting the study. I understand that this participation is entirely voluntary and that I can withdraw consent at any time without penalty and have the results of the participation, to the extent that I can be identified, returned, removed from the research records, or destroyed. Refusal to take part in the research study will involve no penalty or loss of benefits in the Adapted Physical Education Clinic.

1. The following points have been explained.
    a. The reason for the research is to develop an understanding of the components of adaptive physical education in special populations.
    b. The study will benefit the participants by providing knowledge for the participants, teachers, and specialists for better programs addressing specific functional and daily living issues.

2. The procedures are as follows:
    a. If selected, I will participate in an interview session relating my experiences in adapted physical education. Note: interview will take 10-30 minutes. This session will be audiotaped. All audiotapes will be destroyed at the end of the study, December 2007.
    b. The researcher will document observations of activities during the clinic time.
    c. Clinic lesson plans and writings will be examined by the researcher.

3. No risks are foreseen.

4. The results of this study will be confidential and will not be released in any individually identifiable form without my prior consent, unless otherwise required by law. Code numbers will be used to conceal identities. The code list identifying names will be kept exclusive and secured. All code numbers will be destroyed at the end of the study, December 2007.

5. The researcher will answer any further questions about the research, now or during the course of the project, and can be reached by phone at 706-654-2295 (Cora Andrews) or 706-542-4455 (Dr. Horvat).

My signature below indicates that the researcher has answered all of my questions to my satisfaction and that I consent to participate in this study. I have been given a copy of this form.

_____

Signature of Researcher Date

cora@uga.edu

706-654-2295 or 706-542-4455

_____

Signature Date

PLEASE SIGN BOTH COPIES OF THIS FORM. KEEP ONE AND RETURN ONE TO THE RESEARCHER.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706)542-3199; E-Mail Address IRB@uga.edu.

APPENDIX E

Child Interview Guide

1. Tell me about the clinic.
2. What is the best part of the clinic?
3. Do you attend a physical education class in your school? After school (i.e. YMCA, private instruction)?
4. Would you attend clinic more often? How often?
5. What would you change about the clinic?
6. How long have you been attending the clinic?
7. Why do you keep coming back?
8. What have you learned in the clinic?
9. Is there anything you would like to add?

APPENDIX F

Parent Interview Guide

1. Tell me about how your child feels about coming to clinic?

2. What do you expect your child to gain from participating in the clinic?

3. What additional skills, activities, or functions would you like to see added to the clinic experience?

4. How would this clinic have more impact if it were administered on a daily basis, such as a public school setting?

5. How would you rate the undergraduate student working with your child? Examples would be – very patient, good repoire with child, needs additional instruction dealing with child's disability, etc.

6. Any additional comments?

APPENDIX G

Undergraduate Interview Guide

Age:
Gender:
Setting:

1. What year/level are you in school?
2. What is your definition of adapted physical education?
3. Do you think you might teach adapted physical education?
4. How might this class benefit you in the present or future? What are the disadvantages of being in this class?
5. What is your level of experience with people with disabilities?
6. Tell me what types of disabilities you are most comfortable working with?
7. What disabilities do you prefer to work with? More difficult?
8. What are the benefits of being in this class?
9. What would you do differently for participants? Parents? Yourself?
10. How has your view of adapted physical education changed throughout the semester?
11. How necessary is adapted physical education for the participant? For the parents? For the physical education professional?
12. Describe your best experience in the class? Worst?
13. Is there anything you would like to add?
14. Is there anything I should have asked, but didn't?

APPENDIX H

COURSE OUTLINE

PEDS 4610/6610 Adapted Physical Education
Fall 2006

Course Description:

Introductory course in the field of Adapted Physical Education that provides an understanding of the nature, behavioral characteristics and motor limitations of various disabilities and basic skills necessary to prepare meaningful individualized movement experiences of individuals with special needs functioning in an integrated, segregated, community or home environment.

Instructor: **Dr. Michael Horvat**
Phone: 706-542-4455
Office: **323 Ramsey Center**
Time: **Monday - Wednesday 8:00 AM - 8:50 AM**
Tuesday lab 6:15 PM - 7:45 PM
Office Hours: **Monday - Wednesday 7:30 AM - 8:00 AM; 10:30 - 11:30 AM**
Tuesday 5:30 PM - 6:30 PM
E-Mail: **mhorvat@uga.edu**

Course Texts:

Horvat, et al., (2003). Developmental/Adapted Physical Education, (4th Ed.).

Selected readings and journals as assigned.

Course Requirements: PEDS 4610

Three examinations (possibly four exams).

Course notebook which will include class notes, journal articles, homework task cards, lab assignments, IEP's, study guide questions (due April 30th).

Abstract 5 journal articles in Adapted Physical Activity (February 5th).

Develop homework task cards (due in notebook).

Practicum experience in Pediatric Exercise and Motor Development Clinic.

Additional Course Requirements: PEDS 6610

Three examinations (possibly four exams).
Clinical experience in Physical and Motor Development Clinic.
Abstract 10 research articles on Adapted Physical Activity.

Course paper or project.

Competency Areas:

Legislation: Demonstrate a knowledge of current state and national issues and problems, legislation related to the education of individuals with disabilities.

Assessment: Demonstrate a knowledge of appropriate tools for the assessment of motor development, physical fitness and perceptual motor performance. Use the available information to evaluate physical fitness and perceptual motor performance. Use the available information to evaluate physical and motor performance, evaluate program effectiveness and student progress.

Concepts of Exceptionally: Demonstrate a knowledge of the causes, characteristics, etiology and implications of learning disabilities, sensory defects, physical disabilities and conditions effecting individuals in an integrated, special school, or inclusion settings.

Program Development: Demonstrate the ability to plan and implement appropriate teaching methodology based on assessment and knowledge of various exceptionally, and awareness of development of the Individualized Educational Plan, Task Analysis and Behavioral Intervention Techniques to enhance learning and program effectiveness.

Community Agencies and Related Services: Demonstrate a knowledge of the role of community agencies and related services which are appropriate in the education of children with disabilities.

Parental Involvement: Demonstrate the ability to effectively work with parents on the development of the IEP, homebound instruction, and appropriate home learning materials.

Grading System: 4610

Exams

140 pts.
A = 180 pts.

Course Notebook

10 pts.
B = 160 pts.

Practicum (Teaching 25 pts.; Program Plans 20 pts.) 45 pts.
C = 140 pts.
D = 120 pts.

Abstracts

5 pts.
F = below 120 pts.

Grading System: 6610

Exams

140 pts.

Course Paper/Project

40 pts.

Practicum

20 pts.

Absence Policy: Students are allowed 4 (four) teaching hours of absences without penalty. Absences exceeding four teaching hours will result in a deduction of 5 pts./hr. missed. **Absences from clinical experiences will result in a 10 pt. deduction.**

Late Assignments: Late assignments will be penalized 1 pt. per day.

Helpful Hints: If you want to do well in this course the following may be helpful:

1. Read all materials prior to lecture.
2. Attend all classes.
3. Ask questions if you need assistance or do not understand a particular topic.
4. During exams ask for clarification if you are confused.
5. Complete the study guide questions.
6. If available, attend review sessions.
7. Do not wait until prior to the test to read; staying abreast of assignments is critical to performance on your exams.
8. Web sites will be assigned on most topics. They are designed to provide additional information on the subject matter. They are very important and may appear on the exams.

TENTATIVE COURSE CALENDAR AND ASSIGNMENTS

Week 1 – August 23, 2006	Course Overview - Impact of Federal and State Legislation Integration into Physical Education Read Chapter 1-3 and 5 Individualized Educational Plan
Week 2 - August 30, 2006	Continuum of Placement and the Least Restrictive Environment. Read Chapters 22-25 Evaluation Read Chapters 4 and 6, Clinic Program Materials Clinic Preparation
Week 3 – September 6 , 2006	Physical and Motor Proficiency, Fundamental Motor Skill Development. Read Chapters 7, 8 and 9 Pediatric Exercise & Motor Development Clinic Preparation, Read Chapters 22-25
Week 4 – September 13, 2006	Read Chapters 11 and 12, Clinic Program Materials Behavior Management-Learning Disabilities Pediatric Exercise and Motor Development Clinic (1)
Week 5 – September 20, 2006	First Exam Read Chapter 10, Horvat and Croce Assigned Reading Mental Retardation Pediatric Exercise and Motor Development Clinic (2) Abstracts Due
Week 6 – September 27, 2006	Read Chapters 13 and 14 Pediatric Exercise and Motor Development Clinic (3) Visual Impairments

Week 7 – October 4, 2006	Hearing Impairments Second Exam Pediatric Exercise and Motor Development Clinic (4) Read Chapter 15
Week 8 – October 11, 2006	Posture and Orthopedic Deviations Read Chapter 16 Pediatric Exercise and Motor Development Clinic (5)
Week 9 – October 18, 2006	Orthopedic Deviations (continued) Read Chapters 16 and 17 Pediatric Exercise and Motor Development Clinic (6)
Week 10 – October 23, 2006	Neurological Impairments (Cerebral Palsy and Seizure Disorders) Pediatric Exercise and Motor Development Clinic (7)
Week 11 – November 1, 2006	Spina Bifida Pediatric Exercise and Motor Development Clinic (8) Seizure Disorders Read Chapter 18
Week 12 – November 8, 2006	Neurological Impairment (continued) Third Exam Read Chapter 18 Pediatric Exercise and Motor Development Clinic (9)
Week 13 – November 15, 2006	Respiratory Disorders Reading on Homework Read Chapters 19 and 20

Week 14 – November 22, 2006	Respiratory Disorders (continued) Read Chapter 21 Diabetes

Thanksgiving Break, November 24-26, 2006

Week 15 – November 29, 2006	Nutritional Disorders Cardiovascular Disorders Sports for the Disabled, Diabetes

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Week 16 – December 6, 2006	Final Project Fourth Exam

PEDS 4610

Dr. Michael Horvat
Spring 2007

Name: _____

Exams (140 pts.)

Exam I _____ _____

Exam II _____

Exam III _____

Exam IV _____

Practicum

Practicum _____ _____

(Teaching 25 pts.; Program Plans 20 pts.)

Notebooks (10 pts.)

Notebook _____ _____

Abstracts (5 pts.)

Abstracts _____ _____

Total Points

_____ _____

Absence Penalty (if any)

_____ _____

FINAL GRADE

_____ _____

PRACTICUM EVALUATION

STUDENT: _____ **DATE:** _____

EVALUATION COMPLETED BY:

_____

CHILD: _____

PRACTICUM ASSIGNMENT:

_____

Please rate the Intern's performance by checking the appropriate blanks. A rating of 1 indicates a poor evaluation, a rating of 3 indicates a fair evaluation, a rating of 5 indicates the highest evaluation. In case you have no basis for an evaluation, please mark not applicable.

	N/A	5	4	3	2	1
1. Attitude toward the child. ★						
2. Knowledge regarding disabilities.						
3. Ability to control classes. ★						
4. Ability to individualize instruction according to disability. ★						
5. Ability to modify activities and evaluate performance. ★						
6. Ability to establish rapport with child.						
7. Responsibility and punctuality. ★						
8. Quality of preparation.						
Overall Evaluation of Individual as a Teacher						

★ Students will be evaluated on the ★ items.

Lesson Plan 1 _____ COMMENTS:

2 _____

3 _____

4 _____

_____

TOTAL

PRACTICUM PROGRAM PLAN

CHILD'S NAME: _____ **DATE:** _____

STUDENT: _____

COMPLETE THIS SHEET AFTER ASSESSMENT

A. Accomplishments

B. Communication

C. Behavior

D. Motor Development

E. Physical Development

F. Attention Span

G. Needs

H. Recommendation for Intervention

What fundamental motor skills (walking, running, creeping, crawling) does your child do extremely well? What physical developmental disabilities have you been able to identify? Consider strength, flexibility, body image, eye-hand coordination, gross motor balance.

Evaluation of your child's apparent verbal, emotional, and social behavior toward clinic activities, other children, parents, and you as his/her clinician.

PROGRAM PLAN

COMPLETE THIS SHEET AFTER FIRST SESSION

NAME: _____ **DATE:** _____

CHILD: _____

Major Concerns (as a result of tests and observations)

1.

2.

3.

4.

5.

Overall Goals (developed from each major concern)

1.

2.

3.

4.

5.

Behavior Management Strategies (reinforcers)

1.

2.

3.

4.

5.

TEACHING PLAN

COMPLETE THIS SHEET BEFORE TEACHING SESSION

NAME: _____ **DATE:** _____

CHILD: _____

Overall Clinical Goals and Teaching Objectives:

_____

Specific Goal 1:

Teaching Objective and Activity

Teaching Objective and Activity

Teaching Objective and Activity

Specific Goal 2:

Teaching Objective and Activity

Teaching Objective and Activity

Teaching Objective and Activity

Specific Goal 3:

Teaching Objective and Activity

Teaching Objective and Activity

Teaching Objective and Activity

TEACHING EVALUATION

COMPLETE THIS SHEET AFTER EACH TEACHING SESSION

NAME: _____ **DATE:** _____

1. Describe the specific progression of skills presented to your child in both the pool and/or clinical settings and the difficulties the child exhibited.

2. What were the observed verbal, emotional, and social behaviors of your child in both the pool and clinical setting.

3. Recommendations for the next clinical session based on 1 and 2.

4. Changes and/or modifications from previous teaching sessions.

5. What behavior management strategies (reinforcers) were employed? Were any successful in meeting your teaching goals?

CONCERNS AND OBJECTIVES
FOR ADAPTED PHYSICAL EDUCATION PRACTICUM

When you are developing your objectives for your child please follow the format for clinic preparation. Answer all questions as they pertain to your child and prepare your objectives for the next clinic session before that session occurs. Before each clinic session, turn your plans into the clinic supervisor in your area - either the gymnasium or the pool area. Pick up your plans prior to the clinic session. If you have any questions, please ask Dr. Michael Horvat or your clinic supervisor. The first clinic session involves the assessment process for your child. This session is designed to help you get to know your child and his/her strong points and weaknesses. After the session is completed, answer the questions in your plans that proceed the goals and objectives section.

Sample Child's Name: Ron Croce

Major Concerns: These are developed from the assessment.

1. Lack of balance
2. Lack of attentiveness
3. Immature running pattern
4. Lack of upper body strength

Overall Objectives: These are developed from the major concerns.

1. Increase Ron's ability to balance on one and two feet.
2. Increase Ron's ability to pay attention to the task at hand.
3. Improve Ron's running pattern - stride, flight phase and arm motion.
4. Improve Ron's upper body strength.

Behavior Management: What you will do to increase appropriate behavior or decrease inappropriate behavior (NOTE: Chapters 12 and 22 in your text book).

1. Constant or intermittent verbal praise for accomplishments.
2. Token system of rewards for tricycle riding time or other activities at the end of the session.

After the major concerns and major objectives are developed, then the Specific Behavioral Objectives for the next class session may be developed. These behavioral objectives must contain three parts: 1. Action, 2. Condition, 3. Criteria.

1. Action - What skill or activity is to be performed.
2. Condition - How the skill or activity is to be performed.
3. Criteria - When the skill or activity is to be considered mastered to ensure that the child may move on to a higher level or more complex skill.

A sample of a complete behavioral objective is:

(A) Balance

1. Ron will be able to walk the length of a low balance beam (Action) in a forward direction with assistance (Condition), three times in a row without stepping off the beam (Criteria).

The objectives for each class session should be the activities that you plan to teach during that session. These activities should be drawn from the Major Concerns and should lead to the completion of the Major Objectives. Sample activities may be found in many sources that will be shown during orientation. These weekly objectives should be sequenced in each area from the easiest, to the hardest to achieve. A sample sequence for balance without writing out the complete objectives, is given below:

2. Standing with assistance; without assistance.
3. Standing on a line on the floor with assistance; without assistance.
4. Walking on a line on the floor with assistance; without assistance.
5. Standing on a low balance beam with assistance; without assistance.
6. Walking on a low balance beam with assistance; without assistance.
7. Standing on a medium balance beam with assistance; without assistance.
8. Walking on a medium balance beam with assistance; without assistance.
9. Standing on a high balance beam with assistance; without assistance.
10. Walking on a high balance beam with assistance; without assistance.

This is just a sample sequence. When writing the weekly objectives for the balance section other conditions that would have to be accounted for would include standing on one or both feet and walking in a forward, backward or sideways direction, or in all three directions. The Criteria to be accounted for may include the distance to be walking in steps or feet and inches, the amount of time the individual would have to stand on the beam and the number of repetitions required without error to exhibit mastery of the task. The plan will be checked by the practicum supervisor each week. Suggestions for improvement may be written or given verbally. The plan will be graded with a _, _+, or _- grading system. The first three weeks of grading for the clinic are not weighed as heavily as the last six weeks (your grade is based primarily on your last six weeks). Take the early suggestions and use them to improve your objectives for the last six weeks of the practicum. Improve your objectives and you may improve your grade.

Lea Kapsch
24 September, 1987
PED661

Webster, G. E. (1987). Influence of peer tutors upon academic learning time-physical education of mentally handicapped students. Journal of Teaching in Physical Education, 58(8), 393-403.

In this study peer tutors were used to increase the academic learning time-physical education (ALP-PE) of moderately and severely mentally handicapped students. With the use of peer tutors, more individualized instruction could be given to each handicapped student at a cost effective means.

The study was conducted in a suburban elementary, middle and high school adapted physical education class. The students were divided into three levels of activities, with emphasis in the elementary on basic motor skills, the middle on refining skills used in games such as baseball, basketball, and badminton, and the high school level refining skills used in floor hockey, tennis, golf, softball and ultimate frisbee. Most of the students were mentally retarded with only a few being physically disabled. They ranged in age from 9 to 21 years of age. The peer tutors were selected from the regular physical education class and were capable of successfully performing all the skills designated in all three levels of activities.

Lesson plans for the students were designed by the APE specialists for each level. The peer tutors entered the class untrained for eight days and worked with the students. After a three day absence, they returned to collect data on the performances of the students. They found during their absence, the students' performances had lowered due to lack of constant attention during the adapted physical education class. This change in performance however, was largely a resulot of the activities the APE specialists selected during the tutors' absence.

In order for this study to produce conclusive evidence as to the effectiveness of the peer tutors, the APE specialist would have to be certain the tutors were extensively trained in the appropriate areas to be taught. A three day course is certainly not sufficient. However, it is evident with minimal time and money, peer tutors and the APE specialist can increase the amount of time these handicapped students spend in the physical education activities.

The Physical Education Portion of the IEP

The following is the physical education portion of the IEP for a ten year old moderately mentally retarded student. All parts of the IEP are addressed since specially designed physical education is necessary for the student.

Student's Name: Kurt CA: 10 years, 4 months

Date: September 8, 1980 Classification: Mental Retardation

Present Level of Performance

Overall level of motor ability is below average for moderately mentally retarded boys at ten years of age. Scored below the 40th percentile on 7 of 9 test items on the Motor Fitness Tet for the Moderately Mentally Retarded.

Annual Goals

1. Attain competency in the following fundamental motor skills: (a) run, (b) jump and ©) overhand throw

2. Develop and maintain a functional of cardiorespiratory endurance, arm and shoulder girdle strength and abdominal strength.

Short-Term Objectives

Goal 1: Given a verbal request and a demonstration, the student will:

(1) Run unassisted 50 yards in 9 seconds two to three trials in the following manner: (a) knee flexion to 90° ± 10°, (b) foot placement in the direction of the run, (c) arm movements in opposition with leg movements, and (d) smooth integration of arm and leg movements.

(2) Jump unassisted in a horizontal distance of 26 inches two of three trials (50th percentile on Motor Fitness Test for the Moderately Mentally Retarded).

(3) Throw unassisted a softball 30 feet two of three trials (50th percentile of Motor Fitness Test for the Moderately Mentally Retarded).

Goal 2: Given a verbal request and a demonstration, the student will:

(1) Run unassigned 300 yards in 115 seconds (50th percentile on Motor Fitness Test for the Moderately Mentally Retarded).
(2) Perform flexed arm hang unassisted for one second.

(3) Perform seven sit-ups unassisted in 30 seconds.

Evaluation (Criteria Procedures Scheduling)

Criteria: Levels of performance as specified in the short-term objectives.

Procedures: Use of Motor Fitness Test for the Moderately Mentally Retarded.

Scheduling: Motor Fitness Test will be administered during class time at the termination of each semester. Corresponding teacher observation of running pattern will be administered on the same schedule.

Services Provided, Initiation and Duration

1. Instruction in specially designed physical education program.

2. Access to Education Service Unit's Adapted Physical Education Consultant.

3. Services will be initiated September 14, 1980 with instruction in the specially designed physical education program scheduled four days per week, 30 minutes per day through the 1980-1981 school year.

Participation in the Regular Program

Students will be integrated into the regular physical education rhythms program which is conducted each Friday throughout the school year.

Summary

An IEP is a written statement which provides direction in the delivery of educational services of handicapped students. Identification of physical education must be included in every handicapped student's IEP. However, the kind and amount of information depends upon the physical and motor needs of the student. The physical educator should participate in planning and monitoring the physical education portion of the IEP in cooperation with other persons responsible for its formulation.

References

Hayes, J., & Higgins, S. T. Issues regarding the IEP: Teachers on the front line. Exceptional Children, 1978, 44, 267-273.

OSE/DOE. Individualized Education Program (IEP): OSE Policy Paper. Washington, D.C.: U.S. Department of Education, 1980.

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Study Guide Questions

Chapter 1 - Introduction

Define: congenital
acquired
acute
chronic
permanent
non-progressive
adapted physical education
developmental physical education
corrective/rehabilitation
functional skills

Chapter 2 - Legal Mandates

1. Trace the background of legislation prior to P.L. 101-476 in educating individuals with disabilities.
2. Discuss Section 504 of the Rehabilitation Act of 1973 and the ADA and how it effects physical education and sport programs.
3. Discuss the implications of P.L. 101-476 in educating children with disabilities.
4. Define physical education per IDEA-97.
5. What is not physical education according to the mandate of P.L. 101-476?
6. How does the Amateur Sports Act of 1978 and Stevens Amendment of 1998 contribute to sport for the disabled?

Chapter 3 - Continuum of Placements and Program Planning

1. How does the least restrictive environment effect the placement of children in physical education programs?
2. Discuss the continuum of placements which are available for children with disabilities.
3. What is an IEP and whom should it be developed?
4. What are the components of the IEP?
5. What information needs to be included in the IEP for various placements?
6. Discuss the physical educators role in the IEP procesd.
7. Discuss the disability model and how it relates to functional capabilities.
8. Discuss the individualized Transition Plan and Individualized Family Service Plan.
9. What are some of the emerging trends in the field of disability?
10. Define annual goals and short term objective and provide examples of each.

Chapter 4 - Psychological Aspects

1. Define Self-concept and Body Image
2. Discuss the defense mechanisms to deal with disability.

3. Compare empathy and sympathy.
4. What is the teacher's role in teaching a child with a disability?

Chapter 5 - Parents and Collaborative Team

1. What is the function of the collaborative team?
2. Discuss the roles of the PT, OT and physical educator.
3. Discuss the parents role in the education of children with disabilities.
4. What are the benefits of a home-based activity program.

Chapter 6 - Assessment and Evaluation

1. Discuss the types of testing procedures.
2. How does evaluation contribute to the overall functioning of a child?
3. What are the purposes of assessment?
4. How can authentic assessment be used in physical education?

Chapter 7 - Motor Development and Postural Control

1. Discuss several causative factors for low motor skills.
2. Provide examples of interventions aimed at improving motor skill development.
3. Define learning, practice, specificity, grosse and fine motor, cephalocaudal, proximodistal.
4. Provide examples of gross motor tasks and be familiar with the initiation of patterns from initial to mature sequences.
5. Describe the influences of reflexes on motor development.

Chapter 8 - Perceptual Information Processing Development

1. Define perception: auditory, visual, tactile, and kinesthetic.
2. What can you do to overcome or compensate for a perceptual deficiency?
3. Provide examples of perceptual receptors and their functions.
4. Discuss the major shifts in perception that occurs in the development of a child.
5. Define intersensory and intrasensory perception.

Chapter 9 - Physical Fitness Development

1. Define the components of physical fitness.
2. Provide some examples of activities that can promote physical fitness in children with disabilities.
3. What are some of the challenges to developing physical fitness in children with disabilities?4. Developmentally, be familiar with the changes in fitness across the life-span.

Chapter 10 - Mental Retardation

1. What are the physical, cognitive and motor characteristics of children with mental retardation?

2. Describe the guidelines for teaching children with mental retardation.
3. How can the outside of the school program contribute to the development of the mentally retarded?
4. Discuss how children with mental retardation respond to training intervention including type, duration and intensity.

Chapter 11 - Learning Disabilities - Attention Deficit Disorders

1. How do learning disabilities affect the child's attentional and motor performance?
2. Describe the characteristics of children with learning disabilities.
3. What appropriate physical education activities can be used in conjunction with these characteristics?
4. How do the environment social sequence level, and medication effect the learning disabled child's performance?
5. Discuss several relaxation techniques.
6. Define the characteristics

Chapter 12 - Behavior Disorders, Autism, and Head Injuries

1. What is the definition of behavior disorders presented by the American Psychiatric Association and IDEA?
2. Discuss the strategies to strengthen, develop weaken or eliminate behaviors.
3. What are some of the characteristics of autism and how do they effect learning?
4. How do children with autism use sensory input?
5. Describe the behavior and physical needs of children with head injuries.

Chapter 13 - Visual impairments

1. Define the degrees of visual acuity. What is functional blindness?
2. How does a visual impairment interfere with the development of movement abilities?
3. Discuss the considerations for placement of the visually impaired in adapted or regular physical education.
4. Discuss blindisms.
5. How can O&M training be used in physical education for the visually impaired?
6. What modifications are needed in teaching the visually impaired?
7. How can body image, spatial awareness, fundamental movements, and sports be taught for the visually impaired?
8. Why are closed tasks easier to learn than open tasks for individuals with visual impairments?
9. Define fixation; accommodation; binocular fusion; convergence, and stereopsis.

Chapter 14 - Hearing Impairments

1. How does a loss of hearing interfere with the development of movement abilities?
2. Distinguish between deaf and hard of hearing.
3. What is a mixed hearing loss? Conductive loss? Sensori-neural loss?
4. Discuss the problems or benefits which may be available by wearing a hearing aid.
5. Discuss the consideration for placements of deaf children in adapted or regular physical education.

6. Discuss the possibilities of balance loss in the hearing impaired. Can it be alleviated?
7. Define static and dynamic balance.
8. How can dance, swimming, ball games, stunts, and tumbling be taught to the deaf?
9. How can you develop communication for the deaf?

Chapter 15 - Posture and Orthopedic Impairments

1. Define the individual differences in posture and be familiar with specific exercises as remediation.
2. Discuss the levels of functional ability in a spinal cord injury.
3. Define the terminology related to additional complication in spinal cord injuries.
4. What is the importance of good posture and body alignment?
5. Can postural problems be corrected? How?
6. Be familiar with exercises for abnormalities of the vertebral column.
7. What is a functional deviation?
8. What is a structural deviation?
9. Describe appropriate exercises for foot deviations.
10. Describe the appropriate exercises for strengthening the knee.
11. What are scolioses, kyphosis and lordosis and the appropriate exercises for each?
12. What are acquired and congenital amputations?
13. Define A/K, B/K, A/E, B/E amputations.
14. Discuss the complication of a spinal cord injury and how they effect functioning.
15. Describe the training program for an individual with a spinal cord injury.

Chapter 16 - Neurological Disorders

1. Define cerebral palsy and describe the conditions that may indicate the presence of cerebral palsy.
2. What are the causes of cerebral palsy?
3. Describe the severity classification topographical, and physiological classifications of cerebral palsy.
4. Describe the physical characteristics of the three major types of cerebral p[alsy and appropriate physical education activities for each.
5. Describe the physical activities which are used to increase functioning in children with cerebral palsy.
6. Discuss the importance of relaxation training activities for the child with cerebral palsy.
7. How do reflexes interfere with movement in cerebral palsy? Be familiar with muscle spindles, and deep tendon reflex.
8. What are the causes of seizures? What are the warning signs?
9. Describe the types of seizures.
10. How is medication used in the treatment of seizures?
11. Discuss the triggers for seizures and how they affect a child's physical functioning.
12. Describe the first aid procedures for the main types of seizures.
13. Should children with seizures participate in physical education and sports; why or why not?
14. How do attitudes affect the child with seizures?
15. Describe the developmental defect in spina bifida.
16. Define the types of spina bifida.

17. Describe the primary and secondary disabilities in spina bifida.
18. What are the major goals for a child with spina bifida?

Chapter 17 - Muscular Dystrophy and Arthritis

1. Describe the types of muscular dystrophy and arthritis.
2. How does exercise contribute to increase functional ability of muscular dystrophy and arthritis?
3. What are some precautions in developing exercise intensities for muscular dystrophy and arthritis?

Chapter 18

1. What is the importance of the diaphragm in the breathing process?
2. What is dyspnea?
3. What are the types of asthma?
4. What are the causes of asthma and cystic fibrosis?
5. How does medication aid the treatment of asthma and cystic fibrosis?
6. What is EIA?
7. Describe the role of exercise in the treatment of asthma and cystic fibrosis.
8. How can a progressive exercise program be implemented for asthma and cystic fibrosis?
9. Discuss the effect of breathing exercises and relaxation techniques in the treatment of asthma and cystic fibrosis.
10. Compare asthma and cystic fibrosis.

Chapter 19

1. What is diabetes? Juvenile - onset diabetes?
2. Discuss the role of insulin in the body.
3. Compare hypoglycemic and hyperglycemic reactions and their treatments.
4. Discuss the implication of exercise, diet and insulin in the management of diabetes.

Chapter 20

1. Discuss how exercise relates to the control of obesity.
2. Discuss the exceptions that are susceptible to obesity.

3. How does excess weight interfere with physical fitness and motor skill development?
4. Discuss exercise and behavior management for control of obesity.

Chapter 21

1. Define septal defects, coarctation of the aorta, patent ductus arteriousus, tetralogy of fallot, arrythmias.
2. Describe the implications of physical activity for children with congenital heart defects and hypertension.
3. What is rheumatic heart disease?
4. What are the functional capabilities of individuals with hypertension?
5. Describe the exercise intervention for a child with cardiovascular problems.
6. What is the role of exercise?

Chapter 22 - Behavior Management

1. Discuss the effects of the environment and teacher-student interaction on managing behavior.
2. Describe several techniques to develop appropriate behaviors.
3. How can you eliminate inappropriate behaviors?
4. Discuss how prompts can be used to facilitate behavior.

Chapter 23 - Teaching Physical Fitness

1. Describe the principles in developing programs for individuals with disabilities.
2. Discuss guidelines such as overload and adaptations and how they would be used for various disabilities.
3. Plan a strength training program for a specific disability.

Chapter 24 - Teaching Motor, Sport and Play Skills

1. How does the teacher structure the setting to encourage learning of motor skills?
2. How is practice used to ensure retention of a skill?
3. Discuss how play can facilitate motor skill acquisition.

Chapter 25

1. Discuss the importance of aquatics for the disabled.
2. Describe the techniques which are used in teaching the disabled.
3. Describe several considerations of the water environment in the education of children with disabilities.