Therapeutic recreation

Therapeutic recreation is a treatment service designed to restore, remediate and rehabilitate a person’s level of functioning and independence in life. According to WHO- The worldhealthorganisation, health promotion is the process of enabling people to increase control over, and to improve their health. Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals but also the action directed towards changing the social, environmental and economic conditions.

The Ottawa Charter identifies three basic strategies for health promotion. These advocacy’s for health to create the essential conditions for health indicated above enabling all people to achieve their full potential, and mediating between the different interests in society in the pursuit of health. In order to promote healthy lifestyles in a population or an individual a number of models have been created. For this study both the Leisure Ability Model and the Health Protection/Health Promotion Model are being looked at and compared. The first of these models being looked at is the Health Protection Model.

Health Promotion Model

This model, created by Austin 1991, sees the purpose of therapeutic recreation as facilitating the client to recover following a threat to health such asdrug addiction, alcohol addiction, psychiatric disorder etc, also known as health protection, and to achieve optimal health through health promotion. Hence for this reason this models chief aim is “ to use activity, recreation or leisure to help people to deal with problems that serve as barriers to health and assist them to strive for their highest levels of

wellness", (Austin, 1997). There are four major concepts that underlie the Health Protection/ Health Promotion Model (HPHPM). These are the Humanistic Perspective, High-level Wellness, The Stabilisation and Actualisation Tendencies and Health.

Humanistic Perspective

Those who embrace the humanistic perspective believe that each of us has theresponsibilityfor his/her own health and the capacity for making self-directed wise choices about our own individual health status. Because an individual is responsible for their own health it is important to encourage individuals to become involved in decision making and to gather maximum knowledge to improve their health. Austin encourages that the population are " active participants in the world, rather than passive puppets controlled by theenvironment". The humanistic perspective focuses on the positive image of what itmeans to be human. Human nature is viewed as basically good, and humanistic theorists focus on methods that allow fulfilment of an individual's potential.

High-Level Wellness

The term high level wellness was first coined by Dr. Halbert Dunn in his book in 1961, he defined it as "…an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable". Dunn's concept of high level wellness is, like the humanistic perspective is a holistic approach that goes beyond the absence of physical illness to include both psychological and environmental wellness. For this reason Austin surmises that high level wellness goes beyond traditional medicine and toward helping people to achieve as high a level of wellness as

they are capable of achieving. Austin further goes on to compare the similarities between high level wellness and therapeutic recreation as both have been heavily influenced by the humanistic perspective.

Stabilisation and Actualisation Tendencies

These are two motivational forces which the Health Protection/ Health Promotion Model are based on. Stabilising tendencies helps to maintain a steady state of an individual. It looks at keeping thestresslevels of an individual's life at a maintainable level and not to let the stressors in a person's life to spiral out of control leading to health risk behaviour (HRB), hence for this reason stabilisation tendencies is the driving force behind Health Protection. The actualisation tendency drives a person towards health promotion which focuses on achieving an individual's high level of wellness.

Health

Health is the final underlying concept of The Health Protection/Health Promotion Model. The ultimate goal of this concept is to help a client to strive toward health promotion. Pender's (1996) definition of health incorporates stabilisation and actualisation tendencies, therefore interlinking health with the previous underlying concept of the model.

For this reason healthy people can cope with life's stressors and encourages clients to optimise their own health rather than improving their health just to recover form illness. Austin (1997) believes that those who enjoy health have the opportunity to pursue the highest levels of personal growth and development. Having looked at the underlying concepts of the model there

are three broad areas of a continuum to be understood in order to design a therapeutic recreation program for any client. These are:

- Prescriptive activities: When clients initially encounter illnesses or disorders, often they become self-absorbed. The therapeutic recreation personnel, at this stage of the continuum must provide direction and structure to the client as means of an intervention due to a feeling of helplessness that can ultimately produce severedepression.
- Recreation: Through recreation, clients begin to regain their equilibrium disrupted by stressors so that they may once again resume their quest for actualization. They take part in intrinsically motivated recreation experiences that produce a sense of mastery and accomplishment within a supportive and nonthreatening atmosphere. Mutual participation on behalf of the client and the TRP occurs and the client begins to have fun and find new ways to interact with others.
- Leisure: This is a means to self-actualization because it allows people to have self-determined opportunities to expand themselves by successfully using their abilities to meet challenges. This stage is based on The Leisure Ability Model whereby they look at leisure alone as a means of therapeutic recreation.

At this stage of the continuum, clients assume primary responsibility for their own health.

So from looking this model ultimately it can be said that health and actualization are intimately intertwined. The attainment of high level wellness permits actualization. Those who enjoy peak health are free of

barriers to actualization so that they may actively pursue personal growth and development. When clients are initially taking part in a program based on this model they have a learned helplessness and take a lack of responsibility but as they move down the continuum they assume primary responsibility for themselves.

The Leisure Ability Model.

The second model being discussed is The Leisure Ability Model. The Leisure Ability Model (LAM) which was draw up by Peterson and Gunne in1984focuses on leisure as a prevention of illness rather than the use of medication. This model can be used hand in hand with The HPHPM or can be used alone when designing a therapeutic recreation program to demote a health risk behaviour. Peterson and Gunne, when designing this model thought that recreation and leisure are necessary experiences that all people should enjoy and take part in, including those with “ limitations” or disabilities both physical and mental.

The purpose of the model is therefore to “ facilitate the development, maintenance and expression of an appropriate leisure lifestyle” for individuals or groups with physical, emotional, mental or social limitations. The LAM offers an alternative to more traditional medical models for those with special needs. The Leisure Ability Model was constructed with the belief that the end product of therapeutic recreation services for clients was improved independent and satisfying leisure functioning, also referred to as a " leisure lifestyle" (Peterson, 1981, 1989; Peterson & Gunn, 1984).

Similar to the HPHPM, the Leisure ability model also has a number of underlying concepts, these include Learned Helplessness, Intrinsicmotivation, internal locus of control, and causal attribution, Choice and finally Flow. Learned Helplessness- Many individuals with disabilities and/ or illnesses experience learned helplessness. This could be learned duringchildhoodwhen others did things " for" the individual, or through repeated exposure to settings where one learned to become a passive patient upon whom procedures were performed according to a routine.

Learned helplessness robs the individual of a sense of mastery and self-determination but is also beyond that individual’s control. After having experienced life so far as helplessness in one leisure activity, a person may firmly believe that he or she is abnormal, inadequate, and lacks basic skills in that activity. As a consequence, the person believes that they are handicapped to participate in this activity and this belief may then generalize to personal performance in other areas of leisure behaviour.

Iso-Ahola (1980) reports that there are three consequences of learned helplessness, these are:

- A lack of internal motivation to escape the conditions which lead to the state of helplessness.
- A lack of cognitive understanding of personal effectiveness,
- A heightened state of emotionality. Intrinsic motivation, internal locus of control and causal attribution

The three concepts of intrinsic motivation, locus of control and personal attribution are intricately linked, and help to explain the basis for the provision of therapeutic recreation services.

All individuals are intrinsically motivated towards behaviour in which they can experience competence and self-determination. This process is continual and through skill acquisition and mastery, produces feelings of satisfaction, competence, and control. An internal locus of control implies that the individual takes responsible for the behaviour and consequences which may occur from the behaviour. The opposite of this is external locus of behaviour i. e. leaving others take the blame for your own mistakes.

Personal attribution implies that the individual accepts that they can affect the outcome of a situation, they can make a decision that matters somehow to something. Without a sense of personal causation, the likelihood of the individual developing learned helplessness (the feeling that external others are in control) increases greatly.

Choice

The Leisure Ability Model also relies heavily on the concept of choice. Choice implies that the individual has the knowledge, skills and attitudes which facilitate choice and the desire to choose. This suggests freedom, freedom from constraints and freedom to exercise an option to an individual that initially felt restricted. The Leisure Ability Model emphasizes content areas that help clients build skills in a variety of areas which, in turn, should allow them options for future independent leisure functioning.

Flow

A fourth, closely related concept is that of " flow" (Csikszentmihalyi 1990). Flow suggests a state of balance between skill level and activity challenge which leads to a level of concentration and energy expenditure which is absorbing or consummating in form.

When skill level is high and activity challenge is low, the individual is quite likely to be bored. When the skill level is low and the activity challenge is high, the individual is most likely to be anxious leading to an uneven flow. A therapeutic recreation personnel must attempt to balance both to keep flow. These areas of understanding are important for the therapeutic recreation personnel to be able to design a series of coherent, organized programs that meet client needs and move the client further toward an independent and satisfactory leisure lifestyle.

The Leisure Ability Model contains three major categories of service: treatment or rehabilitation which is directed towards therapy and/or rehabilitation, leisureeducationrevolves around the development of activity skills and social interaction skills as well as issues for leisure counselling, and special recreation which involves the provision of recreation programs for members of special groups such as autism or down syndrome.

Each of these three service areas is based on distinct client needs and has specific purposes, expected behaviour of clients, roles of the specialist, and targeted client outcomes. As with The Health Protection/Health Promotion Model these service areas operate along a continuum. The client's role in special recreation programs includes greater decision making and increased

self-regulated behaviour. As with the HPHPM the client has increased freedom of choice and his or her motivation is largely intrinsic without the dictatorship of a TRP.

In conclusion, from having looked at and critically compared and evaluated both The Health Protection/Health Promotion Models and The Leisure Ability, The Health Protection/Health Promotion Model appears to be an extension of The Leisure Ability Model. The Leisure Ability Models ultimate goal is leisure compared to The Health Protection/Health Promotion Model uses leisure as the final means towards its ultimate goal of optimal health. When designing a therapeutic recreation program, the therapeutic recreation personnel may go back and forth between the models in order for the program to be client specific.