Therapeutic Recreation Programming: Theory and Practice

by

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religion, geography, and sexual orientation are among a host of factors that collectively constitute a multicultural society. Although more progress is needed than can be accomplished in this text, we give attention to multicultural considerations in Chapter 2 and throughout the remainder of the text.

Therapeutic recreation practice is rarely, if ever, neutral. It can be conducted in ways that respect people's dignity, privacy, autonomy, and well-being. It can also harm people, violate their confidences, manipulate them, and do them injustice. Accordingly, in Chapter 3 we address the ethics of therapeutic recreation practice by introducing the subject of ethics, exploring several prominent ethical principles, and discussing the resolution of moral dilemmas.

We finish Section One by critically examining models of therapeutic recreation practice. Models describe and explain the components of therapeutic recreation programming. The form that therapeutic recreation practice takes will significantly depend on the model or models to which practitioners subscribe. Therefore, we examine the strengths and weaknesses of the major models in therapeutic recreation.

In summary, Section One provides a broad foundation and vision of therapeutic recreation programming. It stresses the importance of working out a moral and conceptual foundation of therapeutic recreation. At the same time, it makes clear our commitment to a foundation oriented to leisure theory. Section One further emphasizes the importance of a multicultural approach to therapeutic recreation programming. Justice demands that therapeutic recreation not only serve everyone, but also that its services reflect the multicultural diversity of the people it serves. Besides justice, therapeutic recreation programming must be ethical in all other respects. Moreover, therapeutic recreation practitioners must be capable of recognizing and resolving moral dilemmas. Finally, Section One reviews the major models that give practical direction to therapeutic recreation programming.

Chapter 1

Creating a Conceptual Foundation for Therapeutic Recreation: Examination and Legitimation

There is nothing more important than a sound conceptual foundation for any social endeavor. A conceptual foundation consists of a system of ideas that explains something at its most basic level. For example, the foundation of Christianity is the word of God. Everything that Christians think and do is founded on that fundamental source. Sometimes multiple foundations exist for a particular practice. Government, for instance, is based on different conceptual foundations. Monarchy is founded on the belief in a hierarchy of rulers and ruled, descending from God to kings down the line to the common people. Democracy, on the other hand, is grounded on the fundamental principle of universal political equality under law. A foundation, then, is the ultimate source of explanation and justification upon which theory and practice are based. It is not final in the eternal sense of never changing. Most foundations transform over time as conditions change, making alternatives possible and necessitating alterations. Nonetheless, a systematic set of basic beliefs and values should be clearly evident at a given time.

Prior to discussing professional foundations in therapeutic recreation, we want to comment briefly on the relation between philosophy and foundations. By *philosophy*, we mean thinking about the ideas that form the theory and practice of therapeutic recreation, including its basic beliefs and values. Paraphrasing philosopher Hannah Arendt, philosophy is "thinking about what we are doing." As such, we need to think carefully about how we "do therapeutic recreation," because there is no divine or absolute blueprint. Furthermore, we

want therapeutic recreation to consist of the best ideas possible for the purpose of effective practices and worthwhile results. The activity of philosophy seeks to understand what makes something logically and morally sound. It searches for and critiques reasons for regarding some ideas and actions as good and others as bad. For example, is it a "good idea" to stress choice in therapeutic recreation, even when persons in our care may make bad choices? Shank and Kinney (1987) questioned the nature of and limits to leisure choices in clinical settings, while Sylvester (1992) defended the freedom of leisure. On another front, how can leisure or recreation be "ordered" as a "prescription" when by definition they are free and autonomous acts? Do recreation and leisure even matter when people are ill? Is health an absolute value or are other values equally or more paramount? This is philosophy at work. It is a constructive process because it leads to richer and deeper understanding about matters that significantly affect the lives of the people therapeutic recreation serves. We can never stop thinking about the consequences of the actions we have in mind for clients. After all, we too may be "clients" one day, subject to the forces of therapeutic recreation. If we care about how we may be treated, then we should certainly care about how we treat others. Therefore, philosophy is indispensable to the development of a foundation that is built on good ideas for the good of people.

Unfortunately, in our judgment too many persons have little patience for philosophy, considering it abstract, impractical, and irrelevant. Ignoring philosophy is costly, even though those who avoid it may not recognize their own ignorance (see Sylvester, 1989a). By acknowledging the importance of philosophy in therapeutic recreation practice, and by becoming more proficient at all levels, we can develop a firm and functional foundation that is sufficiently flexible for changing times. Indeed, there cannot be a foundation without philosophy. The question is whether our ability to do philosophy will be up to the task of building a strong profession.

The foundation of a profession consists of the principles and values a field stands for and stands on. What a field stands *for* refers to its purpose, mission, or "calling." For example, education stands for knowledge and learning. What a field stands *on* refers to the fundamental beliefs and values that explain and justify the field's existence in relation to its purpose, which gives guidance to theory and practice. A foundation states to the world, "This is *who* we are and *why* we are here." A foundation, therefore, is the single most important structural dimension of a profession, providing a rational basis for its existence as a legitimate social institution. Without it a field literally has nothing to support its existence.

The paramount importance of a conceptual foundation has not escaped the attention of therapeutic recreation. Reynolds and O'Morrow (1985) asserted

that "No single issue could be more important or require more urgent attention from the profession of therapeutic recreation than the development of a well-defined occupational philosophy" (p. 35). In a study conducted by Witman and Shank (1987), therapeutic recreation leaders considered the development of a central mission to be first among 14 characteristics of professionalization. Out of the many urgent tasks, issues, and challenges facing the profession of therapeutic recreation, Kraus and Shank (1992) declared, "If we were to select a single most important priority, it would probably be the need to develop a sounder philosophical base for the field" (p. 16).

Although respected sources have spoken to the importance of a well-developed professional foundation, the outcome has not been as impressive as the testimony. The creation of a rationally coherent and morally compelling professional foundation for therapeutic recreation has been marked by mixed results. Although there have been enough fruitful efforts to have sustained therapeutic recreation during its brief history, it still lacks the maturity characteristic of such professions as law, medicine, and education. One obvious explanation is that being far younger than these fields, therapeutic recreation simply has not had the opportunity to develop a sound foundation. This is partially true, but there are other reasons why therapeutic recreation has not yet developed a firmer foundation. Several of them are worth reviewing, for if a solid foundation is ever to be achieved, it will require the critically intelligent efforts of students when they become professionals.

Peterson (1989) contended that a major barrier to professionalization was therapeutic recreation's "inability or unwillingness . . . to take a stand on philosophical content" (p. 22). We doubt that unwillingness is the problem; professionals have never been shy to *take* a stand. Peterson may be correct, however, in questioning the field's ability to *develop* a stand. Compared to other fields, only a small fraction of the discussion taking place in therapeutic recreation qualifies as philosophical discourse. Since willingness does not seem to be a serious impediment, the problem results largely from the scarcity of professionals who have the skill, background, and the inclination to conduct serious conceptual analyses.

The most likely candidates for the job are educators. Yet Compton (1989) exclaimed that there are "few individuals [in education] who are in a position to conduct such inquiry" (p. 487). Most educators are not prepared to perform the inquiry necessary for examining and building foundations. A number of factors contribute to this deplorable situation. The main culprit, however, is professional education. The vast majority of educators do not have sufficient preparation in history, philosophy, and social and political theory to conduct social analyses. Consequently, philosophy and critical theory are insufficiently understood and rarely practiced. Furthermore, as Hemingway (1987) explained,

"philosophical discussions of therapeutic recreation are too often isolated from relevant sources in the main currents of philosophical inquiry or from philosophically informed discussions of social issues affecting the field" (p. 1).

Professional education in therapeutic recreation has generally placed little emphasis on critical inquiry. Based on the scarcity of adequate philosophy in the literature, students must get a much richer diet of philosophy, as well as social and political theory. To do so, they must be exposed to a wider variety of literature and must practice critical inquiry themselves. Clearly, this will require leadership from educators.

The tendency to borrow foundations from other fields is another reason for an inadequately developed foundation. Lahey (1987a) asserted that therapeutic recreation has expediently adopted the logic and language of medicine at the expense of creating its own foundation. To be sure, therapeutic recreation should study assiduously the foundations of other disciplines and professional fields, such as nursing, medicine, education, and social work. Where elements from other fields and disciplines are relevant, they should be integrated into therapeutic recreation's foundation, as well as fully explained and justified. Other fields can contribute materials, but therapeutic recreation must build its own foundation.

A final factor is the presence of two professional organizations representing therapeutic recreation: the American Therapeutic Recreation Association (ATRA) and the National Therapeutic Recreation Society (NTRS) (see James, 1998). This discussion cannot account for the existence of or the advantages and disadvantages of two professional organizations. In terms of clarity, coherence, consistency, consensus-building, and maximizing resources, one organization would probably be best; but that does not look likely. As long as two organizations do exist, the development of a foundation will require constant cooperation between them. An example of productive collaboration is the joint ATRA-NTRS (1993) statement, *Therapeutic Recreation: Responding to the Challenges of Health Care Reform*. Furthermore, in 1998 ATRA and NTRS formed the Alliance for Therapeutic Recreation (NTRS, 1999, p. 5) and signed a resolution that pledged communication, cooperation, and collaboration for the benefit of consumers and the profession (James, 1998, pp. 34–35).

Of course, every profession has differences. Indeed, differences are desirable, because the alternative is lock-step dogma, which produces no dissent, but also no growth. With a shared foundation, therapeutic recreation has the potential to become a community of professionals who can not only tolerate, but also appreciate their differences while remaining united around a common set of beliefs and values. Such an effort would be remarkably difficult. It would require patience, persistence, leadership, integrity, communication, and, above all, wisdom. Perhaps therapeutic recreation has not matured enough to take on such a challenge. Hopefully, it will be ready in the future.

Regrettably, organizational politics, motivated by the desire for power and control, remain a barrier to the cooperation required to construct a single foundation. Far too much professional rhetoric, some under the disingenuous cloak of "research," is driven by the self-serving interests of organizational cliques. As long as power, prestige, and profit, rather than the public interest, shape therapeutic recreation's discourse and inquiry, a *legitimate* foundation is impossible. For the good of the public and in a spirit of professional cooperation, both professional organizations can facilitate rather than frustrate professional foundations.

For these and other reasons therapeutic recreation has not developed an adequate foundation, impeding professionalization and the ability to serve the public (see Sylvester, 1998). Besides dealing with these problems, therapeutic recreation must adopt two basic approaches as it proceeds to build a foundation. First, it must do what Compton (1989) suggested by returning regularly to the fundamental question *"Why does therapeutic recreation exist?"* The function of a foundation is to explain in basic terms what justifies the existence of a field. Why is it needed? What purpose does it serve? A probing exploration of that simple question will effectively launch the construction of a foundation and keep it on course. Second, examining and justifying the existence of therapeutic recreation will require a liberal education to complement the technical preparation typical of professional education. Current problems in therapeutic recreation are not primarily rooted in the lack of competence, as some have implied (see Russoneillo, 1992; West, 1993). As important as technical competence is, it can be ineffective and even harmful unless it is guided by a legitimate set of foundational beliefs and values forged from a broad base of knowledge. E. L. Boyer (1987), former president of the Carnegie Foundation for the Advancement of Teaching, recommended "enriched majors" that allow students to place their specialized fields in social perspective. Grounded in liberal or general education, enriched majors would respond to three essential questions: "What is the history and tradition of the field to be examined? What are the social and economic implications to be understood? What are the ethical and moral issues to be confronted?" (p. 110). The authors of this text will follow Boyer's advice by maintaining a broad perspective of therapeutic recreation and by situating its technical side in the moral, social, economic, and political contexts in which it operates.

Examining and Justifying Professional Foundations

Given its vital importance, how is the foundation of a profession created? The first step toward answering this question is by way of another question: "What is a profession?"

A profession is a skilled service performed for pay. According to this broad definition, virtually any skilled occupation qualifies for a profession, including farming, plumbing, gardening, and hairstyling. The term has also been more narrowly applied to fields that require extensive education to master a body of applied knowledge to serve a legitimate social need. Moreover, certain fields have been distinguished by their principal orientation to public service rather than financial profit. (Some professions, such as law and medicine, have been criticized for permitting the profit motive to interfere with their primary commitment to public service.) What fields qualify for the distinction of a "profession" in the more restrictive sense has generated considerable debate (e.g., Cogan, 1953; Etzioni, 1969; Goode, 1960; Greenwood, 1966; Hughes, 1963; Vollmer & Mills, 1966). Greenwood (1966) asserted that the crucial distinction between a professional occupation and a nonprofessional occupation rests in the former's "fund of knowledge that has been organized into an internally consistent system, called a *body of theory* . . . a feature virtually absent in the training of the nonprofessional" (p. 11). Authorities in therapeutic recreation have agreed that a theoretical body of knowledge is "the basis upon which the occupation claims its professionhood" (Meyer, 1980, p. 46; also see Reynolds & O'Morrow, 1985; Sylvester, 1989).

A body of knowledge is *one* of the main elements of a profession. Prior to the development of a body of knowledge, however, *service-oriented* fields originate to meet a public need. Knowledge is then sought and created to serve that purpose. Kuhn (1970) contended that public service fields, such as law and medicine, *do not* achieve legitimation on the basis of a scientific body of knowledge. Rather they achieve it on the basis of an "external social need" (p. 19). Therefore, while scientific knowledge is required for performing public service and gaining professional status, a legitimate social need is the original seed from which a service-oriented field, such as therapeutic recreation, sprouts its foundational roots.

Therefore, a profession is formed by two core qualities. The first is an altruistic *calling* to serve an area of public need. The second is knowing what is *called for,* which consists of a comprehensive body of knowledge, including theoretical, historical, moral, and technical knowledge. A calling or mission is thus joined by a body of knowledge, together serving the end of public service. Establishing a profession, therefore, requires locating and justifying what a society needs, as well as continually developing a body of knowledge for the purposes of serving that social need ethically and effectively. The apparently simple question, then, is "What does a society need?"

Beyond the more obvious survival needs of food, water, and protection from harm, basic needs are notoriously difficult to determine. Many theorists agree that basic needs have a large conventional component (Griffin, 1986; Miller, 1976; Benn & Peters, 1959). In other words, many needs are not entirely determined by natural circumstances, but instead are dependent on social expectations and cultural norms. Telephones were once a luxury; now they are virtually a necessity. Formal education was not a universal need in early America, and many people had little if any formal education. Today, a person is likely doomed to a substandard life without at least a high school education. Formal education has thus *developed* into a basic need. In the past, what people needed for a state of health was relief from illness and discomfort. People believe they need far more for "optimal" health today, including positive social, physical, emotional, and spiritual states. As society changes, so does the understanding of "basic needs." As such, basic needs cannot be taken for granted, but instead must be given a "fresh interpretation in each social setting" (Griffin, 1986, p. 45).

Therefore, basic needs are not limited to what is required to sustain biological life. Basic needs also comprise society's conception of a *particular kind of life*. Falling below this standard is viewed as a threat to the humanity and well-being of individuals in that society. Needs must be assessed on the basis of what a society considers "the right ends of human life" (Thomasa, 1984, p. 44). Society may deem it desirable to prolong life indefinitely with medical technology, even if it means being hooked to expensive machinery. On the other hand, safe and pleasant communities that offer a variety of enriching activities are also desirable. But life-prolonging services, as opposed to life-enriching services, may be considered more "necessary." Consequently, people who have lived in poverty all their lives may receive state-of-the-art medical care, only to return to squalor after they have been rescued by medical technology. These results are not written solely by the laws of nature, but rather by the way we choose to live as a society.

Much of what we "need," then, depends on the kinds of lives we desire to lead. Determining our needs and the quality of life requires examining our lives and deciding what is in our best interests for the social, economic, physical, moral, and psychological well-being of everyone. When the right goals of living have been discerned, the types of professions that are required and the forms they should take will become evident. Before discussing social needs

that justify the existence of therapeutic recreation, however, the meaning of some key words must be examined.

Making Meaning: The Challenge of Defining Terms

In addition to compassion, integrity, and diligence, reasoning is one of the most important attributes of a professional. Reasoning requires the ability to use language. As Socrates wisely recommended, we must define the words we use if we hope to achieve understanding about how we should live our lives. But explaining what we mean when we utter, sign, or write words is not at all simple, as anyone who has tried to define something can attest. Concrete objects, such as rocks and trees, are more readily defined because they can be described according to objective properties, such as weight, size, and shape. Abstractions, like "health," "leisure," and "well-being," however, do not have an objective existence of their own. (When was the last time you saw "leisure" out for a walk or "wellness" losing its leaves?) Rather, abstract ideas or concepts are used to express aspects of our lives that do not have a concrete, independent existence of their own. For example, getting up mid-morning on a weekend, choosing what to wear and eat, thinking about who to vote for on election day, reflecting on which church to attend, deciding whether to hit the books or a few baseballs are experiences related to the idea of "freedom," but none of them is an objective "thing" called freedom. Because ideas cannot be connected to any particular object in nature, they require great intellectual care to explain. Furthermore, because our experiences are affected by social, cultural, economic, political, intellectual, and psychological factors, ideas are complex and dynamic. Moreover, we inherit ideas from different times and places. Therefore, historical knowledge, and the lack of it, affects understanding and communication. Finally, no universal language exists to settle the correct use of words. Meaning must be achieved through communication, which has barriers of its own, such as confusion and distortion.

As difficult as definition is, however, we must make an effort to "make meaning." Just as other professionals, such as judges, nurses, or teachers, are expected to understand and explain the basic concepts upon which their fields are founded, we must also be capable of explaining therapeutic recreation and why it exists. We must be able to communicate clearly and logically the meaning and relevance of such terms as "health," "wellness," "leisure," "inclusion," "autonomy," "normalization," "well-being," and "quality of life." We must not only be able to speak to one another, but also to administrators, coworkers, insurance payers, board members, and, most importantly, to our clients and the general public.

Doing justice to complex concepts that have extensive histories is impossible in the space of a few pages. Rather than just give a series of definitions, however, we plan both to define the foundational vocabulary that guides therapeutic recreation practice and discuss some of the issues and problems surrounding it. This will require historical insight. When words are placed into historical perspective, attitudes and practices can be seen that have impacted the lives of human beings, for better or worse. For example, during most of history, the terms "freedom" and "democracy" were mainly reserved for property owning males. Since then their meanings have been broadened. Understanding the background of words can enlighten us so our ideas lead to actions that are in the best interests of our clients. The following discussion is intended as a launching pad into ideas that, with continuous study and reflection, can make a difference in the care of persons who are ill or injured. We will begin with the ideas of *leisure* and *recreation,* after which we will explore *health, well-being,* and therapeutic *recreation.*

Kelly's (1982) conceptual model of leisure incorporates the three most common definitions of leisure into a single construct. First, leisure is interpreted as *time* when one is free from the necessity of having to do something. Clearly, this element can be problematic when trying to discern what is and is not necessary or obligated. Everyone, however, feels constrained to perform certain tasks to survive as an individual, a society, and a species. For example, most people must work at a job to make a livelihood. One may or may not enjoy work, but a job is usually viewed as being obligatory rather than discretionary. During "free-time," however, constraints are minimized, allowing the greatest degree of freedom for people to do as they wish.

Leisure suggests not only freedom *from* necessity, but freedom *for* something, which implies an action or activity. Leisure-time is the opportunity to turn from an activity one feels one must do to an activity one wants to do. The second dimension of leisure, then, is *activity.* More precisely, it is *freely-chosen* activity. As such, a leisure activity is not determined by its content, but rather by the quality of free choice. As Kelly (1982) explained, "It is the quality of the experience of doing the activity, not the activity itself, that makes it leisure" (p. 21). For this reason working in the garden may be labor to some people and leisure to others.

There is a related element to freely-chosen activity that merits a few words. What motivates an individual to choose a particular activity? Theoretically, leisure is *mainly* motivated by intrinsic reasons. By *intrinsic motivation,* we mean that the activity is chosen because of the meaningful qualities it holds for the individual. An action can also be chosen for *extrinsic* reasons, meaning the benefits it produces, such as knowledge, social relationships, and cardiovascular fitness. Nonetheless, the principal motivation for a leisure activity is derived

from the meaning the activity holds for the individual. For example, both baseball and basketball offer beneficial outcomes. Yet one of the authors of this text is indifferent to basketball. He would prefer to live, and die, with bat, ball, and glove on some dusty ballfield. The difference lies in the meaning the action of baseball holds *for him,* even though both activities provide external benefits, such as teamwork and hand-eye coordination. Regardless of extrinsic outcomes, then, free-choice and intrinsic meaning are critical qualities of leisure.

Both choice and intrinsic meaning involve a type of consciousness or attitude toward an action. Therefore, the third element of leisure is *experience.* The perception of free choice and the attitude of doing something for intrinsic reasons are internal aspects of leisure. As Kelly (1982) pointed out, perceptions do not occur in a psychological vacuum; they are responses toward an action. Our perceptions inform us of the quality of the action, whether the action is regarded by the individual as forced or free, futile or fulfilling. On the one hand, a person who is a slave, drugged and chained in a box may say he feels he is experiencing leisure. But we would be wrong to ignore his objective condition, despite his perceptions. On the other hand, a person may have all the free-time in the world, yet not "feel" free because of a compulsive attitude. The "objective" side of leisure—an action that occurs in space and time—and the "subjective" side of leisure—an attitude of intrinsically motivated free choice—are two inextricably related dimensions of leisure.

The term *recreation* is often used as a synonym for leisure activity, a convention we will follow in this text. Recreation generally refers to pleasurable or enjoyable free-time activity chosen for its personal or social benefits. In other words, people seek a particular activity in their leisure—dancing, for instance—because they enjoy doing the activity *and* because they desire certain benefits, such as exercise or companionship.

A distinction between recreation and leisure is sometimes made on the basis of activity that is chosen primarily for its own sake (leisure) and activity that is chosen primarily for its external benefits (recreation). This distinction has produced the issue of "means and ends," which has received much attention in the literature (see Sylvester, 1985, 1996; Mobily, Weissinger & Hunnicutt, 1987; Kraus & Shank, 1992). The debate has revolved around whether recreation is an end, done for its own sake because of the inherent qualities of the activity, or a means, done for the sake of benefits the activity yields.

We agree with Kraus and Shank (1992), who contended that recreation can be both a means and an end. A misconception exists, however, that recreation or leisure activity can be used as a means *by another agent,* such as medical personnel, to produce predictable results. Whether recreation or leisure activity is motivated by intrinsic or extrinsic reasons, the action must be chosen by and remain under the control of the individual for it to qualify as recreation or

leisure. The action cannot be prescribed or principally controlled by someone else, even though it may produce salutary outcomes. Most theorists agree that the definitive element of leisure and recreation is freedom. Regarding freedom, Adler (1970) stated:

> In every conception of freedom . . . the free act is that which proceeds from the self, in contrast to such behavior on a man's part which is somehow the product of another. It is his own act and the result it achieves is a property of himself . . . . A man lacks freedom to whatever extent he is passively affected, or subject to an alien power, the power of another rather than his own. (p. 75)

The same principle holds true for leisure and recreation. Unless an action is predominantly characterized by freedom and autonomy, it is not leisure or recreation. Even when recreation or leisure activity is used as a means by the individual, it contains the inherent elements of freedom and autonomy. In situations where an activity is prescribed to treat a condition, it should be called "activity therapy." The term "recreational therapy," however, is a contradiction, for a freely-chosen activity cannot be prescribed. Since language has implications for action, the problem is not simply a question of logic or semantics. The language of "recreational therapy" can lead to abuses of client freedom, autonomy, and self-determination because of the tacit permission it grants for intervening and assuming control in the autonomous domain of clients. There are, of course, appropriate times for professional control. We contend, however, that freedom, autonomy, and self-determination are important values that should be treated seriously. Freedom, autonomy, and self-determination have been normatively legitimated and empirically verified as being essential to well-being (Sylvester, 1995). Recreation and leisure, in turn, have been suggested as vital sources for these goals in the lives of persons with disabilities. Professionals should do everything possible to preserve and protect these values for persons with disabilities, particularly in institutional settings, where they are too often diminished or altogether dismissed.

No issue exists as long as choice reasonably belongs to the individual. The issue begins the moment recreation or leisure activity is coopted as an instrument of control, irrespective of good intentions or potentially salutary results.

Before attempting a definition of therapeutic recreation, a couple of other terms must be examined. *Health* and *well-being* invariably appear in discussions on the purposes of therapeutic recreation. Therefore, we should also make sense of them, since they represent two of the main destinations of therapeutic recreation practice.

Traditionally, *health* has meant the "absence of organic and mental disease," along with relative freedom from chronic pain and discomfort (Dubos, 1980, p. 461). More recent definitions of health have emphasized the *whole* person and a state of *optimal* functioning, rather than just the absence of disease and discomfort. The "holistic" view of health has led to greater recognition of the integrity of body and mind, the role of the person's environment in contributing to disease and health, and the importance of promoting healthful living.

Expanded definitions of health have been criticized, however, for being too broad (see Callahan, 1973; Dubos, 1980; Kass, 1975; Redlich, 1976; Zola, 1977). For example, the World Health Organization (WHO) defined health as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Callahan, 1977, p. 26). By inflating the meaning of health from mental and psychological functioning to social and spiritual well-being, the idea of health has begun to infiltrate every element of life. Temkin (1973) observed that "the prevailing tendency at the present moment seems . . . to take so broad a view of health as to make it all but indistinguishable from happiness" (p. 407).

We see both sides of the issue. A broad definition of health has advantages, including the importance of healthy living and the influence of various environments and activities, such as home, work, and play, on one's state of health. Recognizing the interrelationships among work, play, education, religion, and health is one thing. Defining work, play, education, and religion as *aspects* of health is another thing entirely. We would conclude that a person who is illiterate is more likely than not to be poorly informed. But we would be mistaken to call that person "unhealthy." Similarly, a person who lacks a sense of spirituality may experience life as meaningless, but we would be hard-pressed to label the person as "sick." Furthermore, a person may be fit and free of organic dysfunction, yet lack in other areas of life, such as compassion and leadership. Therefore, while accounting for the affects of nonmedical areas on physical and mental health, these dimensions (e.g., religion, work, play, family, art, and sport) have their own distinctive nature and are important in their own right regardless of their impact on health. If a person were suffering from an incurable disease and had only six weeks to live, our efforts to provide care would not be concerned with restoring health, but rather with other important human values, such as love, faith, and companionship. A definition of health should be broad enough to include the *effective functioning* of the whole person. Yet the whole person and his or her range of needs and desires cannot be subsumed under the idea of health. For that purpose, the idea of "well-being" is proposed.

Discussions among philosophers and social scientists regarding the meaning and measurement of well-being are complex. As Haslett (1994) observed,

"many different sorts of things—self-realization, autonomy, health, and so on—have been put forth as what constitutes human well-being . . ." (p. 24). The best this discussion can provide is a general description of well-being, while avoiding its debates and subtleties. Paying attention to the idea of well-being is crucial, however, because, along with health, it is often mentioned as one of the main goals of therapeutic recreation (see ATRA, 1988; NTRS, 1994). Yet descriptions of well-being and its relation to therapeutic recreation beg for content and clarity (see Sylvester, 1989b).

First, well-being includes the basic needs required by human beings for survival, such as food, water, and shelter. Rescher (1972) called the basic requisites of well-being (i.e., health, income, housing, education, and employment) "welfare." He and other theorists agree, however, that a "basic needs" definition of well-being is incomplete (see Finnis, 1980; Griffin, 1986). A human life is deemed deprived or incomplete unless it has the vital qualities that are socially recognized as constituting what it means to be a "human being." Here is where the arguments begin. What are the minimum requirements of well-being, below which a person's humanity is violated? Exactly what are the *legitimate* needs, desires, and interests of human beings? Theorists have agreed that not everything people desire is needed for well-being. In fact, some things people desire, such as addictive drugs, can be detrimental to well-being.

Moral inquiry can inform us about the constituents of well-being, enabling us to reach general, if not complete, agreement. Griffin (1986, pp. 66–67) listed five prudential values that are requisite for a life of well-being:

- Accomplishment,
- Components of human existence (autonomy, basic capabilities, and liberty),
- Understanding,
- Enjoyment, and
- Deep personal relations.

Finnis (1980) also derived a list of elements that comprise well-being:

- Life,
- Knowledge,
- Play,
- Aesthetic experience,
- Sociability (friendship),
- Religion, and
- Practical reasonableness (using one's intelligence to choose and shape one's life and character).

Rescher (1972) listed "consensus happiness requisites" that a just society should provide for the purpose of well-being. Among them, he includes such things as health, equality, prosperity and economic well-being, and leisure.

Finnis (1980) and Griffin (1986) also alluded to leisure as a condition of well-being. Although Finnis's account does not specifically mention leisure, it can be postulated as an essential condition for realizing six of the seven basic goods that constitute well-being, especially play, which flourishes in leisure. Griffin contended that "we need a certain amount (not just of resources, but also of liberty and leisure and education) to be able to make something valuable of our lives" (p. 43). Therefore, while well-being includes health and other basic needs, it also involves a group of values that collectively contribute to a life of worth and dignity. The idea of well-being will be revisited later in the discussion, where it will be especially pertinent in determining what constitutes the "total care" of persons who are ill or disabled.

We finally arrive at the task of defining therapeutic recreation. There is no shortage of definitions. Reviewing several should help set the stage for examining the foundations of therapeutic recreation. Virtually every definition of therapeutic recreation includes the notion of involvement in activity that is oriented to treatment, education, or recreation as a means for improving the health and well-being of persons with disabilities. An early definition of therapeutic recreation developed at the Ninth Southern Regional Institute on Therapeutic Recreation (1969) is suggestive:

> [Therapeutic recreation] is a process which utilizes recreation services for purposive intervention in some physical, emotional, and/or social behavior to bring about a desired change in that behavior and to promote the growth and development of the individual. Therapeutic recreation provides opportunities for participation on one's own volition in activities that bring pleasure or other positive personal rewards. (n.p.)

The dual focus of "purposive interventions . . . to promote the growth and development of the individual" and "opportunities for participation on one's own volition in activities that bring pleasure or other positive rewards" is evident in this definition. Similar principles are apparent in more recent definitions. For example, Kraus and Shank (1992) contended that therapeutic recreation service involves programs and activities purposefully designed to alter dysfunctional conditions and maladaptive behaviors and to contribute to personal enrichment. Carter, Van Andel, and Robb (1995) stated that therapeutic recreation "refers to the specialized application of recreation and experiential activities or interventions that assist in maintaining or improving the health

status, functional capacities, and ultimately the quality of life of persons with special needs" (p. 10). Again, practice is aimed at improving the functioning *and* the well-being (quality of life) of persons with disabilities.

The official definitions of ATRA and NTRS are also remarkably alike in terms of their services and goals. According to ATRA (1988):

> Therapeutic recreation is the provision of treatment services and the provision of recreation services to persons with illnesses or disabling conditions. The primary purpose of treatment services, which is often referred to as recreation therapy, is to restore, remediate or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purpose of recreation services is to provide recreation resources and opportunities in order to improve health and well-being

Compare it to the NTRS (1994) definition, which states:

> Practiced in clinical, residential, and community settings, the profession of therapeutic recreation uses treatment, education, and recreation services to help people with illnesses, disabilities, and other conditions to develop and use their leisure in ways that enhance their health, independence, and well-being.

For the purposes of this text, *therapeutic recreation is defined as a service that uses the modalities of activity therapy, education, and recreation to promote the health and well-being of persons who require specialized care because of illness, disability, or social condition. Furthermore, recognizing the potential of leisure for contributing to the quality of life of all people, therapeutic recreation facilitates leisure opportunities as an integral component of comprehensive care.*

While these purposes (i.e., health, well-being and quality of life), modalities (i.e., treatment, education, and recreation), and commitments (creation of leisure opportunities) are theoretically compatible, they have resulted in a stubborn conflict that has plagued therapeutic recreation for decades. We will address that issue in the next section. First, however, we wish to comment briefly on the relation between recreation and therapeutic recreation.

If the concept of recreation implies beneficial outcomes for individuals, and the word "therapeutic" suggests something that is beneficial, one might argue, as some have, that the term "therapeutic recreation" is a redundancy ("beneficial benefits"). Before we are accused of splitting hairs, however, we

wish to make an observation. Writers have attempted to find a way to distinguish between "general recreation" and "therapeutic recreation." In their discussion, Carter, Van Andel, and Robb (1995) stated that:

> Recreation, while closely related to therapeutic recreation, tends to focus on broader, more long-range goals. Although recreation is therapeutic in the sense that it promotes growth and development and may prevent maladaptive behaviors, it does not necessarily assist in diagnosing, treating, restoring, or ameliorating a disease process without some systematic plan and application. (p. 10)

> Therapeutic Recreation . . . cannot be defined by a particular setting or categorical group of individuals. Instead, it must be characterized by the specific process that uses recreation or experimental activities to achieve predetermined health-directed and health-related objectives. (p. 11)

We understand their logic and the reasoning of those who characterize therapeutic recreation as a specialized process. It *is* a specialized service. In *principle*, however, it is really no different than general recreation services. If the purpose of recreation and leisure services is to make life better for human beings no matter where they are found, then all recreation programs *should be* therapeutic or beneficial. This should be true for all people, whether the individual is a middle-aged man recovering from a spinal cord injury in a rehabilitation hospital, a pregnant adolescent, a young mother with AIDS, or a painfully shy and obese nine-year old who is tormented by his peers on the playground. Irrespective of setting, the goal is for people to achieve greater health and well-being according to their needs. As Fred Humphrey (1970) argued, being "therapeutic" is not a professional option or specialization, but rather an ethical responsibility that belongs to all professionals. Therefore, there really is no meaningful distinction in principle and purpose between "general recreation" and "therapeutic recreation." Different settings, of course, will demand different models, methods, techniques, and strategies. Specialization, however, can emphasize dissimilarities rather than common ground. This is unfortunate, because a bond of commonality between general recreation and therapeutic recreation ultimately benefits the people whom both serve. If our job is to make things better for people, and if recreation can contribute to that mission, then we are all therapists *and* we are all recreationists.

Whether conducted in a community or a clinical context, recreation has the potential to benefit the health and well-being of all human beings. The key

connection between general recreation and the specialized field of therapeutic recreation lies in the freedom of people to decide for themselves what those benefits will be and how they will be achieved. Some observers recognize two categories of recreation—recreation that is chosen and recreation that is prescribed (see James, 1998). Both technical and popular understanding of recreation, however, have typically recognized its intimate association with freedom. Activities in the forms of art, dance, and games can be prescribed, but people generally understand recreation as relatively autonomous and self-determining. Embodying principles of autonomy and self-determination, recreation empowers people to choose for themselves what those benefits will be. Therein lies its value and uniqueness.

Sorting out and Searching for Foundations

An exhaustive review of the historical foundations of therapeutic recreation is beyond the scope of this text. Readers are encouraged to consult other sources for a comprehensive account of therapeutic recreation's attempts to set professional roots (see Carter, Van Andel & Robb, 1995; James, 1998; Reynolds & O'Morrow, 1985). The following discussion covers basic themes and issues related to the foundations of therapeutic recreation for the purpose of exploring their legitimacy and provides a foundation of therapeutic recreation practice.

From the earliest days, the core issue of therapeutic recreation's identity crisis has been whether the field exists primarily as a medical service or as a recreation service. Proponents of recreation associated with the Hospital Recreation Section (established in 1948) of the American Recreation Society. Supporters of a medical orientation affiliated with the National Association for Recreational Therapy (NART) formed in 1953. In the mid-1960s, however, a new national organization, the National Recreation and Park Association (NRPA) was forming. Some leaders in therapeutic recreation saw this as an opportunity to reconcile differences. In 1966 HRS, NART, and the Recreation Therapy Section of the American Association for Health, Physical Education, and Recreation, merged to form the National Therapeutic Recreation Society (NTRS). For some people the union was a satisfactory solution. For others it represented a marriage of expediency. And for others it must have been an unholy alliance. For the time being, however, the compromise worked for practical purposes.

Despite the creation of a single organization and the introduction of the term *therapeutic recreation* to cover the functions of treatment and recreation, the presence of two distinct professional identities was still evident. According to Miller (1967), there were:

> those who see themselves as therapists and those who see themselves as recreationists. The former concern themselves with illness and employ recreation as treatment in the rehabilitation process, the latter with leisure time and patients' recreative needs. (p. 34)

Even with a common organization and terminology, bedrock differences still existed. Consequently, the debate continued; indeed it escalated. Hoping to achieve clarity and consensus regarding the field's identity and purpose, the NTRS Philosophical Issues Task Force polled the NTRS membership regarding which of four positions it preferred to represent therapeutic recreation. The positions were largely derived from a study conducted by Lee Meyer (1980) on the philosophical bases of therapeutic recreation. Position A held that the purpose of therapeutic recreation was to provide opportunities for persons with special needs to experience recreation. Position B viewed recreation services as treatment for enhancing the total functioning of the individual. Position C, based on a model developed by Gunn and Peterson (1978), interpreted therapeutic recreation as a continuum of services, which included treatment, education, and recreation. Position D included Positions A (recreation) and B (treatment). Position C was favored by the majority of members who responded to the survey and was accepted in May 1982 as the NTRS Philosophical Position Statement. The continuum model found room for treatment and recreation, as well as leisure education. Clearly, though, leisure ("leisure lifestyle") was the overarching mission of therapeutic recreation, with treatment, education, and recreation functioning as contributing services toward that goal.

The peace was short-lived as dissatisfaction mounted. At least two reasons account for the discontent. First, many professionals were concerned whether NTRS could adequately meet the needs of therapeutic recreation professionals, most of whom worked in healthcare settings. Second, smoldering disenchantment persisted over the principal orientation of therapeutic recreation to recreation and leisure. Disgruntled professionals asserted that because therapeutic recreation was mainly situated in healthcare settings, its goal should be identical to other therapies. Like physical therapy and occupational therapy, it should be a medical specialty designed to help people regain their health. Although the effort did not materialize until several years after the founding of the American Therapeutic Recreation Association (ATRA) in 1984, sentiment was building for change. A contingent in ATRA recommended reforming as "recreation therapy." Concentrating primarily on treatment, the field of recreation therapy would distance and even divorce itself from recreation and leisure (see Carter, Van Andel & Robb, 1995, p. 58). Both reasons for creating another

organization are reflected in the comments of Peg Connolly (n.d.), founding President of ATRA. First, she addressed the organizational issue, observing that:

> a need exists for a national, professional association which is *solely* devoted both philosophically and with full financial commitment to the advancement of this important field of service. Since no autonomous, national *professional* organization existed specifically for the advancement of the Therapeutic Recreation profession in healthcare and human service settings as a priority concern, these professionals have joined forces to found ATRA. . . . ATRA can advocate specifically for the needs of Therapeutic Recreation in healthcare and human services as a priority focus rather than a special interest of a diverse organization (emphases added). (n.p.)

Connolly (n.d.) also attended to the purpose of therapeutic recreation, declaring that:

> ATRA defines the Therapeutic Recreation process in terms of improved human functioning with an emphasis on leisure as a viable concern in human development. *The focus of our services is on the delivery of Therapeutic Recreation as a means to improved independent functioning, not on the provision of adapted or special recreation as an end in itself* (emphasis added).

Despite the renewed emphasis on treatment, leisure remained conspicuous. A promotional brochure published by ATRA (n.d.) stated that "Therapeutic Recreation places a special emphasis on the development of an appropriate leisure lifestyle as an integral part of . . . independent functioning." It continued:

> The underlying philosophy of Therapeutic Recreation is that all human beings have the right to and need for leisure involvement as a necessary aspect of optimal health and, as such, Therapeutic Recreation can be used as an important tool for these individuals in becoming and remaining well. (n.p.)

Deciding not to divorce recreation from its definition of therapeutic recreation, the ATRA Board of Directors adopted the following Definition Statement in 1987:

> Therapeutic Recreation is the provision of Treatment Services and the provision of Recreation Services to persons with illnesses or disabling conditions. The primary purpose of Treatment Services which is often referred to as Recreation Therapy, is to restore, remediate or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purpose of Recreation Services is to provide recreation resources and opportunities in order to improve health and well-being.

Discontent remained, however, over any formal commitment to recreation and leisure. In comments intended to support a proposed name change of ATRA to American Recreational Therapy Association (ARTA), West (1993) advocated a treatment orientation, arguing that:

> It is very important that the name of the Association reflect the primary purpose of the organization. Most of ATRA's members work in clinical settings. Most of ATRA's resources are devoted to the support of the service as a treatment or therapy. ATRA is the only national professional association devoted to addressing the allied health needs of our field. Today the term "Recreational Therapy" is the most politically correct and most commonly used term, both within the profession and by those in allied health and healthcare, to describe our discipline as a treatment modality. (p. 6)

The attempt to change the name of the organization from ATRA to ARTA was narrowly defeated. This did not deter those who believed that treatment should be the exclusive focus of the field. Efforts continued within ATRA to establish a medical foundation for practice. In *Recreational Therapy: An Integral Aspect of Comprehensive Healthcare* (ATRA, 1993), ATRA's official definition was wholly ignored. Instead, the document stated that:

> Recreational therapy, also referred to as therapeutic recreation, is defined by the United States Department of Labor as a profession of specialists who utilize activities as a form of treatment for persons who are physically, mentally or emotionally disabled. Differing from diversional or recreational services, recreational therapy utilizes various activities as a form of "active treatment" to promote the independent physical, cognitive, emotional, and social functioning of persons disabled as a result of trauma or disease, by enhancing current skills and facilitating the establishment of new skills for daily living and community functioning. (n.p.)

Where ATRA will finally come to rest on the issue of its identity remains to be seen. Because of the sentiment to promote a treatment orientation, efforts will likely continue not only to alter the name of the organization, but also to change its definition and goals.

After sorting out the various conceptual orientations, there still appears to be two foundations. The current ATRA and NTRS definitions share much in common, including the goals of independence, health, and well-being. Fundamentally, they differ in their orientation to leisure. ATRA's early affirmation of leisure has weakened as the movement to promote treatment has gained momentum. Although ATRA's official stance has yet to be determined, recent events and developments suggest that ATRA is increasingly embracing the medical orientation implied by "recreational therapy." Russoneillo (1994) defined this orientation as "the prescription of recreational activities to predict, prevent and/or treat disease, illness, and pathological conditions as well as to improve and maintain overall health" (p. 249)

On the other hand, the NTRS (2000) definition of therapeutic recreation makes an explicit commitment to promoting leisure in the lives of persons who are ill or injured:

> Therapeutic recreation uses treatment, education, and recreation services to help people with illnesses, disabilities, and other conditions to develop and use their leisure in ways that enhance their health, functional abilities, independence, and quality of life.

So, as the saying goes, "The more things change, the more they stay the same." After nearly 50 years, therapeutic recreation still must decide, as Peterson (1989) put it, "whether our basic contribution to society is in the domain of leisure or in the domain of therapy" (p. 22). Resolving the issue must begin where Peterson suggests—with society. The issue is what does society need in order for its members to function, grow, and develop as human beings. The most sound and legitimate foundation for therapeutic recreation, therefore, is derived from an analysis of the public good. The authors' conviction is that the most defensible foundation for therapeutic recreation is primarily oriented to leisure and recreation. An integral role is reserved for treatment where it is needed for improving functioning so clients can use recreation or leisure activity in ways that contribute to their health, independence, and well-being

during and after the time they are receiving care. The remainder of this chapter is devoted to making a case for a foundation that includes a commitment to recreation and leisure for persons who are ill or injured.

Making a Case for Leisure

The position of this text is that the most socially legitimate justification for therapeutic recreation is derived from an orientation to leisure for the purposes of health, well-being, and quality of life. Prominent roles are reserved for treatment, education, and recreation as key aspects of therapeutic recreation services. Therapeutic recreation, however, is not a medical specialty. It is a unique human service that complements, but does not duplicate, medical services. The following discussion lays out a rationale for a foundation of therapeutic recreation oriented to leisure. It starts by asking "What would be the status of therapeutic recreation *without* leisure?"

If leisure were removed from therapeutic recreation, what would distinguish it from activity-based therapies, such as occupational therapy, physical therapy, music therapy, and art therapy? In effect, nothing would differentiate it. Consider the following definitions of occupational and recreational therapy in *Glossary for Therapists* (burlingame & Skalko, 1997):

> *Occupational therapy:* A clinical specialty which uses "purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, poverty and cultural differences, or the aging process to maximize independence, prevent disability and maintain health." (p. 188)

> *Recreational therapy:* A clinical specialty which uses leisure activities as the *modality* to restore, remediate or rehabilitate the patient's functional ability and level of independence and/or to reduce or eliminate the effects of illness and disability. (p. 218)

Fundamentally, there is no difference between the definitions. "Purposeful activity" implies that the action is intentional for the purposes of maximizing independence, preventing disability, and maintaining health. The term "leisure activities" in the definition of recreation therapy is used synonymously with "purposeful activity," because in each case the intention is to use activity *prescriptively* to achieve medical goals. As such, the reference to "leisure activities" is misleading, because leisure activities are, by definition, freely

chosen, rather than prescribed. The term *leisure* really has no logical place in the preceding definition of "recreational therapy." Conceived solely as treatment ("recreation therapy"), therapeutic recreation is indistinguishable from other activity therapies, such as occupational therapy. It does not meet needs that other activity therapies are not already satisfying or could potentially satisfy by an adjustment in their methods. One might argue that the difference lies in the medium of activity, but therapeutic recreation does not own exclusive rights to the domain of activity. Occupational therapy, for example, also uses activity as its medium.

Another argument holds that therapeutic recreation makes a contribution by preparing clients to function in their communities (ATRA, 1993). Community-based efforts make good sense, but they do not represent the defining characteristic of therapeutic recreation. Other services, such as social work and occupational therapy, should and do work with clients to help them function successfully in the community. Staking claim to the community, therefore, does not by itself justify therapeutic recreation.

If therapeutic recreation is basically assuming the same role as other activity-based services, it faces the problem of duplication. Why should the public support a service that is already being made by other established fields? One retort to that question is that therapeutic recreation is a "bargain" compared to other activity therapies. For example, an ATRA document on health-care reform (ATRA, 1993) contended that:

> Recreational therapy services utilize both individual and small group intervention strategies, therefore, staff/patient ratios are cost-effective. More patient treatment hours per therapist can be generated through the use of such small group interventions. (n.p.)

Cost-effectiveness, however, is not an argument for the existence of a *profession*. Even if therapeutic recreation could demonstrate that its services are delivered more economically than other activity therapies, it would only resolve the problem of duplication, not the question of social need. Furthermore, if the difference between therapeutic recreation and similar fields is mainly cost-efficiency, therapeutic recreation should honestly admit that it is a market competitor rather than an allied field.

We fail to see an adequate social justification for therapeutic recreation without a clear and direct association with leisure. That still leaves unanswered the question "What does an orientation to leisure contribute to a comprehensive approach to care that improves health and well-being?" The following seven fundamental reasons constitute a foundation for therapeutic recreation that is embedded in leisure theory.

1. *Leisure affords opportunity for activity, which has been credited as an effective means for meeting the adaptive needs of human beings.*

Driver, Brown, and Peterson (1991) observed that "the issue is not whether leisure activities produce beneficial consequences. The questions are: What are those consequences? Who benefits? What are the magnitudes of the beneficial consequences?" (p. 7). Although more and better research is needed (Witt, 1988), some of the benefits of play and recreation have been documented. While the body of research findings cannot be listed here for lack of space, we recommend that readers consult two publications. First, *Benefits of Leisure* (Driver, Brown & Peterson, 1991) surveys the research across a broad array of needs, including physiological, psychological, and sociological domains. Second, *Benefits of Therapeutic Recreation: A Consensus View* (Coyle, Kinney, Riley & Shank, 1991) contains extensive literature reviews of the effects of activity in a number of areas, including chemical dependency, developmental disabilities, gerontology, pediatrics, physical medicine, and psychiatry.

Perhaps leisure activity can best be viewed as a stimulus to health rather than a cure for disease. The medical model is inclined to emphasize the pathogenic factors that affect disease. Surely, they should be treated. Mordacci and Sobel (1998) contended, however, that "just as there are factors that destroy health, so there are factors that support, enhance, and produce health" (p. 34). These factors they call *salutogenic* for their beneficial property. Among the myriad salutogens, they identify freedom of choice, humor, love, and intimate relationships. Besides the experience of freedom, leisure provides opportunity for a long list of potential salutogens that promote health, including challenge, laughter, creativity, curiosity, imagination, social relationships, and play for its own sake.

Therefore, the common sense conclusion that benefits come to people who are socially, physically, and intellectually active, as well as emotionally involved, is receiving empirical confirmation. This supports the age-old conviction that activity enhances human growth and development. Exercise does improve cardiovascular fitness. Reading does improve memory. Therefore, leisure activity can contribute to human growth and development and can promote health. Despite the apparent efficacy of activity, however, therapeutic recreation lacks justification if that is the only reason for its existence. In addition to its adaptive benefits, leisure opportunities should be offered for at least six additional reasons.

2. *Leisure contributes to a greater sense of well-being.*

Freedom, autonomy, and self-determination have been identified as defining characteristics of recreation (Brightbill, 1960; Miller and Robinson, 1963) and leisure (de Grazia, 1964; Kelly, 1982; Neulinger, 1981). In turn, recreation and leisure are recognized as vital sources of freedom, autonomy, and self-determination. The relationship between recreation and leisure and freedom, autonomy, and self-determination is morally significant in its own right, because freedom, autonomy, and self-determination are primary norms in American society, valued for their own sake. Furthermore, they have been credited for contributing to psychological well-being (Mannell & Kleiber, 1997). Operationalized as "perceived freedom" (Ellis & Witt, 1986), leisure has been recommended for alleviating "learned helplessness" and enhancing well-being (e.g., Dattilo & Barnett, 1985; Iso-Ahola, 1988; Langer & Rodin, 1976). Leisure has also been recognized for promoting well-being by contributing to positive identity, perceptions of competence, and feelings of enjoyment (Mannell & Kleiber, 1997; Dattilo, Kleiber & Williams, 1998). The psychosocial benefits of leisure are compelling for persons who are ill or impaired as they face challenges regarding freedom, control, competence, identity, and self-determination. Mannell and Kleiber's (1997) contention that leisure is a powerful "autonomy supportive context" (p. 145) can be plausibly extended to other psychological factors that contribute to well-being (e.g., perceived competence, intrinsic motivation, locus of control).

3. *The opportunity of leisure is necessary for meeting the creative-expressive needs of clients.*

Adaptive or functional needs pertain to what is physically, socially, cognitively, and emotionally required for individuals to cope successfully. They are first-order needs because they are necessary for individual functioning and species survival. Earlier the adaptive benefits of activity were acknowledged. But adaptive needs are only part of the picture. Beyond their strictly animal functioning, human beings *make* their own worlds of meaning and value, creating their identity (self-concept) and sense of worth (self-esteem). The other half of the picture is comprised of *creative-expressive needs*. Whether we wish to call these outcomes "existential," "spiritual," or "psychosocial," the important point is that besides the needs to clean, dress, and feed themselves, human beings also need to create and express themselves. Viktor Frankl (1959) claimed that the "search for meaning is a primary force" so powerful that people not only live for their ideals and values, they will die for the sake of them as well (p. 97). Richter and Kaschalk (1996) boldly recommended that therapeutic recreation take on the unique role of helping people whose lives have been disrupted by injury, illness, or impairment to create experiences of personal meaning and worth through the medium of leisure (also see Murray, 1998). The quest for meaning has important implications for healing. In reviewing research on the parallels between psychological and physiological events, Jourard (1964) observed:

> When a man finds hope, meaning, purpose and value in his existence, he may be said to be 'inspirited,' and isomorphic brain events weld the organism into its optimal, antientropic mode of organization. 'Dispiriting' events, perceptions, beliefs, or modes of life tend to weaken this optimal mode of organization which at once sustains wellness, and mediates the fullest, most effective functioning and behavior, and illness is most likely to flourish then. It is as if the body, when a man is dispirited, suddenly becomes an immensely fertile "garden" in which viruses and germs proliferate like jungle vegetation. In inspirited states, viruses and germs find a man's body a very uncongenial milieu for unbridled growth and multiplication. (p. 53)

Besides creating environments conducive to healing, creative-expressive opportunities provide incentive for living that is both functional and fulfilling. In other words, where people are involved in experiences they care about, they are more likely to take care of themselves *for the sake of* those things that give meaning and purpose to their lives (Sylvester, 1996). When human service fields speak of serving the "whole" person, they make a commitment not only to the individual as a functional entity, but also to the person's life as an expression of meaning and purpose. Both moral and medical reasons, therefore, support the important human need for meaning and value, which the condition of leisure is well-suited to serve.

4. *Leisure is a flexible medium for helping persons with illnesses and disabilities to reintegrate into community life.*

Much has been said and written about the importance of inclusion, mainstreaming, and integration (Hutchison & McGill, 1998; Schelein & Ray, 1988). Out of the many benefits that involvement in community leisure opportunities offer for persons with disabilities, perhaps the most important one is the achievement of an identity. Guess (1981) stated that:

> Participating in a culture is a way of satisfying certain very deep-seated human needs. Humans have a vital need for the kind of "meaningful" life and the kind of identity which is possible only for an agent who stands in relation to culture. (p. 22)

A culture supplies the beliefs, values, and social practices that collectively constitute ways of life that offer people suitable models for achieving personal meaning and worth. A culture provides norms of what is "good," "desirable," "successful," and so forth. To the extent that any person does not have access to culture, he or she remains "invisible," having no means to determine where he or she stands in relation to the world. Bullock and Howe's (1991) reintegration model emphasizes the importance of social participation by way of the concept of "social role valorization." Identity or self-concept comes from interaction with others and participation in social practices and cultural rituals. Ironic as it may sound, an individual identity depends on other people and the available identities found in culture. For persons with disabilities to achieve valued identities, they must have access to the key domains in society and culture where those identities are created and sustained. Community integration is vital because it is in communities where people work, worship, shop, play, interact, and create contexts that provide models for "successful" living. According to Bullock and Howe (1991), "social valorization theory identifies the individual's right and responsibility to assume a valued social role in society and society's obligation to allow the individual to pursue that role without constraint" (p. 9).

Leisure has been increasingly recognized by people as a viable medium for engaging in activities that are seen as worthwhile and meaningful. For example, the Roper Center (1990) reported that for the first time in fifteen years people identified leisure as "more important" in their lives than work. Furthermore, the changing nature and structure of work (e.g., downsizing, automation) suggest that leisure may be playing a greater role in the lives of many people (see Rifkin, 1995). For these reasons, the connection between therapeutic recreation in institutional settings and community recreation and leisure opportunities is vital. All efforts in clinical settings should be aimed at enabling clients to gain access to their communities. In turn, community services should be doing everything possible to facilitate the successful reintegration and inclusion of persons with disabilities into the community. Insofar as community life is essential for meeting human needs, it should be infused into institutional settings as much as feasible. Institutions are notorious breeding grounds for negative identities. Leisure affords opportunities for individuals who are residing in institutional settings to continue to have culturally meaningful and valued experiences. As such, holidays, birthdays, and other important cultural events and rituals are not just "diversions," and should not be referred to as such. They are intrinsically meaningful and significant *immersions* in living that help people form self-concept, self-worth, and significant relationships. From start to finish, the therapeutic recreation process should enable individuals to create identities of choice, form meaningful relationships, and express themselves through social, cultural, and political media. This is best achieved in the community.

5. *The social institution of leisure is an avenue for addressing structural deficiencies that affect the health and well-being of individuals.*

While praising holistic medicine for being sensitive to environmental factors, Freund (1982) also criticized it for being too individualistic and for failing to restructure environments that produce "diseases of civilization" (e.g., cancer, anxiety, depression, and heart disease). He commented:

> Healing is generally accomplished within the narrow confines of a professional setting and tends to be separated from prevention and above all from everyday life. More shelters for the broken humans, better job conditions, more parks, better public transportation, easier access to all of these appear at first to be unrelated to health but are essential to it. These must be important considerations for a holistic/social medicine that is truly "whole," meaning oriented towards changes of economic and social conditions that are unhealthy. (p. 130)

Rusalem (1973) offered similar advice to therapeutic recreation, arguing that because social structures cause illness and injury, disabling environments should be diagnosed and treated. Preventive medicine that addresses environmental deficiencies and dysfunctions that are deleterious to human health and well-being recommends an important role for leisure. The correlation between good health and good habits of living, such as sufficient rest, diet, hygiene, exercise, and the enjoyment of intrinsically motivated activities, is receiving more attention. Similar opportunities should be made for persons who already have disabling conditions in order to prevent deterioration and to promote health and well-being.

Besides the more constructive habits of living cultivated in leisure, structural changes to work—permitting more frequent and flexible opportunities for leisure—are urged. Freund (1982) alluded to shortening the work day so people can become better informed and more responsible for their own health, reducing dependence on healthcare specialists. Expanding the definition of what constitutes "success" by easing the constraints imposed by the work ethic and by recognizing social contributions that occur during leisure will further widen social participation, which is essential to self-concept and self-esteem. Altering social structures in similar ways will make environments more conducive to fitting the needs of human beings. As such, Callahan (1990) called for a "society prepared to make room for those it cannot cure or return to 'productive life'" [work], suggesting a range of services that go "well beyond the narrowly medical" (pp. 148–149). In his critical theory of play, Hearn (1976/77) explained how industrial capitalism distorted and weakened play in order to create a compliant work force malleable to the requirements of factory life and productive labor. The suppression of play has deprived people of opportunities

for meeting creative-expressive needs and greatly limited the freedom and control that play affords. Therefore, therapeutic recreation must not restrict itself to narrow, vocational models of rehabilitation, but must address the broader environmental issues that affect the lives of clients, including the environment of leisure. In fact, as rehabilitation embraces quality of life as its goal (Sandstrom, Hoppe & Smutko, 1996), therapeutic recreation would do well to adopt quality of life as its primary mission. Arguably, no other human service field is as well-suited for that role as therapeutic recreation.

6. *Leisure is a significant contributor to quality of life, which is being recognized as the overarching goal of rehabilitation.*

Imagine a world in which individuals with impairments could be rehabilitated to function flawlessly. They could walk, communicate, reason, and relate as well as persons without impairments. Unlike persons without impairments, however, their world is devoid of opportunities to hold jobs, form relationships, participate in their communities, or enjoy the outdoors. In other words, even though they have achieved functional ability, they lack the opportunities that make functioning worthwhile. Such an existence, all too real for some people, would be hell on earth. For this reason, rehabilitation is embracing quality of life as its goal. As Sandstrom, Hoppe, and Smutko (1996) expressed:

> *The goals of rehabilitation are twofold: promote the wholeness and integrity of the person and enable the individual to live a full life with an illness or disability. . . .* In doing so, rehabilitation needs to focus on the care not the cure, not isolated pathologies but the whole person, and on the quality of life of the individual. *. . . Improvement of the quality of life is the central mission of rehabilitation.* (emphases added) (p. 44)

Speaking about therapeutic recreation, Dr. Lynn Gerber (1994/95), a professional in rehabilitation medicine, stated:

> Clearly, quality of life is more than survival and productive capacity. It includes full participation in society. Leisure activities that give a sense of purpose and enjoyment to life must be made possible. Recreation participation must be measured by its ability to provide meaning and dignity to life so that people with disability have reasons to live, not merely exist. (p. 3)

Quality of life refers to the subjective experience that life is good, meaningful, and satisfying. On a phenomenological level—the realm of our subjective experience—most people can attest to perceiving their lives as fulfilling

and satisfying as opposed to degrading and despairing. Furthermore, most people can point to particular conditions that are conducive to experiencing their lives as "good," including such things as safe and pleasant surroundings, economic security, social relations, and enjoyable pursuits.

The importance of quality of life has not escaped therapeutic recreation. One of the earliest theorists on the relationship between therapeutic recreation and quality of life, Sylvester (1989b) argued forcefully for placing quality of life at the center of therapeutic recreation's mission. Quality of life is one of the key outcomes of Van Andel's (1998) Therapeutic Recreation Outcome Model. Carter, Van Andel, and Robb (1995) contended that because they produce freedom, satisfaction, and joy, leisure activities are vital "to experiencing a quality of life" (p. 21). Therefore, while extensive study of the relationship among leisure, therapeutic recreation, and quality of life is needed, rehabilitation's embrace of quality of life as a goal invites a central role for leisure and a unique contribution by therapeutic recreation.

7. *All people, including persons receiving healthcare, have the right to leisure for the purposes of health, well-being, and quality of life.*

Lieb (1976) claimed that illness does not turn people into some other kind of creature. Carter, Van Andel, and Robb (1995) made a similar point, asserting that persons with disabilities are still human beings "apart from any impairment, disease, or need they might have" (p. 22). Human beings do not check their humanity at the door when they enter rehabilitation programs. Consequently, they maintain their basic rights. Sylvester (1992) noted that the concept of well-being has served as a principle for determining rights. Arguing that modern life requires leisure for the purpose of well-being, he proposed that "the right to leisure . . . is an indispensable corollary of the right to well-being" (p. 16). Asserting that "disability does not preclude the right to leisure," Sylvester argued that "leisure must be protected and facilitated for people who have limiting conditions, lest they be deprived of their main or only source of well-being" (p. 16). Therefore, leisure is relevant in any setting where people retain their right to live like human beings.

The right to leisure has been affirmed repeatedly in the history of therapeutic recreation (NTRS, 1982, 1990, 1996). Most recently, the NTRS *Philosophical Position Statement* (1996) identified the right to leisure as one of three values that constitutes the field's value structure, proclaiming that "the right to leisure is a condition necessary for human dignity and well-being."

Summary

A conceptual foundation is a critical function for all professions, providing theory and practice with intellectual substance and moral direction. A sound conceptual foundation cannot be developed without philosophy, which is an intellectual process aimed at analyzing and explaining the key concepts and values that ground a field. Although some progress has been made, more philosophical discourse in therapeutic recreation is imperative.

The presence of ATRA and NTRS has also impacted the foundations of therapeutic recreation. Because therapeutic recreation practice, and therapeutic recreation programming in particular, does not operate in a vacuum, students should understand how social and political developments related to professional organizations influence a field's foundation.

Finally, a justification for the profession of therapeutic recreation starts with a legitimate social need or good. The authors of this text contend that an orientation to leisure provides the firmest foundation for the profession. First, leisure activities are gaining empirical support for contributing to growth and development, posing important implications for disease prevention, disability management, and health promotion. Second, leisure contributes to a greater sense of well-being, offering significant psychological benefits associated with freedom, autonomy, and self-determination. Third, in addition to adaptive needs, human beings also have creative-expressive needs. Leisure is often the only, and arguably the best, opportunity to satisfy those needs in rehabilitation. Fourth, without a community to supply meaningful and valued roles and norms, a human being is invisible, a nonperson. Through community-based opportunities, leisure is a flexible medium for helping people to assimilate into cultures in which they can "find" themselves, acquiring an esteemed identity in the process. Fifth, leisure affords a way to deal with structural deficiencies in society, such as noxious and debilitating environments and destructive habits of living, that contribute to illness and disability. Sixth, leisure is a vital resource for quality of life, which is being recognized as a central goal of rehabilitation. Seventh, and finally, all human beings have a right to leisure based on the principle of well-being, which is a goal of therapeutic recreation. Leisure and the related forms of play and recreation are broadly relevant to the needs, values, and interests of human beings with illnesses and disabilities who are receiving medical and rehabilitative care. Any theory of caring for persons who are ill or injured that does not include a prominent role for leisure and therapeutic recreation service is socially limited and morally impoverished.

Recommended Readings

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Chapter 2

Multicultural Considerations

Therapeutic recreation takes place in a society comprised of various cultures. *Therefore, all therapeutic recreation practice occurs in a multicultural context.* It is reasonable to expect that therapeutic recreation would reflect the cultural diversity of the society it serves. Yet Peregoy and Dieser (1997) contended that therapeutic recreation was based on Western beliefs and values, seriously limiting the field's capacity to serve people whose primary world-view is non-Western. The issue is not that Western cultural values, beliefs, and practices are inherently wrong. Clearly, they have a central and significant role in society. The problem is that therapeutic recreation, which has long advocated the principle of inclusion as it pertains to persons with disabilities, has not sufficiently incorporated cultural inclusion, or multiculturalism, into its theory and practice.

Furthermore, multiculturalism is not just about respecting individuals' cultural beliefs and practices; it is also about oppression. The history of oppression in the United States toward such groups as Native Americans, African Americans, and Asian Americans is shameful (see Zinn, 1980). Although no longer considered a mental illness, until 1973 the American Psychiatric Association listed "homosexuality" among mental and emotional disorders. Homosexuals continue to be an oppressed group. Granted, history cannot be changed and progress has been made. But as a calling to serve society, the profession of therapeutic recreation has the moral responsibility to eliminate discrimination and oppression and to foster opportunities for growth and development according to the individual's cultural frame of reference.

Therapeutic recreation has made formal commitments that support multiculturalism. The codes of ethics of both the American Therapeutic Recreation Association (ATRA; see Appendix A) and the National Therapeutic Recreation Society (NTRS; see Appendix C) take stands on justice and equality. Under Principle 3: Justice, The *ATRA Code of Ethics* (1998) states: