

RECREATIONAL THERAPY

An Introduction

FOURTH EDITION

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DEDICATION

To our students, the future of recreational therapy.

PREFACE

The preface to the third edition of this book noted that a revolution has occurred in the depth and breadth of the literature of our ever-evolving and maturing profession, giving testimony to a growing body of knowledge. We believe this fourth edition will play a major role in the continuing advancement in the body of knowledge of recreational therapy.

Our goal in preparing this fourth edition was to provide a book that would clearly define the essence of recreational therapy as a health care profession. Thus, this book is focused on the purposeful use of recreation and leisure as interventions to enhance the health and well-being of clients whom recreational therapists serve. To emphasize this goal, the title used for this edition is *Recreational Therapy: An Introduction*.

To accomplish our goal, we called upon leading authors to join us in writing chapters for this edition. Each author brings his or her expertise to providing the most current information in his or her area of specialization. Readers also may notice that two new editors have agreed to collaborate with the editors of the three prior editions of the book and to author chapters in their areas of expertise. Thus, this new edition benefits from having the best efforts of a team of editors and authors, each of whom brings the most current knowledge available in his or her area of specialization.

Those reading this edition of *Recreational Therapy: An Introduction* will find a continuation of the user-friendly approach employed in prior editions. Chapters begin with a list of learning objectives and end with a series of reading comprehension questions and a complete list of references. This edition also includes the same format being followed in every chapter devoted to a specific client population. This format includes a feature that has been appreciated in prior editions: a case study to illustrate the concepts in each chapter. A unique aspect of this edition is the a chapter on providing recreational therapy for members of the military services as one of the specific client populations.

Instructors using the fourth edition of *Recreational Therapy: An Introduction* as a textbook will have access to an instructor's guide that contains learning activities and examination questions. PowerPoint® slides for every chapter that may be used in classroom instruction are also available to the instructor.

A number of individuals have contributed in many ways to this book. Particular thanks are extended to Joe Bannon and Peter Bannon of Sagamore Publishing, who believed in the unique contribution that this book could make to the practice of recreational therapy. We would also like to express our appreciation to Amy Dagit of Sagamore Publishing for her supreme editorial assistance. Additionally, we wish to acknowledge and thank our coauthors and colleagues who have joined us by providing chapters in their areas of specialization. Their contributions make this fourth edition a truly unique work.

Finally, we would like to express thanks to the scores of individuals who appreciated the format and content of prior editions of the book and who have encouraged us to prepare this fourth edition. Hopefully, this new edition will live up to their expectations and will continue to further the practice of recreational therapy.

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SECTION 1

THEORETICAL OVERVIEW

1

INTRODUCTION AND OVERVIEW

DAVID R. AUSTIN

OBJECTIVES

- Conceptualize recreational therapy.
- Understand recreation and leisure as they relate to recreational therapy.
- Describe the concept of health.
- Describe the humanistic perspective.
- Describe the perspective of positive psychology.
- Understand the relationship of recreational therapy to a high level of wellness.
- Understand the relationship of recreational therapy to the stabilizing and actualizing tendencies.
- Reduce recreational therapy to a series of tenets.
- Identify kindred professions.
- Assess yourself in terms of competencies needed in recreational therapy.
- Know the plan for this book.

Richter and Kaschak (1996) wrote that within the field of therapeutic recreation a “confusion over its role and over its very essence” exists (p. 86). The authors’ criticism of therapeutic recreation professionals is that they have not clearly identified what they do and the purpose they serve. This failure has plagued the field for some time. For instance, Shank and Kinney (1987) wrote that therapeutic recreation has maintained “one consistent theme: the uneasy fit between recreation as a contributor to the normalization and life quality of persons with disabilities and recreation as a means to improve individuals psychological and physiological functioning” (p. 65). Sylvester (2009) suggested that therapeutic recreation has been “caught between two traditions that have resisted assimilation into a single practice” (p. 19). Furthermore, Sylvester wrote “what appears to be a single practice may actually be two, each practice having its own tradition” (p. 18). He went on to state that *leisure facilitation practice* (i.e., the facilitation of leisure for persons with disabilities) and *recreational therapy practice* (i.e., the use of recreation to bring about therapeutic outcomes) are “fundamentally different practices” (p. 18).

The editors of this text agree with Sylvester’s conclusion that the facilitation of leisure for persons with disabilities and recreational therapy (RT) are separate and distinct entities. This book deals with RT.

RECREATIONAL THERAPY: A HEALTH CARE PROFESSION

A number of health care professions exist. RT is one of these. Table 1.1 is a list of several health-related professions, along with their areas of expertise. Each profession has a particular body of knowledge upon which to draw in providing services. This body of knowledge makes the profession unique. In fact, experts (e.g., Schlein & Kommers, 1972; Wilensky, 1964) have long agreed that to claim the title of “profession,” an occupational group must have a defined area of expertise. What is the area of expertise of RT? What makes RT unique? The editors of this text believe that RT involves knowledge of recreation and leisure and their applications as these phenomena relate to achieving optimal health and the highest possible quality of life.

Table 1.1
Health-Related Professions

Profession	Expertise
Nurse	Caring for persons
Occupational therapist	Purposeful occupations
Physician	Illness, disease
Psychologist	Human behavior
Social worker	Support systems
Recreational therapy	Purposeful recreation/leisure

**RECREATION AND LEISURE AS A BASIS FOR
PROFESSIONAL PRACTICE**

Inevitably, textbook authors have emphasized recreation and leisure in attempting to define the still relatively new and emerging profession of RT. One of the earliest conceptualizations of RT contained a definition of recreation within it. Davis (1936) wrote,

Recreational therapy may be defined as any free, voluntary and expressive activity; motor, sensory or mental, vitalized by the expressive play spirit, sustained by deep-rooted pleasurable attitudes and evoked by wholesome emotional release. (p. xi)

More contemporary textbook authors have continued the tradition of including recreation and leisure within their definitions of RT. Two examples follow:

[Recreational therapy is] the systemic and planned uses of recreation and other activity interventions and a helping relationship in an environment of support with the intent of effecting change in a client’s attitudes, beliefs, behaviors, and skills necessary for psychosocial adaptation, health, and well-being. (Shank & Coyle, 2002, p. 54)

Recreational therapy employs purposeful, goal-directed interventions that involve clients in activities that have the potential to produce recreational and leisure experiences that lead them to experiencing what are the optimal levels of health for them as individuals. (Austin, 2013, p. 154)

These definitions of RT both refer to recreation/leisure activities and experiences. Other common themes found in the definitions are the planned and purposeful nature of using recreation/leisure as an intervention and the enhancement of the client's health and well-being as a result of the intervention. In short, these definitions point to the purposeful use of recreation/leisure activities and experiences as means of producing positive health benefits for recipients of RT services. RT practice, then, demands that recreational therapists have a high level of knowledge of recreation and leisure as phenomena, as well as expertise in using recreation/leisure activities to restore health and foster growth.

RECREATION AND LEISURE

Students in college and university departments of recreation, parks, tourism, and leisure studies are asked time and again to define the terms *recreation* and *leisure*. The purpose of the discussion within this textbook is not to cover old ground for those who have undergone the exercise of conceptualizing the meanings of recreation and leisure but rather to discuss these terms, as they form a basis for understanding RT.

Recreation

Voluntary action and activity have been associated with recreation, as have been positive emotions such as enjoyment, fun, and feelings of accomplishment. Recreation has also been perceived to be beneficial or constructive, meeting goals of the participant (Austin, 2011b; Neulinger, 1980; Shank & Coyle, 2002; Smith & Theberge, 1987). Additionally, recreation has been linked with being restorative, offering refreshment or re-creation for the participant (Kelly, 1996). In fact, the view of recreation having a healing function goes back to the writings of Aristotle, who wrote that persons restored their minds and bodies through recreation (Austin, 2011a). This ability to restore or refresh mind and body is perhaps the property that the average person most attaches to recreation.

If recreation is defined as being restorative or re-creative, using the term *therapeutic*, in combination with *recreation* (i.e., therapeutic recreation), seems to be redundant. If all recreation is restorative, is not then all recreation therapeutic? A better term to describe the employment of recreation as a purposeful intervention to promote health outcomes is *recreational therapy*. Today, the terms *recreational therapy* and *recreation therapy* are commonly used and interpret RT as a profession that employs recreation as a planned clinical intervention directed toward health outcomes leading to an improved quality of life.

Leisure

Although many views of leisure exist (Mannell & Kleiber, 1997), authors (e.g., Iso-Ahola, 1980; Neulinger, 1980; Smith & Theberge, 1987) commonly have referred to the factors of “perceived freedom” and “intrinsic motivation” as central defining properties of leisure. Perceived freedom typically is viewed as a person's ability to

exercise choice, or self-determination, over his or her own behavior. An absence of external constraints exists. Intrinsic motivation is conceptualized as energizing behaviors that are internally (psychologically) rewarding. Intrinsically motivated behaviors are engaged in for their own sake rather than as a means to an extrinsic reward.

Connected to the phenomena of self-determination and intrinsic motivation found in leisure is the basic human tendency toward developing or fulfilling one's potential. Renowned psychologists Piaget and Rogers both postulated this propensity, which Rogers termed the *actualization tendency* (Deci & Ryan, 1985). The tendency for self-actualization is directed toward stimulation of the organism to promote change, growth, and maturation within the individual.

Intrinsic motivation is seen as the energy basis, or the energizer, of this tendency for growth and development according to Deci and Ryan (1985). Intrinsic motivation itself rests on the organism's innate need for competence and self-determination. These needs in turn motivate persons to seek and to conquer optimal challenges that stretch their abilities but are within their capacities. When persons are able to achieve success, they experience feelings of competence and autonomy, along with accompanying emotions of enjoyment and excitement (Deci & Ryan, 1985).

Leisure seems to be one of the best opportunities for persons to experience self-actualization because it offers opportunities for individuals to be successful in self-selected, pleasurable activities. The Greek philosopher Aristotle held "that leisure is the way to happiness and quality of life because it provides a means to self-fulfillment through intellectual, physical, and spiritual growth" (Austin, 2011a, p. 15).

Self-Determination and Intrinsic Motivation

The concepts of self-determination and intrinsic motivation, which are central to leisure, deserve further consideration. An idea deeply rooted in Western culture is that human beings strive for control over themselves and their environment. The degree of social adjustment is related to the discrepancy that exists between perceived and desired control (Austin, 2002; Grzelak, 1985; Pender, 1987, 1996).

Research (e.g., Langer & Rodin, 1976; Seligman & Maier, 1967; Voelkl, 1986) has found that feeling a lack of control over aversive life situations produces a sense of helplessness. This in turn leads to the development of apathy and withdrawal that, in extreme cases, ultimately may end in death owing to perceived uncontrollability over a stressful environment (Gatchel, 1980). Unfortunately, much of what transpires in modern health leads to feelings of helplessness. Pender (1996) exclaimed that too often interactions with health care professionals foster feelings of helplessness in clients because of condescending behaviors, paternalistic approaches, and the mystification of the health care process.

Fortunately, RT represents the antithesis of the controlling environment often imposed on the individual who has health problems. Rather than being repressive, RT provides opportunities for clients to escape the normal routines of the health care facility to engage in intrinsically rewarding activities that produce feelings of self-determination, competence, and enjoyment.

Recreation/Leisure and Recreational Therapy

Recreational therapists need to have a highly developed understanding of the dynamics of recreation and leisure as potentially powerful forces they apply to practice within their profession. An essential characteristic of recreational therapists is that

they hold a strong belief in the positive outcomes that may be derived from recreation and leisure. A basic element in RT is that “recreational therapists prize the positive consequences to be gained through meaningful recreation and leisure experiences” (Austin, 2013, p. 226). Recreational therapists must understand recreation as voluntary activity that has restorative properties and leisure as a phenomenon that provides the individual with perceived control, the opportunity to meet intrinsically motivated needs, and a means to actualize potentials and achieve high-level well-being. In short, both recreation and leisure are means to achieve health enhancement. Recreation participation may be used to restore or maintain health, and leisure experiences may lead individuals toward achieving optimal health and well-being.

HEALTH

Because the ultimate end for RT is achieving as high a level of health as possible for each client, recreational therapists must comprehend fully what is meant by health. The term *health* and related terms are given extensive coverage in the following segment.

For many years, the phrase *absence of disease* was synonymous with health. If you felt “okay” and your doctor did not diagnose you as having medical symptoms, you were perceived to be “healthy.” This traditional biomedical model of health dealt strictly with the absence of disease.

Over the years, other definitions of health have evolved. These definitions stipulate a difference between the absence of symptoms of illness or abnormalities and vigorous health. A broad multidimensional view of health is represented in what perhaps is the most cited definition of health; the World Health Organization (WHO, 1947) defined health as “a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.” The term *biopsychosocial health* has been adopted to encompass the WHO’s perspective on health because the WHO definition includes biological, psychological, and social facets of health.

The WHO definition may be criticized as being abstract, vague, simplistic, and unsuitable for scientific interpretation. It does not list specific criteria by which a state of health may be recognized and does not acknowledge the phases of health that persons experience during their life spans (Pender, 1996). Furthermore, the term *complete* in the WHO definition may be questioned as it is unlikely that anyone truly enjoys total or complete “physical, mental, and social well-being”; thus, health under this definition may be considered to be unattainable.

The WHO definition, however, offers concepts essential to formulating a positive conceptualization of health (Austin, 2011a; Edelman & Mandle, 1998; Pender, 1996):

1. It recognizes the interrelated influences of biological aspects, psychological dynamics, and social relationships on health.
2. It displays a concern for the individual as a total system rather than as merely the sum of parts, thus indicating the necessity of taking a holistic view.
3. It places health in the context of internal and external environments.
4. It relates health to self-fulfillment, to creative living.

Health is a complex concept. The following definition of health seems to capture the elements discussed thus far. Jones (2000) wrote,

Health is a positive, balanced state of being characterized by the best available physical, psychological, emotional, social, spiritual, and intellectual levels of functioning at a given time, the absence of disease or the optimal management of chronic disease, and the control of both internal and external risk factors for both disease and negative health conditions. (p. 15)

Good health is a primary requisite to a high *quality of life*. The multifaceted phenomenon of quality of life includes physical, psychological, social, occupational, and leisure functioning, as well as a sense of well-being (Fallowfield, 1990; Jacoby, 1990). To address the total impact of a disease, disorder, or disability, health care personnel with concern for quality of life take a holistic approach that looks beyond primary symptoms. For example, although reduction in the frequency of seizures may be an initial goal in the treatment of a person with epilepsy, quality of life factors such as psychosocial functioning and client satisfaction will also be of concern (Baker, 1990).

At this point, the concept of health within RT will be examined. Often health-related terms such as *functioning*, *well-being*, and *quality of life* are found in definitions of RT, typically along with the term *health*. For instance, Shank and Coyle (2002) listed “psychosocial adaptation, health, and well-being” (p. 54) as outcomes of RT, and Kunstler and Stavola Daly (2010) listed improvements in “functioning, health and well-being, and quality of life” (p. 380) as outcomes of RT.

The health-related terms such as *functioning*, *adaptation*, *well-being*, and *quality of life* in such definitions seem to produce more confusion than clarity. From the information on health presented in this segment of the chapter, these terms may be understood as having application *under the term health* or *as resulting from health*.

These terms may be captured under the concept of health or have health as a basis. First, the term *functioning* will be examined. If RT professionals accept Jones’ (2000) definition of health, they see that functioning is a sign of health. Recall that Jones’ definition of health stated, “Health is a positive, balanced state of being characterized by the best available physical, psychological, emotional, social, spiritual, and intellectual levels of functioning...” (p. 15). Thus, the term *functioning* reflects health and may be subsumed under health. In short, good functioning indicates good health. Therefore, improved functioning does not need to be listed as a separate outcome of RT. Similarly, does not Jones’ term *optimal management*, as an indication of health, incorporate the term *adaptation*? Thus, as with the term *functioning*, the term *adaptation* may be seen as a sign of health to be encompassed under the term *health*.

Now the term *quality of life* will be examined. If RT professionals accept the notions of Fallowfield (1990) and Jacoby (1990) that quality of life includes physical, psychological, social, occupational, and leisure functioning, along with a sense of well-being that results from health, health clearly forms the basis for quality of life, and in fact, good health is necessary for a high quality of life. Using the term *well-being*, in portraying quality of life, expresses a feeling of doing well, satisfaction, or contentment.

Thus, rather than a “laundry list” of terms such as *health*, *functioning*, *adaptation*, *well-being*, and *quality of life* in describing the outcomes of RT, a more succinct expression may be that RT assists clients to bring about health outcomes that permit them to enjoy a higher quality of life or that the ends recreational therapists seek for their clients relate to health and quality of life.

INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY, AND HEALTH

Just as the WHO helped persons to take a new view of health in general, it also developed the International Classification of Functioning, Disability, and Health (ICF) to create a new perspective for conceptualizing the health of persons with disabilities. The ICF represents a paradigm change from the traditional medical model to a biopsychosocial model that is focused on functioning, not disability. The ICF emphasizes the importance of functional health. The focus on functioning allows persons with impairments to be viewed as being “healthy” even though they may have a health condition (e.g., a chronic illness, disorder, or injury), as long as they are functioning well. The ICF then is a tool that provides language that is focused on functioning in society, no matter the reason for the individual’s impairment (i.e., a problem in body function or structure).

Thus, the ICF emphasizes function rather than the etiology. Instead of having an emphasis the person’s disability, the ICF system is focused on the individual’s level of functioning as an indicator of health. From the ICF perspective, functioning is the result of the interplay of body functions (physiological or psychological) and body structures (i.e., anatomical parts such as organs or limbs), as well as activities (i.e., executing a task or action) and participation (i.e., involvement in a life situation). The ICF also accounts for environmental barriers and facilitators that impact the person’s functioning and for personal factors.

Environmental factors and personal factors are termed *contextual factors* under the ICF. Environmental factors include not only architectural accessibility but also terrain, climate, legal and social structures, and social attitudes. Personal factors are internal and encompass age, gender, coping styles, behavioral patterns, profession, education, and social background, as well as other characteristics that may influence how an individual experiences a disability. Under the ICF, therefore, medical diagnoses are seen as not providing the information needed on which to base the delivery of health care services. Instead, interventions are designed to increase the functional capacity of the individual or bring about environmental modifications that will lead to enhancement in functioning. The question for health care providers then becomes, what interventions may bring about the maximization of functioning?

The WHO (2002) report *Towards a Common Language for Functioning, Disability and Health: ICF* explained interventions that increase functioning:

Body level or impairment interventions are primarily medical or rehabilitative, and attempt to prevent or ameliorate limitations in person or societal level functioning by correcting or modifying intrinsic functions or structures of the body. Other rehabilitative treatment strategies and interventions are designed to increase capacity levels. Interventions that focus on the actual performance context of an individual may address either capacity-improvement or else seek environmental modification, either by eliminating environmental barriers or creating environmental facilitators for expanded performance of actions and tasks in daily living. (p. 8)

Thus, the ICF provides health professionals with a new way of conceptualizing health and disability. The ICF goes beyond the traditional medical model that viewed interventions only as dealing with the person’s impairment. Thus, interventions may

be aimed not solely on the individual but also on eliminating barriers to functioning and on developing facilitators to enhance functioning.

Because the ICF does not adhere to the traditional medical model, it fits well with concepts discussed within this chapter as hallmarks of RT, including taking a holistic approach, following a biopsychosocial model, conceptualizing an illness/wellness continuum, acknowledging the effect of the environment, focusing not solely on clients' impairments but also on their functioning, and employing interventions that build strengths and address difficulties (Austin, 2013; WHO, 2002). Furthermore, several RT scholars have described the ICF as being appropriate for incorporation into RT (e.g., Howard, Browning, & Lee, 2007; Porter & Burlingame, 2006; Porter & Van Puymbroeck, 2007; Van Puymbroeck, Austin, & McCormick, 2010; Van Puymbroeck, Porter, & McCormick, 2009).

HUMANISTIC AND POSITIVE PSYCHOLOGY PERSPECTIVES

Beliefs and values that flow out of the psychological perspectives of humanistic psychology and positive psychology have and will influence the practice of RT. In the sections that follow, these two perspectives will be introduced.

The Humanistic Perspective

In the 1950s, humanistic psychology came into existence as a “third force” in opposition to Freud’s psychodynamic approach and Watson and Skinner’s behavioral approach (Austin, 2013). This humanistic perspective recognized the uniqueness of human beings to be self-directed, to make wise choices, and to develop themselves or realize their potentials (i.e., become self-actualized). Humanistic psychologists proclaimed “that striving and growing are essential to human life and health” (Lindberg, Hunter, & Kruszewski, 1983, p. 70).

In general, professionals who embrace the humanistic perspective

- take a holistic view of the person;
- hold that both children and adults are capable of change;
- endorse the concept that individuals are responsible for their own health and possess the capacity to make self-directed decisions regarding their own health;
- follow a developmental model rather than a medical model—the developmental model is focused on client strengths, not pathology;
- see persons as being in dynamic interaction with the environment, not just reacting to the external world;
- view persons who strive for personal satisfaction yet go beyond their own needs to understand and care about others as healthy;
- value a strength-based approach to health enhancement; and
- believe persons express a tendency toward self-actualization. (Austin, 1999, 2011b, 2013)

Halbert Dunn’s conceptualization of health grew out of the influence of the humanistic perspective. Dunn (1961) coined the term high-level wellness, which he defined as “an integrated method of functioning which is oriented toward maximizing

the potential of which the individual is capable, within the environment where he (or she) is functioning” (p. 4). Dunn’s concept of health is centered on the wholeness of the individual and each person’s actualizing tendency, which propels each person toward the fulfillment of his or her potential. Furthermore, Dunn’s notion implies not only an absence of physical illness but also the presence of positive psychological and environmental wellness. Mental and social well-being join with the physical well-being of the total person in forming Dunn’s concept of optimal health, or high-level wellness.

Holistic medicine, as proposed by physicians who have championed high-level wellness, treats the person rather than the disease. Holistic medicine concerns the “whole person” and permits individuals to assume self-responsibility for their own health (Austin, 1999). Ardell (1977) identified the ultimate aim of “well medicine” (in contrast to “traditional medicine” normally practiced by the medical community) to be that of moving individuals toward self-actualization. The sole concern of traditional medicine is illness, whereas well medicine deals with wellness and health promotion.

Extending Humanistic Psychology: The Perspective of Positive Psychology

Positive psychology is focused on the positive side of persons instead of the negative. Similar to humanistic psychology, positive psychology is focused on human strengths and optimal functioning rather than pathology. In fact, positive psychology may be perceived to be an extension or outgrowth of humanistic psychology (Austin, 2013; Austin, McCormick, & Van Puymbroeck, 2010). Joseph and Linley (2004) stipulated that humanistic psychology and positive psychology have more similarities than differences.

Positive psychology came on the scene at the beginning of the 21st century. Championed by Martin E. Seligman, positive psychology developed in response to the orientation of mainstream psychology toward disease and the medical model. As with humanistic psychology, positive psychology is focused on human strengths and optimal functioning rather than pathology (Austin, 2013; Austin, McCormick, & Van Puymbroeck, 2010). Biswas-Diener and Dean (2007) portrayed positive psychology as a “branch of psychology that focuses on what is going right, rather than what is going wrong with people” (p. x).

Briefly, positive psychology is the psychology of human strengths and optimal functioning. Duckworth, Steen, and Seligman (2005) defined positive psychology as “the study of conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions” (p. 629). Linley and Joseph (2004) took an applied approach to positive psychology, stating, “Applied positive psychology is the application of positive psychology research to the facilitation of optimal functioning across the full range of human functioning, from disorder and distress to health and fulfillment” (p. 4). These authors further stated, “Applied positive psychologists may work both to alleviate distress and to promote optimal functioning” (p. 6). Skerrett (2010) explained that “positive psychology is devoted to understanding what goes well in a life and examines how and why, and under what conditions humans flourish.” She went on to state that positive psychology is “not a replacement to the more problem focused or deficit-based paradigms.... it is conceptualized as a complementary and important dimension to understand the full range of human experience” (p. 488). The essence of positive psychology is summarized in Table 1.2.

Table 1.2*Positive Psychology in a Nutshell*

-
1. Positive psychology looks at what is right with people, is focused on when people are at their best, and attends to individual and group flourishing.
 2. Positive psychology is not the focus of positive at the expense of the negative. Positive psychologists recognize negative emotions, failure, problems, and other unpleasanties as natural and important aspects of life.
 3. Positive psychology is, first and foremost, a science. As such, it is principally concerned with evidence, measurement, and testing. That said, positive psychology is also an applied science, and there is a common understanding that research results will lead to the creation of real-world interventions that will improve aspects of individual and social life through evidence-based practice.
 4. Interventions produced by positive psychologists are, by and large, positive interventions.
-

Note. From *Therapeutic Recreation Processes and Techniques* (7th ed.), by D. R. Austin, 2013, Urbana, IL: Sagamore, p. 31, as adapted from *Practicing Positive Psychology Coaching*, by R. Biswas-Diener, 2010, Hoboken, NJ: John Wiley & Sons, p. 5.

Both humanistic psychology and positive psychology likely will influence RT practice as indicated in the following statement:

It is likely that, as positive psychology becomes better known, recreation therapists will embrace it because positive psychology tends to extend the ideas already accepted by recreation therapists through the influence of humanistic psychology. With the welcoming of positive psychology, recreation therapists will likely more strongly embrace health promotion. Health promotion will then join health protection (i.e., treatment and rehabilitation) to provide two primary thrusts for recreation therapy practice in the years ahead. (Austin, 2005–2006, p. 9)

RECREATIONAL THERAPY: ILLNESS AND WELLNESS

As has traditional medicine, RT has long dealt with problems brought about by illness and disability. Unlike traditional medicine, RT has not dealt exclusively with illness and disability. Instead, RT has historically promoted the facilitation of the fullest possible growth and development of clients. In one respect, RT has been much like traditional medicine in its concern for alleviating the effects of illnesses and disabilities. On the other hand, recreational therapists join physicians practicing well medicine, humanistic psychologists, and positive psychologists in their desire to bring about the growth of clients.

Austin (2011a) summed up this perspective in his book *Lessons Learned: An Open Letter to Recreational Therapy Students and Practitioners*:

We, in recreational therapy, can alleviate distress by helping our clients gain relief from their symptoms, but additionally we can go far beyond this, helping clients to develop and to use their strengths and potentials to deal with barriers to health and to facilitate optimal functioning. We cannot only help our clients to become well again, we can help them to become better than they were before they came to us. (p. 2)

Motivating Forces: The Stabilizing and Actualizing Tendencies

Therefore, recreational therapists help clients to strive for health protection (illness or disability aspects) and health promotion (wellness aspects). Major human motivational forces underlie these two aspects: the stabilizing tendency and the actualizing tendency.

The *stabilizing tendency* is directed toward maintaining the “steady state” of the organism. It is the motivational tendency moving persons to counter excess stress (i.e., distress) to maintain their levels of health. When faced with excessive stress, persons engage in adaptive behaviors to regain their sense of equilibrium. They attempt either to remove themselves from the stress or to minimize the effects of the stressor.

The stabilizing tendency is responsible for persons adapting to keep the level of stress in a manageable range to protect themselves from possible biophysical or psychosocial harm. Potentially harmful stressors may result from internal and external stimuli. Negative forms of tension may come either from within persons or from their surroundings. The stabilizing tendency is the motivational force behind health protection (Pender, 1987).

The *actualizing tendency* is the growth-enhancing force discussed earlier in the chapter, when considering self-determination, intrinsic motivation, the humanistic perspective, and high-level wellness. This actualizing tendency is the motivational force behind achieving optimal health.

IS ILLNESS OR DISABILITY EVER POSITIVE?

Health is a complex concept that encompasses coping adaptively, as well as growing and becoming. When persons are healthy, they can cope with life's stressors. Those who enjoy high-level wellness are free to develop themselves to the fullest. Barriers to actualization do not exist, so such persons are free to pursue personal growth and development. Health makes actualization possible.

Because of the natural progression from health protection (illness and disability aspects) to health promotion (wellness aspects), Flynn (1980) suggested that an illness or disability may be positive. The occurrence of a health problem may serve as an occasion for clients to take control over their lives and to learn how to strive toward optimal health. An example would be an individual who has a health problem (e.g., cardiac or mental health problem) because of stress. Dealing with this problem forces the person to seek the help of a health care professional, such as a recreational therapist. As a result of treatment involving participation in physical activity, the client may not only overcome the original health concern but also learn to lead a lifestyle that promotes reduced tension and increased enjoyment. By learning how to deal with stress and participate in healthy activities that provide for growth and enjoyment (e.g., walking, yoga, and swimming), individuals not only are able to con-

quer the initial health problem but also rise to a new level of health that they may not have experienced had the presenting problem not happened.

PRESCRIPTIVE ACTIVITIES, RECREATION, AND LEISURE

Recreational therapists contribute to health by helping persons fulfill their needs for stability and actualization until they are able to assume responsibilities for themselves. This is accomplished through client participation in three interventions: prescriptive activities, recreation, and leisure.

Prescriptive Activity

When individuals first encounter illness or disability, they often become self-absorbed, withdraw from their usual life activities, and experience a loss of control over their lives (Flynn, 1980). To combat such feelings, the recreational therapist selects prescriptive activities to activate clients demoralized by health issues. The rationale for prescriptive activities is that clients must actively engage in life to overcome feelings of helplessness and depression and begin to establish control over the situation. They need to become energized so they are not passive victims of their circumstances but take action to restore their health. Within prescriptive activities, clients begin to experience feelings of fun and accomplishment. They begin to make improvements and to regain a sense of independent functioning and control so they may move past prescriptive activities and engage in recreation. In sum, prescriptive activities become a necessary prerequisite for clients demoralized by illness or disability to move on to voluntary participation in recreation activities that may lead to health restoration.

Austin (2011a) expressed the feelings persons may experience as they gain positive experiences from their prescriptive activities and begin to experience recreation:

When individuals experience positive emotions, they begin to loosen up, to feel free or less encumbered. They open themselves up so they are more receptive to new thoughts and behaviors. They are far more prone to stretch themselves and to try new experiences that they might avoid if they were not feeling happy or being in a good mood. Think about yourself; are you more open to try new things if you are in a positive, optimistic frame of mind? Of course you are. So are clients. (p. 2)

Recreation

Recreation involves activity as one component, but it is more than activity. As previously discussed, recreation may produce restorative results and help persons to cope with chronic conditions or disabilities. Through recreation activities, clients reach health outcomes and regain their equilibrium. Recreation represents enjoyable activities the client selects in concert with the recreational therapist to meet goals and objectives of the intervention plan. Thus, during recreation, clients are exercising some measure of choice and control.

Leisure

Leisure may be seen as a means to self-actualization. Through leisure experiences, persons meet challenges. These leisure experiences feature self-determination, intrinsic motivation, and mastery and competence—experiences that lead in-

dividuals toward feelings of self-efficacy, empowerment, pleasure, and enjoyment (Austin, 2011b, 2013).

A unique virtue of recreation and leisure is that they are components of life free from constraint. In no other parts of their lives are persons allowed more self-determination. During recreation and leisure, individuals may “be themselves.” They may “let their hair down.” They are allowed to be human with all their imperfections and frailties. The caring, accepting attitude the recreational therapist assumes in creating a free and nonthreatening recreation/leisure environment allows for positive interpersonal relationships and for opportunities for accomplishment. The question has been asked, “in what better atmosphere than that achieved in recreation and leisure could growth be fostered and problems met?” (Austin, 1999, p. 144).

SCOPE OF RECREATIONAL THERAPY

RT may be perceived to be a means to restore oneself or regain stability or equilibrium following threat to health (health protection) and to develop oneself through leisure as a means to high-level wellness (health promotion). Thus, RT has the primary goals of (a) restoring health and assisting clients to cope with chronic conditions and disabilities and (b) helping clients to use their leisure in optimizing their potentials and striving for high-level wellness. RT provides for the stabilizing tendency by helping individuals to restore health or cope adaptively with chronic illnesses and disabilities and the actualizing tendency by enabling clients to use leisure as a means to personal growth.

Figure 1.1 illustrates the Health Protection/Health Promotion Model. This conceptual model for RT was recently reformulated to (a) include clients with chronic conditions and disabilities and (b) reflect theoretical perspectives from positive psychology (Austin, 2011b).

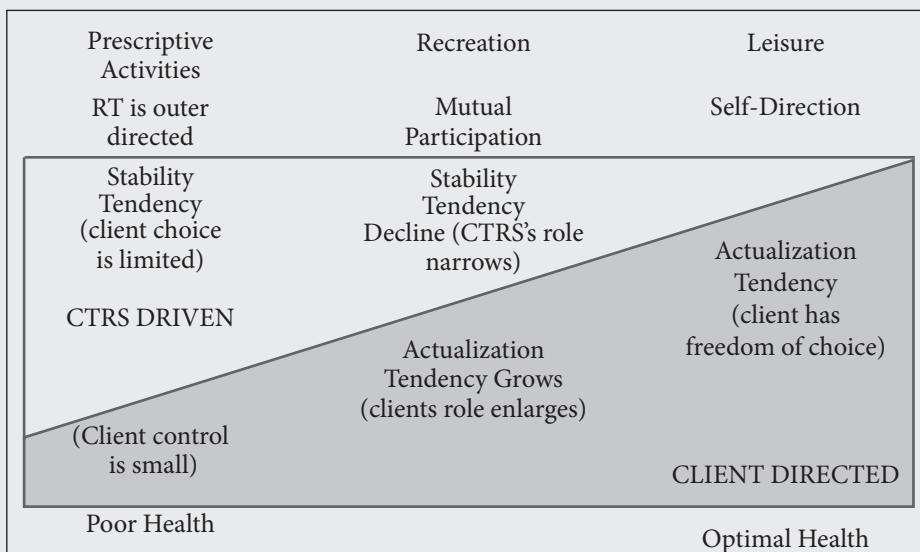


Figure 1.1. Health Protection/Health Promotion Model. TR continuum from *Therapeutic Recreation: An Introduction*, by D. R. Austin and M. E. Crawford, 1996, Needham Heights, MA: Allyn & Bacon. Copyright 1996 by Allyn & Bacon. Reprinted with permission.

In the diagram of the model, as clients move from health restoration toward the achievement of high-level wellness, or optimal health, they exercise greater and greater choice, or self-determination. At the same time, the role of the recreational therapist continually decreases. Clients ideally move to the point that they experience optimal health in a favorable environment and have total self-determination. In this state of optimal health, or high-level wellness, they are free to be self-directed and to pursue self-actualization.

Under the Health Protection/Health Promotion Model, clients may enter the continuum at any point that is appropriate for their needs. Along the continuum are three broad areas. The first area is where the stabilizing tendency is paramount. At the extreme, the client is experiencing poor health in an unfavorable environment, and the recreational therapist helps activate the client. The client's role is relatively passive in terms of selecting activities for participation, as the recreational therapist provides direction and structure for the intervention that involves prescriptive activities.

The next area along the continuum represents mutual participation on the parts of the client and recreational therapist as recreation interventions are selected. The actualizing tendency begins to emerge as the stabilizing tendency starts to decline.

In the third area, the actualization tendency enlarges as the client's health improves and he or she moves toward self-determination. The role of the recreational therapist is to assist the client, who ultimately assumes primary responsibility for his or her own health, to become skilled in and knowledgeable about leisure pursuits and to select leisure opportunities that have the potential to produce high-level wellness.

Thus, the Health Protection/Health Promotion Model reflects the full extent of RT practice. At one extreme of the continuum of service, the recreational therapist is assisting clients in poor environments to restore health. At the other extreme, the recreational therapist is helping clients achieve optimal health, or high-level wellness, in favorable environments (Austin, 2011b, 2013).

ADDITIONAL CONCEPTUAL MODELS

In addition to the Health Protection/Health Promotion Model that I have presented as a basis for the practice of RT, several conceptual models have been developed to offer theoretical bases for the practice of what the authors of the models have termed the field of *therapeutic recreation*.

Leisure Ability Model

The oldest conceptual model is the Leisure Ability Model introduced in 1978 by Gunn and Peterson. This model has been revised through the years. Its most recent revision, by Stumbo and Peterson, appeared in 2009. The mission of the Leisure Ability Model is to help clients with limitations to develop "a satisfying leisure lifestyle, the independent functioning of the client in leisure experiences and activities of his or her choice" (Stumbo & Peterson, 2009, p. 29). The model has three major parts along a continuum. The first, functional intervention, deals with improving functional ability. The second is leisure education, which is focused on the client gaining leisure-related attitudes, knowledge, and skills. The third component, recreation participation, has to do with structured activities that give clients the opportunity to

enjoy recreational experiences (Stumbo & Peterson, 2009). Thus, the thrust of the Leisure Ability Model is on facilitating leisure experiences for persons with disabilities.

Other Leisure-Oriented Models

Similarly, the focus of the Self-Determination and Enjoyment Enhancement Model, developed by Dattilo, Kleiber, and Williams (1998), is on leisure for persons with disabilities. This model gives particular attention to promoting participants' self-determination. Likewise, the Leisure and Well-Being Model of Carruthers and Hood (2007) is focused on the leisure experience of persons with disabilities, along with clients' reactions to disability. Practitioners using the model must have understandings of empirical and theoretical knowledge related to the leisure experience. Anderson and Heyne's (2012) Flourishing Through Leisure Model extends the Leisure and Well-Being Model. This model is grounded in the social model of disability that views disability as a social construct in which the social environment (i.e., society's attitudes and practices) is seen as being disabling for persons with impairments. Thus, this model holds that environments need to be changed to allow persons with impairments to enter fully into society and flourish through their leisure participation.

Health-Oriented Models

Two of the conceptual models share the health orientation evident in the Health Protection/Health Promotion Model of Austin (1998, 2001, 2011b, 2013). The Therapeutic Recreation Service Delivery and Therapeutic Recreation Outcome Models that Glen Van Andel (Carter & Van Andel, 2011) developed share many of the concepts represented in Austin's conceptual model. Van Andel's models have the purpose of assisting clients to attain their optimal levels of health, well-being, and quality of life. For instance, the Therapeutic Recreation Service Delivery Model uses a continuum that begins with diagnosis/needs assessment and is followed by treatment/rehabilitation, education, and finally, prevention/health promotion. The focus of the Therapeutic Recreation Outcome Models is on improving functional abilities that lead to enhancements in clients' quality of life.

Still another health-related model is the optimizing Lifelong Health Through Recreation Model that Wilhite, Keller, and Caldwell (1999) developed. The purpose of this model is to enhance health and well-being and minimize the effects of illness and disability across the life span, through the use of alternative activities to compensate for impaired abilities.

In summary, Austin's (2011b) Reformulated Health Protection/Health Promotion Model is the only model developed expressly to serve as a conceptual model for RT. Conceptual models developed to serve as theoretical foundations for therapeutic recreation, such as those developed by Van Andel and Wilhite, Keller, and Caldwell, share the health orientation of Austin's Health Protection/Health Promotion Model and therefore may have potential application in RT. Others, such as the Leisure Ability Model, emphasize a leisure orientation. Their focus is on facilitating leisure experiences for persons with disabilities.

RECREATIONAL THERAPY, INCLUSIVE RECREATION, AND SPECIAL RECREATION

RT has been presented in this chapter as a purposeful intervention to assist clients to achieve as high a level of health as possible. You may be asking, “Does RT always involve purposeful intervention for health enhancement? Does RT ever simply involve the provision of recreation services to persons who have an illness or disability?”

Certainly general leisure experiences may bring about benefits for participants. Stumbo, Wang, and Pegg (2011) indicated, “It has been widely acknowledged that leisure experiences and participation provide unique and valuable opportunities that may result in numerous physical, social, and psychological benefits, as well as enhance overall quality of life” (p. 92). Amplifying on the value of leisure in persons’ lives, Yalon-Chamovitz and Weiss (2008) stated, “Participation in leisure activities is a fundamental human right and an important factor of quality of life” (p. 273). Based on a review of the literature, Austin and Lee (2013) concluded, “The literature to support the claim that leisure can positively affect people is abundant” (p. 11).

In fact, Austin and Lee (2013) authored an entire book on the need for park, recreation, and tourism professionals to provide leisure services to improve the quality of the lives of all persons by focusing services to encompass underserved diverse populations, including persons with disabilities. The title of that book is *Inclusive and Special Recreation: Opportunities for Diverse Populations to Flourish*.

Within the book, Austin and Lee (2013) employed the terms *inclusive recreation* and *special recreation* to describe the provision of services to persons with disabilities. They wrote, “The term, inclusive recreation, has been used to capture the full acceptance and integration of persons with disabilities into the recreation mainstream” (Austin & Lee, 2013, p. 54). They employed the term *special recreation* to describe programs for individuals with similarities to participate together in recreational experiences. Examples of special recreation programs include wheelchair sports, camps for children with disabilities, the Special Olympics, and the National Veterans’ Wheelchair Games.

Persons with disabilities may be recipients of both inclusive and special recreation services and RT services. So what are the differences between the inclusive recreation and special recreation services that the park, recreation, and tourism professions offer and the interventions those in the RT profession provide?

Simply providing recreation services to clients who have an illness or disability does not constitute the delivery of RT. Therapeutic intent has to be involved in RT. Without a planned intervention to produce a health benefit, what is provided is simply a leisure experience even though it is provided to a person who is ill or disabled. Austin (2011a) stated,

In my mind, to be therapeutic, recreational therapy must display that it is purposeful and goal-directed in terms of supplying health benefits. The outcomes of recreational therapy are not random. They are planned. Recreational therapy employs an evidence-based approach that involves systematically using interventions to bring about specific therapeutic outcomes for clients. (p. 6)

Then what sets RT apart from inclusive recreation and special recreation is both the end sought and the process to achieve that end. The end for both inclusive rec-

recreation and special recreation is to facilitate leisure experiences. The end of RT is to help clients achieve specific health-related outcomes through the use of a systematic process employed by credentialed recreational therapists.

The systematic process involves four phases: assessment, planning, implementation, and evaluation. This process is commonly known by the acronym APIE drawn from the beginning letters of each phase and is often referred to as the *apie* process (pronounced a-pie). More formally, it is known as the recreational therapy process or RT process. An explanation of the RT process follows:

Through the orderly phases of the recreational therapy process, the client's problems or concerns and strengths and needs are determined (assessment), plans are made to meet the problems or concerns (planning), the plan is initiated (implementation), and an evaluation is conducted to determine how effective the intervention has been (evaluation). (Austin, 2013, p. 156)

The RT process provides a cornerstone for RT. Because of its critical nature, a full discussion of its four phases is provided in Chapter 3.

As a caveat to this discussion, it should be mentioned that occasionally, in settings such as skilled nursing facilities, recreational therapists may be called upon to conduct or supervise general leisure activities (e.g., movie nights, bingo parties) that are not included in the clients' intervention or care plans. Such activities are often conducted by RT assistants, nursing staff, or volunteers and are offered to provide an improved quality of life for participants.

TENETS BASIC TO RECREATIONAL THERAPY PRACTICE

To function as protectors and promoters of health, recreational therapists rest their practice on a belief system. The following statements provide basic tenets for RT practice as perceived by the editors of this book. The tenets are as follows:

1. The basic goal of RT is to achieve the highest possible level of health for each client.
2. Good health provides a basis for a higher quality of life.
3. Illness may be a growth-producing experience for individuals who participate in RT.
4. Every client possesses intrinsic worth and the potential for change.
5. Clients should be treated with dignity and respect.
6. Persons are motivated toward health through the stability and actualization tendencies.
7. Illness (poor health) and high-level wellness (optimal health) are dimensions of health that may be perceived to be on a continuum.
8. RT may assist a wide spectrum of clients along the illness–wellness continuum, including persons with chronic illnesses and disabilities, as well as persons with acute conditions.
9. RT involves planned interventions that are purposeful and goal directed.
10. Persons have social needs that include belonging and feeling valued.

11. Social support often plays a prominent role in maintaining and improving health.
12. Problems and concerns in health produce needs that may be fulfilled through interactions between clients and recreational therapists.
13. Being genuine, nonjudgmental, and empathetic toward clients promotes therapeutic relationships and helps create a safe, caring environment.
14. Warm, positive, accepting, and hopeful atmospheres in programs promote client change.
15. Persons strive to maintain control over their lives and to function independently, so recreational therapists should not be manipulative or controlling.
16. Recreational therapists model healthy behaviors and attitudes while helping clients develop personal competence and intrinsic motivation for participating in healthful activities.
17. Positive emotions, such as pleasure and fun, are means to achieve optimistic views that open persons up to new growth-enhancing experiences.
18. Prescriptive activities have the potential to energize clients and motivate clients to take action to restore their health (in the case of acutely ill clients) or adaptively cope with their chronic condition and disabilities (in the case of clients with chronic illnesses or disabilities).
19. Recreation activities and experiences allow clients choice and control, as well as help clients to restore health or adaptively cope with chronic conditions or disabilities.
20. Leisure experiences, which contain the elements of intrinsic motivation, self-determination, and mastery, produce feelings of self-efficacy, empowerment, and enjoyment that, in turn, move participants toward achieving optimal health, or high-level wellness.
21. Different roles are assumed by recreational therapists who, depending on the needs of clients, may serve as guides providing clients with direction (during prescribed activities), partners in mutual relationships with clients (in recreation), or as facilitators of leisure experiences (during leisure).
22. Recreational therapists assist clients to develop healthy living habits that their clients will take with them once they are no longer in RT.
23. Recreational therapists take a strength-based approach that is focused on abilities and intact strengths of the clients.
24. A strength-based approach helps clients to identify strengths and what works for them.
25. RT is concerned with both treatment/rehabilitation and education/reeducation. Therapeutic outcomes emphasize enhanced functioning and the here and now.
26. Typical outcomes for RT interventions include increasing personal awareness, increasing interpersonal or social skills, developing leisure skills, decreasing stress, decreasing depression, improving physical and mental

- functioning, improving physical fitness, and developing feelings of positive self-regard, self-efficacy, perceived control, pleasure, and enjoyment.
27. Recreational therapists have knowledge of the demands inherent in specific activities that are employed as interventions. Activity analysis is used to gain insights into the demands activities make on clients to ensure the careful selection of appropriate activities.
 28. Recreation and leisure activities offer diversion or escape from personal problems and concerns and the routine of health care facilities.
 29. Recreational therapists employ the RT process (often referred to as the a-pie process).
 30. Clients' preferences and perceptions are important in all phases of the RT process.
 31. Recreational therapists operate from a theory base provided by the conceptual model of RT that they adopt.
 32. Recreational therapists engage in evidence-based practice in their clinical decision making by integrating the most current research findings with their clinical expertise and client values and preferences.

KINDRED PROFESSIONS

Recreational therapists do not work in isolation from other health care professionals. In fact, using interdisciplinary teams composed of personnel from various specializations has become widespread through health care. The establishment of interdisciplinary teams is largely based on the notion that clients are so complex that no profession by itself can offer adequate health care (Austin, 2013; Howe-Murphy & Charboneau, 1987). Team membership will vary as a function of the setting in which services are being delivered (e.g., a center for physical medicine and rehabilitation or a center for psychiatric or mental health care) and as a function of the specific problems or concerns of the client.

Although no attempt is made here to discuss all kindred professions, major professions are covered, including medical doctors, nurses, psychologists, social workers, as well as activity or rehabilitation therapy professions.

Medical Doctors

Medical doctors (MDs) use surgery, drugs, and other methods of medical care to prevent or alleviate disease. In hospital settings, physicians' orders are typically required for off-campus activities. There are over 30 specializations of medical doctors (O'Morrow & Reynolds, 1989). Examples are psychiatrists (who specialize in mental and emotional disorders), pediatricians (who specialize in the care and treatment of children), and neurologists (who deal with diseases of the nervous system).

Nurses

Registered nurses (RNs) are responsible for giving nursing care to patients, carrying out physicians' orders, and supervising other nursing personnel such as licensed practical nurses, nurses' aids, orderlies, and attendants. Nurses may be wonderful colleagues as sources of information for recreational therapists because nurses are typically well informed about clients and progress they have made. Nurses who are

enthusiastic about their clients participating in RT may also be invaluable allies for recreational therapists through their encouragement of clients to value and actively participate in RT.

Psychologists

Psychologists usually hold PhD or PsyD degrees in psychology. They engage in psychological testing, diagnosis, counseling, and other therapies. Results from psychological testing may provide important information for recreational therapists to use in assessment. Psychologists may also suggest behavioral interventions for recreational therapists and other members of interdisciplinary teams to follow. Recreational therapists often work closely with psychologists doing group therapy because recreation activities offer real-life means for clients to practice and refine concepts and skills discussed during group therapy sessions.

Social Workers

Social workers use case work and group work methods to assist clients and their families in making adjustments and in dealing with social systems. They prepare social histories of newly admitted clients and are often the primary professionals to assist clients with community reintegration. Social histories may be a particularly valuable resource during the assessment phase of RT. Recreational therapists likely will work closely with social workers when preparing clients for community reintegration.

Physical Therapists

Physical therapists (PTs) are concerned with restoring physical function, reducing pain, and preventing disability following disease, injury, or loss of a body part. They apply therapeutic exercise and functional training procedures in physical rehabilitation. PTs hold either a master's degree or doctoral degree. PTs now entering the profession need a doctorate of physical therapy degree. RT often offers clients opportunities to practice procedures learned during physical therapy sessions.

Occupational Therapists

Occupational therapists (OTs) use purposeful occupations or activities with persons with limitations due to physical injury, illness, psychosocial disorders, developmental or learning disabilities, economic and cultural differences, or aging processes to increase independent functioning in performing all aspects of everyday life, as well as to assist clients in maintaining health and preventing disability. OTs entering the profession need a master's degree in occupational therapy.

Music Therapists

Music therapists (MTs) use music as a medium to reach and involve clients in treatment. Music therapy addresses clients' emotional, cognitive, and social needs through treatments involving creating music, singing, or listening to or moving to music. Music therapy is found primarily in psychiatric treatment programs but may be employed within other settings as well (e.g., long-term care facilities).

Art Therapists

Art therapists use art as a medium to promote self-awareness, nonverbal expression, and human interaction. Art therapy is most widely used within the treatment of persons with problems in mental health. To practice art therapy, art therapists must

have knowledge of visual art (e.g., drawing, painting, sculpture) and the creative process, as well as possess understandings of human development, psychological and counseling theories, and related techniques.

Dance Therapists

Dance therapists use movement as a medium to work with clients. Dance therapy is a nonverbal means of expression employed with both individuals and groups. Although not found exclusively in psychiatric treatment programs, it is most commonly used with persons experiencing problems in mental health. Dance therapy, however, may be used to treat any number of illnesses, disorders, and disabilities.

RANGE OF RECREATIONAL THERAPY SERVICES

Settings for Recreational Therapy

At one time, practically all RT occurred within hospitals and institutions. This is no longer true. Today, RT is found in many settings. Although RT is still commonly found in general and psychiatric hospitals and in residential schools for students with disabilities, it also occurs in settings such as skilled nursing facilities, assisted living facilities, home health care, correctional facilities, outdoor recreation/camping centers, rehabilitation centers, community mental health centers, and other community-based health and human service agencies. Even some public park and recreation departments offer RT services (Austin & Lee, 2013).

Clients Served by Recreational Therapists

RT clients may be any persons who desire to recover from an illness or to adaptively cope with a chronic condition or disability (i.e., engage in health protection) or to enhance their own level of health (i.e., pursue health promotion). Persons participating in mental health programs have traditionally been the largest client group of RT. Other major client groups have been persons with intellectual disabilities or physical disabilities, hospitalized children, and aging populations residing in long-term care facilities. Additional individuals who have benefited from RT include persons with autism, persons with substance use disorders or addiction, persons with cognitive impairments (e.g., head injuries), and persons who experience convulsive disorders. Today, a large population of military veterans who require treatment and rehabilitative services also exists.

Structures for Recreational Therapy

RT interventions occur in several formats. These include structures such as classes, clubs, special interest groups, individual and group leisure counseling sessions, adventure therapy groups, informal recreation programs, special events, and contests (Austin, 2013).

Professional Organizations for Recreational Therapy

Two national professional membership societies exist. In the United States, the organization is the American Therapeutic Recreation Association (ATRA). In Canada, the organization is the Canadian Therapeutic Recreation Association. Both national organizations offer continuing education opportunities, publications, advocacy, and other services for their members.

COMPETENCIES RECREATIONAL THERAPISTS NEED

Few professionals would argue with the contention that competencies gained through the professional preparation of recreational therapists differ from those required of park, recreation, and tourism professionals. Certainly both need solid liberal arts preparation. The liberal learning dimension of curricula offers the depth and breadth of education needed for individuals to be contributing citizens of the world and provides a foundation upon which much professional preparation rests. Both also need to gain understandings of the phenomena of recreation and leisure. Beyond these similarities, competencies that students within professional preparation programs need in RT differ greatly from students studying in parks, recreation, or tourism programs because RT is a distinct discipline that requires competencies unique to persons who meet qualifications to enter the RT profession.

Several sources have been drawn upon to develop the areas of competency needed for the practice of RT that follows in this chapter. These include competency areas listed in the third edition of *Therapeutic Recreation: An Introduction* (Austin & Crawford, 2001); *Guidelines for Competency Assessment and Curriculum Planning for Recreational Therapy Practice* published by the American Therapeutic Recreation Association in 2008; *Standards and Guidelines for the Accreditation of Educational Programs in Recreational Therapy* adopted in 2010 by the Commission on Accreditation of Allied Health Education Programs; the results of a job analysis published in 2011 by the National Council for Therapeutic Recreation Certification; and the seventh edition *Therapeutic Recreation Processes and Techniques* (Austin, 2013).

As you review the listing of areas of competency, think about your own preparation for doing RT. Are you personally gaining the competencies necessary to practice RT?

Areas of competency that you, as an emerging recreational therapist, need to evaluate include the following:

- theories/understandings of recreation and leisure;
- human development throughout the life span;
- anatomy and physiology;
- basic assumptions about human nature;
- clients served in RT;
- etiology, course, and prognosis of various diagnostic categories;
- knowledge of the International Classification of Functioning, Disability, and Health;
- disease sequelae;
- effects of stress on individuals;
- theories of helping (e.g., psychoanalytic, behavioral, humanistic, cognitive-behavioral, positive psychology);
- definitions of RT;
- basic concepts/tenets for RT practice;
- facilitation techniques applied as interventions (e.g., horticulture therapy, values clarification, leisure counseling/education, progressive relaxation

training, physical activity, adventure therapy, aquatic therapy, social skills training, animal-assisted therapy, reminiscence therapy);

- perceptions of clients as “whole persons,” not just as individuals possessing symptoms;
- conceptual models providing a theory base for RT practice;
- strength-based perspectives in RT;
- evidence-based approaches to RT;
- effects of major drugs;
- health and safety information for working with clients;
- medical and psychological terminology;
- concepts of health and wellness;
- attitudes toward illness and disability;
- self-awareness (e.g., values and beliefs);
- cultural diversity;
- characteristics of effective helping professionals and helping relationships;
- theories and techniques of group leadership;
- concerns and strategies for group leaders;
- leadership skills in using recreation/leisure activities (e.g., arts and crafts, physical activities, sports and games, outdoor activities) as therapeutic interventions;
- activity analysis processes and procedures;
- clinical reasoning skills including identifying activities that hold the potential to meet treatment/rehabilitation aims;
- use of self as a therapeutic agent;
- therapeutic relationship skills;
- therapeutic communication skills;
- therapeutic environments;
- interview skills;
- group processing (debriefing) skills;
- leader transactions with clients (i.e., the social psychology of RT involving concepts such as self-views, helplessness, self-fulfilling prophecy, labeling, loneliness, self-efficacy, and attributional processes);
- advocacy (e.g., client or case advocacy, professional advocacy);
- client assessment;
- formulation of treatment/rehabilitation/wellness goals;
- stating specific behavioral objectives;
- development of treatment/rehabilitation/care/wellness/education/intervention plans;

- implementation of treatment/rehabilitation/care/wellness/education/intervention plans;
- evaluation of intervention processes and outcomes;
- client records and documentation (e.g., charting on clients);
- theories in human behavior and in motivating client change;
- program protocols;
- referral procedures;
- behavioral management techniques;
- learning/teaching principles;
- assistive devices for specific disabilities;
- accessibility and usable recreation environments (e.g., universal design);
- ethical and professional standards of practice;
- legal aspects of RT;
- giving and receiving clinical supervision;
- roles and functions of kindred professionals;
- role and function of interdisciplinary teams;
- interdisciplinary teams and teamwork;
- practice settings;
- structures (formats) for RT programs;
- professional organizations for RT;
- current professional issues and trends (e.g., accreditation, credentialing); and
- historical foundations of RT.

Your self-assessment of the competency areas likely will reveal that, although you have started to gain rudimentary skills and knowledge, you are still in the beginning phase of development as an emerging recreational therapist. This is normal, so do not feel discouraged because you do not yet possess the competencies required for clinical practice in RT.

NATIONAL COUNCIL FOR THERAPEUTIC RECREATION CERTIFICATION

Once you have completed your degree requirements, you will be eligible to sit for a national examination administered by the National Council for Therapeutic Recreation Certification (NCTRC). NCTRC was established in 1981 as a nonprofit organization dedicated to maintaining professional standards to protect consumers through the credentialing of well-qualified recreational therapists. The NCTRC grants professional certification to individuals who apply and meet established standards for certification, which include completing a bachelor's degree in RT or therapeutic recreation and passing the national certification exam. The Certified Therapeutic Recre-

ation Specialist® (CTRS®) credential is offered to qualified individuals who meet all of the requirements to serve as recreational therapists.

PLAN FOR THE BOOK

The editors of this text have attempted to make you, the reader, the focal point of this book. The book is organized with objectives at the beginning of each chapter so you will know explicitly what you should gain from your reading. Another aid to help you in your learning is the reading comprehension questions found at the end of each chapter.

Chapters in Section 1 of the book present the nature, purpose, history, and processes of RT. Section 2 covers areas of practice. Taken as a whole, these chapters illustrate the richness and diversity of RT. To facilitate your learning and ensure completeness in approach, the authors for chapters in Section 2 followed a common outline. For example, in each chapter you will learn about current practices and procedures in that particular area of RT and you will review a brief case study that portrays the actual application of practices and procedures. Section 3 deals with professional practice concerns and contains two chapters. The first chapter covers management, consultation, and research in RT. The second chapter is on issues and trends in RT.

SUMMARY

The purpose of this chapter was to provide an introduction to RT and to offer an overview of its components. The chapter presented definitions of RT and followed with an analysis of common elements found within the definitions. It granted recreation, leisure, self-determination, intrinsic motivation, and health particular attention.

The chapter discussed the relationship of RT to health and wellness, together with the tendencies for stability and actualization. This discussion culminated with the presentation of the continuum of services represented within the Health Protection/Health Promotion Model. Following a description of this conceptual model and others, the chapter further described RT by contrasting it with inclusive and special recreation and by providing basic tenets that guide the practice of RT.

The chapter also offered information on kindred professionals, the range of RT, and areas of competency recreational therapists need. The chapter ended with a brief orientation to the plan for the book.

READING COMPREHENSION QUESTIONS

1. Define RT in your own words.
2. What properties are found in recreation?
3. Do you agree that perceived freedom and intrinsic motivation are the factors that define leisure? Please explain.
4. What is meant by helplessness?
5. Do you agree with the definition of health presented by Jones? Explain.
6. Briefly describe the humanistic perspective.

7. What is high-level wellness?
8. Briefly describe positive psychology.
9. Explain the stabilizing and actualizing tendencies.
10. Is illness ever positive? Explain.
11. Explain the continuum presented in the Health Protection/Health Promotion Model.
12. Do you agree that RT and inclusive and special recreation are separate entities? Please explain.
13. Review the basic tenets of RT. Do you understand each of them? Do you agree with each of them? Why or why not?
14. Name at least five kindred professions of RT.
15. In what settings does RT occur?
16. What types of clients do recreational therapists traditionally serve?
17. Name two national professional membership organizations for RT.
18. How do you assess yourself in terms of moving toward becoming a competent recreational therapist?
19. What is NCTRC?
20. Do you understand the plan of the book? Please explain.

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