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RECREATIONAL THERAPY: A MODEL FOR A HUMAN SERVICE PROFESSION THAT TRANSCENDS LANGUAGE, CULTURE, AND GEOGRAPHY

Alexis McKenney

Florida International University, United States of America

Candace Ashton

University of North Carolina, Wilmington, United States of America

Ellen Broach

University of South Alabama, United States of America

Recreational therapy (RT) involves the use of structured and adapted recreational opportunities with the goal of improving physical, cognitive, social, and emotional functioning of people with disabilities, illnesses, or limitations. As a human service centered profession, RT grounds much of its work in the social sciences; therefore, theories, such as self-determination, enjoyment and social fun, and optimal experience are commonly applied. Within the United States of America (USA), recreational therapists work in various settings ranging from rehabilitation and hospital-based settings to community service settings and schools. RT services are similarly available in Canada and increasingly in South Korea, Australia, Finland, New Zealand, and Switzerland. Using research specific to structured recreational activities as they are used to assist in rehabilitative and academic processes within the USA, and to some degree, internationally, the purpose of this paper is to define and describe RT from a global perspective, provide a model for how RT services transcend language, culture, and geography, and how the RT profession within the USA is uniquely positioned to assist individuals in developing a model for similar services within their respective countries.

Keywords: Recreational therapy, International, Enjoyment, Self-determination, Disability.

Introduction

Recreational therapy (RT) is a profession that utilizes structured recreational and life skill activities to assist people with limitations or disabilities in improving functional limitations and increasing healthy recreation activity participation. The purpose of this paper is to present a description of RT services as they are provided throughout the USA and set the foundation for viewing RT from a global perspective. To do this, RT is defined followed by a review of select philosophical and theoretical foundations common to the profession. A description of RT and related professions as they function internationally,

and a description of why RT should expand internationally so to provide individuals with common rehabilitation and quality of life experiences, are then outlined.

Recreational Therapy Definitions and Guiding Philosophies

People are innately driven to find enjoyment. Happiness underlies almost everything people do in their lives (Csikszentmihalyi, 1990; James, 1902; Myers, 1993). Thus, one might argue that it makes sense to utilize structured, yet enjoyable, recreational activities to improve functioning among individuals with limitations or disabilities. Recreational therapy (RT) is a profession that subscribes to this argument and translates the logic into rehabilitative services. More specifically, recreational therapists use "…a wide range of activity and community based interventions and techniques to improve the physical, cognitive, emotional, social, and leisure needs of their clients" (ATRA, n.d., p. 1). Furthermore, recreational therapists provide life skills training programs, as needed, with the goal of helping clients successfully participate in and/or transition fully into the community. Regardless of whether planned programs include structured recreational activities and/or life skills training, recreational therapists consider clients' interests and strengths, available resources (McKenney, Ashton, & Broach, in press), and evidence-based research when program planning to help them improve or achieve functional outcomes. Evidence-based practice (EBP) is the careful and prudent use of current outcomes based research, clinical experience and expertise, and patient values to guide health care decisions (Cook, 1998; Sackertt, 1996). Functional outcomes are, furthermore, sought so that clients develop skills needed to confront real life situations commonly associated with social, educational, and vocational settings. The prompt that would necessitate RT is not so much the actual impairment or disability, but the need for an intervention that will help an individual negotiate an enhanced life challenge (Anderson & Heyne, 2012).

RT is grounded in the philosophical paradigms of leisure, health, inclusion, and strengths-based practice (McKenney, Ashton, & Broach, in press). Compared to other allied therapies (e.g., occupational and physical therapies), the concept of *leisure* is unique to the practice of RT. Whereas old notions of leisure were limited primarily to viewing leisure as "non productive consumption of time" (Veblen, 1899, p. 46), activity (e.g., Dumazedier, 1974), or a state of being (e.g., de Grazia, 1964), recent definitions characterize leisure as an activity or experience grounded in concepts of freedom and motivation (e.g., Kelly, 1882; Neulinger, 1974) and satisfaction or enjoyment (e.g., Henderson & Bialeschki, 2005).

Leisure serves as one of the philosophical foundations of RT because of its capacity for promoting *health* (Godbey, Caldwell, Floyd & Payne, 2005). Recreational therapists view health as more than the absence of disease; recreational therapists embrace the idea of health as being a state of complete physical, social and mental well-being. RT services provide a viable, outcome-based means for advancing health promotion among clients. Outcomes are the changes observed and measured that directly relate to the treatment services provided (Shank & Kinney, 1991). Health-related outcomes (e.g., xxx) are achieved through a systematic application of planned structured RT facilitation techniques. The systematic delivery of RT faciltiation techniques depends on the presence of evidence-based and theory-based programming, systematic program design, and well-targeted client outcomes (Stumbo & Pegg, 2011).

As the RT profession has grown and matured, it has become central to the advancement of *inclusion* within the USA. Inclusion evolved from the concepts of normalization and mainstreaming. Normalization is the idea that individuals with disabilities should be afforded the same life experiences (e.g., being a student or employee) and social roles (e.g., raising a family, participating in leisure) as people without disabilities (Wolfsenburger, 1972). During the 1970s, within the USA, schools began the process of mainstreaming as mandated by federal legislation (Education for all Handicapped Children Act of 1975 [Public Law 94-142], now the Individuals with Disabilities Education Act [1990 & 1997] [Pub. L. 101-476, 20 U.S.C. §1400 et seq. & Pub. L. 105-17, 20 U.S.C.]). Mainstreaming involves providing an education to all students with disabilities in the least restrictive environment by placing them in the same schools, and often the same classrooms, as students without disabilities.

Inclusion advances the concept of mainstreaming and is a founding principle of the American's with Disabilities Act (1990). Title II is part of the ADA's clear mandate to end the segregation of persons with disabilities in virtually all aspects of American Life. The ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity. Segregated placement of individuals who would benefit from community inclusion perpetuates unwarranted discrimination and prevents personal enrichment and growth (of those with and without disabilities) from social interactions and activity in the community. The argument behind inclusion is that individuals with disabilities often need extra resources to be included in normative life activities (McKenney, Ashton, & Broach, in press). For example, a client who is deaf or hard of hearing might require a person to provide sign interpretation to assist that client with participation in select RT activities. A goal of RT is to facilitate the development of the skills and resources necessary for full inclusion into life activities, especially recreation, play and leisure.

Related to leisure, health, and inclusion is the *strengths perspective*. This perspective is based on the argument that all individuals have the capacity for growth and development; possess competencies, potential, purpose, resilience, and resourcefulness; and intuitively understand what is right for them (Saleebey, 2009). The strengths perspective is solution focused rather than problem focused meaning that deficits are de-emphasized so to promote self-determination among clients. Recreational therapists focus on the client's recreation-related strengths, skills, knowledge, and choices when planning interventions to help them treatment and/or wellness goals (McKenney, Ashton, & Broach, in press).

Common Theoretical Foundations

Because leisure is believed to be a fundamental aspect of the human experience, a basic human right, and one that promotes psychosocial development and quality of life (e.g., Kelly & Freysinger, 2000), one might argue that RT should be a natural consideration when determining course of treatment and/or program planning for individuals with disabilities or limitations, regardless of where individuals reside. Similarly, a related concept that transcends language, culture, and geography is that of enjoyment. Recreational therapists use structured activities that clients enjoy to advance their treatment goals. People are more motivated to recover their health and remain healthy when treatment includes experiences of intrinsic meaning and worth that result in enjoyment or fun (Seligman, 2002), and improved self-determination.

The experience of positive emotions, including enjoyment, fun and contentment, are essential to health, well-being and life satisfaction (Broach & McKenney, 2012; Carruthers & Hood, 2004; Deiner et al., 1999). Therefore, RT practice, in part, focuses on the mechanisms through which these states are generated. *Enjoyment and fun* are complex experiences that incorporate physiological arousal and subjective feelings. Enjoyment is more self-oriented (internal) and fun is more closely tied to social interaction in activity.

Positive and negative emotions have psychological, social, physical and cognitive implications. Individuals who have negative mood states are depressed and self-preoccupied. Extreme negative moods can cause compromised health and function, result in reduced activity levels, and more days sick from work than those who have positive mood states (Lyubomirsky, Sheldon, & Schkade, 2005). An acquired physical disability often results in decreased positive mood states and self-determination, as well as increased in stress levels, anger and depression (Jang, Haley, Small, & Mortimer 2002; Wiederholt, 1995).

Enjoyment can positively impact physical health (Davidson et al., 2003; Ostir, Markides, Black, & Goodwin, 2000), immune system function (Davidson et al., 2003), years of living (Danner, Snowden, & Friesen, 2001), subjective pain levels (Gil et al., 2004), and brain system function (Burgdorf & Panksepp, 2006). Positive mood states that include enjoyment and fun also enhance creativity and attention (Csikszentmilahyi, 1996), intuition (Bolte, Goschikey, & Kuhl, 2003), activity adherence (Wankel, 1993); and can decrease negative responses to stress and adversity (Fredrickson, Tugade, Waugh, & Larkin,

2003). The idea of improved cognition and attention was reinforced by Ashby, Isen, and Turken (1999), who stated that enjoyment from activity participation affects brain dopamine levels in the prefrontal cortex and anterior cingulated that may contribute to better cognitive performance. When Lyubomirsky et al. (2005) compared individuals with positive and negative emotions, they found that happy people lived healthier, perceived their life as safer, made decisions with greater ease, and were more energized. Fredrickshon and Branigan (2005) agreed, finding that negative emotions narrow action-thought repertoires by encouraging narrow response tendencies such as the flight or fight, while positive emotions promote a larger variety of thoughts and actions such as exploring, inventiveness, and playfulness.

Enjoyment is an emotional outcome resulting from participating and investing ones attention in an intrinsically motivated activity (Csikszentmihalyi, 1990; Dattilo, Kleiber, & Williams, 1998). Enjoyment is likely to occur when an activity presents a set of challenges that are matched to the person's skill level. According to Csikszentmihalyi (1990), a person will experience boredom if that person is participating in an activity challenge that is less than their skill level. In addition, an individual participating in a challenge that is greater than his/her skill level will experience anxiety. Enjoyment occurs when a person feels a sense of accomplishment after finding a challenge/skill balance that results in goal attainment. People initiate activity with the intent of experiencing enjoyment. Csikszentmihalyi (1996) additionally argued that because enjoyment pushes people to do things beyond their present ability, enjoyment is the method that natural selection has provided to assist in our evolution towards greater complexity and self-awareness. This perspective helps to guide RT practice; in that, RT practice utilizes interventions that assist people with learning skills that result in achievement of goals that occur within an enjoyable context.

Social fun is an emotional state that is similar to enjoyment but experienced within a social context. From an analysis of emergent categories, Podilachak (1991) found that fun, like enjoyment, included active involvement in an intrinsically motivated, self-determined activity, with a feeling of control and a consequential positive state. Podilchak added that, although fun is similar to enjoyment, it not only involves absorption in the activity, it is the successful engagement with another individual that makes it fun. Fun is important for social development and activity adherance (Broach, Dattilo & Mckenney, 2007; Podilchak, 1991; Wankel, 1993). For example, while health benefits are the main reason for starting exercise programs, enjoyment and/or fun are the primary reasons participants continue (Wankel, 1993). Activity commitment from positive emotion states is associated with an individual's health and longevity (Fredrickson & Losada, 2005).

Another theory common to RT practice is *self-determination theory*. Self-determination theory suggests that optimal human functioning is dependent on the satisfaction of the basic psychological needs of competence, autonomy, and relatedness (Deci & Ryan, 1985). A sense of autonomy is experienced when individuals make decisions for themselves without outside pressures. Competence is felt when individuals feel as though they are confident in what they are doing and are capable of accomplishing the task. When individuals feel connected to others, they are experiencing relatedness. Attainment of psychological needs is effected by degree of determination and nuturance from within their social environments (Deci & Ryan, 2002). Recreational therapists recognize activity interventions that serve to empower people to be self-determined satisfy the essential basic psychological needs that result in client interest, engagement and enjoyment.

To conclude, according to enjoyment and fun theories, health does not stop with improved physical ability. Health and well-being being are influenced by experiences that result in the by-products of positive emotions. Most scholars of positive emotions agree that practitioners should use treatment interventions that facilitate positive emotions, including enjoyment and fun. Furthermore, because positive emotions and self-determined behavior are related to good health and well-being (Fredrickson & Losada, 2005), RT practitioners, in part, focus on interventions that facitate both. In addition to the literature that provides the information on biological factors associated with positive emotion that may play a role in promoting better health (Buckworth & Dishman, 2002; Burgdorf & Panksepp, 2006), positive emotions seem to promote greater life activity in general and potentially greater motivation towards self-care and self determined behavior (Buckworth & Dishman, 2002). Positive emotions are

furthermore associated with increased social interactions and self-determination that can act as a buffer to stress and greater coping capabilities (Coleman & Iso-Ahola, 1993; Fredrickson, Tugade, Waugh, & Larkin, 2003).

World Health Organization, the ICF, and Recreational Therapy

The World Health Organization (WHO), which serves as the coordinating authority for health within the United Nations system, contends that 600 million of the world's population has some form of disability, and that number is increasing (n.d.). The WHO defines health "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (n.d.).

In an effort to further the concept of a holistic approach to treatment, the WHO published the International Classification of Functing, Disability, and Health (ICF) (WHO, n.d.). The ICF is a classification of health and health-related domains that emerged as a result of a collaborative effort between health professionals from 60 different countries (WHO, 2001). These domains are classified into the two catagories of body functions and structure, and activity and participation. The ICF uses a bio-psycho-social approach that clearly lays the groundwork for recreational therapists to focus on the integration of the medical and social model of practice. The ICF has been central to advancing the notions of health and disability to incorporate more than the traditional idea of disability as merely a medical or biological dysfunction. The ICF argues that disability is not limited to a small portion of the world's population. Rather, all individuals experience some degree of limitation in health, thus translating into various levels of disability. In other words, the ICF views disability as a "universal human experience." By shifting the focus of disability to a more integrative and holistic view, the ICF considers the social, contextual, and environmental aspects of functioning and disability. Employing an integrative model that combines medical and social models translates into an inclusion of all factors that interact to influence an indivdual's health. One of those factors is specific to recreation and leisure, concepts central to RT practice. The WHO expands the center of attention in health care from treating impairments with medical outcomes to a focus on the idea that a practice cannot succeed unless the clients it serves are able to participate in society. RT has long emphasized the importance of this holistic model.

The WHO (n.d.) advocates for the provision of rehabilitation services that involve holistic treatment that includes enjoyment, also referred to as positive emotion. This advocation is directly related to the argument that positive emotions help to expedite recovery from illness and minimize and delay the emergence of disabilities. This perspective is aiding in the shift of health care focus from acute care to services that better integrate people into their home communities and promote continued enjoyment and personal health and well-being (Broach & McKenney, 2012). This shift in how to best approach rehabilitation practice is ideally suited for RT, therefore, providing a compelling argument for the expansion of services internationally, using the WHO and ICF as the impetus for doing so.

Recreational Therapy and Related Professions Internationally

With the WHO's publication and subsequent world-wide adoption of the ICF, the need for holistic services that include an emphasis on recreation and leisure has emerged. According to Howard et al. (2008), "The *ICF* has given health care professionals a system though which they can communicate and collaborate on an international scale to improve the services that they provide" (p. 236). Using the ICF as a platform for communication among providers across countries and cultures allows for opportunities for collaborative efforts both in practice and in academia, and continued expansion of RT services across the globe. To lay the foundation for this argument, a brief history of RT within the USA is presented followed by a review of RT and related professions as they exist outside of the USA.

The roots recreational rherapy (RT) trace back to Europe. According to Dieser (2008), programs common to European countries during the later 1700s to the early 1900s served as antecedents to the

eventual emergence of RT programs in the USA. For example, Phillippe Pinel of France and William Tuke of England are considered pioneers of the *humanitarian treatment movement* found throughout Europe from the late 1700s to the early 1800s. Pinel, as Director of an "insane asylum", removed patients from dungeons and chains, allowed them access to sunny rooms, and encouraged them to exercise on hospital grounds (Dieser, 2008). Tuke founded the York Retreat, a country home, where he employed a medical and scientific approach to treatment (Dieser, 2008). From the early 1800s through the mid-1900s, a movement generally referred to as the *medicalization of spas and thermal baths* throughout Europe contributed to an understanding of the therapeutic consequences of leisure (Mackaman, 1998). Doctors prescribed spa baths as a means for experiencing leisure during a time that leisure was not commonly accepted. With leisure being justified through medical authority in Europe, *rest cures* became popular in mental health institutions in the USA. The history of RT and how it emerged from events that occurred in Europe is also found in the work of Florence Nightengale, a nurse who worked in British hospitals during the Crimean War (1854-1856) (Dieser, 2008). Nightengale's idea of using recreation for therapeutic purposes when working with soldiers led to the further development of the RT profession in the USA during both World Wars.

Despite a relatively long history of practice that has involved using structured recreation activities as means for improving the lives of people with disabilities outside of the USA, the profession is currently well established only in the USA and Canada. It was not until the 20th century that the RT profession mobilized and proliferated throughout the USA. Throughout the 20th century, and now the 21st century, RT services can be found in a variety of settings ranging from hospitals and rehabilitation facilities, to nursing homes and assisted living facilities, schools, community parks and recreation facilities, and other community based service settings. Outside of the USA, RT services can be found throughout Canada and increasingly in South Korea, Australia, Finland, New Zealand, and Switzerland. Related services, referred to as Psychomotricity, can be found in, and to some degree across 15 European countries.

In an effort to provide professional support for practitioners and advocate for RT services, national organizations have existed within the USA since the 1970s. In *Canada*, the development of a national RT professional organization did not occur in until the mid 1990s (Howard, et al., 2008). Until that time, support for the RT was provided through several provincial and territorial associations. Currently, RT practitioners work in hospitals, hospice centres, rehabilitation centres, mental health facilities, drug treatment programs, agencies serving older adults, community centres, family services centres, schools, and camps.

The roots of RT in *South Korea* can be found in the recreation and leisure movement in the mid 1900s (Howard, et al., 2008). Nevertheless, it was not until the late 1980s that recreation was accepted as an essential part of people's lives. According to Howard et al. (2008), people with backgrounds in the field of social work helped spread the development of RT in South Korea. In 1993, the first national RT professional organization was formed. Shortly thereafter, two more professional organizations were founded followed by the formation of a RT research center, and the publication of South Korea's first RT scholarly journal.

In *Australia*, although RT practice exists in the form of diversional therapy, it has yet to be fully accepted in the health care setting (Howard et al., 2008). Of the commonly used titles, recreaton therapist is included, along with diversional therapist, activities officer, and activity therapist. The national professional organization in Australia, referred to as *The Diversional Therapy Association of Australia* (n.d.), states that diversional therapists facilitate recreation programs for people of all ages and abilities. Specifically, activities are implemented "…to support, challenge and enhance the psychological, spiritual, social, emotional and physical well being of individuals." Although one might argue that the definition of diversional therapy varies from the definition of RT accepted in the USA, the concept of using recreation to improve the well-being of people with disabilities provides a common thread.

Three additional countries in which RT is slowly developing include *Finland*, *New Zealand*, and *Switzerland*. In Finland, formal prepartion in RT began as early as 1947, yet is presently only offered through one university, The HAMK University of Applied Sciences in Hameenlinna (Aho, 2007). Trained professionals work in inpatient and outpatient facilities as facilitators, consultants, and planners (Aho,

2007). RTs often work together with occupational therapists in hospitals, rehabilitation facilities, and prisons. Although it is difficult to discern the scope of RT services in Finland, a national professional organization, the *New Zealand Therapeutic Recreation Association*, exists and defines recreational therapy as "a helping profession which uses leisure and recreation activities, treatment and education, in a holistic way, to help people with illnesses, disabilities and other conditions to enhance health, independence and wellbeing" (NZTRA, n.d.). In Switzerland, a "klinik" located on the eastern side of the country offers "Rekreationstherapie." In the klinik groups that focus on creativity, games, and pain reduction are facilitated. Furthermore, sports therapy in the form of outdoor and traditional sports activities are utilized.

A related profession, that is, one that focuses on services similar RT services is referred to as *psychomotricity* and can be found across 15 European coutries. According to The European Forum of Psychomotricity (n.d.), the profession of Psychomotricity is "Based on an holistic view of the human being, on the unity of body and mind, psychomotricity integrates the cognitive, emotional, symbolical and physical interactions in the individual's capacity to be and to act in a psychosocial context." Similar to RT, psychomotricity works in coordination with the fields of health, education and research. Psychomotricians intervene in the promotion of well-being, prevention, care, rehabilitation, and therapy. Professional education and training involves learning the links between movement, emotion, actual experiences, relationships and personality. Specific techniques, such as relaxation, are mastered.

Conclusion

According to the WHO, "In the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats" (n.d.). According to Howard et al. (2008), "The ICF has given health care professionals a system through which they can communicate and collaborate on an international scale to improve serves they provide" (p. 236). The WHO's ICF provides a paradigm for health-care services that aligns with services provided through RT. Moreover, the ICF, along with RT and related services as they exist internationally, present increased possibilities for collaboration and sharing of information and resources among professionals interested in improving and expanding services for people with disabilities or limitations. RT services are prevalent in the USA and Canada and are emerging in a small number of other nations, the room for expansion of services is unlimited. Ways in which collaborative efforts might be advanced could be through increased efforts among researchers to publish research specific to RT in journals internationally. Similarly, RT professionals might consider seeking opportunities for multidisciplinary research opportunities aimed at exposing RT research to allied health care professionals. Finally, individuals interested in pursuing studies in RT might consider pursuing on campus or online degrees from universities within the USA. Graduates could then, in turn, fullfil a goal of bringing RT knowledge and resources back to their respective countries.

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