Perspectives on Recreational Therapy

David R. Austin
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We dedicate this book to those recreational therapists with whom we worked as emerging professionals. From these seasoned and highly competent clinicians, we learned many of the skills and much of the knowledge that would provide the foundations for our practice as recreational therapists. Their exemplary performances as practitioners who continually displayed an embedding commitment to the clients they served, their work, and their profession has inspired us throughout our careers.

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About the Editors

David R. Austin, PhD, FDRT, FALS, is professor emeritus of recreational therapy, Department of Recreation, Park, and Tourism Studies in the School of Public Health, Indiana University, Bloomington. He has more than 50 years of experience in recreational therapy as a practitioner, educator, researcher, and author. He is the author of over 140 articles and several textbooks, including the widely used book, *Therapeutic Recreation: Processes and Techniques: Evidence-Based Recreational Therapy*, now in its 7th edition. Dr. Austin has given more than 220 presentations in 30 states and four Canadian provinces, as well as in England, Ireland, Puerto Rico, and Australia. Included in his presentations have been two keynote addresses given at Canadian Therapeutic Recreation Association (CTRA) Annual Conferences and the opening keynote address at the 2014 American Therapeutic Recreation Association (ATRA) Annual Conference in Oklahoma City. He has written widely on conceptual models for recreational therapy and is the developer of one of the leading conceptual models in recreational therapy, the Health Protection/Health Promotion Model. Dr. Austin has served as president of the American Therapeutic Recreation Association, the Society of Park and Recreation Educators, and the Academy of Leisure Sciences. He is a fellow in the Academy of Leisure Sciences and a founding fellow in the National Academy of Recreational Therapists. He is the only individual to have received the NTRS Distinguished Service Award, the ATRA Distinguished Fellow Award, and the SPRE Distinguished Fellow Award.

Bryan P. McCormick, PhD, CTRS, FDRT, FALS, is a professor of recreational therapy in the Department of Recreation, Park, and Tourism Studies in the School of Public Health at Indiana University, Bloomington. He has served on the boards of directors of the Recreation Therapists of Indiana (RTI) and the American Therapeutic Recreation Association (ATRA). He is also a past president of ATRA. He has been awarded the Scholarly Achievement Award (ATRA), the David R. Austin Member of the Year Award (RTI), and Centennial Leader Award (East Carolina University). In 2010, Dr. McCormick was the recipient of a Fulbright Scholarship to conduct research and lecture in psychiatric services at the University of Kragujevac, Serbia. His scholarship focuses on the social and community functioning of adults with severe mental illnesses. He is the author or coauthor of almost 50 peer-reviewed publications. His work has appeared in journals such as *Acta Psychiatrica Scandinavica, American Journal of Recreation Therapy, Annual in Therapeutic Recreation, International Journal of Social Psychiatry, Journal of Leisure Research, Journal of Rehabilitation, Journal of Travel Research, Leisure Sciences, Schizophrenia Research,* and *World Leisure Journal.* In addition, Dr. McCormick has authored 11 book chapters, and has served as the coeditor for three books. His most recent text, with David Austin and Marieke Van Puymbroeck, is titled *Management Functions in Recreational Therapy.* Dr. McCormick has been elected a fellow in The Academy of Leisure Science and the National Academy of Recreational Therapists.

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Preface

We wanted to provide this book for those in our beloved profession of recreational therapy because we believe its contents are badly needed and timely. At no time in the history of our profession have we been presented with such a tremendous opportunity to help improve client services and to further recreational therapy as a health care profession. By understanding perspectives that directly relate to our actual practice, perspectives on what it means to be a fully functioning profession, and perspectives related to the past, present, and future of the profession, recreational therapy students and practitioners will position themselves to not only grow as individuals but be in a place to advance their profession.

In order to assure the highest quality in contents for this book, we asked a number of the premier authorities in recreational therapy to join us by contributing chapters in their areas of expertise. Readers, we are sure, will be impressed by the list of contributors who have consented to author chapters.

Organization of the Book

Perspectives on Practice

In many ways, recreational therapy has always been a therapy in search of theory. The chapters in Section I, Perspectives in Practice, provide the latest theoretical perspectives that support recreational therapy practice. Chapters within this section of the book not only provide guidance for practice but offer empirical evidence and theoretical foundations to support the practice of recreational therapists. The reader will find that the chapters in this section emphasize the clients' potential for recovery and growth as well as understandings of the considerable capacities of recreational therapists to be effective in contributing to the therapeutic outcomes achieved by the clients they serve.

Perspectives on Being a Professional

This second section offers a rich store of perspectives on being a recreational therapy professional. Current perspectives on areas that have traditionally been of great concern to recreational therapists appear in this portion of the book. These topics that have had long-standing relevance to those in recreational therapy include professionalism, public policy, certification and licensure, and professional ethics. But this section goes beyond issues that, while critical, are and should be customarily found in texts such as ours. For instance, one chapter encourages students and practitioners to "Dare to Share"

by making presentations. Another chapter offers helpful information on recreational therapists taking care of themselves as helping professionals subject to burnout. Still another gives tips to students and practitioners on how to get the most out of conferences and other continuing education activities.

Two chapters in this segment that may draw the most interest from students are titled "How to Take and Pass Tests" and "Hire Me!" "How to Take and Pass Tests" gives attention to both how to be prepared for tests in courses and the certification exam. "Hire Me!" provides detailed information on how to obtain a position as a recreational therapists.

Perspectives Related to the Profession

Topics covered in Section III, Perspectives Related to the Profession, include the historical development of the profession, the latest on profession preparation, health care regulations affecting recreational therapy, marketing practices for recreational therapy, research within recreational therapy, and cultural competence for those in the recreational therapy profession.

User-Friendly Approach

Throughout the book we have attempted to make the content of the chapters readable and easy to follow. Reading comprehension questions are provided at the conclusion of each chapter. These questions may be useful to students in gaining understandings of the material in the chapters and to instructors as possible exam questions. Instructors using the book in their courses may also obtain objective test items, along with PowerPoint slides of tables and figures that appear in the book, author-constructed PowerPoint slides, and possible learning activities that can be used in class or as assignments to students.

David R. Austin, PhD, FDRT, FALS
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Chapter One

The Therapeutic Relationship

David R. Austin, PhD, FDRT, FALS

The therapeutic relationship plays a critical role in bringing about positive outcomes for clients receiving health care. Within this chapter, the term *therapeutic relationship* is defined and its place in health care is examined. Specific attention is given to the elements of the therapeutic relationship in recreational therapy.

The concept of a therapeutic relationship between the therapist and client grew out of counseling and psychotherapy, where it has long been perceived to be a core concern. Today the notion of forming and maintaining therapeutic relationships has been applied much more broadly, having been embraced by any number of health care disciplines that see the therapeutic relationship (TR) as being essential to the achievement of therapeutic outcomes (Priebe & McCabe, 2008; Stickley & Freshwater, 2002). Any helping enterprise requires a strong working relationship between the professional and client (Hill & O'Brien, 1999).

Therapeutic relationships offer solid foundations for treatment and rehabilitation for professionals from a variety of health professions, such as counselors, psychotherapists, social workers, nurses, physical therapists, music therapists, occupational therapists, and recreational therapists. Austin (2011, 2013) has proclaimed that the therapeutic relationship lies at the heart of recreational therapy practice wherever it is provided.

Accordingly, therapeutic relationships today are employed in a vast array of settings. While once therapeutic relationships were considered to be only important in mental health settings, this is no longer the case. The literature of the 21st century is full of examples of the application of therapeutic relationships in areas such as physical rehabilitation (Ferreira et al., 2013; Hall et al., 2012), substance use treatment (Marcus, Kashy, Wintersteen, & Diamond, 2011), cancer treatment (Schapira, 2013), programs

for persons with learning disabilities (Jones, 2013), community programs for elderly persons with chronic conditions (Burke, 2010), offender rehabilitation programs (Ross, Polaschek, & Ward, 2008), and even in day surgery (Mottram, 2009).

Understanding the Term Therapeutic Relationship

The term *therapeutic relationship* is one that evidently many, including authors writing about it, assume to be implicitly understood. Any number of scholars writing about therapeutic relationships have done so without providing an explicit definition of the central topic of their works (e.g., Fakhoury, White, & Priebe, 2007; Farrelly et al., 2015; Garcia & Weisz, 2002; O'Brien, 2001).

Elements Involved in the Therapeutic Relationship

Other authors, while not providing a definition, have outlined elements involved in therapeutic relationships. For example, George (1997) indicated that a therapeutic relationship is characterized by empathy, positive regard and acceptance, warmth, commitment, trust, genuineness, and being nonjudgmental. Cronin, Lawrence, Taylor, Norton, & Kazantzis (2015) wrote that the therapeutic relationship depends on good counseling skills (including listening), expression of empathy, positive regard, collaboration, and a working alliance. Palmadottir (2006) identified critical characteristics of interactions that occur in a therapeutic relationship as collaboration, communication, empathy, and understanding. Farrelly and Lester (2014) listed major components of the therapeutic relationship to be mutual trust, demonstration of mutual respect, and shared decision-making. Norcross and Hill (2004) listed the general elements existing within the therapeutic relationship to be a therapeutic alliance (referring the quality and strength of the collaboration between professional and client), empathy, positive regard, feedback to the client, repair of alliance ruptures (when collaborative relationships break down), a customized approach for each client and, within psychotherapy, the proper use of self-disclosure and interpretation, and the management of countertransference.

It should be noted that authors have also emphasized the element that both therapists and clients play key roles in the therapeutic relationship. Following the analysis of the therapeutic relationship between a hand therapy therapist and client, Crepeau and Garren (2011) identified the dimensions of the therapeutic relationship as being the use of humor to promote reciprocity, using ordinary conversations to build rapport, social comparison to promote acceptance, and attention to caring. Additionally, these scholars stipulated that their research led them to conclude that the therapeutic relationship was "not a one-way flow from therapist to patient but a mutual exchange between equals" (p. 872). Similarly, Bachelor and Horvath (1999) indicated both the therapist and client contribute in forging the therapeutic relationship. The therapist's role is establishing a climate of trust and safety by attentive listening and being responsive to the client, and the communicating of understanding, liking, and respect for the client. The client's contributions to the therapeutic relationship include a commitment to participate in a therapeutic enterprise and collaborating with the therapist.

As a footnote to the discussion of elements identified as being playing a part within the therapeutic relationship, the contributions of Carl Rogers (1961) should be noted. Rogers maintained that there are three vital relational components that must be present in therapeutic relationships. These three components are genuineness, empathy, and positive regard. It is clear from a review of the elements mentioned in many authors' works presented in this section that these three components are still highly valued today as vital elements for establishing therapeutic relationships. Austin (2013) highlighted this connection when he wrote:

> Carl Rogers has had a significant impact on the helping professionals who have followed him. In fact, the triad of elements originally stipulated by Rogers (1961, pp. 61–62) are reflected in all subsequent lists. His three elements are as follows:
>
> - **Congruence (genuineness).** Helpers are themselves. They do not put up a false front or façade.
> - **Unconditional positive regard.** A warm, positive, accepting attitude is displayed by the helper. The helper prizes the client as a person.
> - **Empathetic understanding.** Helpers experience an accurate understanding of the client's private world. (p. 225)

What the Therapeutic Relationships Is Not

From the elements identified as being a part of the therapeutic relationship, it should be clear what the TR is not. Health care systems sometimes follow a traditional paternalistic biomedical model in which clients are rewarded for passivity and compliance and in which the focus is on technical aspects of treatment and measureable functional outcomes. Settings in which such a biomedical model of care is followed are not conducive to the forming of therapeutic relationships that depend on establishing egalitarian relationships between therapists and clients and in which the full participation of clients is encouraged (Palmadottir, 2006).

Austin (2002) explained:

> A therapeutic relationship does not involve a helpless client who turns to the all-knowing helping professional for wisdom and advice. A true therapeutic relationship between client and helper is not one in which the client becomes dependent on the helper to know what to do. Within a true therapeutic relationship, the helper does not take power and responsibility away from the client. As Friedman (1992) has indicated, a relationship that involves the dominance of one over another leads to a power struggle with the resulting negative ramifications. She goes on to say that if both the helper and client perceive the helper as having power and the client as being helpless, a true therapeutic relationship will not exit, and healing and growth will not transpire. (p. 116)

Interchangeable Use of Terms

It should be noted that the term therapeutic relationship is often used interchangeably in the literature with terms such as *therapeutic alliance, working relationship, helping relationship*, and *patient rapport*. A case in point of the synonymous application of these terms is contained in an article by Varcarolis (2002), who used the terms *therapeutic alliance* and *therapeutic relationship* interchangeably when describing the close association between helping relationships and positive client outcomes. She wrote, "Analysis indicated that the development of a therapeutic alliance (therapeutic relationship) was predictive of treatment success for all conditions" (p. 155).

The interchangeability of the term therapeutic relationship with similar terms has been discussed by several authors. For instance, Bale, Catty, Watt, Greenwood, and Burns (2007) wrote that "different terms, including 'engagement,' the therapeutic or working 'relationship' and the therapeutic or working 'alliance,' are often used interchangeably…." (p. 256). Similarily, Priebe and McCabe (2008) stated that while they used the broad term therapeutic relationship in their article, "it may be variously referred to and construed as, for example, the 'therapeutic alliance,' 'helping alliance,' or 'working alliance'" (p. 521). Finally, Leach (2005) indicated:

> Many terms exist which describe the bond between a client and practitioner. The terms most frequently identified in the literature are therapeutic alliance, therapeutic relationship, and patient rapport….As each of these terms incorporate similar themes, including collaboration, reciprocity, parity and growth, these terms are considered interchangeable. (p. 262)

Thus, it is clear that while the term therapeutic relationship is commonly applied to describe the bond between therapists and clients, other terms (e.g., therapeutic alliance, helping alliance, patient rapport) are also used interchangeably with therapeutic relationship. It is perhaps the term therapeutic alliance that is most employed interchangeably with therapeutic relationship.

Definitions of the Therapeutic Relationship

A succinct and direct definition of the term therapeutic relationship has been provided by Jones (2013), who wrote that the therapeutic relationship "can be broadly defined as the collaborative and affective bond between therapist and client" (p. 194). Another brief definition of the therapeutic relationship was provided by Blattner (1981), who indicated the therapeutic relationship "is the *medium* through which all wellness goals are achieved" (p. 70).

More lengthy definitions also appear in the literature. Leach (2005) has cited a definition of the therapeutic relationship originally proposed by Cole and McLean (2003), which read that the therapeutic relationship is "a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect" (p. 262). Some years ago, Arnold and Boggs (1989) described the therapeutic relationship, stating that:

> It is the goal-directed, helping focus that characterizes a relationships as 'therapeutic.' In this type of relationship, two separately existing individuals come together for the sole purpose of helping one of them, the client, achieve maximum levels of self-care functioning and well-being. (p. 130)

Okun (1992), writing from a counseling perspective, provided a thorough description of the therapeutic relationship that has stood the test of time. She wrote:

> Helping relationships begin with a helper and a helpee meeting to focus attention on the helpee's concern. Thus, a helping relationship is distinct from other relationships in this focus on one party's concerns and issues. However, it shares ingredients common to all satisfactory relationships—ingredients such as trust, empathy, genuineness, concern and caring, respect, tolerance and acceptance, honesty, commitment to the relationship, and dependability. (p. 22)

Similarly, Austin (2013) has written that the therapeutic relationship is "directed toward maximizing the client's growth potential and preventing or relieving problems. Helping is not resolving problems or handling crises for the client." He concluded, "Therefore, the ultimate goal of the helping relationship is to facilitate growth, leading to independence and self-sufficiency" (p. 224).

From the definitions in the therapeutic relationship literature, several generalizations regarding the therapeutic relationship may be made. These include the following:

- Rapport or a collaborative and affective common bond or alliance exists between the therapist and client.
- The therapeutic relationship is the medium or means through which therapeutic outcomes for the client are realized.
- There is a mutuality wherein the relationship in which both the therapist and client have responsibilities.
- There exists equality in the relationship that does not assume the therapist to be all knowing and in charge or in control of the client.
- The relationship is goal-directed toward the client becoming as self-sufficient as possible by achieving optimal levels of independent functioning and well-being.
- A trusting, safe environment exists in which both parties may fully express thoughts and feelings.
- Key components within the therapeutic relationship include concern and caring, the expression of empathy, genuineness, mutual understanding and respect, dependability, and commitment to the relationship.

Elements of the Therapeutic Relationship in Recreational Therapy

In order to more fully understand the therapeutic relationship, it may be instructive to more closely examine specific elements found within therapeutic relationships. Drawing on the works of a number of authors (Arnold & Boggs, 1989; Brammer,

1979; Brill, 1990; Carkhuff & Berenson, 1967; Kottler, 1990; Okun, 1992; Sundeen, Stuart, Rankin, & Cohen, 1994), Austin (2002) identified what he termed the aspects of the therapeutic relationship to be "most pertinent" (p. 119) in the therapist-client relationship in recreational therapy. These included empathy, caring, having positive regard and respect for clients, hope, genuineness, and autonomy and mutuality.

Empathy

Displaying empathy means the therapist understands the ideas and feelings present in the client and communicates these perceptions clearly to the client. In having empathy, the therapist displays an ability to understand the client's world and share those understandings with the client. While we typically think of empathy being communicated verbally, empathy may be communicated nonverbally as well, by a hug or a pat on the arm (Austin, 2002). According to Varcarolis (2002), empathy involves the following:

- Accurately perceiving the client's situation, perspective, and feelings
- Communicating one's understanding to the client and checking with the client for accuracy
- Acting on the understanding in a helpful (therapeutic) way toward the client (p. 157)

Empathy differs from sympathy, which has more to do with compassion, commiseration, or pity. Sympathy involves the sharing of one's feelings in an effort to meet the need to reduce one's own feelings of distress. It is generally thought not to be therapeutic. As Varcarolis (2002) has explained, "When a helping person is feeling sympathy with another, objectivity is lost, and the ability to assist the client in solving personal problems ceases" (p. 157).

Caring

Closely related to empathy is the displaying of caring. Austin (2001) portrayed recreational therapists as being, by their nature, persons who care about their clients and who strive to create a caring, warm, and nonjudgmental atmosphere for their clients. Austin (2002) has explained that there are any number of means to communicate caring to clients. He wrote:

> Being genuinely warm and friendly with clients provides a good start. Just 'being there' or being accessible to clients is an important part of caring. Also important is following through on expectations so clients see that you deliver on your caring—or your actions back up your caring demeanor. Finally, the expression, 'a caring touch,' is one that most of us have heard. When we think of demonstrating caring, physical contact is an element that comes to mind. With most people, reaching out and touching them goes a long way to say that we care. (p. 121)

It should be mentioned that while touch can be a powerful means of communicating caring, it may be open to misunderstanding. Even though the therapist might be attempting to express warmth and caring, the client may interpret it as invading personal space or being demeaning or even seductive. So caution needs to be exercised when using touch. Austin (2013) has listed the following factors to consider when using touch. They include the environment in which touch takes place, whether others are present, the relationship with the person being touched, the gender of the person, the body part being touched (e.g., handshake, hand on shoulder, hug), whether the person is in a mood to be touched, the cultural background of the person, and the history of the individual.

Having Positive Regard and Respect for Clients

The following quotes seem to capture the concept of positive regard and respect for clients:

- "Positive regard implies respect. It is the ability to view another person as being worthy of caring about and as someone who has strengths and achievement potential' (Varcarolis, 2002, p. 157).
- "Every client possesses intrinsic worth and the potential for change" (Stated by Austin, 2015, p. 19, as a basic tenet of recreational therapy practice).

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- "Clients should be treated with dignity and respect" (Stated by Austin, 2015, p. 19, as a basic tenet of recreational therapy practice).
- "Therapists who respect clients do not attempt to control them, but instead allow clients to exercise freedom. An essential element within recreation therapy is allowing as much control as possible to reside with the client" (Austin, 2002, p. 122).

Hope

When clients feel demoralized by their disease, disorder, or disability, they can be overcome with a sense of powerlessness. Austin (2002) has written regarding feelings of demoralization and that hope can counter such feelings. He stated:

> Clients who are demoralized feel they cannot do anything to change their plight. Hope combats demoralization. With hope comes an expectation that things can and will change. While uncertainty still exists in the mind of the person filled with hope, there is an expectation on the part of the hopeful individual that things can change for the better. (p. 122)

Feeling concern and engagement from a health care professional can offer clients a source of hope during times they are experiencing vulnerability (Schapira, 2013).

There are several means for recreational therapists to assist clients to experience hope. These have been outlined by Austin (2002):

> One strategy is for the recreational therapist to help clients to maintain and build their social support systems or their relationships with others who are significant in their lives. Friends and family can then provide a supportive, hopeful environment in which recovery can take place. Another means to encourage hope is to enhance the level of clients' self-esteem. Clients who feel good about themselves and their abilities to achieve are less likely to possess feelings of hopelessness or helplessness. Feelings of mastery and achievement gained during recreational opportunities bolster self-esteem and lead to a hopeful, can-do feeling. Such experiences create optimism and reinforce feelings of hope. Still another strategy to induce hope is to provide new experiences for clients (e.g., adventure challenge activities). Such activities provide an approach not previously tried by clients so there is no danger that, in the past, these activities have failed to produce desirable outcomes. Such new activities, therefore, can naturally produce feelings of hope, which is reinforced with successes gained through participation. (p. 123)

Austin concluded:

> A final measure recreational therapists often take to instill hope is to present themselves as optimistic individuals who are likeable, easy to know, and fun to be around. With their optimism, they radiate a great deal of positive energy. They are excited and energetic about what they do. In short, the best recreational therapists tend to be positive people who have a great deal of enthusiasm for life, and for what they do as helping professionals. This positive approach and

> enthusiasm translates into having optimistic views of their clients in terms of seeing their clients as having abilities to regain their health and to grow toward fulfilling their potentials. The enthusiasm of recreational therapists has the additional benefit of influencing their clients since enthusiasm tends to be contagious. (p. 123)

Genuineness

Being genuine is essential to developing and maintaining therapeutic relationships. But exactly what is genuineness? It is not being a fake who puts up a phony front. It is not hiding behind the role of serving as a therapist and keeping a distance with clients by "acting professionally." Instead, being genuine is being natural or authentic in interactions with clients. It is being sincere and honest with clients. Over time, being genuine with clients develops a sense of trust on the part of clients. With trust come the ability of clients to more openly share thoughts, concerns, feelings, and hopes (Austin, 2002; Varcarolis, 2002).

Recreational therapists who are genuine with clients do not promise more than they can deliver. When promises are broken, so often are therapeutic relationships between clients and therapists. Broken promises lead to a lack of trust in the therapist for not being truthful or genuine. Okun (1992) suggested that therapists can best demonstrate sincerity and honesty "by being open with clients, by answering questions to the best of their ability, and by admitting mistakes or lack of knowledge" (p. 36).

Autonomy and Mutuality

As explained earlier in the chapter, even today, health care systems sometimes follow a traditional paternalistic biomedical model in which clients are expected to be "good clients" or "cooperative clients" who passively comply with the dictates of health professionals. Of course, settings in which such a biomedical model of care is followed do not foster the development of therapeutic relationships that depend on establishing egalitarian relationships between therapists and clients and in which the full participation of clients is encouraged (Palmadottir, 2006).

Austin (2002) has indicated that fewer and fewer facilities are following the biomedical model of care. He wrote:

> Happily, today health care has changed in an effort to allow clients to assume more responsibility in their treatment and, therefore, more control over what happens to them when receiving health care. Clients are seen as being capable of participating in their own treatment. (p. 124)

With the absence of the biomedical approach, autonomy and mutuality then become prominent features in client care.

How are autonomy and mutuality defined? Austin (2002) wrote, "*Autonomy* deals with each client's ability to maintain control or to be self-directed. *Mutuality* concerns the partnership or cooperative working relationship that involves both the client and helping professional (pp. 124–125, italics added).

Prizing the autonomy of clients has long been a part of recreational therapy practice. Austin (2011) explained:

> Recreational therapists are facilitative, not manipulative or controlling. They believe clients possess abilities to take responsibility for themselves and therefore support their clients in their efforts to assume personal responsibility for change. In short, recreational therapists continually attempt to maximize freedom, autonomy, and choice making on the part of their clients. (p. 26)

Further, Austin went on to highlight the concept of mutuality being employed by recreational therapists when he wrote that "recreational therapists become interconnected with their clients by entering into a partnership through which they work toward improving the health of each of their clients" (p. 26).

Customizing Therapeutic Relationships

The importance of the therapeutic relationship in bringing about therapeutic outcomes has been established time and again (Farrelly & Lester, 2014; Lambert & Barley, 2001; Palmadottir, 2006; Singer, n.d.). Having such importance, it is critical that therapists are not only conversant with the elements involved in the therapeutic relationship but also understand that an individualized approach is essential when forming and maintaining a therapeutic relationship with each client (Shattell, Star, & Thomas, 2007). As Bachelor and Horvath (1999) wrote, "The specific therapist responses that best foster a strong therapeutic relationship vary from client to client" (p. 162).

Primary factors for the recreational therapist to consider when customizing an approach to forming and maintaining a therapeutic relationship are the phase of therapy and the client readiness or motivation for change (Bachelor & Horvath, 1999; Lambert & Barley, 2001). The phase of the client's therapy is important because it takes time to build therapeutic relationships (Shattell et al., 2007). Thus the therapist needs to develop the relationship at the rate with which the individual client is comfortable. Recreational therapists often have an advantage in forming relationships with clients over some other health professionals because they tend to spend more time with clients than do, for example, physicians and nurses. Change theories, such as Prochaska and DiClemente's (1982) Transtheoretical Model, can be used to determine the motivational stage of the client and what approaches are appropriate in interacting with the client at that stage (See Austin, 2013, pp. 348–351 for a description of Prochaska and DiClemente's stage model of client motivation).

Phases in the Therapeutic Relationship

Therapeutic relationships develop over time as various phases are passed through. Authors have offered a variety of models for the phases involved in therapeutic relationships. For example, Hill and O'Brien (1999) have a three-stage model involving the exploration stage, insight stage, and action stage. Varcarolis (2002) presented a four-stage model containing the preorientation phase, orientation phase, working phase, and

termination phase. For the purpose of the discussion in this chapter, Austin's (2002) four-stage model to be employed by recreational therapists will be discussed. His suggested phases are the planning phase, the introductory phase, the action phase, and the termination phase.

The Planning Phase

The planning phase is for preparation by the therapist so it does not directly involve the client. In this initial phase, the therapist first reviews the assessment data available on the client. Any restrictions or precautions, such as the client having a heart condition or being suicidal, are noted so the therapist becomes aware of anything that might restrict activity. The client's diagnosis and social history are reviewed. Even though each client is unique, knowing diagnostic information may reveal potential areas of client need that can be explored with the client. Knowing the social history of the client will alert the therapist to be sensitive to certain issues (e.g., cultural or religious issues) when the time comes to meet with the client. While reviewing the assessment information, the therapist of course must remain aware of the danger of stereotyping the individual based upon a preliminary review.

Preparing for the first meeting with the client is another task for the therapist during the planning phase. A meeting with a defined time to begin and end should be set in a location where there will be no interruptions (e.g., phone calls, text messages). The setting should be one in which the client will feel as comfortable as possible. The general structure for the first meeting with the client should also be continued throughout (e.g., information to collect from the client and the interpolation of the nature of the recreational therapist's role in helping the client). Also prior to the first meeting, the therapist should begin to consider potential areas that may be helpful to the client so that he or she is prepared to discuss them.

The Introductory Phase

The first time the recreational therapist and the client meet, they need to get to know one another. As a recreational therapist, you will need to address who you are, what you do, when you do it, why you do what you do, and the purpose of the meeting. You might say, for example, "Hi, I'm Jane Jones, a recreational therapist. I'm here at the hospital every day, Monday through Friday, to work with you and other clients in recreational therapy programs that will be a part of your treatment. Today's meeting is for us to find out about each other. For example, I want to find out what types of recreational activities you like to do. But before we do that, do you have any questions?"

Austin (2002) has suggested the following are covered during the introductory phase:

- Beginning to establish the roles and responsibilities of the therapist and client.
- Letting the client know the purpose of the relationship and what the client should expect from the recreational therapist.

- Discussing the location, frequency, and length of typical individual or group sessions.
- Informing the client about the duration of the relationship and indications for termination.
- Reviewing how confidential material will be handled.

The introductory phase is the time when rapport begins to be established within a warm, nonjudgmental atmosphere where trust is built and the client is encouraged to get out thoughts and feelings. Austin (2002) has suggested that recreational therapists "typically pose open-ended questions, reflect client feelings, and listen using techniques such as paraphrasing, clarifying, and perception checking" (p. 128). As a result, the therapist and client gain insights, client strengths and needs are identified, and then the client and therapist jointly set goals and arrive at strategies to meet those goals.

The Action Phase

The action phase is the time in which the client and recreational therapist work together to reach the goals they have collaborated upon and jointly set. The recreational therapist strives to encourage the client to communicate openly. Communication skills, such as making observations, confrontation, and facilitative questions and statements, are employed by the recreational therapist. Within this phase, the recreational therapist also uses strategies to motivate the client's active participation, as well as provides feedback to support and reinforce behaviors that facilitate the client's progress toward meeting his or her goals. Throughout the action phase, the recreational therapist continually encourages client self-direction and control.

Termination Phase

Termination begins with discussions during the introductory phase and is continually mentioned when appropriate during the action phase. Terminating a therapeutic relationship can be traumatic both for the therapist and client. It is up to the recreational therapist to determine the termination strategy that should be employed with each particular client. To aid the recreational therapist during the termination phase, Austin (2002) has suggested:

> Termination can be used to review accomplishments that produce feelings of achievement for both recreational therapists and clients. If the therapeutic relationship has been a particularly close one, it may be good for both parties to openly share their feelings about terminating the relationship. Emerging recreational therapists may experience feelings of anxiety during the termination phase, and this anxiety may cause them to attempt to avoid the situation because they do not know how to handle it. A good strategy to cope with such feelings is to admit them to his or her clinical supervisor and seek this professional's advice on how to approach the situation. (p. 129)

Skills Needed to Establish and Maintain Therapeutic Relationships

Singer (2006) indicated that therapists need two qualities in order to establish and maintain therapeutic relationships. Those are (1) personal attributes such as honesty, respectfulness, trustworthiness, warmth, and having interest in the client; and (2) the ability to communicate therapeutically.

Attributes of the Therapist

Singer went on to pose a series of questions for therapists to ponder in regard to their abilities to enter into therapeutic relationships. His questions focus on personal attributes of the therapist and were based on those previously presented by Rogers (1961). They are as follows:

- Can I be in some way that will be perceived by the client as trustworthy, dependable, or consistent in some deep sense?
- Can I be real? This involves being aware of thoughts and feelings and being honest with yourself concerning these thoughts and feelings.
- Can I be who I am? Clinicians must accept themselves before they can be real an accepted by clients.

- Can I let myself experience positive attitudes toward my client—for example, warmth, caring, respect—without fearing these? Oftentimes clinicians distance themselves and write it off as a "professional" attitude; however, this creates an impersonal relationship. Can I remember that I am treating a human being just like myself?
- Can I give clients the freedom to be who they are?
- Can I be separate from the client and not foster a dependent relationship?
- Can I step into the client's private world so deeply that I lose all desire to evaluate or judge it?
- Can I receive this client as he or she is? Can I accept him or her completely and communicate this acceptance?
- Can I possess a nonjudgmental attitude when dealing with this client?
- Can I meet this individual as a person who is becoming, or will I be bound by his or her past or my past?

It is helpful for both recreational therapy students and practitioners to take the time for reflection in order to become more self-aware. Addressing the questions posed by Singer is one means to becoming more self-aware. An additional means to self-awareness is found in Austin's (2013) chapter titled "Helping Others" in his book *Therapeutic Recreation Processes and Techniques: Evidence-Based Recreational Therapy.* The chapter contains a segment on self-awareness that raises questions to help readers become more self-aware.

Therapeutic Communication Skills

Singer's call for the necessity of therapists to possess the ability to communicate therapeutically in order to form and maintain therapeutic relationships has been echoed in the literature of recreational therapy. In his recreational therapy text, Austin (2013) wrote, "Success in the helping relationship depends to a large degree on the ability of the recreational therapist to communicate effectively with clients" (p. 281). Austin's book provides an extensive chapter on communicating therapeutically. It encompasses both verbal and nonverbal communications skills needed by recreational therapists, including specific techniques to employ in therapeutic communication.

Recreational Therapy and the Therapeutic Environment

A key concept with the therapeutic relationship is that such relationships demand involvement by both the therapist and client, who work together harmoniously in order to bring about a bond or an alliance. This point has been reinforced by Crepeau and Garren (2011), who emphasized that the therapeutic relationship "is not a one-way flow from therapist to patient but a mutual exchange of equals." They went on to state, "However, it is the therapist who is responsible for establishing the environment for the

therapeutic relationship to develop and flourish" (p. 872). It is with the vital topic of the environment that this segment of the chapter is devoted.

The environment in which therapeutic relationships occur can enhance or disrupt the therapeutic relationship. Failure to recognize the importance of the environment on therapeutic relationships can cause new relationships not be formed and established relationships to be dissolved. Two interacting factors affect whether the care environment is conducive to therapeutic relationships. One is the philosophy of care of the organization. The second is the philosophy of care adopted in recreational therapy.

Philosophy of Care of the Organization

The philosophy of care provides a framework that identifies the goals and values of the organization. An example of a care environment that makes therapeutic relationships difficult to form and maintain is one found in health care facilities that follow a philosophy of care that reflects a traditional paternalistic biomedical model. Following a paternalistic philosophy leads to rewarding clients for passivity and compliance. Within this environment, the focus remains on technical aspects of treatment rather than on healthy interactions between clients and staff. Settings in which such a philosophy of care is followed are not conducive to the forming of therapeutic relationships that depend on establishing egalitarian affiliations between health care professionals and clients and in which the full participation of clients is encouraged (Palmadottir, 2006).

Another case in point is the environment that traditionally exists within custodial correctional institutions. Mainstream custodial environments may create what Ross et al. (2008) have termed "toxic effects" for therapeutic endeavors. These authors have portrayed the custodial environment faced by offenders in rehabilitation programs as follows:

> Prisons are intended to be cold and punitive places where offenders are continuously reminded that they are defective individuals whom society has shut away. Offender clients often come into a therapeutic relationship after months or years in mainstream custody environments: settings in which both other offenders and custodial staff have been uncaring or actively hostile. In such environments they are accustomed to living from day to day, to having little or no control over their living conditions, and to maintaining a guarded and vigilant approach to others. Custodial staff may monitor them only for rule infringements in an impersonal and hostile way. Inmate cultures are predatory, brittle, and dangerous environments where self-disclosure can lead to death at worst and low social status and routine predation by others at best. In this environment, offenders hone their mistrust and consolidate their skills in managing controlling and adversarial relationships. (p. 470)

After reading this description of life within a prison, it is easy to understand the great difficulty therapists face when attempting to form therapeutic relationships with client offenders who they are seeking to help rehabilitate. To say the least, the organizational environment is not at all favorable to the formation and maintenance of therapeutic

relationships. The environments produced by these two of philosophies of care, one in a health care facility and one in a corrections institution, dramatically exhibit the negative effect that the philosophy of care of an organization can have on establishing a therapeutic environment that promotes bonds between helping professionals and clients.

What would constitute a positive philosophy of care that supports a therapeutic environment in which therapeutic relationships may occur? The goals and values of a positive philosophy of care within an organization would reflect an environment constituted to make clients feel comfortable in a clean, safe, and functional setting. All aspects of the clients' experience would be designed to make clients as comfortable as possible while helping them to achieve optimal health outcomes. Positive philosophies of care also value the provision of a workplace structured to bring about ideal conditions for staff to engage in evidence-based practice while helping clients who are active participants in their health care and, as such, are involved in decision making, allowing them choices and feelings of control. The organization with a positive philosophy of care also minimizes stress caused for clients and staff by factors such as noise, lack of privacy, confusion, and bureaucratic operations. The removal of stressors for clients is seen as a necessity so they may concentrate on developing their strengths and arriving at solutions to their health problems or concerns. The best therapeutic environments allow clients to experience positive interactions with health care professions who communicate a caring attitude toward them. Organizations with positive philosophies of care additionally provide maximize opportunities for clients to spend time with friends and family members (who offer social support and normalcy), as well as for client relaxation (e.g., through the provision of connections to nature such as viewing gardens or aquariums).

The Philosophy of Care Adopted within Recreational Therapy

It can be said the therapeutic environment created by recreational therapists is a potent ingredient in fostering therapeutic relationships between recreational therapists and their clients. The framework for the philosophy of care adopted by recreational therapists rests on (a) the goal of helping each client to achieve what is the optimal level of health for them as an individual, and (b) the professional values held by recreational therapists.

Optimal Health as a Goal for Clients

Naturally, as a health profession, the overriding concern for recreational therapy is the goal of assisting clients to achieve their optimal levels of health for them as individuals. Recreational therapy's concern is for the full range of human functioning or the entire range of the illness-wellness continuum with illness (with concern with disease) at one end to wellness (with concern with growth) at the other end. Thus, recreational therapists not only assist clients dealing with illnesses and disorders but also champion high-level wellness to help clients to maximize the potentials of which

they are capable (Austin, 2013). Austin (2011), a recreational therapist, described the range of practice carried out by practitioners within recreational therapy as follows:

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

Values Held by Recreational Therapists

The professional values recreational therapists hold include the following:

- Treasuring the opportunity to assist clients along the full range of human functioning (i.e., the entire illness-wellness continuum) by helping them to both meet their immediate health concerns and to grow and develop
- Appreciating that all persons possess the potential for change
- Recognizing recreational therapy as being purposeful and goal-directed
- Prizing fun and enjoyment as antidotes for negative emotions and as motivators for client participation in interventions
- Recognizing that recreational therapy is action oriented but that the emphasis is always on the client, not the activity
- Appreciating the strengths clients possess or can develop
- Taking a strengths-based approach with clients
- Respecting and promoting the autonomy of clients
- Regarding each client as a person possessing intrinsic worth who should be treated with dignity
- Striving to meet their professional obligations to clients by offering competent and ethical care
- Regarding the therapeutic relationship as a critical element in recreational therapy. (Austin, 2013, p. 231)

The Influence of Humanistic Psychology and Positive Psychology on Recreational Therapy

The philosophical underpinnings that provide a theory base for recreational therapy have largely emerged from humanistic psychology and positive psychology (Austin, 2013; Austin, McCormick, & Van Puymbroeck, 2010; Kunstler & Stavola Daly, 2010). Humanistic psychology, and particularly Rogers' (1961) person-centered therapy, has had a large influence on recreational therapy. One particularly strong influence has

come from humanistic psychology's belief in a developmental model rather than the traditional medical model that focuses on pathology. The humanistic perspective holds to a growth-oriented model that sees people as continually striving for self-fulfillment (Smither, 2009). Thus, under the humanistic perspective, the aim of therapists working with clients is to do more than to simply help them to overcome health concerns. It is to assist clients to develop and grow toward their fullest potentials. Client strengths are emphasized in assisting clients to both overcome problems and strive toward reaching potentials. The therapeutic relationship is seen as a means to not only deal with clients' presenting problems but to promote client growth and to prepare clients to deal with future challenges (Austin, 2013). Humanistic psychology emphasizes that persons possess the ability to make personal choices, to exercise individual freedom, and generally to have the right and responsibility to be in control of their lives (Shapiro & Astin, 1998). As indicated, prominent among humanistic psychologists have been Carl Rogers, who developed the concept of the fully functioning person and person-centered therapy, as well as Abraham Maslow, who is known for his writings on self-actualization (Bonswell, 2006; Wood & Tarrier, 2010).

Positive psychology is an approach that accentuates the positive. It came about in the late 20th century as a reaction to what was predominantly the approach of psychologists at the time to follow a disease and medical model. Rather than focusing on pathology, positive psychology emphasized human strengths and optimal functioning (Austin, 2013; Linley & Joseph, 2004).

Yet positive psychologists recognize that people experience negative aspects of life, such as negative emotions, failure, and problems (Biswas-Diener, 2010). Applied psychologists have acknowledged this in their work. Linley and Joseph (2004) wrote, "Applied positive psychology is the application of positive psychology research to facilitation of optimal functioning across the full range of human functioning, from disorder and distress to health and fulfillment" (p. 4). Additionally, Linley and Joseph (2004) stated, "Applied positive psychologists may work both to alleviate distress and to promote optimal functioning" (p. 6).

Positive psychology is closely linked to the humanistic perspective and echoes many of the views of humanistic psychology. Because of this, positive psychology may be seen as an extensive of humanistic psychology (Austin, 2013). In fact, Clay (2010) has termed positive psychology to be simply the repackaging of humanistic psychology.

With humanistic psychology and positive psychology as foundations, the overall philosophy of care of recreational therapists anchors a unique therapeutic environment for the delivery of health care by recreational therapists. Recreational therapy represents an optimistic, supportive, caring, and strengths-based approach that promotes client choice, freedom, and responsibility within an enabling milieu that stands in stark contrast to the paternalistic approach associated with professions that follow a traditional biomedical model of care.

Unique Elements within Recreational Therapy

In addition to its philosophical foundations from humanistic psychology and positive psychology, several other elements that affect the therapeutic environment add

to the philosophy of care and the uniqueness of recreational therapists among health professionals.

The roles of recreational therapists. One element is the special role assumed by recreational therapists. This role differs from those established by clients with health care personnel such as physicians and nurses. Physicians and nurses tend to do things *to* clients (e.g., conduct physical examines or give injections) while the recreational therapist does things *with* clients (e.g., participates in games or activities; Austin, 2011). Additionally, recreational therapists actively collaborate with clients in working toward mutually defined goals. As such, the client-recreational therapist role is seen by clients not to be one of "patient-therapist" but rather a "client-partner," as termed by Goering and Stylianos (1988).

Offering clients a warm, caring, supportive atmosphere. Another distinctive element that adds to the philosophy of care within recreational therapy is the necessity seen to provide the warm, caring, and supportive atmosphere that is exemplified within recreational therapy groups. Austin (2011) declared that supplying such a positive atmosphere "is a virtue that few therapies can claim." He went on to state, "Within this unique beneficial atmosphere, clients are provided a safe and accepting place to deal with their concerns and to grow toward meeting their potentials" (p. 26). Finally, he concluded, "The warm, supportive, caring atmosphere also frees clients to be themselves. It a safe environment, one unencumbered by restrictions, where clients can freely express themselves and experience joy and pleasure through their play and recreation" (p. 26).

Clients tend to like recreational therapists. Still another notable factor making recreational therapy unique is the degree of liking that clients typically have for recreational therapists. Austin (2011) has observed that recreational therapists tend to be particularly well liked by clients. The explanation he has given for this phenomenon is that the norm of reciprocity is operating. Haidt (2006) captured the notion of the norm of reciprocity by characterizing it as a "tit-for-tat" reaction in which the reactor reacts in kind. Thus, if someone does something nice for us, we develop a liking for him or her or experience a positive "automatic reciprocity reflex," as Haidt (2006) has termed it. Recreational therapists provide enjoyable activities for clients from which they derive positive outcomes. Clients tend to appreciate and value what recreational therapists do for them and therefore develop positive feelings toward recreational therapists. Feeling high regard for recreational therapists helps foster closer client-recreational therapist relationships.

Place matters. Physical environments affect us in many ways. Frumkin (2003), a medical doctor, made this abundantly clear when he wrote, "Some places are romantic and some are depressing. There are places that are confusing, places that are peaceful, places that are frightening, and places that are safe. We like some places better than others. Place matters" (p. 1451). A unique aspect within recreational therapy is where it takes place. In contrast to sterile examining rooms and formal offices that typify health settings, places for recreational therapy activities include game rooms, gymnasiums, swimming pools, and relaxing outdoor settings. Generally people's associations with such recreation venues are positive, so recreational therapy transpires in places where

clients like to be. Thus, recreational therapists enjoy the advantage of conducting their programs in places where clients feel comfortable, places that may even illicit positive attitudes on the part of clients.

Therapeutic Environments Foster Therapeutic Relationships

It can be seen that the factors of the philosophy of care of the organization and the philosophy of care adopted by recreational therapy are key determinants in the establishment of therapeutic environments. Vibrant therapeutic environments serve as conducive settings in for therapeutic relationships to develop and flourish.

Learning Skills to Participate in Therapeutic Relationships

Fakhoury et al. (2007) suggested that therapeutic relationships should be vigorously emphasized in the training of clinicians. Grenness, Hickson, Laplante-Levesque, and Davidson (2014) stated such training should occur during professional preparation and later through continuing education. Rather than in their professional preparation or through continuing education, research has found that most occupational therapists learned therapeutic relationship skills "on the job" (Cole & McLean, 2003). Another study of occupational therapists (Taylor, Lee, Kielhofner, & Ketkar, 2009) indicated inadequate training and a lack of sufficient knowledge about therapeutic relationships. These researchers concluded, "The findings suggest that the field could benefit from an increased focus on the role of therapeutic use of self in classroom education, fieldwork training, continuing education, and research" (p. 206).

If you are a recreational therapy student, has your professional preparation emphasized therapeutic relationships? If you are a practicing recreational therapist, did your professional preparation develop your skills for engaging in therapeutic relationships? Have you received continuing education on the therapeutic relationship since entering the field?

Unfortunately, like our sister profession of occupational therapy, it is likely that many recreational therapy students have not received adequate preparation to engage in therapeutic relationships, nor have continuing education sessions on therapeutic relationships been readily available to practitioners. Hopefully, this chapter will alert students and practitioners to the necessity to obtain backgrounds to engage in therapeutic relationships and knowledge from the chapter will serve as a foundation for working with clients in therapeutic relationships.

Summary

The concept of using therapeutic relationships between clients and health care professionals to enhance therapy had its beginnings in counseling and psychotherapy. Over time, it became a fixture within a number of health care professions and is now employed in a variety of health care settings. While not always defining therapeutic relationships, those writing about therapeutic relationships identified the elements

that play a part within them. Definitions of the term therapeutic relationships now occur in the literature and several are presented in this chapter, as are aspects central to therapeutic relationships in recreational therapy. These include empathy, caring, having positive regard and respect for clients, hope, genuineness, and autonomy and mutuality.

The need for recreational therapists to customize their approaches to building therapeutic relationships and the phases involved follow, along with skills needed by recreational therapists to establish and maintain therapeutic relationships. The final segment of the chapter covers how the philosophy of care of organizations and the philosophy of care of recreational therapy are key determinants in establishing therapeutic environments which, in turn, can enhance or hinder therapeutic relationships. The chapter ends with a discussion of the lack of opportunities to learn about therapeutic relationships and the necessity for recreational therapy students and practitioners to gain therapeutic relationship skills.

Reading Comprehension Questions

1. Is the therapeutic relationship something specific to recreational therapy, or is it found to be important in many professions?
2. What elements of the therapeutic relationship have been identified in the literature?
3. What other terms are often used interchangeably with the term therapeutic relationship?
4. Define the therapeutic relationship in your own words.
5. What elements within the therapeutic relationship in recreational therapy has Austin identified as "most pertinent"?
6. What are the phases in the therapeutic relationship?
7. What two qualities has Singer indicated therapists need in order to establish and maintain therapeutic relationships?
8. Explain how the environment in which therapeutic relationships occur can enhance or disrupt therapeutic relationships.
9. Explain how the philosophy of care of recreational therapists can enhance therapeutic relationships.
10. Think about your professional preparation as an RT. Has the therapeutic relationship been emphasized? Do you believe it should be? Why or why not?

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