Chapter 3
Working with People with Different Disabilities
Chapter 3: Working with People with Disabilities

Introduction

Every person, regardless of gender, age, sexual orientation, race, religion, creed, or ability, deserves to be treated with dignity and respect. Thank you for treating Outdoors for All participants, volunteers and staff the way you would like to be treated, with respect.

A person is a person first, not a condition or a feature. Any reference to a person’s appearance, features, religion, age, gender, ability, etc, is appropriate only when the reference is pertinent to the conversation. A person with a disability happens to have some inconvenience that may make them talk, walk, think or look differently from others. Most people with disabilities learn to accommodate for their differences and live the same type of life as anyone else; just as others have learned to accommodate for their left or right handedness, wearing glasses or contacts.

To be a more effective when working with your participants, you should be knowledgeable about the disability or disabilities that your participants may have. The more knowledge you have about the disabilities, the better you will be able to assess your student’s needs and anticipate potential problems.

Disability Information

This disability information is provided so you can make intelligent decisions when working with participants. The information presented here describes typical characteristics of the different types of disabilities we may see as Outdoors for All volunteers.

Be aware that there is no such thing as a typical person. Use the information here to understand the general nature of the person’s disability and as a guideline for assessing potential issues that may impact the participant’s performance.

Categorizing Disabilities

Disabilities are either congenital or onset later in life. A congenital disability is one that the person is born with, such as cerebral palsy or Down syndrome. People with a congenital disability only know what it’s like to function with their current level of abilities. With a disability onset later in life, the person experiences a traumatic injury or disease after birth, such as multiple sclerosis or a spinal cord injury.

There are two primary types of disabilities: a disease and a condition. A disease is progressive and generally gets worse, resulting in an increasingly disabling condition, such as diabetes, multiple sclerosis, and muscular dystrophy. A condition is the state a person is in, which generally does not get worse, such as a spinal cord injury, cerebral palsy, and mental retardation. The person can benefit from therapy, but cannot cure the condition. Some disabling conditions may begin as a disease, such as cancer or polio, but become conditions when they progress of the disease is arrested.

Physical Disability — A condition or disease that interferes with mobility or physical movement. Onset can be at birth or later in life due to an accident or the onset of a disease. Physical disabilities include: amputee, cerebral palsy, stroke, multiple sclerosis, post polio, spina bifida, spinal cord injury, head/brain injury.
Cognitive Disability — A cognitive or developmental disability encompasses a wide group of conditions that involve cognitive delays as a result of damage to the brain. There are two main categories: developmental disabilities (DD) and cognitive disabilities.

- A developmental disability is a condition from congenital abnormalities, trauma, disease, or deprivation that delays normal growth and development. A developmental disability appears during the first 18 years of life and can have an indefinite duration. Developmental disabilities include: autism, learning disabilities, Down syndrome, attention deficit disorder, Fragile X syndrome, intellectual disabilities, and Prader Willi syndrome.

- A cognitive disability is damage to or deterioration of any portion of the brain that affects the ability to process information, coordinate and control the body, and/or move in space. A cognitive disability can be organic (related to disease) or non-organic (caused by injury or trauma). Cognitive disabilities include: head/brain injury and stroke.

Sensory Impairments — Refers to people who have conditions or diseases that limit their ability to see and/or hear. Sensory impairments include: visually impairments (some vision), blindness (no vision), hearing impairments (some hearing), and deafness (total loss of hearing).

Disability Specific Information

Amputations (See Physical Disabilities)

Amputation is a condition involving the removal of a portion of the body. The types of amputation are as follows:

- **Traumatic amputations** — associated with sudden severe injury, such as severance, burns, mangling by machinery.

- **Surgical amputations** — associated with disease, such as cancer, gangrene, gout, diabetes

- **Congenital loss of limbs** — limb deficiencies due to developmental defect, often during pregnancy

Amputations are characterized by the location of the amputation. Disarticulation refers to the removal of a limb at the joint.

- Hip disarticulation — removal of the entire leg at the hip.

- Above-knee (AK) — above the knee and below the hip.

- Below-knee (BK) — below the knee and above the ankle. Leaves a functional knee.

- Above-elbow (AE) — between the elbow and the shoulder.

- Below-elbow (BE) — between the elbow and the wrist.

- Shoulder disarticulation — removal of the entire arm at the shoulder joint.

- Unilateral amputation — amputations on the same side, for example, BK and BE.

- Bilateral amputation — amputations equal on both sides, for example, legs or both arms, or one arm on one side and one leg on the other side.

When Working With an Amputee: Since Amputees typically wear prosthetics, the type of prosthesis depends on the type of amputation. When working with your participant, make sure the residual limb is protected from injury and the elements. Be aware that people who normally walk with prosthetics may have difficulty adjusting to participation in sports without the prosthesis. Watch for muscle fatigue.
Assess the participant to discover relevant information, such as when the injury occurred and whether there are other hidden disabilities. Because a portion of the body is missing, balance issues may impact the participant’s performance.

Possible medications: Analgesics, antispasmodics, muscle relaxants, anticoagulants, antibiotics, antiemetic, chemotherapy, radiotherapy.

Cerebral Palsy (CP) (See Cognitive Disabilities, Physical Disabilities, Behavioral Disabilities)

Cerebral Palsy (CP) is a condition that affects a person’s movement and posture. Cerebral means having to do with the brain, and Palsy means a weakness or problem in the way a person moves or positions his or her body. The condition is the result of brain damage that may occur prior to, during, or just after birth. CP can be manifested in a variety of ways, usually physical, and may include speech and cognitive involvement. CP is often a result of oxygen deprivation (anoxia) and trauma to the brain that causes permanent damage. The area and the degree of damage to the brain determine the effect of the disability.

Cerebral Palsy can be classified as one or a combination of the following:

- **Spastic** — Constantly tense, contracted muscles. Quick and jerky movements, with a possibly contorted body. This is the most common type of CP.

- **Athetoid** — Excessive, uncontrolled movements. Constant, slow writhing movements of the upper extremities. Muscles are often unsupportive, which will require some bracing or support.

- **Ataxic** — Jerky, uncontrolled movements.

- **Dystonic** — Extremely rigid muscles, stiff uncontrolled movements. No or little flexibility. This type of CP may be associated with cognitive impairment, though not always.

- **Flaccid** — Reduced, diminished muscle tone.

Characteristics: Typical characteristics include paralysis, weakness, or inability to coordinate motor function. CP may involve abnormal muscle tone, a delay in normal development, and abnormal reflex activity. Some people with cerebral palsy have difficulty with hearing, vision, or speaking (dysarthria). CP is generally not associated with learning disabilities or lesser intelligence. People with CP may also experience seizures and abnormal sensation of the limbs, such as hypersensitivity or diminished sensitivity.

When Working with a Person with CP: If the person is non-verbal, ask the participant how he or she communicates. Ask the person to demonstrate how he or she says yes and no. When participating in sports, many people with CP require adaptations to provide stability. In addition, many people with CP cannot relax their limbs. This can make falling more painful and potentially dangerous. Take extra care to avoid falls.

Be very careful when helping a person with rigid limbs. Use gentle, even, and consistent force when moving a person with CP. Sudden movements can increase muscle rigidity or spasticity. In addition, watch your participant if gripping or holding is required. Some people with CP can grip too hard, causing unnecessary stress.

Possible medications: Anticonvulsant, analgesics, antispasmodics, muscle relaxants.

Cognitive and Developmental Disabilities (See Cognitive Disabilities, Physical Disabilities, Emotional and Behavioral Disabilities)

A developmental disability is any condition resulting from congenital abnormalities, trauma, disease, or deprivation that interrupts or delays normal growth and development, having onset before the age of 18. For example: intellectual disabilities, cerebral palsy, autism, epilepsy, and Down syndrome.

A cognitive disability is damage to or deterioration of any portion of the brain that affects the ability to process information, coordinate, and control the body. Cognitive disabilities may involve a combination of physical, cognitive processing difficulties, and behavioral deficits in varying degrees. Physical impairments can include visual defects or motor dysfunction. Aphasia is the inability to understand or use words and their meanings. Many cognitive conditions also include some degree of speech defect. For example, the muscles that produce language may not work. Short-term and long-term memory challenges may be present as well.
People with cognitive impairments are capable of learning when experiences and information are presented in a simple manner, repeated frequently, and delivered with patience.

Developmental and cognitive disabilities can be acquired following ways:

- **Congenital** — A condition present at birth. It may be inherited, acquired during pregnancy, or arise as a result of the birth process.
- **Hereditary** — The genetic transmission of characteristics or traits from parent to offspring.
- **Prenatal** — Existing or occurring before birth, with reference to the fetus.
- **Perinatal** — Occurring during the birth process.
- **Postnatal** — Occurring after birth, with reference to the newborn.

- **Brain injury** — Symptoms are determined by the section of the brain injured and can vary greatly. Effects can be physical, cognitive, social, and/or emotional. Damage on one side of the brain will affect the opposite side of the body, and the degree of impairment depends on the portion of the brain injured. People with brain injuries have a predisposition to seizures.

  - **Acquired Brain Injury (ABI)** — Organic causes are related to disease, such as brain tumors, cerebrovascular disease, Alzheimer’s, Parkinson’s, and Huntington’s disease. Such conditions may continue to get worse (progressive), never get worse (static), or be in remission.

  - **Stroke (cerebral vascular accident)** — Involves disruption of blood supply to the brain, such as a blood vessel braking or being damaged. It may cause paralysis, speech and cognitive impairments, or behavior challenges.

  - **Traumatic Brain Injury (TBI)** — Caused by non-organic events such as injury or trauma. It may cause paralysis, speech and cognitive impairments, or behavior challenges.

Common aspects of brain injuries include partial loss (hemiplegia) or complete loss (hemiparesis) of function or control of one side of the body. People with this condition often have balance issues and/or possible vision loss. As with any cognitive disability, the extent of the impairment depends on the extent of the damage to the brain. **Assess the participant carefully to identify concerns that may impact the participant’s performance.**

For more information, see “The Brain” below.

- **Intellectual Disability** — An intellectual disability limits a person’s ability to learn at an expected level, as well as to function in daily life. It can be caused by injury, disease or development of the brain before or after birth. Intellectual disabilities were formerly known as ‘mental retardation’, which is no longer an acceptable term.

- **Prader Willi syndrome** — Characterized by an intellectual disability, it is the inability to control eating impulses. **People with this condition may require supervision around food.**

- **Down syndrome** — A genetic disorder causing cognitive and physical impairments. It is triggered by a chromosome defect that causes both physical and cognitive impairments. The main physical features are a slightly oblique slant to the eyes; a round head; flat nasal bridge; fissured tongue; abnormalities of the palms; small round or knotty ears, and short stature. Joints are often very loose as well.

- **Learning disabilities** — People with learning disabilities do not have an intellectual disability, and there is usually no obvious physical disability associated with the learning disability. A person with a learning disability has trouble processing information in the brain. The messages can become jumbled, making it difficult for the person to learn, especially in some academic areas. Common symptoms include short attention span, difficulty following instructions, and poor reading and writing ability.

  - **Attention deficit disorder (ADD)** — A neurological syndrome that is usually hereditary, ADD is characterized by distractibility, short attention span, impulsiveness, hyperactivity, and restlessness that interfere with everyday function.

  - **Attention deficit hyperactivity disorder** — Attention deficit disorder combined with excessive activity and energy.
Dyslexia — Condition characterized by a significant delay in one or more areas of learning (i.e., academic, impulse control, and coordination of movement). It may involve difficulty in processing information correctly, and generally occurs in children of average or above average intelligence.

Autism Spectrum Disorders — A group of neural disorders consisting of a collection of communication and behavior impairments; often includes repetitions and limited patterns of behavior, including obsessive resistance to change. Many do not want to be touched.

Some children with autism are prone to eating disorders and seizures. Some also suffer from hearing and language disorders, inappropriate social responses, and aggression. Many individuals have an intellectual disability, but some are very intelligent and may even be gifted in specific areas. While Autism is the third most common developmental disability in the United States, there is no known cure for it. Some also consider autism to be a sensory impairment.

Possible medications — Anticonvulsant, psychostimulant, sedatives.

Deaf or Hard of Hearing (Sensory Impairment)

A hearing impairment occurs when one or more parts of the ear or brain that are needed to process sounds become diseased or damaged, resulting in partial or total loss of hearing. Hearing impairments can be caused by injury to the ear or brain. Damage to the middle ear can often be helped with the use of a hearing aid. Damage to the inner ear or the brain is often more severe and may not be helped with a hearing aid.

Some people with hearing impairments also have balance issues associated with the inner ear. Speech impairments are also common.

There are two primary types of hearing impairments:

- Congenital — Hearing loss occurred before speech and language concepts developed.
- Adventitious — Hearing loss occurred after speech and language concepts developed.

Working With a Person Who is has a Hearing Impairment: People with hearing impairments may communicate in a variety of ways. Some methods of communication include reading lips, sign language, or finger spelling. People with hearing loss often rely on facial expressions and body language to understand the conversation. Be sure to speak clearly and face the person when speaking. Do not over-enunciate words.

Epilepsy (See Cognitive Disabilities)

Epilepsy is a disorder of the central nervous system marked by unusual electric activity in the brain that causes seizures. Seizures are sudden, brief changes in how the brain works. Epilepsy is a physical condition manifested by focal point, petit mal, or grand mal seizures. In many cases, there is no known cause of epilepsy. For others, epilepsy may be caused by head injuries or trauma, lack of oxygen, lead poisoning, developmental disabilities, or encephalitis.

Epilepsy involves a disruption of the brain’s electrochemical balance causing partial or complete, and brief or prolonged, lapses in consciousness and epileptic seizures. Seizures usually last a short time (a few seconds) and can be either convulsive or nonconvulsive.

- Grand mal seizure — The most dramatic type, characterized by loss of consciousness, rigidity, jerking of the extremities, and falling. When a grand mal seizure occurs, move the person to a quiet area or place the person in a comfortable position. Try to position the person on his or her side. Do not place anything between the teeth. Be comforting after the seizure.

- Petit mal seizure — Unconsciousness lasts only a few seconds and may appear to be only a blank stare. Mental processes cease during the seizure. Other symptoms include muscle twitching, rolling or blinking eyes, eyes that are fixed on some object. Assess the participant immediately. Ask questions to determine the cognitive and physical state. Make sure the person is not experiencing abnormal sensations, such as nausea, dizziness, or double vision. If so, contact a Lead Volunteer immediately.

- Psychomotor and focal motor seizures — These types are less frequent and severe. In some cases, the person may not be aware of the seizure. Symptoms include being mentally confused, staggering, performing purposeless movements, making unintelligible sounds. The person should rest after these types of seizure.
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Working with a Person with Epilepsy: Seizures can be brought on by tension, stress, or problems with medications. When a seizure occurs, keep calm and make sure the person doesn't get hurt when a loss of consciousness occurs. Do not attempt to restrain the person. Make the person as comfortable as possible and try to keep him or her warm.

Individuals sometimes lose control of their bladder or bowels during a seizure, and they may bite their tongue. After regaining consciousness, the individual may feel confused, disoriented and sleepy.

Be sure to provide rest after the seizure and report all issues to your Lead Volunteer.

Possible medications: Anticonvulsant.

Multiple Sclerosis (MS) (See Physical Disabilities)

MS is a progressive central nervous system disease in which the body's nerve fibers become scarred (sclerosed). The myelin sheath, insulation surrounding the nerves, allows messages from the brain and spinal cord to be sent throughout the body; an individual with MS loses sections of myelin sheath along different portions of the nervous system. This blocks the electrical impulses of the nerves. The scarring and deterioration of the myelin sheath can take place anywhere throughout the nervous system. Because MS can strike anywhere in the nervous system, the symptoms can vary widely, even with the same person.

There are four types of MS:

- **Benign** — mild or completely remitting attacks with long symptom-free periods.
- **Relapsing-remitting** — periodic onset of symptoms followed by partial or complete recovery, with plateaus of stable involvement
- **Relapsing-progressive** — attacks with some recovery and significant residual involvement, with a slow deterioration of function (40 percent of people with MS)
- **Chronic-progressive** — continuous deterioration of function over years

Characterizations: MS is unique in its cycle of remissions, seeming to come and go over time. Symptoms can vary from day to day and no two people have the same symptoms.

MS is characterized by muscle weakness, chronic fatigue, balance problems, heat intolerance, and sometimes visual and cognitive impairments. Some people experience paralysis or weakness in the extremities, mood swings (lability), and slurred speech. Many people with MS have an unsteady gait and shaky movements of the limbs (ataxia).

Working with a Person with MS: When working with a person with MS, watch for evidence of fatigue. Provide assistance as needed, and avoid unnecessary exertion.

Possible medications: Anticonvulsant, analgesics, antispasmodics, muscle relaxants.

Muscular Dystrophy (MD) (See Physical Disabilities)

MD includes a number of different types of disorders that are hereditary and are characterized by progressive and irreversible wasting of muscle tissue. MD may include weakness of both voluntary and skeletal muscles, which control movement. The degeneration of the muscle tissue originates within the muscle tissue itself (compared to MS where muscle atrophy is the result of neurological defects).

Most types of MD appear by early adulthood and are more common in males than females. The most common type of MD is Myotonic MD, which has a very slow progression and affects the central nervous system, eyes, heart, and endocrine glands. Duchenne MD, the second most common type, affects children (usually boys) and is often fatal (usually in the 20s).

Characterizations: Different types of MD have different symptoms, however all typically experience a progressive loss of muscle tone. The muscles first affected are usually the pelvic girdle and upper legs and the shoulder girdle and arms. People with MD may walk with the aid of crutches or a cane, although eventually most require a wheelchair.
Working with a Person with MD: Because of the lack of muscle tone, the person’s joints may be more susceptible to injury. Strength, endurance and balance may be issues impacting performance. When working with a person with MD, watch for evidence of fatigue. Provide assistance as needed, and avoid unnecessary exertion.

Possible medications: Anticonvulsant, analgesics, antispasmodics, muscle relaxants.

Post-Polio (Paralytic poliomyelitis) (See Physical Disabilities)

Polio is an infectious viral disease affecting the central nervous system, causing weakness and paralysis of the muscles, which can be broadly distributed muscle group or confined to a specific group of muscles.

Mobility impairments associated with Polio frequently occur in the lower extremities, for example, one leg may be shorter than the other. Paralysis is permanent. Other symptoms include fatigue shortness of breath, and balance problems, as well as circulation problems and susceptibility to cold.

Spina Bifida (See Physical Disabilities)

Spina bifida is a birth defect of the spinal column and spinal cord. In this congenital condition, a baby is born with the spinal cord exposed from the failure of the spinal column to close around spinal cord, causing partial or complete paralysis below the open level. There is a disruption in the flow of cerebrospinal fluid (CSF), which nourishes and cushions the brain and spinal cord. This disruption often results in a buildup of fluid and pressure in the head. A shunt is used to relieve the pressure in the brain. It is typically located under the skin running from the base of the skull, down the side of the neck and across the chest, where the CSF is reabsorbed by the body.

Characterizations: Symptoms of Spina Bifida are similar to a spinal cord injury at the level of the spinal cord exposure. The extent of an individual’s impairment depends on the level of the exposure. Most instances of spina bifida occur in the lower spine, but it can occur at any level. The lower the level of exposure, the more lower-extremity function the person will have. In some cases, the person may be able to walk with bracing.

In some cases, if the spina bifida is associated with the brain condition hydrocephalus, the person may also have a developmental disability. Assess the participant for signs of a learning disability, but do not assume that they have a cognitive impairment.

Working with a Person with Spina Bifida: Take special care to provide appropriate padding for the location of the spinal column defect. If necessary, place a donut-shaped pad around the tender area to provide protection. Individuals may also have a curvature of the spine, impacting the person’s center of mass and resulting in balance issues.

People with spina bifida are often prone to skin problems. Poor circulation contributes to this symptom. Make sure to take protective measures to avoid pressure sores, frostbite, excessive heat or cold, etc. Some people with spina bifida also have an allergy to latex, which can result in anaphylactic shock. Do not use latex gloves without verifying the absence of the allergy.

Possible medications: Antibacterial, anticholinergic, analgesics, antispasmodics, anticonvulsant.

Spinal Cord Injuries (SCI) (See Physical Disabilities)

A SCI is a severe injury or disease to the spinal cord that causes partial or complete loss of sensation and loss of voluntary movement below the level of the injury. The injury is often caused by a broken bone of the vertebrae or a dislocation of the vertebrae. Typically, the higher the injury, the greater the loss of function. For information about how the spinal cord works, see “The Spinal Cord” section below.

Spinal cord injury can be caused by disease (tumors, spina bifida) or by traumatic injury (auto accidents, falls, gunshot wounds). Statistically, the majority of people with SCI are young, active males. The most common levels of injury are C5-6, T6-7, and T12-11.

There are two classifications of spinal cord injuries, determined by the level of impact. No two spinal cord injuries are the same, however.

- Paraplegia — Injury of the lower spine (thoracic, lumbar or sacral) with partial or complete paralysis of the lower body without involving the arms, shoulders, neck or head.
• Quadriplegia — Injury of the upper spine (cervical, T1 and above) with partial or complete paralysis of the body involving both arms and legs; may also involve shoulders, neck, head and respiration.

Potential Conditions Associated with SCIs

• Autonomic dysreflexia — Autonomic dysreflexia can be a life-threatening condition! Autonomic dysreflexia is a hypertensive (high blood pressure) crisis that can occur in people with a SCI above T6 level. Symptoms include sweating, gooseflesh, pounding headache, and increased spasticity. It is caused by the body’s inability to sense and react to specific stimuli, including such things as bladder distention from a kinked indwelling catheter or full leg bag, catheter irritation, skin pressure sores or spasticity from a stretched muscle.

When Working With a Person With Autonomic Dysreflexia: If autonomic dysreflexia occurs and is not managed correctly and immediately, it could lead to a stroke, coma, or even death. Many individuals who could be prone to this condition are aware of the symptoms. Should symptoms occur, sit the person upright and loosen any straps to relieve excessive pressure on the skin. Help the participant check the urinary catheter or leg bag for kinks or plugs. Check for spasticity and relieve the muscle by decreasing the stretch on the spastic muscle.

If an individual is experiencing symptoms of autonomic dysreflexia, contact Lead Volunteers and get the person to first aid immediately!

• Spinal stabilizers — Some people with SCI have devices that have been surgically connected to their spinal column. Metal rods or clamps or vertebral fusion with bone grafts are used to hold the vertebrae together. These devices prevent the normal flexion of that section of the spine, decreasing the ability of the spine to absorb impact.

• Skin — Sores can develop in areas of insensitive skin, especially in areas of bony prominence such as ankles, knees, hips, sacrum, and ischium. Pressure sores are a very serious condition. Avoid prolonged pressure on the skin by performing weight shifts often. Be aware of improper positioning and check for pressure and pinching. Use adequate padding on bony areas.

• Thermal regulation — Many people with an injury of T8 or above are prone to impairments in internal temperature control. Paralyzed limbs often have circulation problems. Make sure the participant is dressed appropriately.

• Spasticity — Sometimes paralyzed muscles are prone to involuntary movements below the level of injury. To stop spasticity, help the participant reposition to reduce the stretch on the affected muscles.

• Bladder functioning — Be aware that many people with SCI have a tube (catheter) inserted into their bladder to deal with bladder control. The catheter connects to a plastic bag that attaches to the leg. People with SCIs are trained to deal with this issue. When working with a participant with an SCI, make sure adaptive equipment does not interfere with the leg bag and that the leg bag is placed in a position that will not cause pressure sores.

Working with a Person with SCI: Many people with SCI use wheelchairs for mobility. Remember that just because the person is in a wheelchair, it does not mean there is anything wrong with the person’s brain or hearing. A wheelchair provides a mechanism for moving around and becomes part of the person’s “personal space.” Never move, lean on, or touch a person’s chair without permission. Always ask a person in a wheelchair how you can help before doing so.

Possible medications: Antibacterial, anticholinergic, analgesics, antispasmodics, sedatives.

Visual Impairments (See Physical and Sensory Disabilities)

The most common causes of visual impairment in the US are diabetes, myopic degeneration and glaucoma. Legal blindness is defined as corrected visual acuity of 20/200 or less. This means that at a distance of 20 feet, a person who is legally blind can see what a person with 20/20 vision can see at 200 feet. More than 90% of persons who are legally blind have some residual eyesight. Many can perceive light and can sense motion.
Diabetes Mellitus — Diabetes is one of the main causes of visual impairment in the U.S. Diabetes retinopathy is caused by changes in the retinal capillary blood vessels.

Diabetes is a disease in which the body is unable to use carbohydrates (sugar) properly because of a lack of insulin. Insulin is a hormone produced by the pancreas. Without insulin, the sugar levels in the bloodstream can become toxic. There are two primary types of diabetes: Juvenile Diabetes (the pancreas fails to produce insulin) and Adult Onset Diabetes (the pancreas produces insulin but the body does not use it properly). Stress and food can increase the blood sugar levels.

Symptoms include general lack of energy, frequent urination, and excessive thirst. Many people with diabetes have repeated infections that do not heal properly. Diabetes can be controlled through insulin shots, diet and exercise.

Potential issues include hypoglycemia (low blood sugar). This is serious and can result in seizure. Early warning signs are shakiness, hunger, sweating and weakness. Watch for sudden changes in behavior or mood and slurred speech.

Glaucoma — A condition in which loss of vision occurs because of abnormally high pressure of fluid in the eye. Drops are put in the eye at regular intervals to remove the outflow of fluid from the eye. Common symptoms range from slight visual impairment, often beginning with loss of peripheral vision, to total blindness. People over 35 have a higher risk of developing chronic glaucoma.

Cataracts — The eye’s lens becomes cloudy or opaque, which blocks the passage of light through the eye. Common symptoms are dimmed, blurred, or double vision, and sensitivity to light. Can be causes by diabetes, injury to the lens, aging.

Macular degeneration — A progressive disease that affects the macula (the central part of the retina). Peripheral vision is usually retained.

Strabismus — Both eyes do not face in the same direction. Strabismus is caused by an imbalance of one or more of the twelve muscles that control eye movements. May cause double vision. Strabismus may be congenital, or it may be caused by disease or trauma.

Retinopathy (retinitus pigmentosa) — A hereditary condition involving progressive degeneration of the retina beginning with night blindness and producing a gradual loss of peripheral vision.

Nystagmus — Involuntary, rapid movement of the eyeballs. Can be congenital or result from trauma or neurological disease.

Rerolental fibroplasias (RLF) — Visual impairment caused by oxygen given to incubated premature babies.

Visual Field Conditions — Impairments involving the area that the person can see when looking straight ahead. Peripheral vision, tunnel vision, bilateral vision, myopia.

• Myopia — Near-sightedness (compare to hyperopia). Near objects can be seen clearly, but those in the distance are blurred. Often caused by the eye being too long from front to back or caused by the lens or cornea having too much power.

• Hyperopia — Far-sightedness (compare to myopia). Objects at a distance can be seen more clearly than near objects.

• Tunnel vision — A visual field of 20 degrees or less. The person sees as though looking through a tunnel. Peripheral vision is lacking.

• Peripheral vision — Blindness occurs in the center of the field of vision, leaving only the ability to see around the edges of the field of vision.

• Hemioopia — Bilateral vision, the ability to see only half of the field of vision.

Working with a Person with a Visual Impairments: When working with a person with a visual impairment, communication and guiding are two very important issues. Speak to the participant so he or she is aware of where you are. Use a normal voice and tone. Take the time to determine the level of sight the person has and ask how long
the person has had the visual impairment. A person who has recently lost sight may have more balance issues or nausea. Determine whether the person has other secondary conditions, such as a brain injury.

When guiding, always ask the participant how he or she prefers to be guided. Help to make the person more comfortable and confident. Be consistent and use clear communication. Remember, you are the person’s eyes in an unknown environment.

Possible medications: anticonvulsants (seizures), antiemetics (nausea, vertigo), insulin (diabetes)

The Brain

The brain is responsible for everything we do. It controls our physical functions, communications, thought processes, sensory interpretation, and emotions.

The impact of a brain injury depends on where the brain is injured.

- Frontal Lobes — thinking, speaking, basic movement, emotions, behavior, personality, judgment
- Parietal Lobes — sense of touch, sense of pain, spatial perception
- Temporal Lobes — hearing, memory
- Occipital Lobes — vision

Types of Head Injury

Diffuse Injury — Widespread microscopic damage throughout the brain caused by a closed head injury (a trauma to the head that usually does not fracture the skull). Caused by a violent impact to the head that twists the neck and the brain rotates within the skull. The rotation causes tearing and bleeding throughout the brain. Diffuse head injury affects neurons and their connections throughout the brain, resulting in a variety of problems with physical, emotional, thought processing, and behavioral functions. The degree of seriousness and permanence of these problems vary from patient to patient.

Focal Injury — Damage to the brain in a specific area. Focal head injuries can be caused in many ways, such as gunshot wounds, blows to the head that are hard enough to force pieces of the skull into the brain, strokes, brain tumors, and ruptured blood vessels. The brain is torn and damaged or oxygen deprived in a specific area making the problems that result predictable.
The Spinal Cord

The spinal cord is an extension of the brain and is composed of nerve cells and fibers. The spinal cord connects the brain to the nerves that control the body’s muscles, skin and organs. The spinal cord is a vehicle for the brain to communicate with the body.

Muscle movement begins in the brain and electrical impulses descend through the lateral and anterior parts of the spinal cord, to the spinal nerves and out to the muscles. When this motor pathway is injured, the result is the inability to move muscles.

Sensation occurs when impulses travel from the skin or organs through the spinal nerves, up the spinal cord to the brain. When this sensory pathway is injured, the result is a loss of sensation.

The spinal cord is protected by the backbone, composed of bony structures known as vertebrae. The spinal cord is located in a canal that runs through the center of the vertebrae.

There are four major sections of the spinal column.

- **Cervical** region (neck)
  - 8 nerves, 7 vertebrae (C1-C8)

- **Thoracic** region (chest)
  - 12 nerves and vertebrae (T1-12)

- **Lumbar** region (lower back)
  - 5 nerves and vertebrae (L1-L5)

- **Sacral** region (tail bone)
  - 5 nerves and vertebrae (S1-S5)

Spinal cord injuries are categorized by the area of the spine where the injury occurred. For example, an injury to the third vertebrae of the thoracic segment is known as T3. The different levels of the spine are associated with specific functionality. The higher the injury, the greater the impact on functionality.

Paraplegic Injuries

- **L4 and below** — Paralysis/paresis includes the lower legs, typically from the knees and below. Most people with a sacral or lower lumbar injury can walk with bracing and crutches.

- **L1-3** — Paralysis/paresis now includes the lower extremities, including hip flexors, quadriceps and below. Many people with this level of injury can walk with bracing and crutches.
• **T12 through T9** — Paralysis/paresis includes lower extremities and abdominal muscles. Trunk balance may be compromised. Most people with this level injury use a wheelchair. Upper body strength is not impacted by the injury.

• **T8 through T2** — Paralysis/paresis now includes upper chest muscles and below. Trunk balance is compromised, which can impact dynamic balance. People with T8 and above almost always use wheelchairs that require additional support.

**Quadriplegic Injuries**

• **T1 through C8** — Paralysis/paresis now includes intrinsic hand muscles. A person with a T1 injury and above is considered a quadriplegic (depending on the completeness of the injury) because all four extremities are now involved. At this level, the ability to hold things with the fingers is impacted.

• **C7 through C5** — Paralysis/paresis now includes the fingers, hands and arms. Many people with this level of injury use powered wheelchairs because they lack the arm muscles necessary to propel a manual chair.

• **C4 and up** — Paralysis/paresis now includes the neck. People with this level of injury generally have movement limited to the head and neck. People with injury at this level often require devices to assist with breathing.

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**Working with People with Disabilities**

**Language**

Language can be inappropriate, negative and demeaning. If information about a disability is pertinent, then use language such as "person with a mobility impairment" or "person who uses a wheelchair." What is the most appropriate way of saying things? The following will help. Notice how we choose to put the person first.

<table>
<thead>
<tr>
<th>Old Terminology</th>
<th>Politically Correct Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handicapped</td>
<td>Person with a disability or person who is disabled.</td>
</tr>
<tr>
<td>Afflicted/stricken with</td>
<td>Person who has _____</td>
</tr>
<tr>
<td>Victim</td>
<td>Person who has survived ____</td>
</tr>
<tr>
<td>Crippled</td>
<td>Person with a mobility impairment. Person who uses ____</td>
</tr>
<tr>
<td>Retarded/retard</td>
<td>Person with a developmental disability.</td>
</tr>
<tr>
<td>Lunatic/nuts/crazy</td>
<td>Person with a mental illness.</td>
</tr>
<tr>
<td>Deaf and dumb</td>
<td>Person who is deaf and mute.</td>
</tr>
<tr>
<td>Normal</td>
<td>Person without a disability.</td>
</tr>
</tbody>
</table>
Increasing Your (and your participant’s) Comfort

Each of us has a disability. Some of us can never seem to remember a name or where we put the keys. We may be overweight, underweight, or out of shape. Or when listening to someone talk, there are many times when we cannot say we heard and understood every single word. We all have disabilities — it is just that in some of us they show more than in others.

Most of us feel uncomfortable around people who are different than ourselves. It’s OK if you feel this way; your comfort level will increase with your exposure, practice and knowledge.

Enable Ability

Appreciate what people CAN do. The difficulties a person faces often stem more from society's attitudes and barriers than from the effects of impairment. For example, you may see a person using a wheelchair and think "What a waste, he can't do anything," yet, that person may have much stronger arms than you, compensating for mobility and enabling him to do a variety of activities requiring great arm strength. Focus on ability and use the participant's abilities to compensate or adapt, just as you do your own.

Respect the person’s right to indicate the kind of help he or she wants. Give assistance, if asked, or if the need seems obvious, offer assistance. Do not give unwanted assistance and never insist. If you ever feel like insisting, remember the story about the "Boy Scout" who helped the "little old lady" across the street, although she insisted she did not want to cross. Usually a simple statement such as, “let me know how I may help,” opens up communication without making either party feel awkward or dependent. When someone does indicate desire for assistance, ask HOW you may help. Examples:

- Ask a person with a visual impairment to show you how he or she wants to be guided.
- Ask a person using a wheelchair to tell you how you could assist in transferring.

A person with a visual impairment can usually hear without difficulty, so you need not yell. An adult with an intellectual disability is not a child; so, you may speak to him or her as you would your adult friends. A person using a wheelchair does so because his or her legs do not allow bipedal mobility, not because he or she cannot understand, hear, or see. People in wheelchairs are not confined; rather, wheelchairs liberate by allowing mobility. The wheelchair is part of his or her personal space, so do not lean on the person's "legs" without permission.

When working with a participant in an activity, always allow the person to experience as much independence as possible. Do not assume our participants cannot do something simply because of a disability.

Conversing

If it comes up naturally or you need to know something specific, feel free to ask about the participant’s disability. Let the participant, or his/her significant others, guide you. Be respectful and sensitive in the same manner you want someone to ask you.

Speak directly to the person with a disability, even if they have an interpreter, companion or attendant. Explore your mutual interests and conversational topics just as you would with any new acquaintance. People with disabilities have much more to discuss than their impairments.

Common societal expressions are acceptable, for example, “Did you see that movie?” or “Let's take a walk.” People with disabilities do not usually desire different treatment. Along that line, they also do not want someone to be condescending. Talk to people with disabilities just as you would to anyone their age.

People who have visual impairments use other senses to take in environmental information. Ask him/her if s/he would like you to describe the scenery, explain who else is around, or if s/he would like to hold or touch an object you are explaining. When directing him/her from a distance, use directions or your voice. For example, say “Come over this way toward my voice” or “Just a little to the right.” If you do use your voice as a guide, remember to keep talking.

Be patient with those who have difficulty speaking. Do not finish sentences or thoughts or answer for participants. When you do not understand something said, ask them to repeat. Try repeating what you thought you understood. They will tell you whether you are correct and repeat what you did not understand. Do this as often and as much as
you need. Ask him/her to rephrase if you feel you cannot understand a word or sentence. Most of us prefer to be understood instead of seeing someone say “yes” to “I have to go to the bathroom”, then not take the needed action. If the person cannot verbalize or use other tools to communicate, ask him/her how s/he says “yes” and “no,” then use yes/no questions to communicate. You will soon learn his/her nuances of communication.

Slow your rate and speak calmly without yelling or exaggeration to a person with a hearing impairment. Be sure they can see your face and use gestures or other methods of communication. Ask him/her to show you commonly used gestures so you may use them also.

It is OK to say no to a person with a disability, just as you might to anyone else. You are welcome to set your comfort limits that do not interfere with others' rights. For example, if a person with a disability invades your personal space, you can tell them not to. With some people, you may have to be repetitive, just like you may have to do with your family members.

People with disabilities are not necessarily special, inspirational or courageous. They are people, making the best of their situations — just like you. They usually do not want to be patronized or put on a pedestal — just like you. They just want to be accepted, supported, encouraged, praised, and loved — just like you.

Treat a person with a disability as you would anyone you know. Treat them as you would want to be treated by others.

Disabilities Affecting Participation

People with the same disabilities or condition are still individuals. Focus on abilities, for this assists a person with a disability to succeed and overcome the barriers they face. Disabilities affecting participation are categorized into four areas: physical, cognitive, emotional/behavioral, and social. All issues may be affected to some degree by all disabilities; however, not all with the same disability have the same issues. Always get to know your participant and continually assess his or her needs and abilities. Remember we are individuals — never assume anything.

The participant, with assistance from you and the participant's significant others, determines his/her strengths and participation considerations. You, with input from the participant as to his/her goals, develop a plan to assist him/her to participate using his/her strengths and adapting, as needed, for areas of consideration. In all cases, strive for minimum adaptation to achieve maximum participation and fun. Use the following method to assist you in this process:

1. Obtain and read Outdoors for All’s medical and health status forms. Contact the participant, and/or significant others, before the activity for specific questions and/or information. This is a great time to ask about his/her goals.
2. Observe the participant interacting with you and others, moving around, putting on equipment, during lessons, etc. Your observations will assist you greatly in determining how to best work with your participant. Continue to ask him/her about his/her goals as they may change.
3. Let the participant guide you. Most individuals will offer reliable information and know their compensations. Exceptions may be those with cognitive or behavioral impairments; you may need to confirm information with significant others.
4. Perform simple tests and ask questions with the participant. Examples are testing for basic muscle strength, asking questions to determine understanding of complex information or memory. If in doubt, ask Lead Volunteers for assistance.
5. Talk with significant others, if needed. Significant others may include family, friends or staff. They can confirm and add information.
6. Talk with volunteers who know the participant. Read previous progress reports.
7. Talk with Lead Volunteers. They can direct you to resources and advise you on tips, adaptive equipment and teaching methods. Ask them for any assistance you need. Their job is to help you to do your job.
## Physical and Sensory Disabilities

*May include, but not limited to, Amputee, CP, Stroke, MS, Post Polio, Spina Bifida, Spinal Cord Injury, Head/Brain Injury, and sensory impairments*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Definition</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance</td>
<td>Remain upright while sitting, standing, walking, moving.</td>
<td>Physically test/observe. Compensate with abilities or devices to maintain balance.</td>
</tr>
<tr>
<td>Mobility</td>
<td>Move self from point a to point b, with or without devices.</td>
<td>Physically observe. Use devices to maximize mobility.</td>
</tr>
<tr>
<td>Gait</td>
<td>How walks (e.g., a limp, on toes, toes pointed inward, bowlegged).</td>
<td>Physically observe. Modify stance with devices, as needed.</td>
</tr>
<tr>
<td>Coordination, limb control</td>
<td>Ability to voluntarily control muscles.</td>
<td>Slow muscle movement. Use other movement ability to compensate. Adapt with devices when needed. Teach in small repetitive steps for muscle patterning.</td>
</tr>
<tr>
<td>Strength</td>
<td>Ability of musculature to maintain pose, not to be confused with tone.</td>
<td>Physically test/observe. Use strengths to compensate or assist with strengthening weaker muscles. Adapt with devices when needed.</td>
</tr>
<tr>
<td>Tone</td>
<td>Amount of muscle tension when at rest.</td>
<td>Tone can cause complications in using the muscle appropriately. Do not encourage further muscle tension or strengthening of the muscle opposing a weaker one. Adapt to decrease the tone pattern. Obtain assistance from Lead Volunteers or an occupational, physical or recreational therapist.</td>
</tr>
<tr>
<td>Contracture</td>
<td>Permanent shortening of muscle due to tone or opposing muscle strength.</td>
<td>Do not encourage further muscle tension or strength. Use braces or splints already in use. Use supportive devices to compensate. When you must move contracted muscle, move slowly and steadily, never to point of pain. Obtain assistance from Lead Volunteers or an occupational, physical or recreational therapist.</td>
</tr>
<tr>
<td>Endurance</td>
<td>Ability to continue sustained activity.</td>
<td>Use least amount of energy for most fun. Assist if s/he would like, in tasks needed, take energy, but are not fun (e.g., obtaining equipment). This is one case where more adaptive equipment may be better, give the participant the choice. Take frequent rest breaks. It is not mileage, but length of fun that may be the key.</td>
</tr>
<tr>
<td>Vision</td>
<td>Total or partial blindness, tunnel vision, lack of central vision clarity.</td>
<td>For those with some sight, direct attention as needed. Use verbal or tactile direction such as placing feet, leaning body, positioning arms/hands.</td>
</tr>
<tr>
<td>Condition</td>
<td>Definition</td>
<td>Suggestions</td>
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</tbody>
</table>
| Sensation     | Total or partial lack of body sensation including pressure, temperature, pain and sensations such as a full bladder. | **Pressure/pain** — can develop sores or spasms. Pad areas well without friction. Cue frequent pressure releases. This is a serious issue!  
**Temperature** — can cause frostbite, burns, hypothermia or hyperthermia, worsening of disability or health. Extra insulation for extremities during cold weather, cooling techniques for hot weather or intense activity. Physically check extremities often. Watch for signs of hypothermia, hyperthermia, sweating or lack thereof, and act accordingly before a problem or emergency exists.  
**Bladder/bowel** — most who have problems wear items for control such as absorbent briefs or catheter/collection bags. Assist, as needed, to stay clean and dry. Report problems to significant others, if needed. If a catheter is used, help to keep tubing from kinking and to empty bag. |
| Hearing       | Hard of hearing, particular frequencies, differentiation of sound and total deafness. | Articulate. Face so he/she can see your face. Get closer, speak louder, or obtain attention through touch. Agree upon frequent meeting points for explanation. Use visual or tactile demonstration. Use sign language or an interpreter. |
| Seizures      | Focal point, petite mal, grand mal.                                         | If required, use equipment for safety. Allow seizure to run course. Keep from hitting objects, falling, etc. If less than five minutes, ask if s/he would like medical evaluation. If lasts more than five minutes, there are mitigating medical factors (e.g., diabetes) or in doubt, obtain medical evaluation and notify Lead Volunteer. |

**Cognitive Disabilities**
(May include, but not limited to, Intellectual Disabilities, Cerebral Palsy, Autism Spectrum Disorders, Epilepsy, and Down syndrome)
<table>
<thead>
<tr>
<th>Condition</th>
<th>Definition</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention,</td>
<td>Ability to pay attention, even for a very short time. Ability to pay</td>
<td>Remove as many distractions as possible. Verbally or physically, obtain</td>
</tr>
<tr>
<td>concentration</td>
<td>attention in a distractive environment.</td>
<td>attention. Switch to related tasks as needed to keep attention. Give</td>
</tr>
<tr>
<td></td>
<td></td>
<td>rest breaks.</td>
</tr>
<tr>
<td>Communication</td>
<td>Ability to express self or understand others' communication, verbally,</td>
<td>Expressive — determine yes/no, expressions and gestures, etc. Give ample</td>
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<tr>
<td></td>
<td>gesturally, written, pictorially, with adaptive devices or any other</td>
<td>time for responses. If you do not understand, ask to repeat. Repeat what</td>
</tr>
<tr>
<td></td>
<td>method.</td>
<td>you think was communicated.</td>
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<td></td>
<td></td>
<td>Receptive — express self in person's terms. Maintain eye contact. Allow</td>
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<tr>
<td></td>
<td></td>
<td>ample time for processing.</td>
</tr>
<tr>
<td>Intelligence</td>
<td>Measure of ability to learn/reason, affected by experience/formal</td>
<td>Relate to chronological age: do not talk down, baby talk or singsong.</td>
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<tr>
<td></td>
<td>schooling.</td>
<td>Determine best method of learning: verbal explanation, visual demonstration,</td>
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<td></td>
<td></td>
<td>tactile assistance, experiential. Use that method most often, using other</td>
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<tr>
<td></td>
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<td>methods to augment.</td>
</tr>
<tr>
<td>Ideation</td>
<td>Understand/form complex, abstract thought. Range from complex abstractions</td>
<td>Use only as much abstraction as can understand. Metaphors and other such</td>
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<tr>
<td></td>
<td>(e.g., theory of relativity) to concrete, egocentric thought (body</td>
<td>abstractions will not assist, only confuse.</td>
</tr>
<tr>
<td></td>
<td>functions).</td>
<td></td>
</tr>
<tr>
<td>Direction following</td>
<td>Follow directions in single or multiple steps.</td>
<td>Give only as many steps at one time as can follow, never more than seven.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Steps should be concrete, clear and concise. Teach in a step-wise fashion</td>
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<tr>
<td></td>
<td></td>
<td>with each step building on the last. Allow time to master preceding steps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>before moving to the next.</td>
</tr>
<tr>
<td>Task-transitioning</td>
<td>Ability to move between tasks or do multiple tasks at one time.</td>
<td>Allow ample time for switching between tasks. Concentrate on one task at a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>time.</td>
</tr>
<tr>
<td>Condition</td>
<td>Definition</td>
<td>Suggestions</td>
</tr>
<tr>
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</tr>
<tr>
<td>Memory</td>
<td>Ability to remember. Allow ample repetition and cue as needed.</td>
<td><strong>Long-term</strong> — events from weeks, months or years past. Have recall what learned at lesson beginning, last week, etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Short-term</strong> — events from seconds, minutes, hours or days past. May benefit from written or picture cues for review. If assignment is given, assist to use compensatory techniques to remember to complete assignment. Recall learned information often.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Visual Motor</strong> — movements seen. Use verbal explanation/tactile demonstration.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Auditory</strong> — things heard. Use visual/tactile demonstration.</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Ability to choose between two or more choices.</td>
<td>Give concrete choices, no more than can choose between. Some can choose between yes and no for one choice. Still others must be told choice (e.g., &quot;We are going to stop now.&quot;). Do not offer a choice you cannot live with.</td>
</tr>
<tr>
<td>Problem-solving</td>
<td>Ability to determine options and solutions; determine pros/cons of each.</td>
<td>Cue to define two or more options depending upon decision-making, determine pros/cons of each. Assist choice. Remain concrete. Break problem into smaller steps.</td>
</tr>
<tr>
<td>Judgment</td>
<td>Ability to differentiate between safe/unsafe, right/wrong, etc. Partial or all judgment may be affected.</td>
<td>Supervise activity closely. Give firm cues, concrete expectations. Cue to possible consequences of decision/judgment or various options available. Cue regarding safety judgment; recall safety rules.</td>
</tr>
<tr>
<td>Initiation, motivation</td>
<td>Ability to begin or continue activity or move to next level without encouragement. Usually cooperative.</td>
<td>Task may be too daunting. Cue to break into smaller steps. Remember to encourage and praise participation.</td>
</tr>
<tr>
<td>Visual perceptions</td>
<td>Ability to perceive depth, figure/background, color, spatial orientation, left/right neglect.</td>
<td>Allow choice of reference point. Cue for concrete immovable objects. Use color only if distinguishable. Use verbal explanation or tactile demonstration. For neglect, cue attention to neglected side.</td>
</tr>
<tr>
<td>Insight</td>
<td>Ability to recognize, accept and compensate for own deficits and strengths.</td>
<td>Cue to compensate, determine strengths s/he could use to compensate for deficits, how translate into techniques.</td>
</tr>
</tbody>
</table>
# Emotional and Behavioral Disabilities

<table>
<thead>
<tr>
<th>Condition</th>
<th>Definition</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased self-esteem, negative self-perception</td>
<td>Does not feel good about self, perceives cannot perform activity, low feeling of worth. Can lead to nonparticipation.</td>
<td>Build on positive self-perception. Cue recognition of successes or positive traits, regardless of how small, which occurred in current and/or past lessons. Express positive traits about him/her. Cue to accept praise/compliments with &quot;thank you&quot; without minimizing.</td>
</tr>
<tr>
<td>Fear of failure</td>
<td>May not try or purposefully mis-performs.</td>
<td>Start with familiar/easy skills; small steps to unfamiliar/harder skills; allow control of progress. Encourage all efforts, even those not perceived as successful.</td>
</tr>
<tr>
<td>Perfectionism</td>
<td>Perception that all skills must be performed perfectly. Often defined as how the volunteer performs. Can keep from trying.</td>
<td>Teach new skills demonstrating only as good as you would like to be at that moment. Concentrate on one portion of skill. Cue to state positive things learned from mistakes made and incorporate them in next try. Praise for self-correcting perceived imperfections without bringing them to your attention.</td>
</tr>
<tr>
<td>Frustration</td>
<td>Easily discouraged by perceived failure or slowness of success.</td>
<td>Move from successful skills to harder skills and back again. End lesson with success. Cue state successes, no matter how small. Express all perceived successes.</td>
</tr>
<tr>
<td>Anxiety, apprehension</td>
<td>Unease or distress due to the unknown, can disrupt learning.</td>
<td>Ask what is making him/her anxious, how can contend with difficulties, how can continue to progress. Keep steps small, build on previous successes. Break new tasks into smaller steps or concentrate on one portion of the task. Cue to recall past times when overcame anxiety and how could use these to help now.</td>
</tr>
<tr>
<td>Inflexibility</td>
<td>Inability to stray from routine, unnecessarily resistive to change, inability to change the rules or be spontaneous.</td>
<td>Assist to discuss pros/cons to change to help determine how it can be positive. Give encouragement when needed change is happening. Assist to break unacceptable change into smaller steps. Give opportunity to request change.</td>
</tr>
<tr>
<td>Flat affect</td>
<td>None or small amounts of demonstrated emotion.</td>
<td>This affects you more. Ask how s/he is feeling and believe him/her.</td>
</tr>
<tr>
<td>Condition</td>
<td>Definition</td>
<td>Suggestions</td>
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</tr>
<tr>
<td>Inappropriate emotion</td>
<td>Laughs, cries, etc. at times that seem inappropriate.</td>
<td>Before need, ask how composes self when emotion becomes disruptive. Ignore behavior unless disruptive, then give composure time-outs. Cue use of calming strategies already discussed; give responsibility for self-composure.</td>
</tr>
<tr>
<td>Passive-aggressive</td>
<td>Attempt at aggression or control by being passive.</td>
<td>Ask if there is a problem; give responsibility for solution. Give time to solve problem; cue for solution alternatives. If does not identify problem or desire to attempt solution, give time-out until desires to participate. Give forced choice as to how to spend supervised time without rewarding behavior.</td>
</tr>
<tr>
<td>Chronic complaints</td>
<td>Can be disruptive or lead others to perceive activity negatively.</td>
<td>Give responsibility to solve issue. Cue for solution alternatives and encourage trial of appropriate ones. If complaint continues, repeatedly cue to solve problem and stop discussion.</td>
</tr>
<tr>
<td>Sulks</td>
<td>When perceived needs or desires are not met. Can become disruptive to learning.</td>
<td>Cue to express disappointment and for alternatives to meet perceived needs and desires. Encourage trial of appropriate ones.</td>
</tr>
<tr>
<td>Self-injurious behavior</td>
<td>Behavior that will injure self (e.g., eating or drinking too much, biting self, hitting head).</td>
<td>Cue behavior is unacceptable; redirect to obtain attention in a positive way. Give attention when asked for in a positive way. If cannot understand, simply redirect.</td>
</tr>
<tr>
<td>Inappropriate expression of anger</td>
<td>Through physical means, abusive language or other abusive methods.</td>
<td>Before need, ask for 2 - 4 ways to express anger appropriately, how composes self when angry. Cue use of calming strategies; give responsibility for self-composure. Cue use of alternative appropriate means to express anger. Give responsibility for solving issue. Cue for solution alternatives and encourage trial of appropriate ones.</td>
</tr>
<tr>
<td>Outbursts</td>
<td>Usually angry; can be either verbal or physical. May not be about current topic.</td>
<td>Before need, ask how composes self during an outburst. Give a composure time-out. Cue use of calming strategies already discussed; give responsibility for self-composure. If necessary, end activity for day. Give forced choice as to how to spend rest of supervised day without rewarding for outburst. Cue to recognize when outburst is &quot;coming on&quot; and cue to take a voluntary calming time-out before outburst. If needed, call for help. Never attempt to physically restrain.</td>
</tr>
<tr>
<td>Condition</td>
<td>Definition</td>
<td>Suggestions</td>
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</tr>
<tr>
<td>Intimidates others</td>
<td>Tries to gain favor, power, possessions through intimidating others.</td>
<td>Cue behavior is unacceptable. Give composure time-out. Be concrete, clear and concise about consequences of continuing behavior; be prepared to carry out consequences.</td>
</tr>
<tr>
<td>Easily intimidated</td>
<td>Can be talked into giving up items, often bullied, does not stand up for his/her own rights as a human.</td>
<td>Encourage giving appropriate answers when being requested to do inappropriate things (e.g., say no when asked to give lunch to someone else). Be supportive; give responsibility for chosen responses.</td>
</tr>
<tr>
<td>Sexual inappropriateness</td>
<td>Physical or verbal.</td>
<td>Cue behavior is unacceptable. Give composure time-out. Be concrete, clear and concise about consequences of continuing behavior; be prepared to carry out consequences. If unable to understand, redirect attention.</td>
</tr>
<tr>
<td>Verbal response to internal stimuli</td>
<td>Talks to his/her voices or visions.</td>
<td>Before need, ask how copes with hallucinations when become disruptive; ignore behavior unless disruptive, direct attention back to task; cue to use coping techniques.</td>
</tr>
</tbody>
</table>

**Behavior Management Suggestions**

Most people exhibit appropriate behavior. These suggestions can assist in working with anyone and can be especially helpful in managing inappropriate behaviors:

- You are the role model. Do not model behaviors you do not want copied.
- Be clear, concrete and concise about your expectations to the person and determine his/her expectations of you.
- Various behaviors may be an attempt to gain control. Allow the person as much control as possible; both of you will lose a power struggle.
- The person is responsible for his/her behavior. Self-responsibility is key. Our job is to cue people to maintain responsibility and appropriateness.
- Have, or assist, the person to identify alternative behaviors to meet needs s/he is attempting to meet with inappropriate behaviors. Encourage him/her to try out various alternatives and praise when they work.
- Give ample encouragement to participate and behave appropriately. All encouragement should be non-patronizing and respectful.
- Give ample praise for participation, appropriate behavior, success, etc. Again, praise should be non-patronizing and respectful.
- Have, or assist, the person to determine where s/he succeeded and encourage appropriate self-praise.
- Be consistent.
## Social Disabilities

<table>
<thead>
<tr>
<th>Condition</th>
<th>Definition</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support system</td>
<td>Participant's social/leisure support. May not be significant others.</td>
<td>Encourage support people to review, participate, etc. Knowledge of system assists in conversation.</td>
</tr>
<tr>
<td>Avoids interaction</td>
<td>With volunteer and others. Can be disruptive to learning.</td>
<td>Begin interaction slowly. Allow as much control as possible of interaction level.</td>
</tr>
<tr>
<td>No response to questions or conversation</td>
<td>Can affect safety issues.</td>
<td>Give time for response. Do not assume answer. If does not affect safety, continue conversing allowing one-word answers, move toward more complex answers. If does affect safety, continue to ask or rephrase. If necessary, explain what will occur (e.g., “you do not answer if you are cold so we will go in to let you get warm”).</td>
</tr>
<tr>
<td>Inappropriate conversation</td>
<td>Gives inappropriate answers, switches topics suddenly.</td>
<td>Redirect to topic/question. Give forced choice.</td>
</tr>
<tr>
<td>Interrupts conversation</td>
<td>Can be disruptive to learning or others, affect safety.</td>
<td>Cue that others are talking, wait turn. If not disruptive, ignore. If so, keep cueing.</td>
</tr>
<tr>
<td>Dominates conversation</td>
<td>Does not allow others to talk, answer questions.</td>
<td>Allow to have his/her say for set time then interrupt to allow others (or yourself) to speak. Have those involved to do roundtable conversation - each gets his/her say for set time, in turn.</td>
</tr>
<tr>
<td>Intrusive staring</td>
<td>Stares at others even after they become uncomfortable.</td>
<td>Cue to look elsewhere or distract.</td>
</tr>
<tr>
<td>No respect for personal boundaries</td>
<td>Stands too close, uncomfortable touch, etc.</td>
<td>Cue how/why behavior is inappropriate. Redirect. Cue to identify his/her personal boundaries and what makes him/her comfortable. Cue immediately each time needed and praise when complies without need for cueing.</td>
</tr>
<tr>
<td>Talks down to others</td>
<td>Treats others as inferior or uses speech/tone/body language beneath them.</td>
<td>Cue how/why behavior is inappropriate. Cue to identify positive things about others that show all are equals. Cue how could interact with others as equals.</td>
</tr>
</tbody>
</table>
### Chapter 3: Working with People with Disabilities

#### Condition | Definition | Suggestions
--- | --- | ---
Inappropriate phrases or conversation | Includes such things as sexist, racist and other such inappropriate comments. | In rare cases, the disability causes automatic inappropriate words or phrases; ignore. If not, cue comments are unacceptable; be factual, straightforward, concrete, clear and concise; include consequences of continuing behavior, be prepared to carry out consequences; if unable to understand, redirect attention; also see Emotional and Behavior Issues.

Panhandles | For money, food, cigarettes, other things. | Cue behavior is unacceptable. Be concrete, clear and concise about consequences of continuing behavior; be prepared to carry out consequences. If unable to understand, redirect attention.

Speaking of private matters in public way | Discussing toileting and other private things in a loud voice or to inappropriate people. | Redirect to speak quietly, cue to stop discussion with inappropriate people. If cannot understand, redirect attention.

Exhibit private behavior in public | Scratch genitals, pick nose, masturbate, etc. | Be factual and straightforward. Cue behavior is unacceptable. Redirect how to meet needs (e.g., use tissue to blow nose, go to restroom). When asks to be excused to meet private needs, praise and allow time. Be concrete, clear and concise about consequences of continuing behavior; be prepared to carry out consequences. If unable to understand, redirect attention.

### Medications

Many of our clients will be taking a variety of medications. Many medications have potential physical and/or mental side effects that you should know about. Be sure to consult your participant's medical history to determine if any medications may have side effects that can impact the student's performance.

Not every person experiences side effects in the same way. When possible, consult the participant or participant's caretaker for more information about whether the participant has side effects that can impact performance.

It is not necessary to memorize the details about medications, but you should be aware of the major kinds of medications and the possible effects that the medication can have on a participant's performance.

During the evaluation of your participant, find out about the participant’s medication schedule. You might need to remind your participant to take the medication. Never administer medication to a student!

Always watch your participant closely for possible medical conditions. If you are unsure whether your participant is OK, consult a lead volunteer immediately.
Chapter 3: Working with People with Disabilities

Analgesics
Purpose: To relieve pain
Side Effects: Respiratory depression, circulatory depression, nausea
Examples: Narcotics, Codeine, Demerol, Morphine

Antibacterials and Antibiotics
Purpose: To treat infections, such as urinary tract infections
Side Effects: Nausea, vomiting, dizziness, malaise, headaches, allergic reactions
Examples: Penicillan, Ampicillin, Amoxicillin, Bactrim, Tetracycline, Macrobid, Furdatin,

Anticholinergics
Purpose: To control bladder spasms
Side Effects: Dry mouth, blurred vision
Examples: Daricon, Ditropan, Cystospaz

Anticoagulants
Purpose: To prevent and treat blood clots
Side Effects: Bleeding and bruising
Examples: Heprin, Coumadin

Anticonvulsants
Purpose: To prevent seizures, commonly used after serious head injury.
Side Effects: Slurred speech, mental confusion, dizziness, insomnia, headache, nausea, vomiting, decreased coordination, drowsiness/lethargy
Examples: Dilantin, Pheobarbitol

Antidepressants
Purpose: To control depression
Side Effects: Drowsiness, confusion, blurred vision
Examples: Elavil, Prozac, Zoloft

Antiemetics
Purpose: To control nausea and vomiting
Side Effects: Drowsiness, dizziness, dry mouth, blurred vision, tremors
Examples: Compazine, Phenergan, Vistaril

Antispasmodic Medications
Purpose: To control muscle spasticity
Side Effects: Drowsiness, lethargy, fatigue
Chapter 3: Working with People with Disabilities

Examples: Balcofin, Dantrium, Valium

**Hypertensive Medications**

Purpose: To reduce high blood pressure

Side Effects: Dry mouth, weakness, lethargy, drowsiness, muscle cramps, hypotension, headache, nausea

Examples: Aldactazide, Apresoline

**Muscle Relaxants**

Purpose: To relax stiff or rigid muscles

Side Effects: Drowsiness, dry mouth, dizziness, fatigue, nausea, increased heart rate

Examples: Soma, Flexeril, Robaxin, Maolate

**Psycho-stimulants**

Purpose: To help with behavioral problems, to decrease hyperactivity and increase attention span, to treat narcolepsy to decrease seizures,

Side Effects: Loss of appetite, sleep problems, lethargy, depression, nausea, irritability, restlessness

Examples: Ritalin, Cylert, Dexedrine

**Sedatives**

Purpose: To control anxiety and agitation

Side Effects: Drowsiness, lethargy, dizziness, increased temperature and muscular rigidity

Examples: Benzodiazepine (Valium, Ativan, Xanax), Phenothiazine (Thorazine, Haldol)

Disability/Medical Information Glossary

- **Acquired Disability** — onset sometime after birth; examples include spinal cord injury and stroke; person often remembers what it was like before his/her disability.

- **Amelia** — Congenital total absence of the arms or legs due to a developmental defect.

- **Aphasia** — Condition involving difficulty understanding or producing any form of language. People with aphasia have trouble understanding and using words.

  When working with a person with aphasia, communication may be very difficult. Use gestures to accompany words. Use short, simple phrases. Speak in a normal tone. Be respectful, do not assume that aphasia is associated with a lack of intelligence.

- **Ataxia** — Shaky movement of the limbs.

- **Atrophy** — A condition in which the muscles diminish in size and strength due to a lack of use.

- **Braces** — Splints used to support, align, or hold parts of the body in a correct position, such as leg braces used by a person with spina bifida.

- **Cervical Spine** — Neck region of the spinal column and cord.

- **Cognitive** — Having to do with the brain and mental processing.

- **Condition** — State, generally does not worsen; therapy/treatment decreases impact, but does not “cure”; examples include spina bifida, cerebral palsy and intellectual disabilities. Some began as a disease and become a condition when arrested, such as post-polio.
• **Congenital Disability** — person is born with; examples include Down syndrome and Tay Sachs; person knows what it is like to function only with his/her level of ability and need for assistance or adaptation.

• **Decubitus Ulcer (DECUB)** — sore caused by lack of blood circulation due to pressure or vascular disease; often occurs over a bony area; may or may not be open.

• **Diplegia** — partial or complete paralysis involving two (2) extremities, usually the legs.

• **Disability** — Per Americans with Disabilities Act, “a physical or mental impairment substantially limiting one or more major life activities” such as personal care, leisure, or work.

• **Disarticulation** — A separation of two bones at a joint. May be the result of injury or surgically removed during amputation.

• **Disease** — progressive, if not cured, generally becomes worse with time; usually results in the person becoming increasingly disabled; examples include diabetes, multiple sclerosis and muscular dystrophy.

• **Extension** — straightening

• **Flaccid** — Involving lack of muscle tone, loose muscle tone.

• **Flexion** — bending

• **Gait** — Description of how a person walks.

• **Hemiplegia** — Partial or complete paralysis involving one side of the body. The person’s arm and/or leg may be paralyzed or weakened. There may also be paralysis or weakness of the facial muscles.

• **Hydrocephalus** — An abnormal increase in the amount of cerebrospinal fluid within the brain. In childhood, before the sutures of the skull have fused, hydrocephalus makes the head enlarge. In adults, hydrocephalus raises the intracranial pressure. A shunt is usually required to drain the fluid from the head.

• **Hypoglycemia** — disease affecting production or use of insulin causing a decrease in blood sugar; can be a reaction when a person with diabetes uses too much insulin or engages in excessive activity for the amount of food eaten.

• **Hypoxia** — An injury to the brain caused by the lack of oxygen to the brain. Causes damage to a specific area of the brain.

• **Incontinence** — Decreased control of bladder or bowel.

• **Lability** — The tendency to shift moods quickly and unexpectedly, e.g., laughing one minute and crying the next for no apparent reason.

• **Learning Disability** — Characterized by decreased ability to learn through "standard" methods of instruction; examples include dyslexia and attention deficit disorder.

• **Lumbar Spine** — Mid- to lower-back portion of the spinal column and cord.

• **Medication** — therapeutic, usually prescribed, substance taken for various conditions and diseases; examples include Valium/diazepam (spasticity) and Coumadin (vascular disease).

• **Mental Illnesses** — conditions/diseases affecting reality perception and, therefore, behavior; examples include depression, anxiety, post-traumatic stress disorder, obsessive-compulsive disorder, schizophrenia, bipolar disorder and substance abuse.

• **Occupational Therapy** — The profession focusing on daily functional activity including grooming, dressing, toileting, housekeeping, finances, driving, time management, vocation and leisure; someone working in this profession is called an occupational therapist.

• **Paraplegic** — Involvement or paralysis in the legs only. Can be completely or incompletely paralyzed.

• **Phocomelia** — Congenital absence of the upper arm and/or upper leg, the hands or feet or both being attached to the trunk by a short stump.
• **Physical Disabilities** — Conditions or diseases that interfere with physical movement; examples include amputation, cerebral palsy, stroke, multiple sclerosis, post-polio, spina bifida, spinal cord injury, head/brain injury and muscular dystrophy.

• **Physical Therapy** — The profession focusing on physical functioning of body including functional mobility, transfers, strength, endurance, and range of motion; someone working in this profession is called a physical therapist.

• **Progressive Diseases** — A disease that continues to get worse, for example, muscular dystrophy.

• **Proprioception** — Awareness of location of the body in space.

• **Quadriplegic** — Involvement or paralysis in all four limbs (arms and legs). May be complete or partial paralysis.

• **Range Of Motion** — An arc of movement of the joint.

• **Recreation Therapy (Therapeutic Recreation)** — Profession focusing on functional activity required to participate in leisure and community activity including recreation activity, planning, problem solving, and social skills; someone working in this profession is called a recreation therapist or therapeutic recreation specialist.

• **Sacral Spine** — The lowest portion of the spinal column and cord.

• **Seizure** — A brief episode of disorderly electrical brain activity affecting the body’s normal functioning. A seizure produces changes in a person’s movements, behavior, or consciousness.

• **Sensation** — Pertaining to the senses, physical feelings of touch, sight, hearing, smell, taste, proprioception, temperature and pain.

• **Sensory Impairments** — Affecting the senses, usually sight or hearing; examples include visual impairment, blindness, hearing impairment, deafness and deaf-blind.

• **Shunt** — Device used to redirect the flow of liquids. The shunt is surgically implanted plastic tubing that redirects cerebrospinal fluid (CSF). People with brain injury or spina bifida often have shunts. Be very careful with a shunt so you do not block the flow of liquid. Participants with shunts are required to wear helmets.

• **Spasm** — A sudden, uncontrollable muscle contraction.

• **Spasticity** — Stiffness in the muscles making it difficult to get the muscles to relax. Excessive muscle tone-producing rigidity. (Note, spasticity is not a spasm.)

• **Splint** — Devices used to support or align body parts in appropriate position or to give the body part needed strength.

• **Stroke** — A Cerebral Vascular Accident (CVA) characterized by a sudden, usually severe impairment of body functions caused by a disruption in the supply of blood to the brain. May result in paralysis on one side (hemiparesis), speech difficulties, and/or mental impairments.

• **Teletype (TTY)** — Wired telephone connection allowing typed conversation; typically used by a person with a hearing impairment; was the precursor to today’s modems.

• **Thoracic Spine** — Chest and mid-back portion of the spinal column and cord.

• **Traumatic Brain Injury (TBI)** — A head or brain injury where damage to the brain is the result of a trauma to the head. Causes include motor vehicle accidents, bullet wounds, violent shaking, or any other blow or strike to the head.

### First Aid for Seizures

When encountering someone having a seizure, many people feel ill-equipped to handle the circumstance. They forget that they already have one essential tool within their possession - common sense. The following tips below are simple,
common-sense steps to take when responding to a person having a seizure. First-aid isn't complicated, but it involves a sequence of actions and considerations which are beyond the scope of epilepsy.

Many seizure types—such as generalized absence seizures or complex partial seizures, which involve relatively brief episodes of unresponsiveness—don't require any specific first-aid measures.

Stay calm
1. Prevent injury—during the seizure; exercise your common sense by insuring that there is nothing harmful within reach to the person if she struck it.
2. Pay attention to the length of the seizure.
3. Make the person as comfortable as possible.
4. Keep onlookers away.
5. Do not hold the person down—if the person having a seizure thrashes around, there is no need for you to restrain them. Remember to consider your safety as well.
6. Do not put anything in the person's mouth—contrary to popular belief; a person having a seizure is incapable of swallowing their tongue so you can breathe easy in the knowledge that you do not have to stick your fingers into the mouth of someone in this condition.
7. Do not give the person water, pills, or food until fully alert.
8. If the seizure continues for longer than five minutes, call 911.
9. Be sensitive and supportive, and ask others to do the same.

After the seizure, the person should be placed on her left side. Keep in mind there is a small risk of post-seizure vomiting, before the person is fully alert. Therefore, the person's head should be turned so that any vomit will drain out of the mouth without being inhaled. Stay with the person until she recovers (5 to 20 minutes).

NOTES: