



## Should Social Inclusion Be a Major Goal of Physical Education?

Claudine Sherrill, Guest Issues Editor

Inclusion of students with and without disabilities in general physical education, with appropriate supports, is a desirable practice (Block, 2000; Rizzo & Lavay, 2000; Sherrill, 1998, in press). Everyone knows, however, that physical inclusion (students with and without disabilities receiving instruction, with appropriate supports, in a common space) is not the same as social inclusion (students with and without disabilities interacting with each other in meaningful, satisfying, socially connected ways that contribute to active healthy lifestyles for all). While physical inclusion can be mandated by law and supported by administrative and instructional policies, authentic social inclusion can be achieved only by cooperative home-school-community programming in which inclusion is given high priority both day and night. To give any phenomenon high priority essentially means to make it a primary goal, to break it down into measurable objectives and benchmarks, to frequently assess performance, to count specific inclusion behaviors toward grades, and to reward improvement. Goals ensure accountability!

### AAHPERD Position Statement on Inclusion: A Brief Critique

The AAHPERD (1995) *Position Statement on Inclusion* does an excellent job of describing procedures for facilitating inclusion in physical education. It stops short, however, of recognizing that procedures are best operationalized by specific, concrete goals and objectives that everyone understands and works toward. Steeped in the lore that our unique contribution to education is helping students become active, efficient, and healthy movers, the writers of the AAHPERD document emphasized that the major IEP/IFSP goal should never be social development. This ill-conceived statement sabotages well-written procedures and good intentions. The document does not define social development and, thus, allows free reign to stereotyped notions that the social is play, recreation, or fun and, therefore, not worthy of emphasis in the school curriculum and its grading system.

I contend that, for most persons, a physically active lifestyle and health-enhancing level of physical fitness require social competence to enable lifespan inclusion in physical activities.



Both includers and includees must feel good about inclusion. Photo Credit: Lupe Castenada

Research shows unequivocally that persons with exercise/sports partners and friends are more likely to engage in daily, moderate-to-vigorous activity than those without. Research also indicates that persons with disabilities list lack of companions as a major barrier to participation in physical activities. This finding applies to individuals with and without disabilities. To achieve inclusion, I believe that social competence must be a primary physical education goal for all students and that it should be treated as a companion goal to motor skill and fitness competence, equal in status and deserving of conceptualization as primary, not secondary, not concomitant. It is time for the AAHPERD inclusion statement to be revised.

### The Social Competence Goal Area

Sherrill (1998, in press) defines the social competence goal area as social behaviors that promote inclusion in exercise and sport activities (i.e., such personal interactions as greeting,

smiling, sharing, cooperating, taking turns, helping, following, leading, cheering, supporting). Of special importance are such behaviors as gaining access to an activity, inviting someone to enter into an activity, accepting and rejecting invitations, and leaving an activity. When I was in graduate school, many of these behaviors were considered sportsmanship and included in grading protocols.

The acronym "FIT," which is used to quantify fitness goals, can be applied to measurement of the social inclusion goal:

- F for *frequency* of social interactions (this includes who initiates each interaction)
- I for *intensity* of social interactions (meaningfulness, appropriateness, carryover value)
- T for *time* or duration of social interactions

### What Research Has to Say about Social Inclusion

For over two decades, adapted physical education leaders have supported contact theory (Allport, 1954) as a means of facilitating social inclusion of children with and without disabilities (e.g., Archie & Sherrill, 1989; Slininger, Sherrill, & Jankowski, 2000; Tripp & Sherrill, 1991). Until recently, however, no physical educators have gathered concrete data on social interactions in an integrated instructional setting. Research on

sixth graders and eighth graders, respectively, has now examined social interactions over a period of six weeks (Place & Hodge, 2001; Wells & Sherrill, 2003). The findings are powerful, supporting the need to give primary attention to the goal of social inclusion in physical activity. Place and Hodge (2001) reported that the average percentage of time that 19 classmates gave to three girls with mild cerebral palsy and spina bifida was 2% social talk and less than 1% in each category for praise, use of first name, feedback, and physical contact. Wells and Sherrill (2003) observed that during physical education classes, most of the 30 students made no observable contacts with five boys with emotional disorders who had been integrated in their class for over six months. The low number of contacts was supported also by self-reports filled in twice a week for six weeks. These studies document what many teachers have been telling those of us who ask. Students with and without disabilities simply do not interact unless a social intervention or grading system requires speaking to, smiling, gesturing, or touching.

Little research on the efficacy of social interventions in physical education has been conducted (see Sherrill, 1998, Chapter 9, for illustrative models and measurable objectives). Of these social interventions, peer tutoring has been researched most, but data on improvement in quantity and quality of social interactions have not been collected.

IEP teams place students with disabilities into integrated physical education settings based on the assumption that the tenets of social justice are being met. Everyone seems to believe that improved social interactions will occur naturally, without the hard work that goes into the attainment of other instructional goals. Is it not time to reconsider social inclusion as a major goal in physical education and to teach professionals how to help children achieve this goal?

## Selected References

- Allport, G. W. (1954). *The nature of prejudice*. Cambridge, MA: Addison-Wesley.
- American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD). (1995). *Position statement on inclusion by the National Association for Sport and Physical Education (NASPE)*. Reston: Author.
- Archie, V., & Sherrill, C. (1989). Attitudes toward handicapped peers of mainstreamed and nonmainstreamed children in physical education. *Perceptual and Motor Skills*, 69, 319-322.
- Block, M. E. (2000). *A teacher's guide to including children with disabilities in general physical education* (2nd ed.). Baltimore: P. H. Brookes.
- Place, K., & Hodge, S. R. (2001). Social inclusion of students with physical disabilities in general physical education: A behavioral analysis. *Adapted Physical Activity Quarterly*, 18(4), 389-404.
- Rizzo, T. L., & Lavay, B. (2000). Inclusion: Why the confusion? *Journal of Physical Education, Recreation and Dance*, 71(4), 32-36.
- Sherrill, C. (1998, in press). *Adapted physical activity, recreation, and sport* (5th, 6th eds.). Boston: McGraw-Hill.
- Slininger, D., Sherrill, C., & Jankowski, C. M. (2000). Children's attitudes toward peers with severe disabilities: Revisiting contact theory. *Adapted Physical Activity Quarterly*, 17(2), 176-196.
- Tripp, A., & Sherrill, C. (1991). Attitude theories of relevance to adapted physical education. *Adapted Physical Activity Quarterly*, 8(1), 12-27.
- Wells, S. L., & Sherrill, C. (2003). *Social interactions in an inner city school: Do students interact with peers with emotional disorders in general physical education?* Unpublished manuscript based on thesis, Texas Woman's University, Denton.



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expressions of interest to evaluate the "Athletes at Work Program for Paralympians." Subiaco, Western Australia: Edge Training Solutions.

- Commonwealth Department of Family and Community Services. (2000). *Commonwealth disability services census 1999*. Canberra, Australia: Author.
- Gorely, T., Bruce, D., & Teale, B. (1998). *Athlete career and education program 1997 evaluation*. Brisbane, Australia: The University of Queensland.
- Lavallee, D., Gordon, S., & Grove, R. (1996, Winter). A profile of career beliefs among retired Australian athletes. *Australian Journal of Career Development*, 39-42.
- Martin, J. (2000). Sport transitions among athletes with disabilities. In D. Lavallee & P. Wylleman (Eds.), *Career transitions in sport: International perspectives* (pp. 161-168). Morgantown, WV: Fitness Information Technology Inc.



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The authors thank those who contributed information to the evaluation—in particular, we thank the AWPP athletes and their caregivers, employers, and coaches. Program funding was provided by the West Australian Lotteries Commission.

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