

CORRELATING OBSERVED HELPLESSNESS OF ADULTS  
WITH PHYSICAL DISABILITIES TO THEIR  
PERCEIVED FREEDOM IN LEISURE

By

NANCY ATWATER REESE  
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Bachelor of Science

The University of Tulsa

Tulsa, Oklahoma

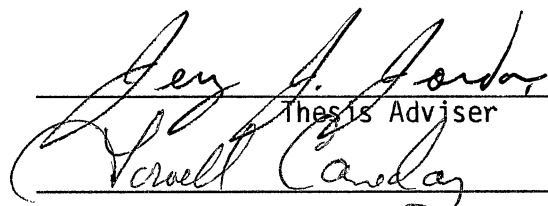
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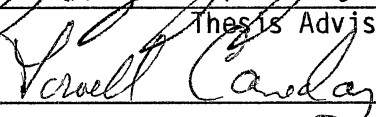
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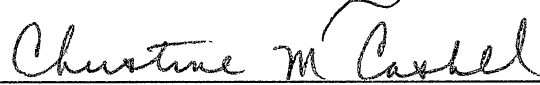
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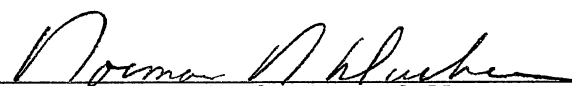
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Thesis Approved:

  
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Thesis Adviser

  
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Dean of the Graduate College

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## CHAPTER I

### INTRODUCTION

With the passage of the Americans With Disabilities Act on July 26, 1990, there is increasing pressure to integrate persons with disabilities into community settings. The field of therapeutic recreation has been developing techniques for remediation through leisure for persons with disabilities for many years. There are three traditional views of leisure that have evolved which address the nature of leisure itself: time, activity, and state of mind. Each view of leisure presents different problems in remediating or overcoming what may be achieved in leisure and the resulting impact on the person with a disability to successfully integrate into the community.

The time view sees leisure as nonwork time (Brightbill, 1960). The purpose of leisure in this sense is to prepare oneself to return to work refreshed and ready to work productively. Approximately 66% of persons with disabilities are unemployed (Harris and Associates, 1986), and for those persons who do not work this view of leisure is obviously problematic. Our society views much of what to do in free time as a reward for work. If one does not work, how is leisure to be justified? This belief has led to a view held by society (and often the person with the disability) that much of what they do is somehow useless, unearned, and of no purpose or value.



The activity view defines leisure as

. . . activity, apart from obligations of work, family, and society, to which the individual turns at will, for either relaxation, diversion, or broadening his knowledge and his spontaneous social participation (Dumazedier, 1967, p. 16).

It is difficult to agree on what activities should be viewed as leisure.

It is easier to agree that no activity is always leisure (Kelly, 1990).

For persons with disabilities, there are often architectural, attitudinal, or personal barriers which hinder participation in normal activities that measure up to standards of success based on "normal" criteria. Thus, the activity view of leisure tends to reinforce a perception of the disabled as unable and out of the normal range of participation in community programs.

The emergence of the state of mind view has provided a conceptual framework for understanding leisure experiences of persons with disabilities and for addressing barriers to community integration. deGrazia (1964, p. 5) developed one of the best known contemporary definitions when he described leisure as ". . . a state of being, a condition of man, which few desire and fewer achieve." It is not the activity or the time that is as important as the subjective perception of the individual about their experience that is ultimately related to satisfaction or well-being.

Neulinger (1981) developed a more attitudinal approach to leisure through the measurement of perceptions of individuals. Most simply, leisure is the perception of free choice for the sake of doing or experiencing. The choice is made for reasons intrinsic to the activity rather than as a means to an end (Neulinger, 1981). Neulinger and other leisure researchers such as Iso-Ahola (1980) and Mannell (1980) have gone so far as to specify certain conditions that are necessary for an individual to

view a particular experience as leisure. Leisure may be seen as a means to self-actualize. Through leisure experiences challenges are met. These leisure experiences feature a sense of freedom, intrinsic motivation, and mastery and competence--experiences that lead people toward feelings of self-efficacy, empowerment, pleasure, and enjoyment.

A unique virtue of recreation and leisure is that they are components of life free from external constraint. People are in control while experiencing recreation and leisure. There are perhaps no other parts of our lives where we, as human beings, are allowed more self-determination. During recreation and leisure we can "be ourselves." We are allowed to be human with all our imperfections and frailties. The caring, accepting attitude the therapeutic recreation specialist assumes in creating a free and nonthreatening recreation/leisure environment allows for positive interpersonal relationships as well as for opportunities for accomplishment (Austin, 1987). Additionally, Austin (1982, p. 57) asked, "In what better atmosphere than that achieved in recreation and leisure could growth be fostered and problems met?"

In essence, there seems to be a necessity to change emphasis from activities to experiences, and in particular, to the meaning of experiences to the individual. With this view, the aim of interaction with the client must be the facilitation of the client's perceptions of freedom rather than participation. This comprehensive approach to leisure is useful because it emphasizes the meaning of the involvement to the client and the interrelated roles of environmental planning, leadership, and programming in maximizing the client's perceptions of freedom as opposed to simply maximizing client participation (Witt, Ellis, and Niles, 1984).

Perceiving that choices are available and being able to choose between available choices is basic to the concept of freedom. Part of the

problem faced by many persons with disabilities is the perception that there are few things to do and few people to do them with, and the ability is lacking to do what is available (Witt, Ellis, and Niles, 1984). This perception often results in an observed level of helplessness by the professional in therapeutic recreation. This study adds to the research which explores the correlation between perceived freedom and observed levels of helplessness in adults with physical disabilities in a community-based recreation setting.

#### Statement of the Problem

The focus of this study was to correlate the levels of observed helplessness to levels of perceived freedom to add to the research related to the application of the state of mind approach in the field of leisure services, and specifically, in community-based therapeutic recreation services for persons with physical disabilities. The application of the state of mind view of leisure to the delivery of services may influence the ability of persons with disabilities to more successfully integrate into the community.

#### Purpose of the Study

The purpose of this study was to compare observed helplessness of adults with physical disabilities to their perceived freedom in leisure in a community-based therapeutic recreation setting. For the purposes of this study, the concept of leisure in the subjective or state of mind view is inherent in the discussion. By viewing leisure from a state of mind perspective, an individual could have the requisite skills to participate but still view him/herself as unable to fully enjoy and derive optimal benefits from leisure. While skills are important for

participating in an activity, there seems to be unexplored avenues for developing assessment approaches and associated remediation strategies when dealing with self-definitions of success, competence, and ability as opposed to objectively rated skills based on externally judged standards.

### Hypothesis

The following hypothesis was developed to guide the study:

There is no correlation between clients' observed level of helplessness and level of perceived freedom in leisure.

### Basic Assumptions

This study was based on the assumption that subjects voluntarily participated and responded honestly to the instrument used to measure perceived freedom in leisure. Additionally, it was assumed that there would be constant evaluation by the intake specialist who measured observed levels of helplessness.

It was further assumed that the Leisure Diagnostic Battery Short Form is a reliable and valid instrument used to measure perceived freedom (Ellis and Witt, 1984). Additionally, it was assumed that the Brief Leisure Rating Scale is a reliable and valid instrument used to measure observed helplessness in other populations (Ellis and Niles, 1985).

It was also assumed that the 64 subjects who participated in this study were representative of a larger population of over 400 clients at The Center for the Physically Limited.

### Delimitations

This study was delimited to adults with physical disabilities who voluntarily participate in community-based therapeutic recreation

programs at The Center for the Physically Limited in Tulsa, Oklahoma. Sixty-four clients were included in this study.

### Definition of Terms

For the purposes of this study, terms which were important for its understanding are defined as follows:

Adults With Physical Disabilities--Individuals 18 years of age and older, who have some form of significant physical impairment that limits their participation in various experiences, including recreation (Kraus, 1983). For purposes of this study, subjects were required to have a physician's certification of a significant physically disabling condition qualifying the individual for participation at The Center for the Physically Limited. Participants are also screened for appropriate mental and social levels of functioning.

Attribution--The everyday process of interpreting social events, including perceptions of the characteristics of other persons and explanations of their behavior. The explanation of causes of behavior includes external (conditions of the environment) and internal (nature of the person) factors (Kelly, 1990).

Community-Based Recreation--A setting for recreation programs for individuals who live at home or in other than institutional or clinical settings.

Helplessness--A psychological state that frequently results when events or behaviors are perceived as uncontrollable (Seligman, 1975).

Leisure--From the Latin, "licere," meaning "to be free" (Webster, 1986, p. 1242), a ". . . state of being, a condition of man, which few desire and fewer achieve" (deGrazia, 1964, p. 5), or a paradigm that includes three dimensions: perceived freedom, intrinsic motivation, and

noninstrumentality. Most simply, leisure is the perception of free choice for the sake of doing or experiencing. The elements are choice and motivation (Neulinger, 1981).

Levels of Functioning--Levels of observed control ranging from one (the lowest) to five (the highest) that differentiate individuals with physical disabilities and allow them to exhibit control through decision-making, accepting responsibility for decisions, commitment, internal motivation, and willingness to work with others in a group setting. The level of functioning is not a reflection of the degree of impairment, but to the observed level of control by the individual (see Appendix A).

Perceived Freedom--The feelings of control over one's own behavior which includes the concepts of locus of control and intrinsic motivation (Iso-Ahola, 1976).

Therapeutic Recreation--A process which utilizes recreation services for the purposive intervention in some physical, emotional, and/or social behavior to bring about desired change in that behavior and to promote the growth and development of the individual (Frye and Peters, 1972).

## CHAPTER II

### REVIEW OF LITERATURE

The purpose of this chapter was to review the literature concerning continuum models of leisure services, the application of attribution theory to leisure services, the concepts of helplessness and perceived freedom, and community-based therapeutic recreation services for persons with physical disabilities.

As previously stated, the state of mind approach can be used to better understand leisure functioning. The term "leisure functioning" describes how individuals feel about their leisure experiences and what kinds of outcomes result from these experiences. Certain conditions differentiate an involvement and a leisure experience. These conditions include an individual perceiving competence, being able to control the initiation and outcomes of experiences, and participating in activities more out of intrinsic desire than extrinsic reward expectations (Ellis and Witt, 1984).

Individuals who meet these conditions are thought to be in a better position to derive maximum benefits from their recreation activity involvements (Ellis and Witt, 1984). Levels of leisure functioning which reflect the above criteria can be assigned to individuals to provide a framework for providing opportunities for maximizing benefits and for developing a continuum of services for a wide range of disabling conditions in the community.

## Continuum Models for Delivery of Services

The types of benefits which an individual may derive from maintaining a high degree of perceived freedom in leisure may be identified by considering the history and evolution of continuum models for the delivery of therapeutic recreation services. Since the late 1960's there has been much written about understanding the concept of a continuum of therapeutic recreation service. Berryman (cited in Frye and Peters, 1972, p. 41) contributed a model wherein recreational activities become "experiential bonds," joining the client with the environment.

Initially, the professional presents activities that are expected to have a positive effect on the client and establishes the first bond between the client and the environment. As new recreative experiences are introduced, new bonds are created. Eventually, clients no longer need the assistance of the professional and pursue experiences on their own, establishing new bonds between themselves and the environment. According to Berryman (cited in Frye and Peters, 1972), the self-actualization process continues ad infinitum with recreative experiences creating ever new bonds between the clients and their environment.

Ball (1970), in her continuum model, outlined a series of four progressive stages that a client may move through to reach a true recreative experience" (see Appendix B, Figure 1). Ball assumed that the client may function simultaneously in all four stages. Stage one is characterized by extrinsic motivation and obligation or activity for the sake of activity, and stage four is characterized by intrinsic motivation and unobligated time (Ball, 1970).

Frye and Peters (1972) developed a clinical model that identified five stages. Stage one is highly structured and controlled by the



professional. In stage five, the client is free to participate in any activity available to him. Stages two, three, and four are characterized by decreasing control by the professional and increasing control and freedom for the client (Frye and Peters, 1972).

In Gunn and Peterson's (1978) model, three service provider roles are related to the behavior of the client. When a client's leisure behavior is extrinsically motivated, the appropriate role of the therapeutic recreation specialist is prescriptive and directive, or a "recreation therapy" approach is implied. As progress is made, the therapeutic recreation specialist ". . . instructs, cooperates, encourages, and counsels" rather than being prescriptive and directive (Gunn and Peterson, 1978, p. 15).

As the client becomes increasingly intrinsically motivated, independent, and self-regulated, the role of the therapeutic recreation specialist is that of special recreator or resource. The client moves through a continuum of services, from recreation therapy to leisure education to recreation participation (Gunn and Peterson, 1978).

In Compton and Witt's (1979) model, clients' whose leisure functioning is described by the lower end of the continuum are characterized by a need for extrinsic motivation, low levels of functioning and skills, provider control, and a highly controlled and scheduled environment. As progress is made along the continuum, the individual achieves the desired state of increasing self-sufficiency and the degree of control shifts from the therapist to the consumer and is manifested in perceived freedom (Compton and Witt, 1979).

In all the models, the principal concept is moving the client along a continuum, from helplessness to freedom. The continuum concept is well founded in both the philosophical and empirical literature in the field

of therapeutic recreation (Kelly, 1972; Neulinger, 1981; Kleiber, 1979; Bregha, 1980; Iso-Ahola, 1980; Mannell, 1980; Kleiber and Crandall, 1981; Ellis and Witt, 1984). As the clients move along the continuum, they should experience the changes outlined in Table I.

TABLE I  
CLIENTS' CHANGES AS THEY MOVE ALONG CONTINUUM  
FROM HELPLESSNESS TO FREEDOM

From	<u>Client Changes</u>	To
Extrinsically motivated		Intrinsically motivated
Control by provider		Control by client
Dependence		Independence
Low level of functioning		High level of functioning
Low level of competence		High level of competence

As providers give up control, clients gain freedom and greater satisfaction from their leisure experiences (see Appendix B, Figure 2). These models are the basis for the National Therapeutic Recreation Statement of Philosophy developed in 1982. The Statement of Philosophy addresses not only the three areas of service provision, but the diversity of service delivery settings.

The perceptions of freedom can be high if a person attributes the initiation of leisure behavior to self, or low if a person ascribes the source of behavior to external factors. This relationship has been

explained through the application of Iso-Ahola's (1980) attribution theory to the understanding of leisure.

### Attribution Theory

Attribution has gained strong theoretical and methodological attention over the past several decades. Heider (1926) was credited with the initial conceptualization in the early 1920's. The first attempt to discuss the issue was in 1926 with the presentation of his paper, "Thing and Medium" (Heider, 1926). The medium is that which allows us to get the information about things. Later, the label "attribution" theory appeared and became a major area of study among psychologists.

Attribution theory defines the process by which a person obtains information about an act and then makes inferences about the cause of the act (Iso-Ahola, 1976). Attribution approaches are based on the assumption that people are motivated to seek meaning in their own behavior as well as in the world around them. Based on how one perceives a given situation, the outcomes can be attributed to one of several causes. Individuals can attribute outcomes to self, someone else, or their environment. In other words, causes can be external or internal.

In social-psychological literature there is evidence which indicates that a subjective sense of freedom has important consequences. People frequently make inquiries and attributions about their state of freedom in various social settings and their feelings about freedom often represent a matter of considerable importance to them. In his essay on attributional theory, Kelly (1967, p. 192) used Brehm and Cohen's definition of freedom as ". . . the feeling of control over one's own behavior," and compiled from their analysis a series of general conditions necessary for a high perception of subjective freedom. Kelly stated that

individuals feel more freedom when they deliberate longer and/or experience high uncertainty and conflict in making a choice. Lefcourt (1973, p. 420) noted, ". . . the sense of control, the illusion that one can exercise personal choice, has a definite and positive role in sustaining life."

Individuals form attributions in order to explain outcomes. These outcomes can be explained by four cognitive elements: (1) ability, (2) effort, (3) difficulty of the task, or (4) luck, chance, or fate (Ellis, Witt, and Niles, 1982). Weiner (1974) developed a two-dimensional representation of causal attribution which, in turn, has been adapted to leisure-type situations by Ellis, Witt, and Niles (1982) (Table II).

TABLE II  
TWO DIMENSIONS OF ATTRIBUTION IN LEISURE SITUATIONS

	Unstable Attributions	Stable Attributions
Internal Locus of Control	Effort Mood	Physical Capabilities Ability Intelligence
External Locus of Control	Fate Luck Chance	Barriers Task Difficulty

Attribution theory plays a critical role in the development of therapeutic recreation service because it implies a conceptual basis for overcoming helplessness and improving overall functioning. If individuals can learn to attribute their successes to internal causes, a healthy self-image and satisfying experience can result. If, on the other hand, individuals attribute their successes to external causes, it can take away from their feeling of self-esteem and the experience. Additionally, a negative experience can lead to increased feelings of helplessness and depression (Iso-Ahola, 1980).

### Helplessness

Seligman (1975) has previously been defined helplessness as "A psychological state that frequently results when events or behaviors are perceived as uncontrollable. Behavior is uncontrollable when something happens, regardless of a person's attempt to stop it; in other words, the person's actions are perceived as making no difference. According to Seligman, the major consequences of experience with uncontrollable events are: (1) motivational--there is a reduced motivation to initiate voluntary responses that control other events; (2) cognitive--when a person has had the experience of uncontrollability, he has trouble learning that the new response has succeeded when it actually did and there is a distortion of the perception of control; and (3) emotional--initially, there is a heightened state of emotionality (fear) which, with further experience with uncontrollability, changes to depression. Once a person has inferred helplessness, motivation is drastically reduced and consequently, the individual is likely to give up or become passive.

Abramson, Garber, and Seligman's (1980) analysis of the characteristics of observed helplessness concluded that helplessness has four

major effects: self-esteem, cognitive, emotional, and motivational. Self-esteem and cognitive effects have to do with the beliefs individuals hold about their abilities. If individuals believe that they lack personal competence, they would not be expected to attribute success to their own ability. They would more likely perceive themselves to be incompetent and attribute any success to external factors such as luck or fate. Helpless individuals usually hold negative beliefs about their self-worth and feel that others are more important (Iso-Ahola, 1980).

Two other effects of helplessness are emotion and motivation. The major emotional consequence of helplessness is depression (Abramson, Garber, and Seligman, 1980). Motivation is a function of desires to achieve a particular goal or outcome and also individual's expectations of their abilities to achieve that outcome (Vroom, 1964). Helpless individuals would exhibit decreased desires to participate and would not expect to have positive experiences when they do participate.

The challenge to therapeutic recreation services is identifying ways to ". . . alleviate learned helplessness and its negative consequences" (Iso-Ahola, 1980, p. 329). By better understanding the elements of helplessness, the therapeutic recreation professional should be able to provide opportunities for movement along the continuum away from helplessness and towards freedom. Alleviating learned helplessness can lead to increased perception of control, perceived competence, and intrinsic motivation as an alternative to chronic perceived helplessness as a result of a disability. Additionally, alleviating learned helplessness could lessen feelings of negative self-worth and increase perceptions of freedom.

The Brief Leisure Rating Scale (BLRS) developed by Ellis and Niles (1985) measures the degree of helplessness presented by the individual.

The scale is designed to be completed by an external evaluator and consists of six factors. These factors are: (1) apathy, (2) anxiety, (3) negative self-esteem, (4) somatic indicators of depression, (5) hostility/uncooperativeness, and (6) depressed affect. These effects are measured using a 25-item scale that rates the client on a five-point continuum (one = not very characteristic of the client; five = very characteristic of the client).

#### Perceived Freedom

There is a widely recognized relationship between the concept of perceived freedom and the state of mind view of leisure. Iso-Ahola (1976, p. 4) defined perceived freedom as ". . . feelings of control over one's own behavior which includes the concept of locus of control and intrinsic motivation." Iso-Ahola's (1980) development of attribution theory includes individuals' perceptions of their own freedom to act that will make the greatest impact on leisure functioning and satisfaction. Bregha (1980, p. 35) stated that "Leisure is undoubtedly the most precious and also most fragile expression of our freedom."

A relationship between leisure and freedom can be traced to the Greek philosopher Aristotle. In Politics, Book 1, Aristotle described leisure as "scholē" in the sense of time free from the necessity of labor, a requirement for rulers. Leisure in this sense has certain prerequisites; without wealth and freedom there can be no state, no life, and no leisure. Leisure is not just freedom from necessary occupation, but freedom to engage in fulfilling activity for its own sake. In Nicomachean Ethics, Book 2, Aristotle said that leisure calls for opportunity for the exercise of choice using rational principles to seek a relative mean between polar excesses (Great Books of the Western World, 1952).

Leisure, for Aristotle, is contrasted not only with work but also with the childhood activity of play and with recreation. Leisure may take activity forms related to philosophy and to the arts. However, what distinguishes leisure is not the activity, but that it is done for its own sake and for the sake of the development of character. Leisure, pleasurable in itself, also builds virtue in the character of a person. Leisure is an end in which the satisfaction produced is a fulfillment in its own right. In Politics, Book 8, Aristotle again described leisure as having in itself intrinsic pleasure, intrinsic happiness, and intrinsic felicity (Great Books of the Western World, 1952).

Aristotle also discussed two types of freedom: "freedom to" and "freedom from," which have been echoed in leisure studies by Fromm (1941) and Bregha (1980). "Freedom from" is also called negative freedom; when external constraints are negated, the person is thought to be free. "Freedom to" is called positive freedom and includes the ability to act.

"Freedom from" may be constraints in the environment or a particular personal barrier. These barriers might include lack of accessible facilities, overbearing time constraints, lack of financial resources, lack of opportunities for recreation, lack of knowledge or skills. Barriers might also include attitudes, social norms, or prohibitive values the individual believes are held by peers or family or by society as a whole. If such barriers exist, the enhancement of the individual's leisure functioning must include not only the elimination of the barrier, but also the elimination of the perception of the barrier. In the process, the individual must be "freed from" both personal and environmental barriers (Witt, Ellis, and Niles, 1984).

Besides being "free from" personal and environmental barriers, Iso-Ahola (1980) discussed the concept that to feel "free to" pursue leisure



in the manner of their choice there are three necessary elements. One aspect of "freedom to" is perceived control. Individuals who believe that they have the ability to control the process and outcome of an experience or situation through their own efforts and abilities are considered to be internally controlled. For many persons with disabilities, an internal sense of control is lacking due to the effects of the disability or the degree to which professionals or family members make decisions for them. Perceived competence can also influence the "freedom to." The individual who perceives self as competent is in a position to feel a sense of "freedom to" pursue leisure. This perception of competence provides the individual with a degree of assurance that their involvement will be rewarding and satisfying and that the probability of failure is unlikely. Individuals who perceive self as competent in a variety of activities is more likely to experience a high degree of leisure functioning because they can expect positive experiences to result from participation in many different activities and situations.

Together, attributions of competence and internal control are powerful forces enabling the individual to feel a sense of "freedom to." At the opposite extreme, individuals perceive themselves as helpless and experience a feeling of avoidance or dislike for a given situation. The possibility that individuals will generalize feelings of helplessness across a variety of situations is worse. They may see themselves as generally low in ability, lacking in control, and in addition, perceive environmental problems as unsolvable.

The third aspect of "freedom to" is intrinsic motivation. Intrinsic motivation refers to the extent to which individuals engage in certain behaviors for intrinsic reasons, such as pleasure, enjoyment, curiosity, or the satisfaction of internal needs (Deci, 1975). Deci also suggested

that personal control and competence are internal needs, that they are intrinsically motivated. Researchers on intrinsic motivation suggest that individuals who engage in intrinsically motivated activity are characterized by total involvement and absorption in the activity, commitment to the activity, and a lack of anxiety or feelings of threat (DeCharms, 1968). This is related to the "flow" concept introduced by Csikszentmihalyi in 1975.

Extrinsically motivated behavior, on the other hand, is one in which the individual becomes involved due to the presence of external influences such as rewards and prizes or threats and sanctions. Intrinsic motivation is important because it describes the individual who feels "free to" pursue personally preferred leisure involvements (Iso-Ahola, 1980).

The dynamics of the three aspects of "freedom to" are important. For instance, achieving a sense of personal control may be a necessary condition for achieving a sense of personal competence or intrinsic motivation. Iso-Ahola (1980) suggested that perceived control acts as a threshold necessary to the other two components. For example, individuals may feel competent at bowling, but if they are forced to participate they perceive the situation as not under their control. They may consequently not be able to achieve satisfaction even though they are adequately able to do the activity (Iso-Ahola, 1980).

The concept of "flow" is important to the discussion of perceived freedom. Flow is the experience of purely intrinsic satisfaction that may accompany familiarity and mastery in participation. In essence, the achievement of perceptions of competence and control and the resultant feelings of intrinsic motivation open the door to feelings of leisure involvement that are characterized by excitement, enthusiasm, commitment,

and absorption. The ability to become totally absorbed and unaware of small concerns and limitations when this state is achieved is one of the chief advantages of leisure pursuits. For persons with disabilities, the state of flow provides an opportunity for self-enhancement and personally derived meaning and satisfaction (Csikszentmihalyi, 1975).

In addition to helping achieve a sense of absorption and involvement, the perceived control-competence-intrinsic motivation definition of perceived freedom also points to the possibility of the individual developing a high degree of playfulness in leisure involvements. Playfulness is composed of cognitive, physical, and social spontaneity, as well as manifest joy and sense of humor (Liebermann, 1977). Manifest joy and a sense of humor may reflect freedom through social competence. In order to be spontaneous, one must feel a degree of freedom. Spontaneity is the ability to make something of nothing, to take chances, to be creative (Liebermann, 1977). Playfulness and achieving flow are important elements of freedom that can allow persons with disabilities to increase their perceived freedom in leisure. The Leisure Diagnostic Battery (LDB) developed by Witt and Ellis (1987) was developed in response to the mandate of Public Law 94-142 and addresses the issues of perceived freedom.

The LDB consists of 95 summative rating items. Components of the LDB include perceived leisure competence, perceived leisure control, leisure needs, depth of involvement, and playfulness. Follow-up scales for persons who rate low on the LDB include barriers to leisure involvement, knowledge of leisure opportunities, and leisure preference. The LDB has been criticized for being a self-report measure and for the length of time it takes to complete the instrument (30 to 40 minutes). In response to the length of time required to complete the long form of the LDB, two versions of a short form (one for adults and a second for

children), consisting of 25 questions each, were developed. The Leisure Diagnostic Battery Short Form (LDBS) is a self-report measure which was developed from a principal axis factor analysis of the 95 perceived freedom in leisure items of the LDB. The 25 items with the highest loading on the first factor were used in constructing the scale.

In a comparative study by Ellis and Niles (1985), the correlation of the BLRS to the LDBS scores was found to be  $-.28$  ( $p < .01$ ). Although the correlation was significant, it was not as strong as would be expected. The researchers offered three possible explanations for the weak correlations:

1. There may be a very distinct difference between the absence of "freedom from" and "freedom to" and how it relates to helplessness. (This explanation would necessitate two models of therapeutic recreation service to deal with the therapist's role in dealing with "freedom from" as opposed to "freedom to" with a client.)

2. Professionals in the field have a limited understanding of the leisure functioning of the people they serve.

3. Scores on the LDBS may be affected by social desirability in that respondents are not willing to admit their difficulties when responding to a self-report instrument like the LDBS. There was no evidence of this in the research associated with the long form of the LDB.

#### Community-Based Services

In 1977, community-based recreation services for persons with disabilities became a major concern of the White House Conference on Handicapped Individuals. Proceedings from this symposium induced a state-of-the-art overview and survey of current programs meeting the recreational needs of the disabled. A plethora of research before and

after the conference has implicated attitudinal and other barriers as primary obstacles to meaningful opportunity (Austin and Austin, 1987; West, 1984; Wilkerson, 1984; Schleien and Werder, 1985; Austin, 1982). According to Halberg (1989), a recent national survey revealed that only 43% of municipal recreation departments provided recreational services to individuals with disabilities.

Even in those settings where services are being provided, it appears that the planning of recreational opportunities is based more on provider assumptions regarding the target population rather than actual knowledge. Zoerink (1989, p. 18) stated: "It may be that recreation programmers intuitively develop and offer recreation activities they believe to be of interest without carefully considering activity preferences of persons with disabilities." Halberg (1989, p. 313) commented: ". . . a relatively small percentage (37.3) of departments engage in systematic or long-term planning of programs for individuals with disabilities."

Coyle and Kinney (1990) interviewed 790 adults with physical disabilities regarding their leisure participation characteristics and barriers they encountered when engaging in leisure activities. Only 21% of the sample were employed on a full-time basis, and 10% on a part-time basis. Over 46% of the sample reported income of less than \$11,000 per year, and 19.5% reported income of more than \$32,000 per year. A portrait of adults in the community who have physical disabilities would be individuals who are typically single, living with members of their immediate families, in urban environments, with at least a high school degree, unemployed, and living on an extremely limited income (Coyle and Kinney, 1990).

The majority of the sample identified reading (14%) or television viewing (12%) as the leisure activity they engaged in most frequently.

Socializing (15%), individualized noncompetitive sports (11%), and art or music appreciation (8.2%) were the three remaining leisure activities that made up the top five leisure preferences. Coyle and Kinney (1990) found that the leisure preferences were not much different from those identified by the nondisabled population. Leisure preferences of adults, both with and without a physical disability, involve activities that occur inside the home, are sedentary, and require little in terms of physical skill or social involvement. However, barriers to participation in leisure were weather, transportation, and accessibility. Unfortunately, these barriers are taken for granted by the vast majority of nondisabled individuals, who also have more social opportunities and are not so isolated as their disabled peers (Coyle and Kinney, 1990).

Approximately half of the sample had not thought about nor had a preference for integrated versus segregated leisure activities. Over 46% were unable to identify more than three accessible leisure, recreation, or cultural facilities in their communities. It suggests an isolated and segregated population that is not actively integrated into community life despite legislative and advocate efforts directed at this goal (Coyle and Kinney, 1990).

## CHAPTER III

### METHODS AND PROCEDURES

The purpose of this study was to evaluate whether or not there is a correlation between observed helplessness and perceived freedom in leisure of adults with physical disabilities. This chapter discusses methodology and procedures involved in the study. The discussion includes a description of the subjects utilized in the study, the research design of the study, the use of the Brief Leisure Rating Scale as a valid instrument to measure helplessness, the use of the Leisure Diagnostic Battery Short Form (computer version) as a valid instrument to measure perceived freedom in leisure, the collection of the data, and the procedure for data analysis.

#### Subjects

The subjects were male and female adults with physical disabilities who routinely renew their membership on an annual basis at The Center for the Physically Limited in Tulsa, Oklahoma, or who applied for membership between July 1, 1990, and December 31, 1990. The applicants provided certification from a physician of their physically disabling conditions that qualified them for a special facility. The subjects represented a wide variety of disabling conditions that included head and spinal cord injured, visually and hearing impaired, multiple sclerosis, muscular dystrophy, amputation, cerebral palsy, cerebral vascular accident, polio, and arthritis. Individuals with both congenital and acquired

disabilities were represented. The ages ranged from 22 to 83 years of age. Additionally, the subjects represented a range of levels of functioning from one to five (one = low; five = high) (see Appendix A).

### Research Design

This study was a correlational study designed to correlate scores of the Brief Leisure Rating Scale (BLRS) and the Leisure Diagnostic Battery Short Form (LDBS). Scores of the computerized version of the LDBS for adults were used to measure levels of perceived freedom. Scores from the BLRS were used to measure levels of helplessness.

Initially, each set of scores were arranged into a simple frequency distribution of scores. Then, scores were rank-ordered from smallest to largest, with the smallest values listed at the top of the list. A mean was computed for each set of scores. The scores were then correlated using the Pearson product-moment correlation coefficient.

### Reliability and Validity of Instruments

The BLRS was designed to be completed by an external evaluator who has some degree of familiarity with the client. Six factors as a result of a factor analysis are identified. These factors are: (1) apathy, (2) anxiety, (3) negative self-esteem, (4) somatic indicators of depression, (5) hostility/uncooperativeness, and (6) depressed affect (Ellis and Niles, 1985). These effects are measured in a 25-item scale that rates the client on a five-point scale (one = not very characteristic of the client; five = very characteristic of the client).

Scores are tallied by adding the number of responses in each column, multiplying the number of responses by the column value (one through five), totaling these sums, and dividing by 25 (number of responses). A



score of one indicates low levels of helplessness; a score of five indicates high levels of helplessness. The evaluator rates how well each item described the client.

Evidence of reliability or internal consistency of the scale is assessed through the calculation of Cronbach's Alpha. The coefficient of .93 was calculated in the initial study conducted by Ellis and Niles (1985). Evidence of validity was reported as a result of a factor analysis, which explained 71% of the variance.

The Leisure Diagnostic Battery (LDB) was developed in response to the mandate of Public Law 94-142, which requires that an assessment of leisure functioning be included in handicapped students' individualized education plans. Ninety-five summative rating items are included on the LDB measure of perceived freedom. Five factors are identified as: (1) playfulness, (2) perceived competence, (3) perceived control, (4) perceived needs, and (5) depth of involvement. Clients read each item and indicate, on a five-point scale, the extent to which each item "sounds like" themselves (five = strongly agree, one = strongly disagree).

The LDBS is a self-report measure which was developed from a principal axis factor analysis of the 95 perceived freedom in leisure items of the LDB. The 25 items with the highest loading on the first factor were used in constructing the scale. Scores are tallied by adding the number of responses in each column, multiplying by the value of the column (one through five), adding the sums of the column scores, and dividing the total score by 25 (number of responses). A final score of five would be a high level of perceived freedom; a final score of one would indicate a low level of perceived freedom. Extensive evidence of a high degree of reliability and validity of the LDB has been reported (Ellis and Witt, 1984).

Evidence of validity and a high degree of internal consistency ( $\alpha = .88$ ) were found when the LDBS was used with samples of young people in a summer playground program, college students, and youth (Ellis and Witt, 1984). (A computerized version of the LDBS was obtained from Dr. Peter Witt for use in this investigation.) It greatly enhanced the client's ability to respond to the questions independently with the use of adaptive equipment and minimal intervention from the therapeutic recreation specialist.

#### Procedure for Data Collection

The data were collected by the therapeutic recreation specialist who performs intake duties at The Center for the Physically Limited. She routinely collected the data as a part of the membership renewal or application for membership procedure of clients prior to their continued association with The Center.

The specialist met initially with the client and filled out membership application and physician release forms. Upon receiving the completed medical form from the physician (which certified a physically disabling condition and the need for a special program), an appointment was scheduled to continue the process. At that appointment, the specialist performed a functional assessment, a leisure interest survey, recorded a social history, and administered the LDBS.

A tentative schedule was developed which included enrolling in activities which are available and of interest to the client. If necessary, the specialist attended the first several sessions with the client initially to assure the appropriateness of the activity choice and the client's ability to assimilate into the agency structure. Within two weeks of enrolling, the therapeutic recreation specialist performed a

BLRS on the client. All of the information became a permanent part of the client's file.

#### Procedure for Data Analysis

The correlational procedure used was a Pearson  $r$ . The data were tested to see if the requirements of linearity and homoscedasticity necessary for the Pearson  $r$  were met. The correlations were then evaluated in terms of significance by using the SPSS Release 4.0 software through the Oklahoma State University Computer Center.

## CHAPTER IV

### ANALYSIS OF THE DATA

This study was conducted to examine the relationship between perceived freedom and the observed level of helplessness of adults with physical disabilities in a community-based setting. The data were collected over a six-month period from 64 clients at The Center for the Physically Limited in Tulsa, Oklahoma.

The survey studied correlation of the BLRS and the LDBS scores of the subjects. The range of ages of the subjects was from 22 to 83 years. In regard to age, the mean was 47.79, the median was 43.50, and the mode was 32.

Twenty-seven of the subjects (42%) represented congenital disabling conditions. In this study, congenital disabilities included disabling conditions with an onset prior to the age of five. Disabilities included were cerebral palsy, visual and hearing impairment, and muscular dystrophy.

Thirty-seven of the subjects (58%) represented acquired disabilities. Disabling conditions included were arthritis, amputation, cerebral vascular accident, head injury, multiple sclerosis, spinal cord injury, polio, and visual impairment.

The largest grouping of disabling conditions was cerebral palsy, which represented 34% of the group. Cerebral vascular accident and visual impairment each represented 14%, head injury represented 12%, arthritis, muscular dystrophy, polio, and spinal cord injury each

represented 5%, multiple sclerosis represented 3%, and hearing impairment and amputation each represented 1.5% of the group. There were 31 males in the study (48.4%) and 33 females (56.6%).

Disability levels of functioning of the subjects were evenly distributed (Appendix A). There were five level one subjects (7.8%), 17 level two subjects (26.6%), 21 level three subjects (32.8%), 17 level four subjects (26.6%), and four level five subjects (6.3%). The mean level for the group was 2.97, the mode and median were 3.00, and the standard deviation was 1.05 (Table III). Table IV shows the frequency distribution of the LDBS and the BLRS.

The mean of the BLRS was 2.25, the median was 2.18, and the mode was 1.72. The standard deviation was .735 (Table V). The mean of the LDBS was 4.01. The median was 4.0, the mode was 3.92, and the standard deviation was .524 (Table VI).

When the scores of the LDBS were correlated with the scores of the BLRS, the correlation was  $-.19$ , two-tailed. The correlation was not significant at the  $.05$  level. In a previous study correlating the scores of the BLRS and the LDBS by Ellis and Niles (1985), the correlation was  $-.23$  ( $p < .05$ ). Though their findings were significant, the relationships were not as strong as would be expected.

In further analysis using the scores from the total group and controlling for age, the correlation was  $-.18$ . Controlling for disability level of the total group, the correlation was  $.09$ . Controlling for both age and disability level in the total group, the correlation was  $.08$ . None of the correlations was significant at the  $.05$  level (Table VII).

TABLE III  
DESCRIPTIVE DATA

Variable	N=64	Percentage
Age (in years)		
Mean	47.79	
Median	43.50	
Mode	32.00	
Standard Deviation	16.41	
Range	61.00	
Minimum	22	
Maximum	83	
Gender		
Males	31	48.4
Females	33	51.6
Levels of Functioning		
Mean	2.97	
Median	3.00	
Mode	3.00	
Standard Deviation	1.05	
Range	4.00	
Level 1	5	7.8
Level 2	17	26.6
Level 3	21	32.8
Level 4	17	26.6
Level 5	4	6.3
Disabilities		
Arthritis	3	5.0
Amputee	1	1.5
Cerebral Palsy	22	34.0
Cerebral Vascular	9	14.0
Head Injury	8	12.0
Hearing Impairment	1	1.5
Multiple Sclerosis	2	3.0
Muscular Dystrophy	3	5.0
Polio	3	5.0
Spinal Cord Injury	3	5.0
Visual Impairment	9	14.0
Acquired Disability	37	58.0
Congenital Disability	27	42.0

TABLE IV  
FREQUENCY DISTRIBUTION

BLRS	Frequency	LDBS	Frequency
1.12	1	2.76	1
1.20	1	2.84	1
1.32	3	3.00	2
1.40	1	3.12	1
1.44	3	3.28	1
1.52	1	3.42	1
1.56	2	3.44	2
1.60	1	3.48	1
1.72	5	3.52	1
1.74	1	3.56	2
1.76	2	3.60	1
1.80	2	3.68	1
1.86	1	3.72	3
1.92	2	3.76	4
1.96	1	3.80	1
2.04	1	3.88	3
2.08	2	3.92	5
2.12	1	4.04	3
2.16	1	4.08	3
2.20	2	4.12	1
2.24	2	4.16	3
2.32	1	4.20	1
2.36	2	4.24	1
2.40	1	4.28	1
2.44	2	4.32	2
2.48	1	4.40	1
2.52	1	4.44	1
2.56	2	4.48	3
2.64	1	4.52	1
2.68	1	4.60	2
2.72	1	4.64	3
2.76	4	4.68	1
2.96	3	4.72	1
3.00	1	4.80	1
3.12	1	4.84	1
3.14	1	4.88	3
3.16	1		
3.24	1		
4.04	1		
4.12	1		
4.92	1		
Total	64	Total	64

TABLE V  
BRIEF LEISURE RATING SCORES

Mean	2.25
Median	2.18
Mode	1.72
Standard Deviation	.735

TABLE VI  
LEISURE DIAGNOSTIC BATTERY SHORT FORM SCORES

Mean	4.01
Median	4.04
Mode	3.92
Standard Deviation	.524

TABLE VII  
CORRELATION OF BLRS AND LDBS SCORES

	Controlling For			
	Correlation	Age	Disability	Age/Disability
Total Group	-.19	-.18	.09	.08
Males	-.05	-.14	.23	.23
Females	-.31	-.32	-.12	-.13



Overall, the mean scores of the BLRS (2.25) and the LDBS (4.01) indicated that this particular population had relatively low levels of observed helplessness and relatively high levels of perceived freedom.

#### Discussion

Ellis and Niles (1985, p. 55), in discussing their findings, suggested that ". . . the perceived freedom concept, as measured by these instruments, is not unidimensional." In analyzing the scores from this study, it appeared that, while there are 36 individuals who perceived high freedom (above the mean of 4.01) and low levels of observed helplessness (below the mean of 2.25), there were also 13 individuals who perceived high freedom and high levels of observed helplessness, and 15 who perceived low freedom and low levels of observed helplessness. There does not seem to be a consistent pattern of different ends of a continuum of helplessness and perceived freedom.

If, in fact, there are two dimensions of perceived freedom (negative and positive) as Ellis and Niles (1985) suggested, this study would more strongly support the fact that the initial study, while significant, was a weak correlation. As has been discussed earlier, "freedom to" relates to an individual's perceived competence and control. The absence of "freedom to" may not create a sense of helplessness. "Freedom from" may be more closely associated with helplessness and may be a function of exposure to external pressures and limitations. Langer (1983, p. 20) suggested a relationship between the two types of freedom as ". . . the exercise of control over the environment," rather than "perceptions of competence and choice."

As a result of conducting the study, this researcher believed it was appropriate to comment on selected issues:

1. Professionals practicing in a community-based therapeutic recreation setting should rely more on clients' perceived freedom than on observed levels of helplessness in setting program goals. This may be due to the implication of "freedom to" as opposed to "freedom from" that was discussed by Ellis and Niles (1985) in their study of the BLRS.

It may also be a result of an evaluation by professionals that cannot accurately relate to subjective qualities of perceived freedom, control, and intrinsic motivation of clients. Perhaps professionals are making evaluations based on clients' abilities to participate and physical characteristics of their disabling conditions rather than on considering the personal level of perceived freedom of each individual.

To successfully apply the state of mind approach to leisure in the field of therapeutic recreation, it is imperative that professionals leave behind their own stereotypes (lack of ability based upon physical limitations) and move forward in their endeavors to enhance perceived freedom through the development of the concepts of control over the environment. To realize that an individual may in fact be dealing with real and perceived barriers that represent "freedom from" aspects rather than "freedom to" could change the individual's overall level of observed helplessness and alleviate a segregated and isolated status of persons with disabilities in their leisure experiences in the community.

2. Professionals practicing in a community-based therapeutic recreation setting should not use observed levels of helplessness in setting program goals and objectives relative to perceived freedom. Since helplessness is defined as "events or behaviors that are perceived as uncontrollable," and perceived freedom as "feelings of control over one's own behavior," the individual should be given the opportunity to control

the leisure experience and be guided to make appropriate choices to feel control, regardless of the level of observed helplessness.

The individual's definitions of success, competence, and ability are all relative to the feedback received from peers and the professional. By defining success, competence, and ability consistent with the individual's needs rather than objectively rated skills or externally judged standards, the feeling of control can almost be guaranteed.

3. Ball's (1970) early theory of continuum for the delivery of services suggested that individuals can be at more than one level relative to their perceptions of freedom, competence, and control. If an individual is competent at basketball, but not at knitting, the level of intrinsic motivation, freedom, and control required may differ greatly. This may be true for each leisure experience the individual undertakes.

If, in fact, this is true, the multiplicity of leisure experiences requires the professional to evaluate the individual's overall potential for freedom or level of helplessness and relate it to his/her ability to make choices for specific interests. Not only does the success of good choices become a factor in the individual's perception of freedom, but the availability of appropriate experiences could have a tremendous impact on perception of freedom or the level of observed helplessness.

## CHAPTER V

### SUMMARY, CONCLUSION, AND RECOMMENDATIONS

#### Summary

The purpose of this study was to correlate the observed levels of helplessness to perceived levels of freedom in adults with physical disabilities. Sixty-four individuals with severe physical disabilities who participated in a community-based recreation program were assessed by a therapeutic recreation specialist over a six-month period to provide data for this study. The individuals represented a population of over 400 clients at The Center for the Physically Limited in Tulsa, Oklahoma.

It was hypothesized that there would be no correlation between the BLRS (measuring observed helplessness) and the LDBS (measuring perceived freedom). This study failed to reject the null hypothesis, as no significant difference was found.

#### Conclusion

The following conclusion was reached, based on the findings of this study: A significant correlation between the observed level of helplessness and the perceived level of freedom did not exist.

#### Recommendations for Future Study

The following recommendations for future study were derived from the results of the present study:

1. It is suggested that the results of this study may not be indicative of the correlation of observed helplessness and perceived freedom. This study, as the study conducted by Ellis and Niles (1985), failed to identify a strong correlation between observed helplessness and perceived freedom. Other variables, such as length of participation in community-based programs and the number of years the individual has been disabled, may have a bearing on the strength of this relationship. Length of participation and number of years disabled were not collected in this study. Future studies might examine these variables.

2. Further studies should be undertaken to examine the relationships between levels of helplessness, perceived freedom, and leisure satisfaction.

3. Additional studies are warranted to examine the methodology of professional evaluation of helplessness.

4. Additional studies are warranted to examine the individual's perception of helplessness in leisure in community-based settings as opposed to professional evaluation of helplessness.

5. Additional studies are warranted to examine the effect of multiple leisure experiences and the perception of freedom relative to one or more leisure experiences.

6. Further studies need to explore the differences between "freedom from" and "freedom to," and the relative importance to overall perceived freedom and helplessness.

In summary, the results of this study have not substantiated the theory that helplessness and freedom are opposite ends of a continuum that can be correlated. The use of the BLRS as a measure of helplessness does not appear to provide an opposite relationship to perceived freedom. More research is needed to examine the effect of observed helplessness

and perceived freedom, and specifically, the relationship of "freedom from" and "freedom to" in adults with physical disabilities participating in community-based programs.

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## APPENDIXES

APPENDIX A

MULTI-TRACK PROGRAMMING INFORMATION

## Information on Multi-Track Programming

LEVEL I

Member to staff/volunteer ratio 1 to 1  
Staff/volunteer total assists in participation of programs/activities  
Needs total personal care (feeding, toileting, activities of daily living, ADL)

LEVEL II

Member to staff/volunteer ratio 3 to 1  
Actively makes choices in programming/activities  
Staff/volunteer assists in participation of programs/activities  
Personal care provided as needed (activities of daily living, ADL)

LEVEL III

Member to staff/volunteer ratio 6 to 1  
Participates in specific programs/activities  
Participates in activities with little or no assistance  
Helps other members with activities  
Assists the Leadership Council by serving on committees or assisting staff/volunteers  
Assists in volunteer/leadership roles  
Sets own goals and objectives with assistance from staff/volunteers  
Infrequent (occasional) personal care (ADL) provided

LEVEL IV

Member to staff/volunteer ration 10 to 1  
Participates in specific programs/activities  
Initiates programs/activities through design, leadership, and instruction  
Serves on the Leadership Council by holding office, participates as chair of special committees, and recruits new members  
Involved in community affairs  
Sets and implements own goals and objectives  
Emergency only personal care (ADL) provided

LEVEL V

Initiates own leisure pursuits independently  
Utilizes community resources for programs and activities  
Participates in more than 20 hours per week of volunteerism or paid employment

APPENDIX B

MODELS OF CONTINUUM OF SERVICE

PRESCRIPTIVE ACTIVITIES	RECREATION	LEISURE
TR is outer directed and is structured	Mutual Participation	Self-Direction
Stability Tendency (TRS is active; client choice is limited)	Stability Tendency Declines (TRS role narrows)	Actualization Tendency (Client has freedom of choice)
TRS DIRECTED	Actualization Tendency grows (Client role enlarges)	CLIENT DIRECTED
Client control is small		
Poor health in unfavorable environment		Optimal health in favorable environment

Figure 1. TR Continuum Modeled After Continua Presented by Ball (1970), Fink (1976), and Frye and Peters (1972)

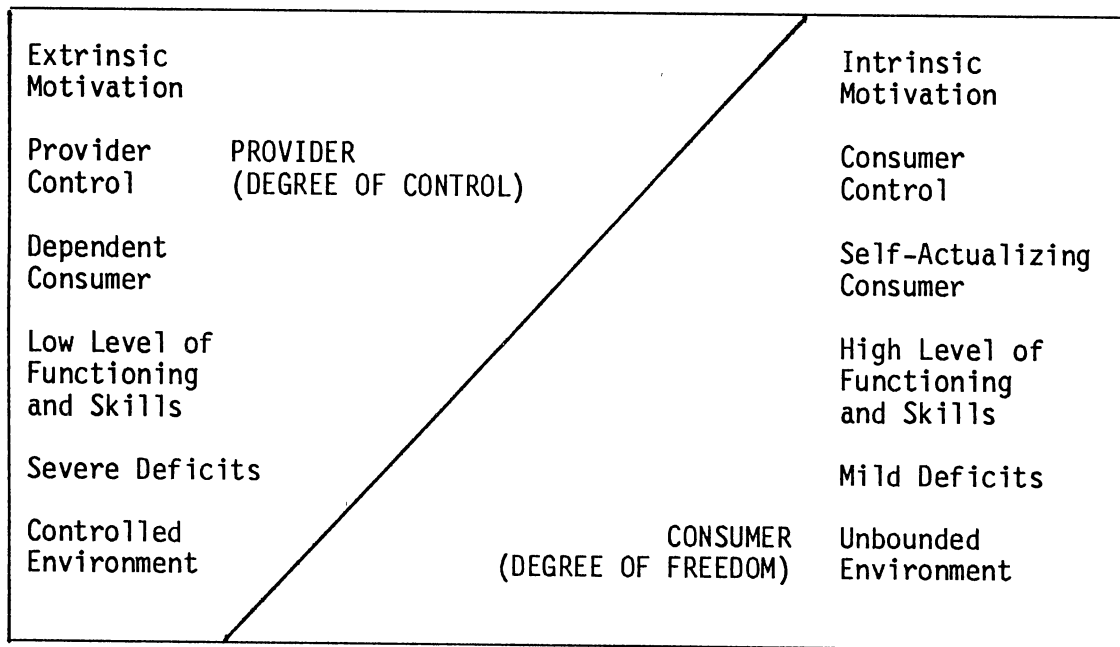


Figure 2. NRPA Model for Delivery of Leisure Services



APPENDIX C

TABLE OF RAW DATA

TABLE VIII

## RAW DATA

INDV.	A/C	LDBS	BLRS	AGE	SEX	DISABILITY	LEVEL
1	C	3.44	2.40	30	F	CP	3
2	A	3.72	1.76	40	F	Amputee	4
3	C	4.52	4.92	26	M	CP	1
4	A	4.68	1.80	38	F	Arthritis	3
5	A	3.56	1.32	75	M	CVA	5
6	A	3.92	2.08	38	F	Arthritis	3
7	A	3.28	2.68	52	F	VI	2
8	C	3.68	2.76	67	M	VI	2
9	A	4.16	1.52	46	M	VI	4
10	A	3.76	3.14	40	M	Spinal Cord	2
11	A	4.16	1.56	66	F	VI	4
12	A	3.72	2.96	71	F	Polio	2
13	A	4.60	2.76	76	F	VI	2
14	C	4.48	2.56	27	M	CP	2
15	C	4.04	2.52	27	M	CP	2
16	A	4.08	2.96	50	M	Head	2
17	A	3.72	1.40	56	M	CVA	4
18	A	4.84	2.08	42	F	MS	3
19	C	3.92	1.76	40	F	CP	4
20	C	3.88	1.86	80	M	VI	3
21	A	4.72	1.96	32	M	Head	3
22	C	3.44	2.12	25	F	CP	3
23	C	4.28	3.12	51	F	CP	2
24	C	3.92	2.04	42	M	CP	3
25	A	4.48	1.72	56	M	CVA	4
26	A	3.60	2.20	68	F	VI	3
27	A	3.52	1.80	60	M	Head	3
28	A	4.88	2.32	43	M	Head	3
29	A	3.88	2.44	36	M	Head	3
30	C	4.88	1.72	47	M	CP	4
31	A	4.80	2.24	44	F	CVA	3
32	C	3.80	1.72	43	F	MD	4
33	A	4.04	1.92	31	M	Head	3
34	A	4.64	1.20	32	M	Spinal Cord	5
35	C	4.32	1.72	22	M	CP	4
36	C	3.76	1.56	28	F	CP	4
37	C	4.40	1.92	68	F	CP	3
38	C	2.84	2.36	33	F	CP	3
39	C	4.64	1.32	26	F	MD	5
40	A	3.00	2.24	65	F	Polio	3
41	A	3.76	2.36	41	F	MD	2
42	A	4.12	2.44	61	F	Arthritis	3

TABLE VIII (Continued)

INDV.	A/C	LDBS	BLRS	AGE	SEX	DISABILITY	LEVEL
43	C	4.44	2.56	72	F	CP	2
44	A	4.04	1.74	71	M	CVA	4
45	C	4.48	2.64	60	F	HI	2
46	A	4.32	1.12	43	M	CVA	5
47	A	4.64	2.48	22	F	Head	3
48	C	2.76	3.24	36	F	CP	1
49	C	4.60	2.16	32	F	CP	3
50	A	3.88	2.76	32	M	Spinal Cord	2
51	A	3.56	1.44	59	M	CVA	4
52	C	4.24	1.40	34	F	CP	4
53	A	3.92	1.72	57	F	VI	4
54	C	3.12	2.76	52	M	CP	2
55	A	4.20	1.32	47	M	Head	4
56	C	3.92	1.60	24	M	CP	4
57	A	3.00	2.72	81	F	CVA	2
58	A	4.08	3.00	83	F	Polio	2
59	C	3.76	4.04	41	M	CP	1
60	C	4.16	2.96	41	M	CP	2
61	A	3.48	4.12	68	F	MS	2
62	A	4.08	1.44	57	M	CVA	4
63	A	4.88	2.20	50	M	VI	3
64	C	3.42	3.16	44	F	CP	1
Totals		256.86	143.82	3059			
Mean		4.01	2.25	47.79			

VITA

Nancy Atwater Reese

Candidate for the Degree of

Master of Science

**Thesis:** CORRELATING OBSERVED HELPLESSNESS OF ADULTS WITH PHYSICAL  
DISABILITIES TO THEIR PERCEIVED FREEDOM IN LEISURE

**Major Field:** Health, Physical Education and Leisure

**Biographical:**

**Personal Data:** Born in Springfield, Illinois, February 23, 1950,  
the daughter of Ralph and Margaret Atwater; married to Ron  
Reese; daughters, Andrea and Sarah.

**Education:** Graduated from Springfield High School, Springfield,  
Illinois, in 1968; received Bachelor of Science degree in Rec-  
reation from the University of Tulsa in May, 1972; completed  
requirements for the Master of Science degree at Oklahoma State  
University in July, 1991.

**Professional Experience:** Supervisor, Tulsa Park Recreation Depart-  
ment, Tulsa, Oklahoma, 1972-81; Director of Annual Giving for  
the University of Tulsa, 1981-85; Executive Director, The  
Center for the Physically Limited, Tulsa, Oklahoma, 1985 to  
present. Became a certified therapeutic recreation specialist  
in June, 1989.

**Professional Organizations:** National Recreation and Park Associa-  
tion, American Therapeutic Recreation Association, Oklahoma  
Recreation and Park Society, ORPS Certification Review Commit-  
tee, National Fundraising Executives, and Oklahoma Governor's  
Advisory Committee on the Concerns of the Disabled.