

## Best Practices

### Sports and Disability: Enhanced Health, Self-Efficacy, and Social Inclusion Through Athletic Participation

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**Abstract:** Sports and recreational participation have demonstrated health and social benefits. However, persons with disabilities are typically not provided the same opportunities as people without disabilities. This article discusses the benefits of sports and recreation, and the barriers that have existed for persons with disabilities. The purpose is to demonstrate the need for rehabilitation counselors to consider the utility of physical activity as a way to enhance health, self-efficacy, and community inclusion. Recommendations are presented for rehabilitation counselor advocacy for improved participation in sport and recreational pursuits by persons with disabilities.

**Keywords:** disability, social inclusion, rehabilitation counseling

There are over one billion persons with disabilities around the globe (World Health Organization & World Bank, 2011) and an estimated 53 million in the United States (Center for Disease Control & Prevention, 2015). Disability has been a permanent part of human history, and the number of people with disabilities increases with the aging global population, as the result of congenital conditions, and accidents or injury causing physical limitations (Larkin, Alston, Middleton, & Wilson, 2003; Smart, 2016). However, it has been suggested that people with disabilities have never been allowed to be ordinary citizens, and represent a disenfranchised minority group (Smart, 2016). Negative attitudes towards people with disabilities persist (Wilson & Scior, 2014), and this may stem in part from the historical propensity to view people with disabilities from the Biomedical Model of disability, which focuses on the anatomy and physiology of a person. Alternative models of disability developed over time, with the recommendation of the World Health Organization's International Classification of Functioning (ICF) as an appropriate framework for quality of life measurement and assessment for rehabilitation professionals (Chan, Tarvydas, Blalock, Strauser, & Atkins, 2009; Fleming, Fairweather, & Leahy, 2012). The purpose of this article is to demonstrate the need for rehabilitation counselors to consider the utility of physical activity as a way to enhance health, self-efficacy, and community inclusion. In turn, enhancing these aspects may have a positive impact on overall quality of life.

Efforts to address the needs of people with disabilities has led to legislative protections and specific services designed to increase the quality of life of people with disabilities. Rehabilitation counselors are tasked with assisting people with disabilities in meeting

personal goals, securing employment, and addressing independent living needs (Commission on Rehabilitation Counselor Certification – CRCC, 2015). While facilitating employment has been the historical emphasis, recent research has suggested rehabilitation counselors should also attend to more subjective components of QOL (Fleming et al., 2013). Quality of life can be “explained as a combination of function, difficulty with work and daily living activities, community participation, and environmental support” (Fleming et al., 2013, p. 21).

Rehabilitation counselors have a long history of advocating for people with disabilities, particularly in those areas where there is a lack of opportunity and full participation. One area where people with disabilities have been excluded is sports and athletic recreation. People with disabilities generally show lower levels of participation in sports and athletic recreation than their peers (Anderson & Heyne, 2010; Kroll, Kehn, Ho, & Groah, 2007; Murphy & Carbone, 2008). While there are opportunities for sports participation (e.g., Paralympics, Special Olympics, adaptive sports), event participation with these organizations is based on the type of disability. The Special Olympics represents over 4 million participating athletes with intellectual disabilities hailing from over 169 countries (Special Olympics, 2016). When considered in light of the almost 200 million people with an intellectual disability (Special Olympics, 2016), this represents an extremely small portion of athletic participation by persons with intellectual disabilities. Participation rates of people with disabilities in athletics and recreational pursuits are influenced by a variety of factors, including poor concept of self (Scarpa, 2011), lack of support services (Foley, Harvey, Chun, & Kim, 2008), low self-efficacy (Dixon-Ibarra & Driver, 2013), and accessibility issues resulting from health and disability status (Burns & Graefe, 2007; Murphy & Carbone, 2008). Sports participation and increased physical activity is not a traditional service provided directly by a rehabilitation counselor. However, gym memberships can be included in a plan for employment as an appropriate service for some rehabilitation service recipients. Rehabilitation counselors have an obligation to attend to the personal, social, and psychological goals of people with disabilities (Rehabilitation Counseling Consortium, 2005), not just employment. Rehabilitation counselors can better meet this obligation by advocating for inclusive physical activity and sporting opportunities.

### **Health Benefits of Physical Activity for People with Disabilities**

The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2002). Previously, disability began where and when health ended; once persons were considered disabled, they were placed in a different health category (WHO, 2002). Thus, people with disabilities were often perceived as having ill or poor health and many definitions of “good” health center on the absence of pathology. This means that the presence of any “deformity” or “deficit” may result in the individual being considered unhealthy. Such views are based predominantly in the medical model of disability, where having a disability is viewed from a pathologizing, objectifying, and categorizing framework (Smart & Smart,

2006). When viewed from this model, people with disabilities are often perceived as having ill or poor health, which can lead to a host of negative social sanctions including social exclusion, being ostracized, and marginalized.

Regular physical activity enhances the health of people with disabilities, such as improved cardiovascular and muscle fitness, mental health, and increased ability to do daily tasks e.g., dressing, eating, hygiene (Dixon-Ibarra & Driver, 2013). Other benefits include the increase of muscle mass, increased range of motion, reduction of stress, increased self-efficacy, and increased confidence. Benefits can be further categorized into physical, mental, and emotional gains. Health benefits for people with disabilities can have a significant impact on how they view themselves. Streber, Peters, and Pfeifer, (2016) asserted that physical activity may diminish some physical limitations associated with the long-lasting effects of a disability or chronic illness. Physical activity over an extended period may reduce some symptomatology of chronic illness or disability, thus reducing the severity (Foley et al., 2008; Streber et al., 2016). However, many people with disabilities do not participate in regular physical activity (Anderson & Heyne, 2010; Kroll et al., 2007).

### **Social and Emotional Benefits of Physical Activity and Sports**

One reason for the lack of participation in physical exercise by individuals with disabilities is low self-efficacy (Dixon-Ibarra & Driver, 2013). Bandura (1977, 1997) defined self-efficacy as one's beliefs in their capabilities to execute an action to obtain a certain outcome. An individual with greater self-efficacy will pursue greater challenges and strive for higher goals. In contrast, an individual's self-efficacy may decrease if they experience negative psychological states such as pain, fatigue, and anxiety (Middleton, Tran, & Craig, 2007). Self-efficacy has been found to be an important factor influencing health for people with disabilities in diverse areas including improvement in rehabilitation after a stroke (Robinson-Smith, Johnston, & Allen, 2000), and stuttering cessation (Craig, 1998).

The construct of self-efficacy has been heavily employed in sports to understand how performance can be related to self-confidence. The Disabled Sports USA (DSUSA) program conducted a survey in 2009 with their member participants, the majority of whom are veterans with acquired physical disabilities. They found an overwhelming majority of DSUSA members felt physical activity significantly improved their QOL, and that physical activity helped them secure employment, be given greater responsibilities in the work setting, and provided opportunities for raises when compared to the general population of adults with disabilities (DSUSA, 2009). Thus, a reasonable solution to increase self-efficacy in the populace with a disability, is to participate and engage in sports, leisure, or recreation activities. These benefits include increased health and fitness, longer lifespan, greater mental and social well-being, increased self-esteem and socialization, and decreased stress (Kristen, Patriksson, & Fridlund, 2002; Kristen, Patriksson, & Fridlund, 2003; Martin, 2006). Sports can also be a gateway for providing social support (e.g., teammates, coaches, athletic staff) to

the disability community.

A social support system involves close individuals who provide emotional support and resources in times of need (Pines & Aronson, 1988; Wright & Fogler, 2017), and often this support system is comprised of the family, primary caregivers, and a few relationships with individuals without disabilities (Lippold & Burns, 2009). For individuals with disabilities, these networks are often smaller than individuals without disabilities. Sports can provide a responsive and supportive social environment, which can stimulate confidence and growth for people with disabilities. Participation in extracurricular, leisure and fitness based activities by college males has led to feelings of empowerment and enhanced perceptions of personal accomplishment and social inclusion (Blinde & Taub, 1999). Participation in these types of activities not only has benefits in the classroom, but across the individual's lifespan (Astin, 1999).

In recent years, general physical education (GPE) programs in the United States have incorporated disability sports to their physical education curriculum (Davis, Rocco-Dillon, & Grenier, 2012; Grenier & Kearns, 2012). Sports such as wheelchair basketball and sitting volleyball can provide unique skills for able bodied students as well as deliver an influential message regarding how difficult it can be for an athlete with a disability. Grenier and Kearns (2012) implemented a disability sport program for a southern New England school, which enrolls 400 students from kindergarten through the fifth grade. The authors sought to first educate these students on the Paralympic Games, and to also understand how participation in a disability sport could alter students' perceptions of classmates with disabilities. Four disability sports were introduced to the students over a five-week period: wheelchair basketball, goalball, sitting volleyball, and sledge hockey. Students were asked to report what they learned and how they felt about playing the sport at the conclusion of the activity. The results found that including a disability sport in GPE programs may be a plausible avenue for reducing the stigma linked with having a disability (Krahe & Altwasser, 2006). This example provides a model for more schools within the United States to incorporate inclusive physical education programs. However, the careful planning, appropriate design and implementation of the such disability simulations is imperative (Burgstahler & Doe, 2004). While simulation exercises have the ability to engage learners and foster discourse about people with disabilities (French, 1994; Kiger, 1992), unintentional and long lasting negative attitudes towards people with disabilities have resulted from simulation exercises (Burgstahler & Doe, 2004).

### **Sport as a Model of Social Inclusion**

Social inclusion has been defined as “societal acceptance of people with disabilities within school, work, and community settings” (Walker et al., 2011, p. 15). Social inclusion is impacted by subjective societal attitudes towards people with disabilities (Simplican, Leader, Kosciulek, & Leahy 2015) and is a key element in the overall well-being of people with disabilities (Buntinx & Schalack, 2010; Simplican, et al., 2015). Social inclusion is also a

primary element and focus of the United Nations Convention on the Rights of Persons with Disabilities (Quinn & Doyle, 2012; Simplican, et al., 2015). Other pieces of legislation here in the United States have also sought to increase community access and community involvement of people with disabilities by removing socially constructed barriers to integration (e.g., Public Law No: 93-112, the Rehabilitation Act Amendments of 1973 [P.L. 93-112], Americans with Disabilities Act of 1990 [P.L. 101-336]). Yet, social isolation or social exclusion remains a pervasive issue for individuals with intellectual and developmental disabilities (Bigby, 2008; Forrester-Jones et al., 2006; Milner & Kelly, 2009; Robertson et al., 2001; Simplican, et al., 2015).

The United States is a sporting-crazed nation (Abdel-Shehid, 2002). This love affair with sports positions athletes to take on important cultural, social, and political roles and has provided opportunities for sporting figures to transcend boundaries and push for social inclusion through the promotion and creation of equal-status relationships (Davis et al., 2012). Jackie Robinson was the first man of color to play professional baseball in the modern major leagues, breaking the culture barrier by introducing racial integration of sports into American society (Mann, 1951). Jesse Owens, another prominent athlete of color for the United States, triumphed in Hitler's Berlin, winning multiple gold medals in the 1936 Olympic Games (Frost, 2014). Drawing from both national and international fame, profound charisma and dedication to faith, Muhammad Ali protested a variety of established laws and systematic repression of African-Americans (Abdel-Shehid, 2002). More recently, former President Barack Obama and Raul Castro used baseball to break down the barriers of the past relationship between the United States and Cuba, with President Obama suggesting, it was "sports that can bring the American and Cuban people closer together" (Korte, 2016). These examples demonstrate how sports and athletes can transcend social boundaries and help foster social change, providing a model for people with disabilities.

People with disabilities have sought access to sports based on the perception that sports can serve as an equalizer, and a means for gaining acceptance (Devine, 2013; DePauw & Gavron, 1995). Several professional athletes with disabilities have become successful in the mainstream world of sports. Kickboxer and amputee, Baxter Humby remains the only kickboxer to ever win a world title with one hand. James Abbot played major league baseball for ten years despite being born without a right hand. Humby, Abbot and other athletes with disabilities have opened doors for marginalized groups by increasing the awareness of athletes with disabilities. Increased awareness has helped to establish accessible sporting facilities and organized sport programs for people with disabilities (DePauw & Gavron, 1995). In addition to sports participation, physical activity has been found to reduce the marginalization of people with disabilities (DePauw & Gavron, 1995).

Physical activity assists in improving inclusion for people with disabilities by altering the societal stigmas about people with disabilities and shifting internal perceptions of how people with disabilities feel about themselves (United Nations, n.d.). Emotional and psychological benefits, social benefits, and community and societal benefits have all been



suggested as outcomes of people with disabilities pursuing and engaging in physical activity (Anderson & Heyne, 2010). There is something about physical activity, and sport in particular, that has provided a platform for individuals seeking greater social inclusion and social justice.

### **Barriers to Participation**

Research has found that people with disabilities are less physically active compared to the general population (Heath & Fentem, 1997). Inactive lifestyles of people with disabilities often contribute and lead to higher risks of mortality, as well as various chronic diseases such as coronary artery disease, diabetes, colon cancer, and osteoporosis. Participation in sports may improve the lifestyles of people with disabilities and increase their physical activity. A physically active lifestyle, including sport participation could also have a positive effect on the risk of coronary artery disease, diabetes mellitus type 2, high blood pressure, obesity, depression, diminished self-concept, and dependence upon others (Durstine et al., 2000). Participation in sport related physical activities (e.g., swimming, fitness exercises) have been found to keep people with disabilities fairly active during treatment (van der Ploeg van der Beek, van der Woude, & van Mechelen, 2004). People tend to become physically inactive after their rehabilitation period due to rehabilitation centers not providing enough effort to keep former patients active (van der Ploeg et al., 2004). There is a desperate need to provide recommendations to assist people with disabilities on how to self-initiate daily physical activities outside of rehabilitation treatment, such as an involvement with sports.

While the arguments for physical activity and participation in sports increasing individual health, self-efficacy, and social inclusion are compelling, there is another aspect to this relationship. For some individuals, having a disability negatively impacts their sense of self (Toombs, 1994). Research has found that people with disabilities may have lower self-efficacy due to internal or external barriers. Internal barriers involve different types of pain or fatigue, inadequate physical functioning, psychological uncertainty, and susceptibility to psychological grief. External barriers relate to attitudes of society (e.g., stereotyping) and environmental obstacles, such as poor building designs (e.g., steps and no ramp, Barlow & Harrison, 1996). Personal factors, such as personality, social support networks, and age of disability onset may exacerbate or reduce the impact of barriers experienced on an individual (Blake & Rust, 2002). When combined, such barriers lead to participation rates of people with disabilities in regular exercise or sporting pursuits as low as seven percent (Lohrey, 2015).

Individuals with physical disabilities reported the main reasons for the lack of physical activity were: environmental barriers, insufficient social support, pain, physical limitations and negative beliefs about exercise benefits (Aguiar et al., 2017; Dixon-Ibarra & Driver, 2013; Nosek et al., 2006). Kerstin, Gabriele, and Richard (2006) examined self-efficacy for individuals with spinal cord injuries. They found that previous performance accomplishments increased self-efficacy, due in part to a recall of past positive physical activity experiences. Understanding the different antecedents of efficacy (e.g., vicarious experiences, past

performances) will assist practitioners in establishing a framework for increasing self-efficacy.

Waring and Mason (2010) found that in order to encourage participation in sports by typically underrepresented groups (e.g., women, ethnic minorities, individuals with disabilities), a targeted outreach, focusing on these specific populations is necessary. While the idyllic and aspirational line from *Field of Dreams* (Frankish & Robinson, 1989) positively suggests, “If you build it, they will come,” reality is far different. Encouraging marginalized groups to participate fully in sports requires the recognition of and targeted efforts to overcome environmental and social barriers that might otherwise limit participation. Targeted efforts can range from being inclusive in recruiting efforts (e.g., targeting all marginalized groups) to ensuring that the facility is welcoming to people with disabilities. In the United Kingdom, Waring and Mason (2010) specifically noted adapting sport and recreational facilities to meet the needs of people with disabilities prior to the facility opening their doors to the public is one way to promote inclusion. People with disabilities felt the four-court sports hall, the changing facilities, and the fitness studio had been designed with them in mind, and accommodations or adaptations were not an afterthought. Over a relatively short amount of time, the overall percentage of patrons with disabilities raised to 29% of the facility membership. This approach to fostering inclusion demonstrates the need for considerable effort to attract targeted individuals and to overcome existing and significant barriers to inclusion. This approach also requires dedicated human resources collaborating with agencies possessing the experience and knowledge of working with marginalized groups.

### Exclusion

There have been many calls for inclusive approaches to foster greater participation rates of individuals with disabilities in sporting programs (Anderson, Wozencroft, & Bedini, 2008; United Nations, 2007). The need for advocacy and inclusion arises out of a reality rife with exclusion. Table 1 outlines four types of social inclusion/exclusion as suggested by Bailey (2005).

**Table 1. Types of Inclusion/Exclusion**

|                   |                                                                                         |
|-------------------|-----------------------------------------------------------------------------------------|
| <i>Spatial</i>    | Social inclusion relates to proximity and the closing of social and economic distances. |
| <i>Relational</i> | Social inclusion is defined in terms of a sense of belonging and acceptance.            |
| <i>Functional</i> | Social inclusion relates to the enhancement of knowledge, skills, and understanding.    |
| <i>Power</i>      | Social inclusion assumes a change in the locus of control.                              |

Bailey (2005). Used with permission (R. Bailey, personal communication June 2, 2017).

While exclusion can take many forms, exclusion is essentially present when an individual or group experiences a lack of access to power, knowledge, services, facilities, choice, and opportunity (Bailey, 2005). Historical aspects of social inclusion have focused primarily on poverty and ways to raise income levels of deprived citizens; more contemporary definitions focus on enabling and empowering individuals to fully participate in society and improve life opportunities through enhanced social experiences (Waring & Mason, 2010). In addition to the many health benefits previously outlined, sport is generally recognized as one medium for providing social activities where a range of social experiences occur and participants develop a variety of life skills (United Nations, 2007; Waring & Mason, 2010). Sport also offers a unique way of addressing Relational Exclusion and Power Exclusion by shifting the decision to participate more fully to the individual with a disability (increasing their power) and fostering social relationships (increased sense of belonging and acceptance).

### **Improving Participation by Increasing Contact and Information**

There is place for inclusion and participation for people with disabilities in athletics. “Individual and group-based benefits from social inclusion hinge upon broader changes in the attitudes and behaviors of society” (Simplican et al., 2015, p. 22). In discussing societal rehabilitation, or efforts to reduce the general public’s prejudicial attitudes towards people with disabilities, Anthony (1972) suggested a two-part process: contact and information. Contact with people with disabilities, moderated with information about the individual and their specific disability type was essential in order to foster a favorable impact on persons without disabilities and change attitudes and beliefs. Abbott and McConkey (2006) found providing the community with information on the individual and their disability was one component of overcoming social exclusion. Research has shown contact with people with disabilities to have a positive effect on societal attitudes, thus increasing social inclusion can lead to decreased levels of negative attitudes in society (Sharma, Forlin, Loreman, & Earle, 2006). However, mere contact with people with disabilities does not always lead to an increase in positive societal attitudes about people with disabilities (Alghazho, Dodeen, & Algaryouti, 2003). The effectiveness of the contact with people with disabilities in positively impacting social inclusion hinged on the quality of contact (McManus, Feyes, & Saucier, 2011), and contact alone, where information about the individual on a personal level or knowledge about the disability is not increased, can serve to reinforce negative stereotypes (Siperstein, Norins, & Mahler, 2007).

### **Recommendations for Rehabilitation Practitioners**

Given the findings by the DSUSA (2009) relative to athletic participation, work related gains, and QOL in general, rehabilitation counselors may better assist the individuals they work with by helping them seek out and participate in athletic and recreation based pursuits. While employment is definitely an ideal aspiration and can be measured objectively, employment by itself is not a complete indicator of social inclusion and overall QOL. The



International Classification of Functioning, Disability, and Health (ICF) has been recommended as a model for service provision appropriate to rehabilitation counseling (Chan et al., 2009), and the ICF’s attenuation to the subjective components of health and wellness will help rehabilitation counselors in all settings attend to their ethical obligations of respecting human rights and dignity, acting to alleviate personal distress and suffering, and advocating for the fair and adequate provision of all services (CRCC, Preamble, 2017). This requires the consideration of subjective measures of QOL, of which physical activity is one.

Further, while the participation in a sporting team or event helps to foster social relationships and is supported through legislation, institutional barriers, environmental barriers and social barriers exist and limit participation in sports for people with disabilities. By attending to this lack of inclusion, rehabilitation counselors, administrators, and educators adhere to their ethical obligation of advocacy. Section C.1.a of the Code of Professional Ethics for Rehabilitation Counselors states, “In direct service with clients, rehabilitation counselors address attitudinal barriers, including stereotyping and discrimination, toward individuals with disabilities. They increase their own awareness and sensitivity to individual with disabilities” (CRCC, 2017, p. 10).

Many counselors must document a comprehensive needs and skill assessment. This assessment is meant to justify how the rehabilitation plan addresses the needs of the individual being served. Comprehensive needs assessments often focus primarily on vocational match to the individual’s skill set. These assessments could be expanded to holistically address the needs of the individual by using the CBR-Matrix (depicted in Table 2) as a way to develop plans for employment that address social, recreational, and vocational needs of the client (United Nations International Children’s Education Fund – UNICEF, 2013).

**Table 2. WHO Community-Based Rehabilitation (CBR) Matrix**

| CBR Matrix     |                    |                    |                                 |                            |
|----------------|--------------------|--------------------|---------------------------------|----------------------------|
| <i>Health</i>  | <i>Education</i>   | <i>Livelihood</i>  | <i>Social</i>                   | <i>Empowerment</i>         |
| Promotion      | Early Childhood    | Skills Development | Personal Assistance             | Advocacy and Communication |
| Prevention     | Primary            | Self-Employment    | Relationships Marriage & Family | Community Mobilization     |
| Medical Care   | Secondary & Higher | Wage Employment    | Culture & Arts                  | Political Participation    |
| Rehabilitation | Non-Formal         | Financial Services | Recreation, Leisure & Sports    | Self-Help Groups           |

|                      |                      |                      |         |                                 |
|----------------------|----------------------|----------------------|---------|---------------------------------|
| Assistive<br>Devices | Lifelong<br>Learning | Social<br>Protection | Justice | Recreation, Leisure &<br>Sports |
|----------------------|----------------------|----------------------|---------|---------------------------------|

Source: United Nations International Children's Education Fund (2013). Used with permission (World Health Organization, personal communication, June 23, 2017)

The CBR-Matrix was originally designed for countries serving people with disabilities with little or no rehabilitation service infrastructure. However, it is an ideal framework for use by rehabilitation professionals everywhere as it emphasises the empowerment and inclusion of people with disabilities in decision-making across all activities of daily living, and was designed based on an ultimate goal of reducing poverty.

To help encourage physical activity in people with disabilities outside of rehabilitative settings, expansion of adaptive sporting leagues should be considered (e.g., wheelchair basketball, cycling, racing). Participation in these physically adaptive programs may foster social inclusion and even promote a sense of empowerment due to being around individuals who also have some sort of disability. DSUSA is an example of an adaptive sports program that assists over 60,000 youth and adults with disabilities. Involvement with their program assists participants with developing independence, confidence, and fitness. This program provides over 30 sports throughout 100 community chapters in 37 different states nationwide. Research has found that it is possible to obtain a long-lasting improvement in physical activity participation by using physical activity promotion programs, with tailored counseling sessions (van der Ploeg et al., 2004).

### Future Research

Research into the link between participation in sports and employment outcomes for people with disabilities will provide insight into how success in one area of the WHO's Community Rehabilitation Matrix might overlap into success in other areas. The WHO suggests the domains are interrelated and the overall health of an individual is benefited when all domains and areas within the domains are addressed. Attending to the sports, leisure, and recreation area of the Social and Empowerment domains would in theory have a positive impact on the Livelihood domain and its areas focusing on employment. Such an approach will begin to better attend to the objective and subjective domains of overall QOL as outlined by the ICF. Qualitative research could examine this relationship more closely and gain insight into the participants' perceptions on the impact of increased participation in athletics, recreation, and leisure on satisfaction and improvement in vocational pursuits. In order to increase effectiveness of practice and strengthen inclusion and overall advocacy of people with disabilities in sports and recreational activities, future research should:

- Help to build a framework of evidence-based practice linking subjective and objective measures of QOL.

- Offer insight into the direct impact of sports and recreational activities on vocational pursuits.
- And serve as a reference for rehabilitation counselors to utilize in the development of comprehensive needs assessments and corresponding plans for employment.

Future research may also involve surveying athletes with disabilities in established programs (e.g., Paralympics, Special Olympics, World Dwarf Games) to better understand how sport participation can foster social inclusion. Qualitative and quantitative research could examine what participation in sporting events has done for improving self-efficacy and confidence in these athletes, as well as perceived contributions to their overall QOL. The relationship between sport participation, self-efficacy, and employment may also be explored. Such research will further build the evidence based rationale for rehabilitation counselors to more closely examine the utility of sporting participation in service delivery, particularly in relationship to building social networks and social support for people with disabilities. Additionally, qualitative research might examine volunteers with these associations to better understand concepts related to social inclusion, motivation to volunteer, and societal benefits from the volunteers' perspectives.

### Summary

As the late Nelson Mandela stated in his speech for the World Refugee Day in 2006, "Sport speaks to people in a language they can understand" (Curatolo, 2014). Sports have been a great avenue for creating an environment that provides opportunities for all human beings regardless of race, religion, age, physical ability or economic background (Curatolo, 2014). For individuals who are vulnerable, sports can serve as a positive alternative place to go and feel physically or emotionally safe (Curatolo, 2014). In the late 1800s, Sweden used gymnastics as a means of therapy for people with disabilities (Sherrill, 2004). Since this time, there have been more than 17 high-profile international games for people with disabilities that have assisted in fostering social inclusion, including the Deaflympics (for athletes with hearing impairments) the Paralympics (for athletes with physical disabilities), and the Special Olympics (for athletes with intellectual/developmental disabilities; DePauw & Gavron, 2005). These Olympic games are motivating and empowering, and the participating athletes represent a diverse array of disability types.

While opportunities for athletic participation and recreation have been provided, they are often centered in exclusionary principles. These policies and recreational guidelines are typically constructed by well-intended, able-bodied individuals, who often possess a limited understanding of how to accommodate, and occasionally have no intent of including people with disabilities on any level (likely stemming from misunderstanding of disability and unconscious discrimination). Seeking to remove those environmental and social barriers that presently impede the full inclusion of people with disabilities will help increase overall health, levels of self-efficacy, and community inclusion of people with disabilities. Enhancing these aspects may have a positive impact on the overall QOL and sense of community not just

people with disabilities but people without disabilities as well.

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