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Special Recreation: A Manual for Theraputic Riding Programs

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Special Recreation: A Manual for Therapeutic Riding Programs

A Project Report

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by

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Preface

Recreational opportunities are limited to individuals with disabilities. Recreation and learning how to utilize leisure time can be more important to individuals with disabilities than to others. Therapeutic riding was studied as a means to meet this perceived need. A manual was developed describing a professionally directed service designed to meet the recreational needs of individuals with disabilities in a therapeutic riding program.

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Chapter 1

Focus of Project

Introduction

Therapeutic horseback riding dates back to ancient Greece where patients who were ill and unable to be healed were given a horseback ride to raise their spirits (Haskin, 1974). Therapeutic horseback riding has been conducted in Germany since the 1600's. However, it is only recently that the use of the horse as a therapeutic modality has become popular in the United States (Gentry, 1986). In 1969, the first therapeutic riding program was established in Augusta, Michigan. Today, over 200 centers are in existence in the United States and Canada that provide horseback riding programs for individuals with disabilities (Bertoti, 1988).

Statement of Problem

Like all people, individuals with disabilities need recreational and leisure activities to balance the rigors of daily living. Unfortunately, too many individuals with disabilities remain outside the mainstream of community life in these areas. In spite of this, evidence documented in literature supports that health, physical fitness, language, social skills,

and self-esteem can be enhanced through participation in various recreational and leisure pursuits (Wilson, 1974).

Statement of Purpose

The purpose of this project is to develop a therapeutic riding program manual which will describe the roles and responsibilities of volunteers and staff, lesson methods and procedures, including evaluation of participants and the documentation needed to justify programs. The program manual will be designed to provide individuals with disabilities the opportunity to ride horses in a recreational setting utilizing the horse and its movements in the safest manner.

Significance of the Project

The manual developed as a result of this project is a condensed version of the literature available on the guidelines of operating a therapeutic riding program as perceived by the author. The manual will serve as a resource for those advocates of individuals with disabilities who would like to start a therapeutic riding program in their community.

Limitations of the Project

The project will be limited to justifying and describing a nonprofit organization that will provide a setting for therapeutic riding. An instructional curriculum will not be described because extensive work has

already been done in this area.

Definition of Terms

Adaptive behavior: The individual's ability to function independently in the family, neighborhood, school or community. It includes a set of appropriate functional areas at each age level; for example, during infancy and early childhood, adaptive behavior would encompass sensory-motor skills development, communication skills, self-help skills and socialization (Engel, 1992).

Aggregate: Refers to part of a larger group, but not in direct interaction with other members of the group. Some examples may be attending a movie or concert (Kraus, & Shank, 1992).

Aphasia: A communication disorder affecting all forms of language and communication. "Receptive" aphasia is an impairment in a person's ability to understand spoken and written language; "expressive" aphasia is an inability to use words and sentences to express oneself. *Agnosia* is difficulty in discriminating the meaning of sounds. Words often lose their meaning and may be responded to incorrectly. Finally, *apraxia* is difficulty in planning and initiating motor movements. It is often necessary for the therapist to use body language and gestures, and to simplify verbal directions given in activity programs (Engel, 1992).

Disability: The restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being (World Health Organization, 1980).

Habilitation: Deliberately designed educational and behavior-modification programs intended to help an individual reach his or her fullest potential (Kraus & Shank, 1992).

Handicap: The disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual (World Health Organization, 1980).

Impairment: The loss or abnormality of psychological, physiological, or anatomical structure or function (World Health Organization, 1980).

Learning disabilities: The cognitive condition in which those individuals who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia (Shulman, 1976).

Leisure: The opportunity to engage in pursuits that are freely and voluntarily chosen, that enrich the individual's life and contribute to his or her fullest possible self-actualization. It has also been viewed from a social-psychological perspective as a state of mind marked by perceived freedom, intrinsic motivation, and a holistic blending of spiritual, physical, emotional and intellectual expression (Kraus & Shank, 1992).

Mental disability: Significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period (Crawford & Mendell, 1987).

North American Riding for the Handicapped Association (NARHA): A service organization created to promote the well-being of individuals with disabilities through equine activities (NARHA Guide, 1992).

Occupational therapist: A person with a credential in occupational therapy who treats disease and injury by the use of activities with emphasis on adaptation (Clark & Allen, 1985).

Physical therapist: A person with a degree in physical therapy who treats disease and injury by physical means such as light, heat, cold, water, ultrasound, massage, and exercise with emphasis on mobility (Clark & Allen, 1985).

Recreation: In the twentieth century, the word recreation has three

primary meanings; (1) as a form of voluntary activity that is carried on in leisure time, usually for pleasure but also to satisfy other personal needs or drives; (2) as a positive emotional state, with feelings of well-being, achievement, self-discovery, and satisfaction derived from successful participation; and (3) as a societal institution composed of varied governmental, commercial, non-profit and other sponsoring organizations (Kraus & Shank, 1992).

Special populations: Individuals in need of special considerations and adaptions regarding their handicapping condition (Engel, 1992).

Special recreation: This aspect of therapeutic recreation service is found primarily in community settings. Physically or mentally disabled persons are enabled to meet their normal needs for leisure outlets (Kraus & Shank, 1992).

Therapeutic: Of or pertaining to the healing art; concerned with remedies for disease; curative. In modern usage, its meaning has been extended to a variety of treatment situations or services (Kraus & Shank, 1992).

Therapeutic facility: A facility that is accessible to individuals with disabilities that incorporates therapeutic practices (Kraus & Shank, 1992).

Therapeutic recreation: A professionally directed service designed to meet the needs of individuals who have some significant degree of illness or disability that limits their ability to use leisure enjoyably or fully (Kraus & Shank, 1992).

Therapeutic riding: Employs the horse as a means to achieve specified therapeutic goals. Functional riding skills or a portion of a skill may be incorporated into the program but is done so only for its therapeutic value. Glascow (1986) stated that "the client not only accommodates with automatic reactions to the movement of the horse but also performs active exercises while the horse is in motion." Specific exercises are prescribed for each individual based upon their treatment goals and may include stretching, strengthening, balance, coordination, relaxation or movement patterns.

Chapter II

Review of Literature

Recreation and Leisure

Though many people who are mentally disabled express interest in a wide range of activities, their recreational repertoire consists mainly of passive activities like watching television or videos, listening to music, and looking at magazines. Their activities are restricted to those they can do alone or with family members, and to those that avoid contact with strangers or new places (Katz & Yekutiel, 1974). This uncreative use of leisure time results from factors associated with both the individual and the community. Although difficulties in these areas are not inherent in mental disabilities, many do not have recreational skills. This may be because of limited experiences or instruction, slow or uneven physical development, or a lack of friends with whom to learn or play. These difficulties may be more pronounced for persons living in more independent settings, as they may have less accessibility to peer groups or transportation than persons living in group or family homes.

Katz and Yekutiel (1974) suggested that the use of leisure time by those with mental disabilities is characterized more by a lack of choice and knowledge than an expression of true interest. As with other skill

areas, persons who are mentally disabled need intentional and systematic instruction in the use of leisure time skills in order to develop hobbies and participate in activities with confidence along with their nondisabled peers.

Recreation and Socialization

For the severely disabled, elderly, and poor, an increase in the amount of idle time because of their inability to fully utilize it can be a frustrating and demoralizing experience. Many of the disabled have a great deal of time, but no way to enjoy it. The severely physically and mentally disabled and others who are homebound or institutionalized have limited or no formal leisure (Schleien & Yermakoff, 1983).

The importance of recreation in aiding the social, physical, intellectual, and emotional development of individuals and families has long been recognized. The disabled's chances for full development of recreation skills has been a result of being denied equal access to recreational experiences (Kraus & Shank, 1988). While active recreation can be a positive form of maintaining physical and mental well-being, it can often become a method of physical and mental therapy for individuals with disabilities.

Community Model

Gerald O'Morrow (1976) identified several different approaches to the provision of therapeutic recreation services. While they were characterized as "models" of service, they actually described major types of overall institutional or agency approaches which in turn influenced the goals and program planning of therapeutic recreation.

The community model implies that a critical aspect of recreation service for individuals with disabilities lies in the provision of a wide range of leisure opportunities geared to meeting their needs. These are provided by sponsors such as: (1) public recreation and park departments; (2) voluntary agencies, service clubs, or organizations intended to serve disabled populations; and (3) agencies or institutions that develop out-reach or satellite programs to serve individuals living in the community.

Special Recreation

O'Morrow (1976) defined "special recreation" as being the community approach to serving disabled persons with needed leisure programs. The focus of special recreation is on the provision of programs and opportunities for individuals with disabilities to develop, maintain and express a self-directed, personally satisfying lifestyle that actively involves leisure. Special recreation seeks to create accommodating

environments and to help individuals gain optimal leisure skills required for such involvement. Special recreation makes a vital contribution to the overall quality of life, both physically and emotionally for persons with disabilities. The assumption is that many disabled persons desire and in varying degrees require assistance in acquiring skills and ultimately being able to enter socially integrated programs.

Recreation's Role concerning Individuals with Disabilities

Individuals with disabilities still find major areas of normal life closed to them. In a systematic study of nearly 800 physically disabled adults living in the greater Delaware Valley region of the United States, Kinney and Coyle (1989) documented both the economic and social difficulties of this group and their continuing lack of adequate leisure involvement. They found that only one in five physically disabled adults was employed on a full-time basis, and only 31 percent had any employment at all. Financially, the physically disabled sample was an impoverished group, with nearly half living on a total annual income of $10,999 or less. Many had recurrent health problems, with one-third of the sample requiring hospitalization during the past year. The study concluded that the physically disabled adults had "remarkably lonely and isolated" lifestyles (Kinney & Cole, 1989).

Impact on Loneliness

Another important contribution of recreation to one's wellness lies in its ability to combat loneliness and isolation. Harry Stack Sullivan (1988), a leading psychotherapist, states that loneliness is an intense, unpleasant experience that can happen to an individual at any point in the life cycle. Man is a social animal with a need for contact with others. When this need is unfulfilled, it is expressed in loneliness. When action is taken to avoid or relieve loneliness, there is a resulting enhancement of self-esteem.

In a study done by Young (1984), it was found that loneliness was the most frequently mentioned personal problem, with 38 percent of female and 43 percent of the males saying they often felt lonely. Young points out that people who are chronically lonely are often less productive in their work lives. They feel that life is less satisfying and are prone to psychiatric disorders such as depression and anxiety.

The value of recreation in overcoming loneliness is very important for individuals with disablilities. Harry Stack Sullivan (1988) suggested that most leisure activities are carried on in groups, and sociability is a key outcome of many recreational involvements.

Stress as a Health Factor

Stress is usually thought of as a form of pressure leading to anxiety, inability to function well and even emotional or physical illness (Courtney & Escobedo, 1990). It may stem from job or economic pressures, family crises, or a host of other upsetting events or conditions. One of the best ways in which to handle stress is through healthy physical outlets and other absorbing and satisfying recreational pursuits.

Social Development

Too often mentally disabled individuals are isolated from the mainstream of community life. Perceived by others as "different" because of their appearance and behavior, they are often excluded from peer groups and find it difficult to establish meaningful social relationships with others (Schleien & Ray, 1986). Often they are insecure in groups, partly because of repeated failures and rejection by others. Carefully planned recreational activities in either segregated or integrated, groups may do much to overcome these limitations.

Physical Development

The physical appearance, strength, stamina, motor skills and overall physical development of the mentally disabled is often inferior to their nondisabled peers (Crawford & Mendell, 1987). Physical development is

important not only because it contributes to the health of the individual, but also, because a person's physical status contributes to a positive self-concept. It is therefore essential that individuals with disabilities be given a full opportunity to improve their motor skills and fitness through active play.

Contribution of Physical Play

An article in the Journal of the American Medical Association (1989) confirms that even a minimal amount of regular exercise provides significant protection, not only from cardiovascular disease and cancers but also against death from a wide range of other causes.

Crawford and Mendell (1987) stated that one of the most important contributions that recreation can make to one's health is through vigorous physical exercise. While exercise can be taken as medicine, that is, as a prescribed daily routine, it is far more enjoyable and likely to be continued regularly in the form of sport or other recreational activities.

Recreation in the Lives of Mentally Disabled Individuals

One of the most important outcomes of the President's Panel on Mental Retardation, instituted by John F. Kennedy (1962), was its recognition of the vital role played by recreation in the lives of mentally retarded persons. Recognition was given to this need during the 1970's

through legal authorization of recreation as part of the overall community services within federal programs for people with developmental disabilities (Hawkins, 1988).

Particularly for individuals with disabilities who do not attend school or work, the empty hours in their day are characterized by lethargy, frustration and a feeling of uselessness. Katz and Yekutiel (1974) have suggested that carefully planned recreation programs can do much to provide a useful and pleasurable existence for mentally disabled individuals.

Recreation may greatly promote the mental development of disabled children and youth. Since mentally disabled individuals are so often deprived of normal, important developmental experiences, it is essential that their lives be enriched. Too often leisure has been viewed solely as the opportunity for diversionary activity for mentally disabled individuals. This view, however, is changing, particularly for individuals living in community-based residences.

Programming for Individuals with Disabilities

According to Dattilo and Barnett (1985), individuals with severe disabilities tend to have fewer opportunities to make self-determined choices of free-time pursuits, and this creates a major barrier for them in gaining satisfaction in their leisure time. Dattilo (1988) stated that even the most severely mentally disabled individuals can be helped to show their leisure preferences. Once service providers determine the client's preferences, opportunities for choosing activities can be arranged, thus enhancing the quality of their leisure and ultimately their life.

Based upon years of research and demonstration projects supported primarily through the U. S. Department of Education, Office of Special Education and Rehabilitation Services, Schleien (1989) and his staff have identified what constitutes "best professional practices." They have developed useful training materials as a result of research and demonstration programs. Categories of "best professional practices" include (1) comprehensive needs/preference assessment, utilizing multiple and varied sources of information; (2) skill-selection guidelines/functional curriculum, which targets the most important and relevant skills for subsequent training; (3) the instructional program,

based upon behavioral principles and techniques such as task analysis, shaping and chaining, cue hierarchy and prompting, reinforcement, and choice training; (4) adaptations and modifications of materials and equipment, procedures and rules, facilities, skill sequence and lead-up activities; and (5) maintenance and generalization, so that the learner can transfer skills across environments, people and activity materials.

Schleien (1989) suggested that individuals with severe multiple disabilities can be assisted most effectively when there is extensive networking among professionals, service agencies and families, and the application of state-of-the-art "best professional practices" in leisure programming.

Programs for Those with Learning Disabilities

Learning disabilities stem primarily from neurological origins and not from a visual, hearing or motor handicap, mental retardation or emotional disturbance (Clark & Allen, 1985). It should be stressed that learning disabled children are not mentally disabled. According to Clark and Allen (1985), such children, despite their frequent inability to read, write, speak or move with appropriate control, often have intellectual potential that is normal or better than that of the general population.

Certain activities, such as creative dance and movement exploration,

lend themselves to working with learning-disabled children. Schmitz (1989) pointed out that dance experience can make the following important contributions to the motor and psychological development of these individuals:

> ...enhancement of self-image; greater risk-taking; development of social cooperation and group sharing; development of kinesthetic sense, which leads to better mobility, laterality, and directionality; development of physical strength, coordination, and flexibility; development of mind-body connections; development of the aesthetic realm; enhancement of motivation; and refocusing attention on ability rather than disability. (p. 60)

In a study conducted by Shulman (1970) on recreation programs for children with specific learning disabilities, the following general rationale underlying the development of such programs was determined: (a) children with specific learning disabilities require remedial attention outside the classroom, much of which can be provided in a recreational atmosphere; (b) these children cannot function adequately in a regular community recreation program because they lack the necessary physical, social and/or behavior skills; and (c) special programs can help develop the skills needed for later integration into regular community recreation programs.

The learning disabled individual has the capacity to mainstream with their peers in a recreational activity that highlights their ability. Special recreation programs can give the learning disabled individual a chance to compete and be successful based on equal abilities.

Traumatic Brain Injury (TBI)

Contemporary lifestyles of many individuals often result in accidents which cause extensive injuries to the brain. These necessitate highly specialized acute care and rehabilitation centers specializing in head trauma. Most injuries result from automobile accidents, street violence and assorted other accidents related to leisure-time behavior. Harrison (1987) stated that traumatic brain injuries involve two types: (a) a penetrating injury such as a bullet wound; and (b) a closed head injury such as when the brain actually slams against the cranium when a person's head is propelled against the windshield of a car. They often result in problems with attention, concentration, memory functions, reasoning and problem-solving, and the use of language, and behavior disorders.

Therapeutic recreation services are used throughout the rehabilitation of traumatic head injuries. The 1987 Commission on Accreditation of Rehabilitation Facilities required all brain-injury programs to include therapeutic recreation. Therapeutic recreation is

used to increase cognitive and social functioning. It is also used to assist the individual in regaining independence by learning to compensate for areas of dysfunction and resuming as active a leisure lifestyle as possible.

Mainstreaming as a Goal

The most desirable situation is one in which individuals with disabilities are mainstreamed and share recreational and social experiences with other nondisabled individuals. Janicki, Marty, Krauss and Selter (1988) suggested that the degree in which this can be successfully accomplished depends on several factors, including: (1) the individual's own level of socialization and ability to mingle effectively with others; (2) the nature of the activity, in that some activities require a high degree of interaction and performing skill, and may be above the capacity of the disabled individual, while others may be reasonably their own ability range; (3) the receptivity of the group overall, and the willingness of its members to encourage participation and (4) social conditions that encourage the presence and involvement of individuals with disabilities in community facilities and programs.

A degree of integration may be obtained by having groups of disabled participants take part in aggregate activities with nondisabled persons.

Integration can be facilitated by gradually building up the individual's skill, confidence, and ability to mingle effectively with others (Janicki, Marty, Krauss & Selter, 1988).

Research on Outcomes of Recreation with Physically Disabled Participants

The following research has been done in an effort to examine the effectiveness of therapeutic recreation activities with physically disabled participants. Sessoms (1979) found that many physically disabled children who attended a North Carolina special camp made significant progress in terms of self-concept and independent functioning. Patrick (1986) reported similar positive gains from wheelchair sports programs, and Black (1983) measured the improved locomotor skills of visually impaired adolescents that resulted from an outdoor adventure program.

The research conducted on therapeutic riding further reveals benefits to the participant in the following: improved postural control, gait functional abilities and posture of children with cerebral palsy (Bertoti, 1988); improved arm and leg coordination of physically disabled persons (Brock, 1988); positive changes in balance, mobility, and posture of physically imparied persons (Copeland, 1989); and increased relaxation of spasticity found among persons with cerebral palsy (Glascow, 1986).

In her study, Bertoti (1988) undertook the challenge to obtain objective information concerning postural changes in children with cerebral palsy after participation in a therapeutic riding program. Assessment of postural change was determined by three pediatric physical therapists based on a scale designed by the author. Eight out of eleven children participating in the study were found to have improved posture on the post test of the postural assessment scale. Improvements were noted in midline head control, trunk symmetry with less lateral flexion, and trunk elongation. Subjective improvements included: increased self-confidence, increased mobility, improvement in sitting, stance and gait, and general overall strength.

The research conducted on the effectiveness of therapeutic recreation supports the fact that individuals with disabilities who participate in special recreation experience physical and emotional benefits.

Quality of Life

In the fullest sense, special recreation plays an important role in health care and human services for individuals with disablities by being a means of achieving optimal physical and psychological health, and strengthening their resources for coping successfully with life's challenges (Crawford & Mendell, 1987). Leisure represents a sphere of daily life in which one can achieve a variety of satisfactions which contributes to their enjoyment of life, self-esteem, and acceptance by others (Kinney & Coyle, 1989). Particularly for individuals with disabilities who have an impairment that limits their involvement in other aspects of life, recreation may provide an ideal opportunity to discover one's talents, to enjoy a sense of achievement and self-discovery and to provide goals that make life worthwhile (O'Morrow & Reynolds, 1989).

CHAPTER III

Procedures

Methods and Procedures

There is growing agreement by many administrators that local funding for specialized programs for individuals with disabilities is difficult to generate. However, much can be done to adapt existing programs and assist other public and private organizations which provide supportive services for individuals with disabilities. One method of assistance is to take a proactive approach in showing concern for the disabled. The process starts with the development of a greater consciousness of the recreation needs of individuals with disabilities. It then involves research into the techniques of programming, types of facilities and equipment needed, and staffing requirements (O'Morrow, 1989).

Need for Accountability and Documentation

Schleien and Yermakoff (1983) have pointed out that in the past, therapeutic recreation practitioners placed primary emphasis on the number of clients served, progress notes of an anecdotal nature and other subjective forms of data. Often they rationalized not carrying out more rigorous forms of evaluation by arguing that recreation involves emotional

or attitudinal reactions that are difficult to measure, and that recreation leadership itself is more of an art than a science. Trends in the 1970's and 1980's enforced the need for fuller accountability. Schelein (1983) stated that "in addition to planning and implementing programs, therapeutic recreation services must be responsible for the continued evaluation of recreational situations and outcomes, and make required, ongoing revisions and modifications to guarantee continued relevancy and practicality."

Within therapeutic recreation service, the role of recreation as therapy, its goals and outcomes, its methodologies and its relationships to other rehabilitative functions demand thoughtful analysis and documentation. Not only must the benefits of therapeutic service be documented for administrators in individual programs, but they must also be provided to professionals in related fields and used to justify financial reimbursements. Above all, the credibility of the field as a profession is questioned if it avoids systematic inquiry about the quality and appropriateness of its services. Without evaluation and research, the practice of therapeutic recreation will not improve and grow.

CHAPTER IV

The Project

The purpose of this project was to provide a manual describing a therapeutic riding program. The manual establishes staffing, methods and procedures, and evaluation and documentation practices of a therapeutic riding program. The manual was developed according to the recommended procedures of the North American Riding for the Handicapped Association (NARHA). Safe horsemanship is stressed throughout the program.

THERAPEUTIC RIDING:

A MANUAL FOR VOLUNTEERS AND INSTRUCTORS

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TO THE VOLUNTEER

Volunteers help with the many tasks and goals in the riding session.

Volunteers do many supportive jobs which make the non-profit programs work.

Volunteers bring new ideas for the lessons and the program.

Volunteers help make the riders happy with their new friendships; they support riders emotionally as well as physically.

Volunteers bring in their knowledge and expertise.

WHAT DOES THE VOLUNTEER DO IN A THERAPEUTIC RIDING PROGRAM?

There are many positions a volunteer can fill, from being an instructor to cleaning tack. Each person on the team should be able to fill the position that matches his or her interest and skill.

RIDING LESSON ACTIVITIES

Leading horses.

Walking beside a mounted rider.

Assisting the instructor.

Helping with mounting.

Grooming and tacking-up the horses.

Setting up for the lessons.

Making special equipment.

Cleaning tack.

NON-RIDING LESSON ACTIVITIES

Recruiting volunteers.

Orienting volunteers, families, groups, professionals.

Conducting public relations.

Training volunteers.

Carrying out secretarial and bookkeeping activities.

Scheduling lessons.

Being involved in phone activities.

Helping with fund raising.

Recruiting membership.

Producing newsletters.

Planning social activities for volunteers, riders, and/or families.

THE HORSE LEADER

The horse leader has had experience with horses and is comfortable dealing with them. This person understands the nature of the horse and can control it under unusual circumstances.

THE SIDEWALKER

The sidewalker walks beside the horse and the rider. This person helps with the safety of the rider or helps the rider carry through with the instructions from the instructor. There may be one side-walker or two sidewalkers for the safety of the rider. Sidewalkers need to feel comfortable walking next to a horse.

RESPONSIBILITIES OF ALL TEAM MEMBERS

Is on time and adheres to program policies.

Call in if unable to attend a lesson so that a replacement can be found in time for the lessons. This avoids disappointed riders.

Coordinates team efforts, as directed by the instructor during any emergency situation.

Reads lesson plans and meets and discusses responsibilities with the instructor and team members.

Is familiar with the forms and charts used in the program.

Is sensitive and understanding to the needs of individual riders.

Knows where the first-aid supplies are located and becomes familiar with basic first aid methods.

Knows the procedure for dealing with types of seizures, tantrums or other medical problems.

Knows the location of the telephone, numbers to dial for emergency help and the phone number you are calling from.

Knows how to direct emergency help to the stable, specifically the street numbers and the names of the nearest cross streets.

Attends team meetings. Many ideas and concerns can be discussed and worked out so that volunteers will be better informed and will feel more secure in their roles.

Discusses with others, if needed, problems related to disabilities, special equipment, positioning and handling of rider and any discomforts the team members might have.

Never teases or abuses a horse. Your safety may be threatened since the horse may develop bad or dangerous habits. A horse never forgets.

Never correct a horse in such a way as to endanger the rider; punish it only for blatant disobedience.

Corrective techniques may be applied in subsequent training sessions by the instructor to eliminate future behavior with the horse.

Be firm, consistent, gentle and kind. Be sure the horse understands what you want.

Knows that a horse responds well to kindness and is not normally vicious.

Instructor I

Works with and under the guidance of other instructors during lessons.

Desires to increase riding and instruction skills.

Learns adaptive methods and techniques appropriate for various disabilities.

Trains or exercises program horses as indicated.

Strives to increase knowledge of horse care and management.

Cleans and maintains tack and equipment.

Performs or assists with extra activities as directed by supervising instructors.

Instructor II

Sets up lesson plans.

Supervises ring or arena preparation.

Conducts riding lessons.

May make rider evaluations as directed.

Exercises and trains horses.

Assists and trains volunteers.

Performs horse-care management as assigned.

Has a working knowledge of the disabilities served.

Directs volunteers in assigned tasks, jobs, and responsibilities.

Willingness to perform additional activities as assigned by Instructor III.

Instructor III

Supervises all instructors and volunteers.

Makes assignments for level I and II Instructors.

Develops a team approach and commands the full cooperation of team members.

Consults with therapists and other specialists.

Applies a working knowledge of disabilities to the program.

Selects horses for the program.

Sets up training and exercise programs for each horse.

Supervises horse care and management.

Supervises the selection of horses, tack and special equipment for the riders.

Approves applications and placement of new students to the program.

Evaluates riders and supervises development of goals and lesson plans.

Evaluates lesson plans and instructions.

Conducts or supervises all mounting and dismounting procedures.

Writes progress reports when this is not done by a therapist.

Demonstrates riding skills.

Maintains safety standards.

Delegates responsibilities as needed.

Conducts in-service training sessions for all team members.

Coordinates the therapeutic riding lessons with other aspects of the organization.

Teaches lessons as necessary and coordinates the team.

Attends workshops, meetings and conferences to maintain a professional level of competency and to stay current of the latest advances in riding therapy.

Supervises attendance of appropriate team members and present for all lessons and meetings.

Enacts and enforces program policies to assure an organized and safe environment.

PREPARING A WRITTEN LESSON PLAN

Lesson plans are developed on a sequential bases:

1. Long range-- for the year
2. Short range-blocks of shorter periods (three months)
3. Divide the short range goals into smaller sections in developing progressive objectives. Each lesson builds on itself and on the one which came before. Smaller segments allow the instructor to handle the material more effectively and to accommodate the rider's varying condition.

Development of long range goals:

Riders will be able to get horses from stalls, groom and tack them for their lesson independently.

Riders will be able to perform all skills required in the Training Level Dressage Test 1.

Development of short range lesson plan goals:

Riders will assist each other in grooming and tacking.

Riders will learn to:

a.) saddle their horses with only verbal assistance
b.) sit with their weight on their pelvic bones
c.) use light rein aids
d.) use leg aids for all transitions
e.) ride a perfectly round circle

From the short range goals the instructor will develop objectives for specific lessons. Since progress to achieve a specific objective may take a month or two, the objectives may remain the same but the instructor may vary the lessons to make them more interesting. Some riders progress faster with a routine they understand. Changes would occur only to increase the level of difficulty to progress toward the objectives. Full description of the objectives, as developed from the long range plan, do not need to be placed on the daily lesson plan.

Development of objectives:

At the end of 12 sessions John will:

a.) rotate his trunk while sitting on a saddle, as observed by the instructor
b.) sit on the saddle with a straight back for ten minutes of each session, as observed by the instructor
c.) hold the reins between his fingers in normal English style while guiding his horse, as observed by the instructor
d.) mount from the ground with leg-up assistance from the instructor, as observed by the instructor

All lesson plans should be divided into five sections:

Preparation:
getting the horse groomed and tacked
rider locate helmet

Warm-up:
warming up the horse for the lesson
rider warms up for lesson-stretches

The skill development to meet objectives:
instructor goes over basics
introduces new skill

Wind-down
free riding
walking horse to cool down
rider relaxes

Put away
remove saddle
horse groomed and returned to stall

Writing the lesson plan must also include a list of:

a.) riders
b.) staff who will participate in the preparation of the lesson
c.) horses and each horse's possible equipment
d.) lesson objectives
e.) equipment needed and location
f.) warm-up procedures
g.) lesson exercises
h.) procedures to address the lesson objectives
i.) wind-down procedures
j.) evaluation of the lesson

The Therapist

The therapist acts as a consultant to the team within the context of the use of the horse.

The therapist can be a physical or occupational therapist, a speech and language pathologist or a psychologist who is a registered or licensed medical specialist, and who is working with the rider in a treatment situation to attain specific treatment goals.

Uses the movement of the horse to influence and stimulate the muscles and the nervous system of the rider or to influence psycho-social changes in the rider.

Trains the volunteers and the instructor to assist in carrying out the treatment session.

Works with and directs the other team members during the therapy session with the rider.

Selects special equipment or methods to benefit treatment.

May incorporate horse grooming, tacking up or riding skills to accomplish certain therapeutic goals.

Communication should be ongoing between the therapeutic riding team members and any active rehabilitation team members to make the experience most beneficial to the rider. The physician who makes the referral and signs the authorization should certainly receive periodic updates on the client's progress. It is often useful to invite members of the rehabilitation team to a session to observe.

Some additional concerns that should be noted if present on the initial assessment include hypertension, heart problems, osteoarthritis and back problems such as degenerative disc disease and stenosis. The rider's physician should be consulted if any questions arise.

SAFE PROCEDURES IN WORKING WITH RIDING GROUPS

1. Riders are under direct supervision and control of a riding instructor at all times, whether mounted or unmounted.

2. Instructors have a comprehensive knowledge of individual horses in the program, and are able to judge their suitability for various riders.

3. Student/instructor ratios:
   a. Ring riding classes may not exceed ten minutes with an instructor and an assistant.
   b. Trail riding groups may not exceed six riders per instructor with a minimum of two instructors on every trail ride.

4. All riders wear safe and suitable attire including:
   a. Long pants and shirt.
   b. Protective head gear, facility supplies helmets.
   c. Riding boots.

5. The quality and condition of equipment used in the horse program is:
   a. Appropriate for it's intended use.
   b. Sized correctly to the riders.
   c. Fitted correctly to the horse.
   d. Properly maintained.

6. Safety checks are done on equipment and rider's clothing:
   a. Before each class begins.
   b. Each time a rider is mounted.

7. Before being allowed to ride out on the trail:
   a. All riders are instructed in horse control.
   b. All riders demonstrate horse control.

EMERGENCY ACTION PLAN

1. Know your Mounted Activity Emergency Action Plan.

2. Individual plans should be developed for severe weather and fire emergencies. Refer to you local telephone directory and consult your insurance company for guidelines.

3. Safety drills should be reviewed and practiced with all operating center personnel and volunteers at least twice per working session.

4. Make sure staff, volunteers and parents know the location of the following: human and equine first-aid kits, telephone, emergency telephone numbers and written directions to the operating center.

5. The cabinet or location of the human first-aid kit would be clearly marked, preferably with a large visual Red Cross emblem. The human and equine first-aid kits should be accessible to staff and volunteers during all operating center activities.

6. No toxic materials, such as pest controls, veterinary supplies and cleansers, should be located in the human first-aid kit.

7. All mishaps needing first-aid treatment at the operating center should be reported to the instructor and recorded on an Incident Report form.

8. Incident Reports are to be kept in a permanent file.

9. Know your insurance carriers' requirements.

10. Authorization Emergency Medical Treatment Release forms are to be on the premises and accessible if needed.

11. If an accident such as a fall or seizure happens while students are mounted, all riding stops until further notice is given by the instructor.

12. The instructor is to be in charge of any riding session emergencies.

13. The type of accident or results of any mishap will determine whether the instructor will dismiss or continue the class.

14. No one, including parents, is permitted in the arena or working area if an accident happens. Only those summoned by the instructor are allowed to enter the area quietly.

15. There is to be no excessive talking or noise.

16. Rider assistants are to explain the situation quietly and reassure the other mounted riders.

MOUNTED ACTIVITY EMERGENCY PLAN

If there is an emergency while a lesson is in session:

1. All horses will be halted.

2. All leaders will position themselves in front of the horses.

3. All sidewalkers will stabilize their riders, unless backriding, in which case sidewalkers will stabilize the backrider who will stabilize the rider.

4. The instructor will supervise dismounting procedures verbally or personally.

5. If circumstances call for the arena to be evacuated, the riders will be escorted out first by their volunteers and the horses will be removed by their leaders to an appropriate place, after the riders are out of danger.

6. The instructor will determine if medical personnel are required and will request assistance in contacting specified personnel.

WHAT TO DO WHEN A SEIZURE OCCURS

MINOR SEIZURES;
1. Stop the horse. Support the rider and check to make sure he or she is normal. If the rider is not O.K. after a few seconds, stop the ride for the day.

2. With a seizure that may last "a blink of the eye" without drowsiness or loss of consciousness, the rider may continue to ride. Place your arm over his or her legs to steady them for awhile.

3. Be aware of loss of balance even after a small seizure.

4. Do not put demands on the rider after a seizure. There may have been only a pause in awareness with a seizure, but there may be some disorientation. Be sure the rider is completely "oriented" before giving any commands.

MODERATE OR MAJOR SEIZURES;
1. Stop the horse. Calmly lower the rider to the ground and lay him or her on his or her side (in case the rider vomits). All other horses and riders should carefully leave the arena. Do not try to interfere with the seizure; let it run its course. Do not give the rider anything to drink. After the seizure, take the rider out of the arena and let him or her rest. The instructor must take charge of the rider as soon as possible. Do not attempt

to insert anything into the rider's mouth. Call the paramedics for severe seizures.

2. Instructors or therapists (unless they are RN or LVN) are not qualified to give seizure medicine--or any medicine--and can put themselves "at risk" if they give any medication to riders/program participants.

WHAT TO DO WITH A RIDER WITH AIDS

1. Let the client ride in the program as long as they are able to do so. They may need healthy exercise and challenges.

2. Cuts, rashes, abrasions or other injured areas of the skin should be covered with water proof dressing. Clothing will be sufficient in protecting against any contact.

3. Avoid sharp instruments with which the client might cut him or herself. Wear latex gloves when attending to a wound and wash hands afterward.

4. Washing hands and any exposed skin with soap and water is a preventive measure also after being in contact with body fluids.

5. Let the members of the team who are dealing with this client know of his or her condition but remember this information should be kept confidential.

WHAT TO DO WITH A PERSON WHO HAS AN ARTHRITIC CONDITION

1. The ride should be smooth and not longer than the rider can tolerate. Periods of rest may be needed. A horse with smooth gaits and transitions will be most comfortable.

2. Be gentle when assisting the rider; do not pull on joints that are painful or have a contracture. Ask the rider how to help.

3. A good balanced posture can help take stress off specific joints.

4. Exercises to relax the rider are helpful. The gentle rocking of the horse helps to stretch tight muscles and overall relaxation.

5. Children may need support. Some may need a therapist to backride with them. The backrider must be careful to provide support without applying pressure or causing the rider to lean to one side.

6. Do not ride if the rider complains of pain.

WHAT TO DO WITH A PERSON WHO IS AUTISTIC

AUTISM- Autism is a neurological disorder which produces the following characteristics in those affected.

a. Self-preoccupation--may not relate to people; avoids eye contact; has delayed or no social smile.

b. Communication dysfunction--lack of speech or unusual speech patterns; may repeat what you say ("parrot-like"); difficulty in expressing wishes.

c. Basically normal physical development with abnormal repetitive movement actions, such as moving the fingers continuously.

d. Perseveration or sameness--tends to get "stuck" in an action or obsessed with something such as a possession, spinning an object, rocking or perseverance of an idea, and may be fearful of new things.

e. May appear deaf or blind although he or she can hear and see.

f. May be very smart in specific skills, generally has excellent memory. Autism may be very mild with near normal functioning to very severe with functional retardation.

g. Function can vary from hour to hour or day to day: for instance a skill can be performed at one time but not at the next try. Autism can exist in combination with other problems created by organic brain disorders.

Procedures

1. Treat the person according to the degree of disability.

2. Approach the individual slowly and without demands.

3. Help make him or her comfortable with tasks that are easy and that bring the most joy. Add new tasks or skills slowly according to his or her ability to accept them. Give praise for accomplishments. Do not create stress, the rider may be stressed already due to his or her inability to communicate.

4. Do not force or expect interaction including eye contact. Be alert to any communication attempts and offer praise for all efforts. Lack of response to your statements does not mean a lack of understanding. Some riders may need to be shown what to do.

5. A person with autism may have low tolerance for stress and may show unusual behavior for no apparent reason. Be ready for actions such as getting off the moving horse or having a tantrum.

6. Do not allow improper actions. Expect good behavior. Be calm, friendly and firm.

7. Discipline much the same as with any other child.

WHAT TO DO WITH A PERSON WHO HAS EMOTIONAL OR BEHAVIORAL PROBLEMS

ATTENTION-DEFICIT-DISORDER (ADD) - Attention span can be disrupted by brain damage of various kinds. The individual may have difficulty focusing on instructions. Attention may drift or be diverted to something else. Attention span may be shortened due to a related language disorder or poor stress tolerance. Short attention span has nothing to do with intelligence.

ATTENTION-DEFICIT HYPERACTIVE DISORDERS (ADHD) - This diagnosis is frequently associated with learning disabilities and has gone through a multitude of redefinitions. At different times attention-deficit or hyperactivity were considered entirely separate diagnoses. Usually onset of ADHD is during pre-pubescence or early childhood. It might be most appropriate to view this diagnosis as a multiple handicap.

1. Listen carefully to your rider, do not argue or challenge a fantasy. Direct the rider's attention to the task.

2. If a rider blames you for problems that you have no control over, do not take this personally or respond to it. The rider may be projecting his or her feelings for someone else onto you.

3. Provide the rider with balance and security as needed. Some may need assistance until riding becomes more familiar.

4. Find in each rider something unique and nice. People with long term psychiatric problems may be difficult to like but all have some traits to which you can relate to on a personal and friendly basis.

5. Try to develop a relationship between horse and rider. Have the rider spend more time with grooming and touching the horse. Touching brings one in contact with the real world.

6. Encourage completion of the task and successes.

WHAT TO DO WITH A PERSON WHO HAS DOWN SYNDROME

1. Support the back if it is weak and balance is poor. Encourage good posture so muscles develop in good form.

2. This person may have a fear of heights and movement when he or she first starts riding. Be supportive. Let him or her just get used to being on the horse. The instructor may backride with him or her.

3. The rider's legs should be in a normal riding position so that the hip joints are not stressed. With small children, use a narrow horse.

4. The instructor should increase riding time slowly to increase strength and endurance.

5. Riders that have the strength to steady their heads and bodies will enjoy trotting.

6. Encourage coordination activities, mental development and riding skills that challenge the rider. Riders with Down Syndrome may have near normal intellect and can perform all kinds of horsemanship skills successfully.

7. Do not over challenge these riders. They will always try to please you. Some can be very manipulative. Set limits for them to carry out.

8. Try to relate to each in a way that is age-appropriate to the rider.

9. Be gentle with corrective criticism.

10. Be careful to avoid dust and to protect sensitive skin from the sun and the wind.

11. Many riders with Down Syndrome become skilled in all areas of competitive riding and vaulting.

12. Persons with instability at the cervical1-2 (Altanlo-Axial Instability), must not ride.

WHAT TO DO WITH A PERSON WHO IS MENTALLY RETARDED

1. Work with the riders on their level of ability and not below it. Have the rider tell you what he or she likes in general. This will give you some idea of the rider's level of function. All people can learn but at different rates.

2. Keep the activities simple until you know the rider can do more. Most rider will need time to adjust to the feel of the moving horse before they can do any activities.

3. The rider may need strict guidance to behave in an appropriate way. If this is not necessary, do not provide the structure.

4. Do not give reins to riders until they have been instructed in rein management and you are sure they will not yank at the horse's mouth. It is easier to set good habits than to correct bad ones. Even if the reins are attached to a halter, pulling on the reins develops poor riding skills. Explain to riders that yanking on reins hurts the horses. If

they cannot understand this concept, go on to games that areat their appropriate level.

5. The use of Peggy the Teaching Horse allows riders to learn the concept of reins without involvement of the horse. The use of reins may be more important to the staff than to the rider.

6. Encourage situations which produce success. Give plenty of praise for a job well done. Do not praise a poor job, since this does not give the rider proper feedback.

7. Activities should be challenging and fun.

8. Make sure the rider understands your directions. Speak slowly and use common words and short sentences.

WHAT TO DO WITH A PERSON WHO IS VISUALLY IMPAIRED

1. Let the rider tell you if his or her vision will cause a problem during riding or other activities.

2. Let the rider help you understand his or her problem, listen carefully. Observe what the rider can see. Some people may deny their problems.

3. Allow the rider time to interpret what he or she sees and to adjust eye focus or feel. Have the rider feel the saddle and reins. Name aloud the parts of the horse, saddle and bridle. Orient the rider well to his or her surroundings.

4. Give a mental picture if the rider cannot see an object or his or her environment.

5. Gently touch or speak to him or her. Do not surprise a blind rider with a heavy grasp or a sudden touch.

6. Have the rider use other senses such as feel and sound. Encourage him to "feel" the horse and to count the strides to be covered. Use a beeping device to identify distances. Beepers are allowed in competition for the blind. Try using a walkie-talkie that consists of a head set worn under the helmet.

7. Describe the environment. Many completely blind persons can "feel" their environment such as an object coming toward them.

8. Use textured and high contrast colored or white reins. It is difficult to see brown reins on a brown or black horse.

9. Let the rider know that another horse is close by or that he or she is approaching the fence, gate or pole. Use high contrast colored objects to mark the arena's borders and content.

10. Help to develop good posture. Watch for balance problems. Encourage good perception in a totally or near blind rider by helping him or her "feel" the correct body position requested by the instructor. Give him or her feedback in what his or her body is doing.

11. Give lots of **very specific instructions**. Talk most of the time so that the rider has a reference point.

12. Encourage independence as confidence builds.

WHAT TO DO WITH A PERSON WHO IS HEARING IMPAIRED

1. Help riders to develop all their senses.

2. Teach riders to feel the horse's movements and understand what they mean. The horse can provide the riders with much information as they learn to interpret its movements.

3. Know your riders' skills in communication. Some hearing impaired people lip read and others use sign-language and lipreading together, others use sign-language alone. Be prepared and know how you need to interact with them.

4. Become as proficient in sign-language as possible or utilize a sign language interpreter. Also remember that we all use extensive hand and body language. The hearing impaired person can understand this in much the same way that a person with normal hearing can.

5. For riders who lip read, be sure you are face to face with them and have their attention when you give directions. Speak clearly and slowly but use <u>normal</u> pronunciation. Use a pause between sentences. Speak slowly with children. Restate sentences which are not understood after 2 or 3 repetitions.

6. Be certain that you are close enough for the riders to clearly see your hands and face (in order to read your signs/speech).

LESSON SUGGESTIONS:

1. Due to the fact that congenitally deaf/hearing impaired persons have never heard the language, some concepts may be unfamiliar to them. Do not hesitate to ask for assistance from an experienced classroom teacher to be an interpreter when one runs into difficulties explaining equestrian concepts to the riders (e.g., diagonals, leads, rein and leg aids, and so forth).

2. If "a picture is worth a thousand words", a live demonstration is too. Use lots of visual demonstrations by a mounted instructor or other skilled rider rather than attempting to use lots of lengthy explanations.

3. Ask the riders to ride into the center of the ring and halt so that the instructor can give explanations or complicated directions. Do not attempt to give any but the simplest directions while the riders are circling the arena.

WHAT TO DO WITH A PERSON WHO HAS A LANGUAGE DISORDER

Expressive disorders:

1. Keep in mind that intelligence is not the problem (although children with mental retardation can have these problems).

2. It takes alot of patience to understand these riders. If possible, encourage non-verbal language.

3. Do not be afraid to say you do not understand what the rider says.

4. Try to encourage the use of single word responses. Say the word, then have them repeat the word, but do not push them if they cannot respond. Not being able to speak is very frustrating.

5. It is easier to initiate speech than to respond to someone else, so give the person time to try to express him or herself.

6. Use directions that do not require an answer. When possible, phrase sentences appropriate for a simple verbal or non-verbal yes/no response.

7. Some people may have only a few words they can say. They may use these words as though they were using full sentences. They may not be aware they cannot be understood. Tell them you do not understand.

8. Wait a longer time for responses than when talking with people without language disorder.

Receptive Disorders;

1. Use as much non-verbal language as possible. Show the rider what you want. Often visual demonstrations can preclude the use of language.

2. Speak slowly and look at the rider when you speak. Use single words for children or adults with severe problems. The rider may be able to understand a little. Give him or her time to process what you say. This can take several minutes.

3. Do not treat the rider as though he or she is stupid because they cannot understand you. Just do the best you can to communicate meanings, and smile.

Problems with persons having both expressive and receptive disorder:

1. Communication is very difficult and frustrating with this rider. Try different methods and see what works.

2. Be patient and relax, for nothing is gained by getting upset.

3. Use touch, expression and gestures to communicate.

WHAT TO DO WITH A PERSON WHO HAS A LEARNING DISABILITY

1. Try to develop some understanding of the rider's problem. When appropriate, have the rider tell you what activities are especially difficult and which are the best ways for him or her to learn and understand.

2. Do not use statements such as, "Oh, everyone has some problems like that". "There is nothing wrong with you, just pay attention".

3. Problem areas need alot practice and patience. They cannot be corrected easily, and some not at all.

4. Try to figure out how the rider can learn best through his or her strong areas. Some learn best visually, others through listening. Do not pressure. Most people with learning disabilities are already under stress since they must put so much effort into concentration and carrying out tasks. This lack of being able to perform is frustrating and degrading to them since their environment demands more from them. This causes a decrease in self esteem. Try to keep everything light and happy.

5. Give feedback on what the rider is doing and what the rider should be doing. The rider may also reverse things such as turning left for right. Saying "stop" may trigger a "go".

6. Do not get upset at the rider's slow response. The rider needs time to process information without added pressure.

7. It is very important that the activities are challenging, not dull. Remember this rider has normal or above average intelligence. Being slow is not dumb.

8. Remember that the rider is intelligent and generally understands, but may not be able to perform exactly as desired.

9. Make sessions short when necessary, but always challenge the rider. It is depressing for a person with a learning disability to be treated as though they are retarded or incapable.

10. End the session with a successful activity and a positive comment.

11. These riders may need structure. Do not confuse structure with repetition. Repetition of simple tasks are dull and unchallenging and do not help the rider to progress and resolve his or her disorder.

WHAT TO DO WITH A PERSON WHO HAS A BRAIN DISORDER

1. A rider will need more time to react to stimuli since the messages from the brain to the limbs may be either imperfect, misdirected or slow.

2. Be supportive. A great deal of effort may be needed to do a simple task.

3. Encourage relaxation. Have fun, laugh and sing. Laughing and singing increases breathing, and in turn, helps relaxation.

4. Help the rider to maintain the best possible posture. This will help him or her to develop muscle balance. Do not give unnecessary help, since this does not encourage strength and independence.

5. A rider tends to lean into support. Discourage this poor habit. Be careful not to lean on the rider with your arms or hand.

7. Encourage the rider to look up. This improves head control, posture and balance.

8. Exercises for stretching and balance are important. Exercises should be done while the horse stands. Later, when the rider can maintain balance, they should be done at a walk.

9. Ataxia and athetosis make the rider appear as though he or she will fall. He or she can maintain his or her balance better than one may think. Be alert for needed support but do not be over-protective; give him or her a chance to be independent.

WHAT TO DO WITH A PERSON WHO HAS A SHORT ATTENTION SPAN

1. Keep the tasks short. Repeat them if necessary.

2. Make sure you have the rider's attention before giving instructions. He or she may look at you but not be attending. Speak slowly and clearly. Ask if the rider understands you and have him or her repeat the instructions back to you.

3. Make the instructional part of the session short and allow for fun and relaxation at the end of the session.

4. Be aware of signs of stress such as tenseness, twitching or nervousness, not following through with instructions, chatting, showing no interest, changing the subject, having increased muscle tone, sweating, or difficulty with breathing.

WHAT TO DO WITH A PERSON WHO HAS FRAGILE EMOTIONS

1. Understand that the rider may not be able to control his or her emotional reactions, what the rider wants to do may not be what happens.

2. Do not react to inappropriate behavior but rather in a matter-of-fact fashion; go on with the lesson.

3. Give physical and mental support when needed and be patient.

4. Use a calm, slow moving horse.

5. Do not allow outrageous behavior. Take a "time out" for children, and adults also. Tell the rider when he or she is doing well and what is not appropriate. End the session if necessary.

6. Do not get angry with the rider.

WHAT TO DO WITH A PERSON WHO IS HYPERSENSITIVE

1. Touch the rider as little as possible. Firm touch is less offensive that light touch.

2. Do not act as though the rider's behavior is unacceptable if he or she over-reacts touch.

3. Long sleeve shirts and long pants help protect against offensive sun, touch and other skin irritations.

4. Do not force the rider to touch things.

WHAT TO DO WITH A PERSON WHO HAS HYPOSENSATION

HYPOSENSATION- decreased awareness of stimuli to the body.

1. Be patient. The student may not be able to do what is requested or at least in the way which is requested.

2. Show the rider what is meant or how to do it. Have the rider copy what is expected.

3. Do not expect the problem to go away quickly. It may take a long time for sensation to improve or it may never improve.

4. Use techniques to help overcome the problem, such as adaptive reins or textured

reins. Using tape or finger to increase feeling in the hand, or attaching weights onto the limb may help. Therapist approval is required for use of weights.

5. A rider may not know right from left if the brain cannot distinguish body parts. The instructor may put a red mark on the left hand and a blue mark on the right hand or use one red rein and one blue rein. Say to the rider, "turn red--left".

6. The therapist will provide exercises to increase sensation, such as putting the hands on the horse's shoulder to feel the movement. The therapist will have additional ideas. Give the rider feedback on his or her actions.

7. The horse provides the rider with stimulation in movement, pressure and skin sensation. Let the horse stimulate the rider with a good walking or trotting pace when this is appropriate.

8. Remember that poor sensation has nothing to do with intelligence.

9. For a person with little feeling in the legs and buttocks, be aware that pressure sores can develop. A pressure sore happens when there is continuous pressure on skin and muscle tissue without allowing for circulation of blood. Since this person has no feeling, he or she will not know that damage is occurring. The therapist will instruct you on how to decrease the chances of these sores developing.

WHAT TO DO WITH A PERSON WITH ALTERED MUSCLE TONE

ALTERED MUSCLE TONE (TONUS)- Muscle TONUS is the degree of tension a muscle needs to maintain the limb or body position in a relaxed state. A relaxed muscle normally shows slight resistance when another person tries to stretch it. If there is to much tension, muscles will be stiff or spastic. If there is not enough tension, muscles will be weak or floppy.

1. Be gentle handling tight limbs. Pulling on tight muscles will make them tighter. The limb will resist quick change.

2. Give the limb time to relax by itself, if possible.

3. Have the rider breathe deeply, this helps to relax the rider's muscles.

4. The rider should be allowed to maintain his postural control over his body as much as possible. Do not do anything to decrease his control since this will increase his stiffness. Help the rider balance as necessary.

5. If the altered muscle tone is in the legs, have the rider sit astride a wooden horse or barrel for approximately ten minutes before riding to encourage stretch and relaxation.

6. Initially after mounted, one may need to let the rider relax while the horse stands so

that the rider can adjust to sitting on the horse and the horse can adjust to the rider's weight.

7. Give the rider extra time to mount or do exercises.

8. Let the slow rocking movements and warmth of the horse relax the rider's body and limbs.

9. Use mental image games to help the rider stretch out, such as "pretend to be a rag doll and let everything "go", or "imagine that there are strings tied to your legs pulling them down".

10. The therapist may request that the limbs be gently shaken with slow, mild movement to relax the rider. Make sure not to grasp the limb tightly.
11. Use a horse with a smooth gait and smooth transitions.

12. Use a horse with a narrow barrel.

Weak or sloppy muscles:

1. When positioning the rider, be careful not to pull so hard as to dislocate a joint. The muscles may be weak and not able to hold the joints firmly together.

2. Be especially careful with young children whose bones are fragile and developing.

3. Allow the motion of the horse to add "tonus" to the muscles before doing exercises that demand strength.

4. Give support where needed until the rider can balance alone. Backriding by your therapist may be necessary to give good support and avoid damage to the joints.

5. Do not allow the rider's limbs to rest in awkward or abnormal positions.

6. Make sure the rider's head does not "bob" excessively (this can produce a whiplash effect). Stop trotting or slow down the walk. A rider with a weak head/neck posture must be carefully watched by the therapist.

7. If the rider does not have head control off the horse, he or she should not ride unless a therapist is directly treating him or her.

8. Use a horse that provides a lot of stimulation with gaits energetic enough to increase tone but not so much as to cause imbalance.

WHAT TO DO WITH A PERSON WHO HAS PARESIS

Paresis-is the incomplete loss of muscle power rather than total paralysis. A limb may

appear to be immobilized but may have the potential of gaining function. Any movement possible may be weak, clumsy, or "floppy" with poor control.

1. The rider may not be able to control the muscle actions of the body part affected with paresis. Help the rider to perform the movement.

2. In some exercises, it may help for the rider to "think" the movements. For example: the rider will visualize squeezing the legs around the horse and say "squeeze" to help do this. The rider is reinforcing with the mind whatever muscle movement there is to help move the legs.

3. Remember that it will take months or several years for strength and coordination to increase.

4. Let the horse's movements help strengthen the rider's movement patterns. The horse's good symmetrical walk challenges the rider with the balance and stimulation exercises needed to increase strength and endurance.

WHAT TO DO WITH A PERSON WHO HAS LIMITED RANGE OF MOTION

1. Move a spastic limb very slowly and gently. Do not pull on a tight muscle to increase the range; this can cause the range to become tighter or possibly tear the muscle/tendons.

2. Encourage the rider to move his or her own spastic limbs and also to use his or her voice with the movement, "I lift my arms up, up, up".

3. Consult with a therapist.

WHAT TO DO WITH A PERSON WHO HAS PATHOLOGICAL REFLEXES

PATHOLOGICAL REFLEXES- a person with brain damage may have weak or absent protective reactions, which may result in an inability to stay upright in sitting or standing or to re-balance when thrown off balance. Reflexes are seen in specific patterns.

1. The head is lifted and the total body straightens.
2. The arms bend and the total body bends.
3. The hand is raised to the face while the arm turns inward toward the body.
4. The legs may cross each other (scissoring).

Example: A small rider is raised out of his or her wheelchair by being lifted up under the arms, causing the legs to cross (scissoring).

1. A therapist with neurodevelopmental training will show the team how to avoid triggering pathological reflexes.

2. Do not expect the rider to be able to correct his or her posture easily or at all.

3. Relaxation will help the rider to control his or her movements with a more normal pattern.

4. Do not expect the rider to relax upon command. He or she is more likely to become tense to this command. Movement, singing, fun or other tactics are more likely to produce the right response.

5. When the rider is relaxed and having fun, abnormal reflexes may decrease.

6. Do not expect or encourage the rider to accomplish skills or tasks that increase abnormal movements.

7. Refer to the chapter in Engel, Helping the Rider Sit Up on the Horse for assistive techniques.

8. Have the rider sit upright on his or her seat bones to create a deep seat. This may encourage a straighter back--but watch out for, and prevent a posterior tilt and rounded back.

WHAT TO DO WITH A PERSON WHO HAS VESTIBULAR PROBLEMS

VESTIBULAR SYSTEM DEFICITS--This system affects muscle tone, body balance, visual perception and alertness. A rider has difficulty with balance and the muscle tone necessary to maintain balance against gravity.

1. For riders who need lots of movement, change directions and speed frequently.

2. Riders who are hypersensitive to movement may need to ride for short periods until they can tolerate movement better. A backrider may make them feel more secure at first.

3. The therapist may have you trot the horse for short periods. Make sure the rider does not slip while trotting.

4. Do not say things like "it's O.K., that's not so bad". Remember that the problem is disagreeable to the rider; his or her physical system is over-reactive.

5. Most riders who are hypersensitive to movement have fewer problems with a rough gait or trotting. The therapist may mix slow movements with fast movements to increase the rider's tolerance to subtle movements. Ask the rider what feels best and repeat that action. Even a non-verbal rider will indicate what is pleasing.

6. If the rider gets too tense from trotting, trot only for short periods. Help the rider to

relax. Have the rider sit on a sheepskin pad and use a vaulting surcingle. The softness of this pad may help to relax him or her and the vaulting surcingle provides good solid handles for security.

WHAT TO DO WITH PERSONS WHO HAVE RESPIRATORY DISORDERS

1. Exercise is good for this rider as it improves the lung muscles and stimulates general health.

2. Exercise should be carefully increased to tolerance.

3. Dust must be avoided, both the dust from the arena and the dust that comes from the hair of the horse. Wipe the horses with a damp cloth prior to mounting. A surgical or dust mask over the nose of the rider may help decrease dust inhalation.

4. Cold or dampness may trigger an asthmatic attack.

5. Have plenty of water on hand for riders with cystic fibrosis since they sweat more than usual and may get dehydrated.

WHAT TO DO WITH PERSONS WITH NEUROMUSCULAR DISORDERS

1. Do not let the rider get too tired or stressed. Increase demands in sessions slowly; stop for rest periods.

2. Always encourage good, balanced posture, with a level pelvis, so that spinal curvatures and contractures do not develop. Encourage equal strength and full range of the limbs on both sides of the body to prevent deformities. The therapist will advise you on proper seating and exercises.

3. Provide the rider with support when necessary, making sure the sidewalkers do not lean on the rider or pull him or her off balance.

4. Ask the rider how he or she is doing today, since people with these disorders experience changes from day to day. Get the rider involved in decision making. Remember, this person is generally of average or above average intellect.

5. Be careful of tight hip muscles when putting the rider on the horse. This can cause considerable pain from stretching.

6. A good exercise program is important to increase lung capacity and circulation for overall health.

7. Coordination may be poor due to poor sensation, hypersensation or weakness.

8. Watch for pressure sores if the rider has poor sensation in the legs and buttocks.

The stirrups should be adjusted to provide adequate support for weak legs with poor sensation. A sheepskin saddle cover can protect sensitive skin. Have the therapist assist you in these areas.

9. **Excessive exercise, stress or heat can temporarily increase the symptoms.** This can be prevented or decreased by providing rest periods of ten to twenty minutes. A weakened state can be noticed by unsteadiness, slurred speech, cramping, spasms, and/or decreased sensation.

10. Make the lesson stimulating to the rider's intellect. Many riders can develop intermediate to advance riding skills.

11. **In hot weather, have water available for the rider to drink during the lesson and spray the rider's arms and face with a light water mist to cool him or her off. Riders find this light mist cool and refreshing.**

WHAT TO DO WITH A PERSON WITH A SPINAL DISORDER

1. The rider's **skin** may be very prone to **pressure problems**. There may be a need for a sheepskin or other seating equipment to cover the saddle to avoid pressure areas. Watch for any reddened areas, and inform the instructor **immediately**.

2. Remember that this person has had structural damage to his or her body and not to the mind.

3. This person may wear braces to protect weak areas.

4. The instructor may select special riding equipment and tack for support and security.

5. The rider should wear pants without seams to prevent skin irritation from friction.

6. **Be sure that the rider feels balanced after mounting before you move the horse.** Provide adequate support.

7. Include this rider on your team to assist you in understanding his or her specific problems.

8. A therapist shall help to instruct in exercises to develop balance and increase strength.

WHAT TO DO WITH A PERSON WITH A SPINAL CURVATURE

1. A rider with a spinal curve must be carefully positioned on the horse with the pelvis level. Improper positioning can cause the spinal curve to worsen. **It is important for a therapist to supervise this rider.**

2. It is important that the person's riding posture keep him balanced and upright.

3. Muscle balance can be increased by:
    a.) a well-balanced horse.
    b.) a deep seated, balanced saddle properly centered on the horse.
    c.) circling the horse in large circles in the direction that tends to straighten the spine.

4. Supporting the rider from the back by a backrider will not necessarily straighten the spine. The backrider should be a therapist who knows how to best position the rider's spine.

5. Stirrups should be adjusted to achieve a level pelvis and encourage symmetry.

EVALUATION FORMS

THERAPEUTIC LESSON EXERCISES

Name:_____

Instructor:_____

Program:_____

Date:						
inhale/ex						
arm stretch						
hand circles						
twist						
foot circles						
touch toes						
arm circles						
head roll						
swing legs						
stand up						
lie on croup						

INSTRUCTOR/VOLUNTEER EVALUATION

Date: _____
Instructor: _____
Evaluator: _____
Position: _____

Scoring: 1=low, 10=high.	Score	Comment
Appearance		
Voice: quality, audibility, pitch, diction, variability		
General teaching attitude/ability		
Communication with students: verbal, non-verbal		
Understanding and use of horses		
Understanding and use of equipment		
Organization of lesson: mounting		
warm-up/down		
exercises		
new-skill		
game		
dismounting		
Lesson material: knowledge		
organization		
presentation		
Punctuality		

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CHAPTER V

Summary, Conclusions, and Recommendations

Summary

The purpose of this project was to describe and implement a therapeutic riding program for individuals with disabilities. To accomplish this purpose, a review of literature concerning the significance of recreation in the lives of the disabled was conducted. Information obtained from the literature was used to develop the philosophy in establishing the implementation of a special recreation service. A manual was then developed describing the roles and responsibilities of volunteers and staff, and methods and procedures for conducting a therapeutic riding lesson.

Communities are beginning to respond with preparation and opportunities to enable individuals with disabilities to make choices and to gain personal and social enrichment through recreational activities. Recreational activities may be used as a medium by which to achieve other learning objectives, or as an end in themselves by providing pleasurable leisure experiences. Throughout all such recreation programs, advocates must recognize that individuals with disabilities have a special need for self-respect and a feeling of accomplishment.

Conclusion

Conclusions reached as a result of the project were:

1. Most leisure activities are carried on in groups, and socialization is a key outcome of many recreational involvements.

2. Integration can be facilitated by gradually building up the individual's skill, confidence, and ability to associate with others in a positive manner.

3. Special recreation makes a vital contribution to the overall quality of life both physically and emotionally for persons with disabilities.

4. Therapeutic riding programs provide special recreation services for individuals with disabilities.

Recommendations

The author would like to suggest that it is necessary to examine recreation as a health-related field, and as a therapeutic modality.

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