

# Therapeutic Recreation Modalities and Facilitation Techniques: A National Study

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## Abstract

In light of the health care environment, it is imperative that Therapeutic Recreation (TR) Specialists have a thorough knowledge of and skills in the purposeful selection of modalities and facilitation techniques to ensure successful treatment outcomes. The purpose of this study was to determine the current use of modalities and facilitation techniques in TR practice and to identify critical skills for entry level therapists. One thousand current Certified Therapeutic Recreation Specialists™ (CTRS®) were surveyed with 306 respondents (31% response rate). Results indicated significant differences exist in use of modalities and facilitation techniques by population. Respondents also identified critical skills that entry level therapists should possess. Implications for TR curricula are discussed.

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## Introduction

The therapeutic recreation (TR) specialist utilizes a variety of knowledge, skills, and abilities in the planning and implementation stages of the TR process. These include knowledge of the nature and variety of activities, the therapeutic use of activities, and selection of appropriate and theoretically based intervention techniques (NCTRC®, 1997; Peterson & Stumbo, 2000). The purposeful use and appropriate selection of modalities and facilitation techniques is essential to successful outcomes for TR interventions. Proficiencies in modalities and facilitation techniques can serve the dual purpose of enhancing the value of programs for clients while at the same time increasing levels of respect and support for TR service providers (Witman, 2002).

Austin (2001) defined modality as an “activity used as an intervention for treatment or rehabilitative purposes” (p. 42). Burlingame and Skalko (1997) defined the term as “the type of activity used to deliver treatment” (p. 179). Peterson and Stumbo (2000) defined activities as “... the method by which therapeutic recreational specialists help clients change their abilities, knowledge and attitudes” (p. 174). For the purpose of this paper, therefore, modality will be defined as *an activity that is specifically selected to bring about therapeutic outcomes.*

As important as activity selection is, the method in which the activities are presented is equally important. Facilitation techniques

... are needed in order to deliver the program or activity in the most effective and efficient manner possible. The competent therapeutic recreation specialist is well versed in a variety of facilitation techniques ... Much like activity skills, the more competent the therapeutic recreation specialist is with a variety of facilitation techniques, the more likely the specialist will be able to rapidly and meaningfully facilitate change in client behavior (Peterson and Stumbo, 2000, p. 173).

According to Russell (2001),

facilitation assists individuals to reflect on their experiences; evaluate the good and bad of the experience; analyze their mistakes, failures, or successes in the experience; consider the impact of their actions and decisions during the experience; anticipate consequences from the experience; and understand how they have learned, grown, or changed as a result of their experience (p. 167).

Peterson and Stumbo (2000) defined a facilitation technique as the "process by which the TR specialist delivers the activity" (p. 173). Russell (2001) referred to facilitation techniques as "guiding people through reflections and analysis" (p. 166). She also stated that a variety of facilitation techniques are used to "help participants maximally attain desired outcomes" (p. 166) which can focus on educational, developmental, or therapeutic (generalization) benefits. Kinney, Warren, Kinney, and Witman (1999) defined facilitation techniques as "methods or procedures that are applied to specific treatment interventions based on presenting problems of the client" (p. 1).

Competent recreational therapists must be proficient in techniques and processes so that effective treatment can occur (Russoniello, 2000). In order for an intervention to be considered a facilitation technique, it should be grounded or firmly established in a theoretical construct. Austin (1999) stated that a theory is a "unifying focus for the assumptions that underlie therapeutic approaches. A case can be made for the necessity of theory to direct methods of practice" (p.8). For the purpose of this paper, a facilitation technique is defined as *a theoretically grounded process that guides how the modality is applied and is based on the presenting problems of the client.*

Therefore, a modality is an activity in which the client participates and a facilitation technique is the theoretically based method in which the therapist structures the activity and his or her interactions with the client. The two, together, make up an intervention in which the outcome is to help a client(s) change and grow in a predictable manner. Attendees at the 1995 American Therapeutic Recreation Association (ATRA) Curriculum Conference came to consensus to identify a total of 23 modalities and 21 facilitation techniques commonly utilized by TR specialists (Kinney & Witman, 1997; see Table 1).

As important as modalities and facilitation techniques are to the TR discipline, there remains no consensus as to the emphasis that should be given to teaching these skills in TR curricula or which, if any should be given a priority in the curriculum. Differences exist in TR curricula across the country. Some programs offer an entire course on the use of modalities and facilitation techniques in TR while others teach a learning module on modalities and facilitation techniques within a course. Since there are a limited number of hours that TR majors spend in TR courses, then certain skills must be learned outside the classroom. The question remains which ones should be taught and which ones should be learned independently?

The purpose of this study was to determine the use of modalities and facilitation techniques in current TR practice and to determine critical skills and educational emphasis for entry level therapists in terms of modalities and facilitation techniques. A previous study (Kinney et al, 1999) examined the use of modalities and facilitation techniques in the Northeastern United States. The current study built upon this body of work using a larger, national sample.

Three hypotheses guided this study:

- 1) TR specialists would use some modalities and facilitation techniques more frequently than others.
- 2) Use of modalities and facilitation techniques would differ based on population (e.g. mental health, physical medicine and rehabilitation (PM&R), older adults, other populations).
- 3) The modalities and facilitation techniques that practitioners identify as critical for entry-level therapists to know and critical to teach would differ based on population.

### Review of Literature

Increase in accountability and quality of services are two pressures that healthcare professionals face today. These pressures affect not only the discipline of therapeutic recreation but all healthcare professions. According to Lenburg (1999)

The nursing profession is struggling with increasing urgency to change its culture by creating and implementing the level of competence in professional practice required

by ... stakeholders. Documented competence is essential – not optional – and is likely to become mandatory in the near future for initial and continuing licensure and certification, and perhaps even for employment (p. 7).

The Center for Public Health defined competencies as “applied skills and knowledge (blended with behaviors) that enable people to perform work” (Gebbie, 2002, p. 5) well in an efficient and effective manner. The Office of Workforce Policy and Planning (OWPP), the Centers for Disease Control and Prevention (CDC) and the Public Health Workforce developed a set of competencies for public health-related professions in 2001. This report also addressed competency-based curriculum stating “competencies are not curricula, learning objectives or performance standards ... Competencies do, however provide a framework based on performance outcomes on which curriculum and training are developed and delivered and against which performance can be measured” (p. 19). It is evident that healthcare professions must address the issue of competencies as it relates to accountability and quality of care. This includes measurable client outcomes.

“The therapeutic recreation profession has responded by undertaking several significant efforts in recent years. These efforts primarily have revolved around data-based client outcomes, integration of practice decisions, and increasing standardization of practice and education” (Stumbo & Hess, 2001, p. 15). O’Morrow and Carter (2001) stated “curricula for therapeutic recreation education must be designed to anticipate as well as reflect changing healthcare needs” (p. 64). Many have expressed the need to standardize curricula so that all graduates possess the competencies needed for practice (Brasile, 1992, 1998; Kinney & Witman, 1997; Monroe & Connolly, 1997-1998; Stumbo & Carter, 1999a, 1999b). Kinney, Sable, Witman and Kinney (2001) conceptualized a standardized curriculum. They proposed a 3-tier system - Tier 1 included TR required courses, Tier 2 included TR required fieldwork and internship, and Tier 3 included external required courses. One of the 7 Tier 1 courses included a course on “modalities and facilitation techniques”.

When reviewing material from the two national professional organizations and the National Council for Therapeutic Recreation Certification, it was evident that modalities and facilitation techniques are recognized as essential skills. Both standards of practice guidelines provided by the National Therapeutic Recreation Society

(NTRS, 1995) and the American Therapeutic Recreation Association (2000) address the use of modalities and facilitation techniques in TR practice. Both the Professional Job Responsibilities and the Professional Knowledge Areas for TR Specialists developed by the NCTRC include planning and implementing as major areas which comprise 41% of the NCTRC, exam content (NCTRC, 1997). The Standards of Minimal Knowledge, Skills, and Abilities (9 standards) for entry level therapists developed by NCTRC addresses modalities and facilitation techniques in 2 standards. Standard 5 addresses knowledge of the intervention planning process, which includes “the nature and scope of interventions”. Standard 6 addresses implementation of the intervention plan which includes “theory and application of facilitation styles, intervention techniques, and methods for behavioral change” (NCTRC, 1998, p.7).

The importance and use of these interventions are also evidenced by the increasing attention that has been given to modalities and facilitation techniques over the past few years. The ATRA Curriculum Conference in 1995 developed two lists of interventions – those that were identified as modalities and those that were identified as facilitation techniques. These lists are contained in the *Guidelines for Competency Assessment and Curriculum Planning in Therapeutic Recreation: A Tool for Self-Evaluation* (Kinney & Witman, 1997).

Some authors provided lists of modalities and facilitation techniques while others provided descriptions and application of various modalities and facilitation techniques (Austin, 1999; Carter, Van Andel, & Robb, 1995; Dattilo, 2000; Peterson & Stumbo, 2000; Shank & Coyle, 2002). These listings and descriptions are far ranging and consist of traditional interventions (e.g. adventure/challenge, games, music, and sports) to relatively esoteric interventions (e.g. Tai Chi, aromatherapy, and guided imagery). While listing and describing the wide range of potential interventions that are available is educational, it provides little guidance in terms of what modalities and facilitation techniques are most often used by practitioners or with which populations they are most often used. In fact, there is only one recent study that has empirically documented the primary use of modalities and facilitation techniques utilized in TR practice (Kinney et al., 1999).

In that study, Kinney et al. (1999) surveyed TR practitioners in the Northeast (Pennsylvania to Maine) on modalities and facilitation techniques, specifically how often practitioners utilized them in daily practice

and the importance of each for entry level skills. A total of 135 practitioners responded to the survey in the Northeast study and had an average experience of 11.5 years (range of less than 1 year to 30 years). In terms of "overall use of modalities", the top 5 modalities identified were games, arts and crafts, problem solving activities, exercise/fitness, and community reintegration activities. In terms of "critical for entry level therapists to know", the modalities changed – the top 5 were community reintegration activities, problem solving activities, empowerment/self-esteem experiences, exercise/fitness, and games. The more complex modalities were determined to need the most attention for entry level therapists. The top 5 facilitation techniques used in practice were leisure education, social skills training, stress management, resocialization, and reality orientation. The top 5 "critical for entry level therapists to know" changed slightly to leisure education, social skills training, stress management, behavior management, and resocialization. It should be noted that use of modalities and facilitation techniques significantly differed by population (e.g. mental health, rehabilitation, older adults and other populations; Kinney et al.).

Another interesting factor emerged during this regional study. There were almost twice as many facilitation techniques (11) as there were modalities (6) that had a mean score over 4 out of a possible 5. A higher score indicated that it was used more often. The six modalities included community reintegration activities, problem solving activities, empowerment/self-esteem experiences, exercise/fitness, games, and assertiveness training. The eleven facilitation techniques included leisure education, social skills training, stress management, resocialization, cognitive retraining, therapeutic community, group therapy, sensory stimulation, reality orientation, and remotivation. Values clarification (3.99) came close to the cut-off score of 4.00.

It is surprising that so little research has been conducted on the use of modalities and facilitation techniques given their centrality within the TR process. As discussed earlier, the power of activity is paramount. Russoniello (2000) goes so far as to say, "prescribed recreational activity acts as a non-pharmacological intervention and evokes the natural healing process" (p. 72). Shank and Coyle (2002) advise, "to make thoughtful selection decisions, you will need knowledge and understanding of three primary things: *clients*, *activity-based interventions*, and *yourself*" (p. 157). Shank and Coyle further make the point that "the

types of activities utilized in practice are quite diverse and continually changing" (p. 152). The current study provides a national perspective on the use of modalities and facilitation techniques in practice and identifies critical entry level skills professionals need to know.

## Methodology

### *Sample*

The sample used in this study consisted of a randomly selected purchased list of active CTRS'. A total of 1000 active CTRS names and addresses were provided to the investigators of this study for one-time use. The sample obtained was compared against the NCTRC July 1998 report on certified personnel by US States to determine whether the sample was representative by region of the country. The Pacific Region comprises 13% of CTRS in the U.S. and the percentage of respondents was 10% in this study. The West Region comprises 13% of CTRS and 12% of respondents in this study. Great Lakes comprises 28% of CTRS and 30% of respondents. Finally, the Northeast comprises 20% of CTRS and 22% of the respondents in this study. When compared, the sample remained close to the percentages of CTRS by region. Therefore the respondents in this study appear to be consistent with the distribution of CTRS' by region of the country.

The sample of 1,000 individuals received a cover letter explaining the purpose of the study, the questionnaire, definition of terms, and a self-addressed stamped envelope to return completed surveys. A follow-up letter was sent 3 weeks later to remind individuals to return the questionnaire. This was an attempt to increase the response rate.

### *Instrumentation*

The Modalities and Facilitation Techniques survey consisted of a total of 139 questions developed for this study. There were four components to the survey. Demographic information was obtained at the beginning of the survey. The next component (Section 1) included questions about the use of modalities in TR practice (23 modalities). The third component (Section 2) explored the use of facilitation techniques in TR practice (17 facilitation techniques). And the last component (Section 3) had respondents' rate modalities and facilitation techniques that were critical for entry level therapists to know as well as rate them in terms of those that were critical to teach.

The 23 modalities and 17 facilitation techniques were selected based on the *ATRA Guidelines for Competency Assessment and Curriculum Planning in Therapeutic Recreation: A Tool for Self-Evaluation* (Kinney & Witman, 1997). All 23 modalities were included in the study. A total of 4 facilitation techniques were eliminated from the list of 21 based on the analysis of the Kinney, et al. (1999) study. Respondents in the pilot study indicated that biofeedback, American Sign Language, and grief counseling required specific training and qualifications that most CTRS' do not possess and therefore, do not use. The last facilitation technique that was eliminated – therapeutic community – had been used in mental health settings. Due to the changing nature of healthcare with very short length of stays, this facilitation technique has virtually been eliminated.

The demographic section included 12 questions that asked about job function, position, population served, service setting and length of stay of clients served. Additional questions asked for state in which they worked, gender, years as a practitioner, highest degree earned, organizational memberships, and certifications earned.

Section 1 asked participants to rate the frequency with which they used modalities in their TR practice on a monthly basis. Using a 5-point Likert scale from 1 (*never*) to 5 (*most of the time*) individuals rated 23 listed modalities. Respondents had the opportunity to identify 3 additional activities they used that were not included on the list (total of 26 questions).

Section 2 asked participants to rate the frequency with which they used facilitation techniques in their TR practice on a monthly basis using the same 5-point Likert scale. There were 17 identified facilitation techniques to rate with 3 additional techniques that they used that were not on the list (total 20 questions). An additional question at the end of Section 2 asked participants to indicate the emphasis that should be placed on teaching of modalities and teaching of facilitation techniques (based on a total of 100%).

Section 3 included 2 separate questions that asked participants to rate modalities and facilitation techniques in terms of how critical they were 1) for entry level therapists to know and 2) to teach in TR courses in university curricula. Both questions utilized the same 5-point Likert scale from 1 (*not at all critical*) to 5 (*very critical*). Each section had 40 items (23 modalities and 17 facilitation techniques) for a total of 80 items.

Content validity on the survey instrument was established by asking a panel of experts (3 researchers

in the discipline of TR and 4 TR graduate students who had several years experience as TR practitioners) to evaluate the instrument. Written and verbal feedback regarding the relevance of the topic, breadth of scope, adequate measurement of the construct, response sets (Likert scales), and the layout of the survey was obtained from the panel. Changes were made to the survey based on the feedback received. For example, all rating scales were based on 5-point scales. Originally, the use rating scales in Sections 1 and 2 were 4-point scales and critical skills in Section 3 were 5-point scales.

#### *Analysis*

For the purpose of this study, all data were coded and analyzed using the Statistical Package for Social Science (SPSS) – Windows version 11.0. Null hypotheses were rejected at or below the .05 level of significance. Analysis conducted in this study included frequency distributions, means, standard deviations, and analysis of variance (ANOVA).

### **Results**

A total of 1000 surveys and a subsequent follow-up letter were sent out to currently Certified Therapeutic Recreation Specialists of which 985 were delivered (15 returned as “undeliverable”). Three hundred six (306) surveys were returned for a response rate of 31%. Two hundred seventy-six (276) completed questionnaires were used in the analysis. The remaining 30 were not included in the analysis because they were either not currently working in TR, took time off to have a family, or returned to school.

Females consisted of 86% ( $n = 297$ ) of the sample, males 14% ( $n = 39$ ). Almost two-thirds (64%,  $n = 177$ ) of the respondents had a primary position as therapist. An additional 28% ( $n = 77$ ) were supervisors/administrators, 4% ( $n = 11$ ) educators, 2% ( $n = 6$ ) consultants and other 5% ( $n = 14$ ). Almost three-fourths (73%,  $n = 201$ ) had earned a BS degree, 24% ( $n = 67$ ) a Masters degree, and 3% ( $n = 8$ ) a terminal degree. Respondents had varied work experience from less than 1 year to 36 years, with a mean of 9 years and a median of 8 years. Respondents on average, indicated their typical daily job responsibilities included direct patient care 67%, management 27%, and education 12%.

Most respondents (78%,  $n = 215$ ) indicated that they belonged to at least one professional organization. Only 22% ( $n = 60$ ) did not belong to any organization, 47%

( $n = 129$ ) belonged to one, 21% ( $n = 57$ ) belonged to two, 10% ( $n = 27$ ) belonged to three, and 1% ( $n = 3$ ) belonged to four. Thirty-six percent (36%,  $n = 99$ ) belonged to a state organization, 35% ( $n = 96$ ) indicated they were ATRA members, 34% ( $n = 94$ ) were NTRS members, and 16% ( $n = 43$ ) belonged to other organizations.

In terms of primary population served, respondents fell into the following categories: 32% ( $n = 87$ ) mental health, 31% ( $n = 86$ ) worked with older adults, 23% ( $n = 64$ ) physical medicine and rehabilitation, 7% ( $n = 19$ ) developmental disabilities, 3% ( $n = 8$ ) pediatrics, 1% ( $n = 3$ ) corrections and other ( $n = 8$ ). In this case, "other" included educators who did not identify any specific disability group. Primary settings included inpatient (40%  $n = 110$ ), long term care (28%,  $n = 77$ ), outpatient (9%,  $n = 25$ ), community (6%,  $n = 17$ ), residential treatment (5%,  $n = 14$ ), and subacute (4%,  $n = 11$ ).

#### *Use of Modalities*

Out of a possible score of 5.0, the average scores for modalities ranged from a low of 1.32 for horseback riding to a high of 4.01 for games. The top ten modalities used by all respondents were: games (4.01), exercise (3.72), parties (3.57), arts and crafts (3.53), community reintegration activities (3.36), music (3.33), problem solving activities (3.31), sports (3.22), self-esteem experiences (3.09) and activities of daily living (2.97).

Means for each modality by population (PM&R, mental health, older adults, and other populations) were calculated to determine whether differences existed in use depending on the population (see Table 2). The top 5 modalities used in PM&R were community reintegration activities (3.98); games (3.97); arts and crafts (3.53); problem solving activities (3.52); and exercise (3.33). The top 5 modalities in mental health included games (3.95); self-esteem experiences (3.87); problem solving activities (3.76); exercise (3.72); and arts and crafts (3.38). In older adult populations the top 5 modalities were music (4.30); parties (4.30); games (4.22); exercise (4.12); and arts and crafts (3.66). In other populations, the top 5 were sports (3.90); community reintegration activities (3.74); games (3.65); arts and crafts (3.58); and parties/special events (3.52).

#### *Use of Facilitation Techniques*

Average scores for facilitation techniques ranged from a low of 1.41 for use of pre/post operative preparation to a high of 3.74 for social skills training. The top ten facilitation techniques used by respondents were:

social skills training (3.74), leisure education/counseling (3.56), behavior modification (3.43), resocialization (3.38), reality orientation (3.35), stress management (3.29), group therapy (3.27), sensory stimulation (3.17), cognitive retraining (3.13), and reminiscence (3.12).

Means for each facilitation technique by population were calculated to determine whether differences existed in use by the type of population with which individuals worked (see Table 3). The top 5 facilitation techniques utilized in PM&R were leisure education (4.00); cognitive retraining (3.66); social skills training (3.65); resocialization (3.49); and group therapy (3.36). In older adult populations, the top 5 were reminiscence (4.25); sensory stimulation (4.17); reality orientation (3.94); resocialization (3.56); and remotivation (3.51). In mental health the top 5 facilitation techniques were social skills training (4.24); leisure education (4.14); stress management (4.08); group therapy (3.90); and behavior modification (3.71). In the other group, the top five included behavior modification (4.15); social skills training (3.94); leisure education (3.30); sensory stimulation (3.20); and play therapy (3.00).

#### *Group Differences for Use of Modalities and Facilitation Settings*

Analysis of variance (ANOVA) was conducted to determine if use of modalities and facilitation techniques differed significantly by population (mental health, PM&R, older adult, and other populations). In terms of modalities, significant differences in use by population were found in 18 of the 23 modalities (See Table 4). Interestingly, all facilitation techniques differed significantly by population as reported in Table 5.

#### *Percent of Teaching Emphasis Placed on Modalities and Facilitation Techniques*

Respondents were asked what percentage of teaching emphasis (based on 100%) should be placed on modalities and what percentage should be placed on facilitation techniques. The average score for modalities was 45% with a range from 5 to 90 percent. The average score for facilitation techniques was 55% with a range from 10 to 95 percent. When viewing the frequency distribution of scores, it appears that facilitation techniques received higher emphasis than did modalities. While the means were relatively similar, the majority of respondents placed modalities in the 30 to 50 percent range and facilitation techniques in the 50 to 80 percent range (See Chart 1).

*Critical Entry Level Skills for Therapists*

Most of the modalities and facilitation techniques had mean scores above 3.00 (see Table 6). Overall, respondents rated facilitation techniques higher than they did modalities. Only one modality was in the top 5 overall scores - community reintegration activities (tied for 3<sup>rd</sup>), two more were in the top 10 - problem solving activities (6) and self esteem (7) and one more was in the top 15 - assertiveness training (13). The five highest rated facilitation techniques were leisure education (1), social skills training (2), behavior modification (tied for 3<sup>rd</sup>), stress management (5), and resocialization (8).

*Group Differences for Critical Entry Level Skills*

Analysis of variance (ANOVA) was conducted to determine if critical entry level skills differed significantly by population. The following differences were noted.

*PM&R populations.*

Two modalities were rated as more critical entry level skills in PM&R including aquatic therapy and community reintegration activities. Aquatic therapy  $F(3, 261) = 6.49, p < .001$  was rated more critical in PM&R (3.84) than in all other populations including mental health (3.00), older adults (2.93) and other (3.24) populations. Community reintegration activities  $F(3, 260) = 3.86, p < .01$  was rated significantly more critical in PM&R (4.69) than in all other populations including older adults (4.27), other populations (4.49) and mental health (4.69) although all had high mean scores.

One facilitation technique was rated more critical as an entry level skill in PM&R: reality orientation. Reality orientation  $F(3, 269) = 4.51, p < .004$  was rated significantly more critical in PM&R (4.37) than in Other populations (3.78).

*Mental health populations.*

Three modalities were rated as more critical entry level skills in mental health including assertiveness training, self-esteem experiences and problem solving activities. Assertiveness training activities  $F(3, 260) = 6.49, p < .001$  was rated more critical in mental health (4.37) than in older adult populations (3.79). Self esteem  $F(3, 262) = 7.29, p < .001$  was rated higher in mental health (4.65) than in all other populations including older adults (4.11), PM&R (4.19) and other populations (4.29). Problem solving activities  $F(3, 261) = 4.71, p < .003$  was rated higher in mental health (4.61) than

in all other populations including older adults (4.18), others (4.33), and PM&R (4.37). All had high mean scores, thus recognizing the importance of this modality.

One facilitation technique, stress management, was rated as a more critical entry level skill. Stress management  $F(3, 262) = 8.03, p < .001$  had a significantly higher critical mean score in mental health (4.70) than in all other populations including other populations (4.09), PM&R (4.34), and older adults (4.36).

*Older adult populations.*

One modality was rated more critical as an entry skill in older adult populations – music. Music  $F(3, 262) = 17.20, p < .001$  was rated more critical in older adult populations (4.04) than in all other populations including other populations (2.91), mental health (3.06) and PM&R (3.20).

Two facilitation techniques were rated more critical entry level skills and one was rated less critical in older adult populations. Reminiscence  $F(3, 263) = 20.72, p < .001$  was rated more critical in older adult populations (4.58) than in all other populations including other populations (3.38), PM&R (3.73), and mental health (3.83). Sensory stimulation  $F(3, 263) = 18.29, p < .001$  was also rated more critical in older adult populations (4.70) than in all other populations including mental health (3.83), other populations (4.00) and PM&R (4.17). One facilitation technique, leisure education  $F(3, 263) = 9.19, p < .001$  was rated less critical in older adult populations (4.24) than in all other populations including other (4.59), PM&R (4.62), and mental health (4.76).

*Other populations.*

One facilitation technique was rated less critical for an entry level skill – reality orientation. Reality orientation  $F(3, 262) = 5.10, p < .002$  was less critical in other populations (3.62) than in mental health (4.22), older adults (4.34), and PM&R (4.37).

*Comparison of Ratings of Critical Entry Level Skills by Years in Practice*

Respondents reported they had worked from under a year and up to 36 years in practice. An ANOVA was conducted to determine if there was a difference between ratings of critical entry level skills by years of experience. For this analysis, the variable “years in practice” was collapsed into 5 groups as follows: *up to 2 years* ( $n = 50$ ), *3 to 5 years* ( $n = 55$ ), *6 to 9 years* ( $n = 51$ ), *10 to 15 years* ( $n = 55$ ) and *16 or more years* ( $n =$

53). Only those modalities and facilitation techniques that were determined to be at least "moderately critical" or "very critical" (mean scores of 4.00 or higher) were used in the analysis. It was important to determine whether there were any differences in those modalities and facilitation techniques that were rated most critical by respondents. Only two facilitation techniques revealed statistically significant differences. Those who worked longest in the discipline (*16 or more years*) rated group therapy and reality orientation significantly lower than the other groups. Group therapy  $F(4,259) = 4.39, p < .002$  had a lower mean score for those working 16 or more years ( $M = 3.85$ ) than 10 to 15 years ( $M = 3.95$ ), 6 to 9 years ( $M = 4.29$ ), 3 to 5 years ( $M = 4.33$ ) and up to 2 years ( $M = 4.41$ ). Reality orientation  $F(4,259) = 3.36, p < .011$  had a lower mean score again for those working 16 or more years ( $M = 3.85$ ) than 10 to 15 years ( $M = 4.22$ ), 6 to 9 years ( $M = 4.33$ ), 3 to 5 years ( $M = 4.33$ ), and up to 2 years ( $M = 4.41$ ).

*Critical to Teach at the Undergraduate Level*

Respondents were asked to rate modalities and facilitation techniques on how critical they were to teach at the Undergraduate level. Each modality and facilitation technique was rated on a 5-point Likert scale that ranged from 1 (*not at all critical*) to 5 (*very critical*). Most were rated with mean scores above 3.00 (see Table 6). Overall, respondents rated facilitation techniques with higher mean scores than they did modalities. A total of 4 modalities were listed in the top 15 combined modalities and facilitation techniques. The 3 common modalities identified in all groups were community reintegration activities, problem solving activities, and self-esteem experiences. Assertiveness training was utilized in PM&R, Mental Health, and Other populations; in older adult populations exercise was utilized. The top 5 facilitation techniques overall were leisure education, social skills training, behavior modification, stress management, and cognitive retraining. All 4 populations rated leisure education in the top 5 critical interventions. Behavior modification was rated in the top 5 in all but PM&R (rated 7) and social skills training rated in top 5 in all but older adult populations (rated 7). Community reintegration activities were rated in the top 5 in PM&R and Other populations and stress management was rated in the top 5 in PM&R and Mental Health.

## Conclusions

The use of modalities and facilitation techniques in TR practice are the tools of our discipline. One purpose of this study was to determine those modalities and facilitation techniques most widely used in current TR practice. A second purpose was to determine which modalities and facilitation techniques were critical skills for entry level therapists and which should be emphasized in an undergraduate curriculum. Results of the study are as follows.

The modality most widely used across all population groups was games. In terms of facilitation techniques the most widely used interventions (except for older adult populations) were leisure education and social skill training. The modalities most frequently used in practice were games, exercise, parties, arts and crafts and community reintegration activities. The critical modalities that entry-level therapists should know were different from those reported most often used. Respondents identified more complex skills such as community reintegration activities, problem solving activities, self-esteem experiences, and assertiveness training as those most critical for entry level knowledge. These were also the modalities that practitioners indicated were critical to teach in an undergraduate curriculum.

The common facilitation techniques used across population groups (except for those working with older adults) were leisure education and social skills training. All groups indicated leisure education, social skills training, behavior modification, stress management, and cognitive retraining were skills critical for entry level therapists to know. They indicated that these facilitation techniques were also critical to teach in an undergraduate curriculum.

The first hypothesis, that practitioners would utilize some modalities and facilitation techniques more than others, was supported by the results of this study. Tables 2 and 3 give the average ratings for each modality and facilitation technique by population. Games, exercise, parties, arts and crafts, and community reintegration were the most frequently used activities overall. The ratings changed when mean scores were calculated by population. The greatest difference by population were those respondents who worked with older adult populations. Music and parties were the most frequently used modalities in older adult populations. Community reintegration and games were the most

frequently used modalities in PM&R. In mental health, the top modalities were games and self-esteem. In other populations, sports and community reintegration were the top modalities. These differences continued when comparing facilitation techniques. In the older adult population group, reminiscence and sensory stimulation were the most frequently used facilitation techniques. In PM&R, leisure education and cognitive retraining were the top facilitation techniques. In mental health, social skills training and leisure education were the top facilitation techniques. In other populations, behavior modification and social skills training were the most frequently used.

Analysis of variance (ANOVA) indicated that there were significant differences in the use of modalities and facilitation techniques across populations. Thus, the second hypothesis of the study was supported. Tables 2 and 3 indicate whether significant differences across populations were found. The most unique population in terms of use of modalities and facilitation techniques was the older adult population. Modalities that were used more in older adult populations included music, parties/special events, dance/movement, bibliotherapy, and exercise. The facilitation techniques that were reported as used more frequently with this population included reality orientation, reminiscence, sensory stimulation, and remotivation. The more frequent use of these facilitation techniques seems logical when considering the nature of the aging process with common diagnoses such as dementia and Parkinson's Disease.

Analyses indicated that specific modalities and facilitation techniques were used more in one population than others. This seemed to be dependent on the nature of presenting problems and diagnoses. In PM&R, community reintegration activities, problem solving activities and cognitive retraining were used more frequently than in some populations. In mental health, problem solving activities, assertiveness training, self-esteem activities, social skills training, stress management, values clarification, behavior modification and group therapy were used more than in some populations.

The third hypothesis stated that there would be differences in ratings of critical skills and critical to teach in undergraduate curricula by population. This was also supported in this study; there were differences in critical skills and critical to teach by all populations. The older adult population had distinct needs from the other populations. Older adult populations focused more on cognitive and behavioral skills when identifying critical skills for entry level therapists

to possess. These included sensory stimulation, reminiscence, resocialization, behavior modification, and stress management. The older adult population was the only group where leisure education was not one of the top 2 critical skills (rated 11). In addition, social skills was also rated much lower (rated 7). All other population groups rated leisure education and social skills training as highly critical. PM&R focused on community reintegration activities, problem solving activities, reality orientation and cognitive retraining. Mental health focused on stress management, self-esteem experiences, problem solving activities, and assertiveness training. Those in other populations (pediatrics, developmental disabilities, and corrections) focused on behavior modification, community reintegration activities, and problem solving activities.

An ANOVA was conducted to determine whether there were differences between ratings of the critical skills required for entry level by years of TR practice. Significant differences were found in only 2 facilitation techniques. Those who worked longest in the discipline (16 or more years) rated group therapy and reality orientation significantly lower than the other groups. While there was a statistical difference, the difference was too slight for practical purposes. The most important finding of this analysis is that most therapists, regardless of years of practice, are in agreement in their ratings of importance for entry level skills. Experience does not appear to change the perception of the fundamental skills required for entry level practitioners.

Some modalities and facilitation techniques that had low use/importance ratings overall, may be used extensively in a specific population. While knowing the overall most frequently used modalities and facilitation techniques can be used as a guide to teaching in a general curriculum, this study indicated that modalities and facilitation techniques most frequently utilized will vary by specific populations. For those programs that have specific courses in various disability groups, the information obtained in this study can be used as a guide to identify the modalities and facilitation techniques that were most frequently used and deemed critical to know by population.

In a separate question, respondents were asked to indicate the amount of emphasis that should be placed on teaching modalities and facilitation techniques based on 100 percent; what percentage should curricula focus on modalities and how much should focus on facilitation techniques? Respondents indicated that on average,

modalities should consist of 45% and facilitation techniques 55% of teaching. However, when interpreting the bar chart (See Chart 1) respondents clearly placed heavier emphasis on facilitation techniques. This is consistent with their ratings of modalities and facilitation techniques in terms of critical to know and teach in an undergraduate curriculum. When listing the top 10 mean scores overall, only 3 were modalities (community reintegration activities, problem solving activities and self-esteem experiences). The seven facilitation techniques were leisure education, behavior modification, social skills training, stress management, cognitive retraining, resocialization, and group therapy.

Respondents clearly indicated that facilitation techniques were more critical skills for entry level therapists to possess. The majority of respondents also indicated that greater emphasis should be placed on teaching facilitation techniques as opposed to modalities. Facilitation techniques guide the selection of modalities selected by the CTRS. They are based primarily on theory. Possessing knowledge and skill in selecting the appropriate facilitation technique to bring about desired client change is critical. Use of facilitation techniques involves processing the intervention so that learning and generalization can occur. Without skills to process an activity, no real change is likely to occur. Therefore, it stands to reason that most therapists would place more emphasis on facilitation techniques as necessary to the education of entry level therapists. A comparison with the Northeast study (Kinney, et al., 1999) indicated the same 10 modalities were identified but in a different order (see Table 7). Use of games was the most widely used in both studies. In terms of facilitation techniques, the selection was similar, however, social skills training was used more frequently than leisure education (opposite from the Northeast study). The consistent response across studies lends support to recommendations concerning emphasis on teaching. Although the response rate is not ideal (32%), it is within the expected range for mailed questionnaires (Wolpert, 1991).

## Recommendations

This research provides information for both educational programs and professional organizations in terms of addressing pre-professional, in-service education, and continuing educational needs of practitioners. While some caution should be taken given the response rate (31%), the study does provide current information about what is happening in TR practice. There are important implications if the TR discipline is to move towards a standardized curriculum. Greater emphasis could be placed on facilitation techniques. That is not to say that modalities should be ignored. Table 6 lists the top 15 modalities and facilitation techniques and can provide some direction for educators and conference planners. Respondents indicated the facilitation techniques that should to be taught included leisure education, social skills training, behavior modification, stress management, resocialization, reality orientation, sensory stimulation and group therapy. The modalities that should be taught included community reintegration activities, problem solving activities, self-esteem experiences, and assertiveness training activities.

What is important to note is that these are skills and knowledge that the practitioners in current TR practice felt that TR clinicians should possess at entry level. Students should also be aware that some skills would most likely need to be learned independently such as games, parties, arts and crafts, and sports. While these are widely utilized they are not recommended as critical to teach in an undergraduate curriculum.

Some may be surprised that certain modalities and facilitation techniques were widely used but not recommended to teach in an undergraduate curriculum. For example, out of the top 10 modalities only 3 were identified as critical to know and critical to teach (community reintegration, problem solving, and self-esteem exercises). The top 4 overall mean scores for modalities (games, exercise, parties, and arts and crafts) were not identified as critical to know. Out of the top 10 facilitation techniques, only 1 (reminiscence) was not identified as critical to know and critical to teach. It is our interpretation that practitioners regard modalities as easier to learn; or that people are frequently exposed to these modalities outside of the classroom. As stated above, the only facilitation technique in the top 10 not to make the critical to know/teach categories was reminiscence, which is specific to only one population

(Older Adults). Classroom time should be spent on the more complex modalities and facilitation techniques.

TR educators should give consideration to the extent they focus on modalities and facilitation techniques. Discussion should center on whether they should focus on those identified as most critical or those most widely used. TR curricula that offer specific courses by disability group can focus on the modalities and facilitation techniques that are used and deemed critical to that particular population (e.g., TR and Rehabilitation, TR and Older Adults, etc.). Those curricula that have a global course dealing with all disability groups could use the overall scores, or select the scores for each of the specific disability groups that are covered in the course.

TR educators should also focus on teaching the difference between and the relationship of modalities and facilitation techniques in the treatment process. Understanding the relationship may enhance students' abilities to identify and select purposeful treatment interventions based on client needs. Educators should consider incorporating the most widely used modalities and facilitation techniques in lectures that deal with specific disability groups.

Continuing education could offer sessions that refine skills and develop advanced competencies. Textbook authors could place more emphasis on facilitation techniques as modalities have received extensive coverage. Discussion could focus on the distinction between modalities and facilitation techniques and address how they are selected and implemented in the treatment process.

The focus of efforts in competency based education cannot be the sole responsibility of educators. This must be a combined effort. If the TR discipline is to remain competitive in today's healthcare climate, outcomes based research should focus on the treatment results and efficacy of various facilitation techniques and modalities.

Table 1

*Modalities and Facilitation Techniques Identified By the ATRA Education Task Force*

Modalities	Facilitation Techniques
Activities of daily living (ADL)	American Sign Language *
Adventure experience/initiatives	Behavior modification/management
Animal facilitative interventions	Bio-feedback *
Assertiveness training	Cognitive retraining
Athletics/sports	Family interventions
Aquatics	Grief/loss counseling *
Arts & crafts	Group interventions
Bibliotherapy/storytelling	Guided imagery
Camping/Outdoor recreation	Humor
Community reintegration activities	Leisure education/counseling
Dance/Movement	Play therapy/skills
Drama	Pre/post operative procedural training
Empowerment/Self-esteem experiences	Remotivation
Exercise/fitness/aerobics	Resocialization
Games	Reality orientation
Horseback riding	Reminiscence
Horticulture	Sensory stimulation
Meditation	Social skills training
Music/singing	Stress management/relaxation
Parties/Special events	Therapeutic community *
Problem solving activities	Values clarification
Projects/service activities	
Weight training	

\* Not used in the current study

Table 2

*Mean Scores (and Standard Deviations) of the Use of Modalities by TR Population*

Modality	Overall	PM&R	Mental Health	Older Adult	Other
Games	4.01(0.97)	3.97(1.18)	3.95(0.91)	4.22(0.84)	3.65(0.92)
Exercise	3.72(1.15)	3.33(1.22)	3.72(1.21)	4.12(0.89)	3.39(1.17)
Parties	3.57(1.17)	3.26(1.25)	3.09(1.04)	4.30(0.87)	3.52(1.15)
Arts/crafts	3.53(1.09)	3.53(1.22)	3.38(1.06)	3.66(0.97)	3.58(1.78)
Community reintegration	3.36(1.39)	3.98(1.33)	3.18(1.53)	2.96(1.13)	3.74(1.21)
Music	3.33(1.26)	3.02(1.28)	2.66(1.04)	4.30(0.84)	3.16(1.16)
Problem solving	3.31(1.21)	3.52(1.22)	3.76(1.05)	2.86(1.13)	2.84(1.24)
Sports	3.22(1.21)	3.21(1.45)	3.24(1.25)	2.93(1.19)	3.90(1.04)
Self-esteem	3.09(1.21)	2.54(1.09)	3.87(0.99)	2.78(1.16)	2.68(1.01)
ADLs	2.98(1.24)	2.98(1.33)	2.85(1.20)	2.95(1.15)	3.39(1.33)
Dance	2.67(1.24)	2.44(1.25)	2.33(1.12)	3.17(1.15)	2.74(1.37)
Horticulture	2.56(1.23)	2.84(1.34)	2.20(1.19)	2.88(1.09)	2.19(1.14)
Animal therapy	2.53(1.26)	2.48(1.32)	2.07(1.23)	3.16(1.11)	2.23(1.76)
Projects	2.49(1.11)	2.54(1.19)	2.31(1.18)	2.67(1.05)	2.42(0.85)
Assertiveness training	2.45(1.91)	2.32(1.11)	3.17(1.12)	1.81(0.97)	2.29(1.01)
Bibliotherapy	2.34(1.19)	1.88(1.11)	1.85(0.93)	3.19(1.03)	2.40(1.16)
Adventure therapy	2.28(1.23)	1.91(1.04)	2.71(1.38)	1.99(1.02)	2.52(1.21)
Meditation	2.14(1.17)	2.14(1.07)	2.30(1.26)	2.11(1.14)	1.77(1.15)
Aquatics	2.11(1.38)	2.69(1.58)	1.93(1.23)	1.44(0.94)	3.23(1.29)
Weight training	1.96(1.31)	2.12(1.32)	2.16(1.38)	1.56(1.11)	2.16(1.34)
Camping	1.86(1.06)	1.93(1.10)	1.85(1.14)	1.63(0.82)	2.37(1.19)
Drama	1.80(0.96)	1.55(0.80)	1.68(0.93)	2.03(1.02)	2.03(1.05)
Horseback riding	1.32(0.83)	1.49(1.07)	1.25(0.69)	1.11(0.53)	1.71(1.13)

Table 3

*Mean Scores (and Standard Deviations) of the Use of Facilitation Techniques by TR Population*

Facilitation Technique	Overall	PM&R	Mental Health	Older Adult	Other
Social skills training	3.74(1.18)	3.65(1.22)	4.24(0.96)	3.16(1.20)	3.94(0.99)
Leisure education	3.56(1.17)	4.00(0.85)	4.14(0.82)	2.73(1.20)	3.30(1.10)
Behavior modification	3.43(1.24)	2.98(1.15)	3.71(1.20)	3.13(1.22)	4.15(1.03)
Resocialization	3.38(1.17)	3.49(1.17)	3.34(1.20)	3.56(1.05)	2.85(1.23)
Reality orientation	3.35(1.34)	3.34(1.32)	3.18(1.36)	3.94(1.06)	2.30(1.26)
Stress management	3.29(1.29)	3.32(1.20)	4.08(1.05)	2.58(1.09)	2.91(1.31)
Group therapy	3.27(1.48)	3.36(1.31)	3.90(1.45)	2.95(1.39)	2.27(1.33)
Sensory stimulation	3.17(1.45)	3.07(1.32)	2.29(1.31)	4.17(1.03)	3.20(1.41)
Cognitive retraining	3.13(1.31)	3.66(1.23)	2.91(1.37)	3.16(1.26)	2.64(1.14)
Reminiscence	3.12(1.46)	2.93(1.35)	2.67(1.40)	4.25(0.89)	1.91(1.23)
Remotivation	3.08(1.23)	3.11(1.16)	2.87(1.12)	3.51(1.20)	2.55(1.42)
Humor	2.75(1.47)	2.63(1.18)	2.71(1.03)	3.14(1.17)	2.12(1.02)
Values clarification	2.73(1.32)	2.53(1.32)	3.53(1.21)	2.12(1.05)	2.42(1.20)
Guided imagery	2.22(1.12)	1.98(1.04)	2.50(1.21)	2.19(1.01)	1.91(1.10)
Play therapy	2.20(1.21)	2.12(1.09)	2.17(1.22)	1.96(1.08)	3.00(1.39)
Family therapy	2.11(1.16)	2.57(1.20)	1.91(1.21)	2.17(1.08)	1.67(0.82)
Pre/post operative play	1.41(0.93)	1.31(0.74)	1.32(0.91)	1.41(0.89)	1.82(1.26)

Table 4

*Analysis of Variance on the Top 10 Modalities Used by TR Populations*

Modality		df	Mean Square	F	p
Games	Between groups	3	2.718	2.97	.03
	Within groups	252	.916		
	Total	255			
Exercise	Between groups	3	8.518	6.95	.001
	Within groups	253	1.226		
	Total	256			
Parties	Between groups	3	23.292	20.87	.001
	Within groups	254	1.116		
	Total	257			
Arts/crafts	Between groups	3	1.136	.966	.41
	Within groups	254	1.177		
	Total	257			
Community reintegration	Between groups	3	14.161	7.98	.001
	Within groups	253	1.774		
	Total	256			
Music	Between groups	3	40.888	36.83	.001
	Within groups	252	1.110		
	Total	255			
Problem solving	Between groups	3	14.164	10.88	.001
	Within groups	250	1.302		
	Total	253			
Sports	Between groups	3	7.171	5.11	.002
	Within groups	252	1.403		
	Total	255			
Self-esteem	Between groups	3	27.876	24.26	.001
	Within groups	251	1.149		
	Total	254			
ADLs	Between groups	3	2.229	1.462	.225
	Within groups	250	1.525		
	Total	253			

Table 5

*Analysis of Variance on the Top 10 Facilitation Techniques Used by TR Populations*

Modality		<i>df</i>	Mean Square	<i>F</i>	<i>p</i>
Social Skills	Between groups	3	16.776	13.80	.001
	Within groups	253	1.216		
	Total	256			
Leisure Education	Between groups	3	32.684	32.91	.001
	Within groups	253	.993		
	Total	256			
Behavior Modification	Between groups	3	14.266	10.34	.001
	Within groups	252	1.380		
	Total	255			
Resocialization	Between groups	3	4.211	3.18	.025
	Within groups	254	1.323		
	Total	257			
Reality Orientation	Between groups	3	22.340	14.30	.001
	Within groups	256	1.562		
	Total	259			
Stress Management	Between groups	3	33.361	26.13	.001
	Within groups	253	1.277		
	Total	256			
Group Therapy	Between groups	3	25.172	13.13	.001
	Within groups	251	1.917		
	Total	254			
Sensory Stimulation	Between groups	3	50.174	32.42	.001
	Within groups	255	1.548		
	Total	258			
Cognitive Retraining	Between groups	3	9.495	5.84	.001
	Within groups	251	1.626		
	Total	254			
Reminiscence	Between groups	3	57.063	38.67	.001
	Within groups	254	1.476		
	Total	257			

Table 6

*Top 15 Mean Scores (and Standard Deviations) of Critical Entry Level Skills and Critical to Teach*

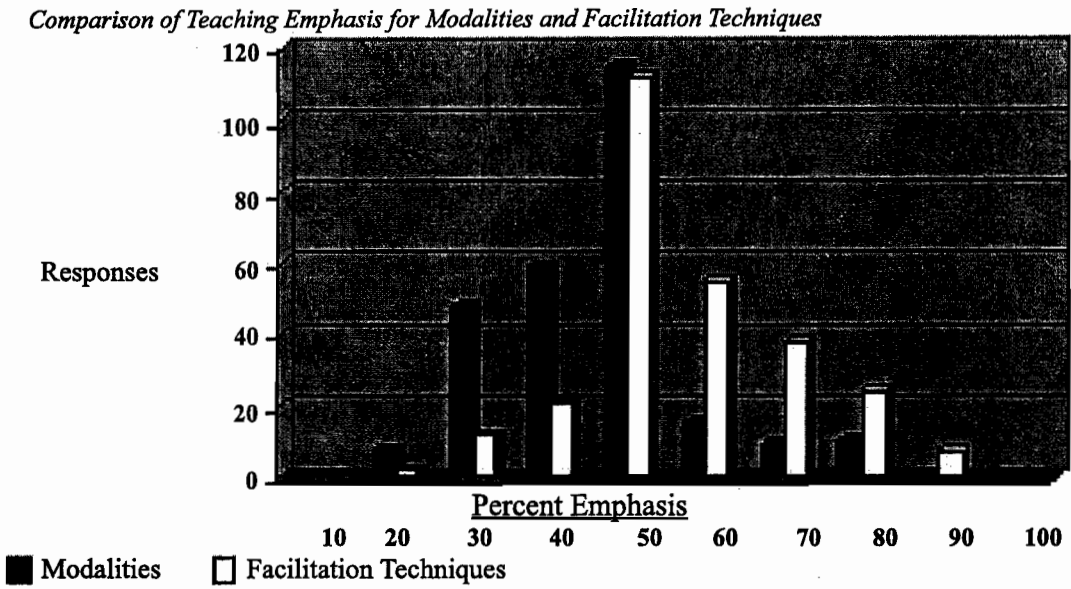
Rank	Critical Entry Level Skills			Critical Skills to Teach		
	Modality	Facilitation Technique	Score (SD)	Modality	Facilitation Technique	Score (SD)
1	—	Leisure Education	4.54 (0.70)	—	Leisure Education	4.61 (0.69)
2	—	Social Skills Training	4.51 (0.69)	—	Behavior Modification	4.56 (0.71)
3	—	Behavior Modification	4.46 (0.68)	—	Social Skills Training	4.52 (0.74)
3/4	Community Reintegration	—	4.46 (0.76)	—	Stress Management	4.44 (0.77)
5	—	Stress Management	4.44 (0.72)	Community Reintegration	—	4.37 (0.80)
6	Problem Solving	—	4.39 (0.78)	Problem Solving	—	4.35 (0.82)
7	Self Esteem	—	4.33 (0.83)	Self Esteem	—	4.33 (0.85)
8	—	Resocialization	4.31 (0.81)	—	Cognitive Retraining	4.32 (0.81)
9	—	Reality Orientation	4.23 (0.89)	—	Resocialization	4.30 (0.82)
10	—	Sensory Stimulation	4.20 (0.87)	—	Group Therapy	4.43 (0.99)
11	—	Cognitive Retraining	4.19 (0.85)	—	Sensory Stimulation	4.23 (0.99)
12	—	Group Therapy	4.18 (0.97)	—	Reality Orientation	4.23 (0.89)
13	Assertiveness Training	—	4.07 (0.90)	—	Remotivation	4.08 (0.96)
14	—	Remotivation	4.06 (0.91)	Assertiveness Training	—	4.06 (0.94)
15	—	Values Clarification	4.01 (0.92)	—	Values Clarification	4.00 (0.97)

Table 7

*Comparison of Mean Scores (and Standard Deviations) between Northeast Study and National Study*

Use of Modalities				Use of Facilitation Techniques			
NE Study	Score (SD)	National Study	Score (SD)	NE Study	Score (SD)	National Study	Score (SD)
Games	3.71 (0.53)	Games	4.00 (0.97)	Leisure Education	3.70 (0.60)	Social Skills Training	3.74 (1.18)
Arts & Crafts	3.46 (0.73)	Parties	3.57 (1.17)	Social Skills Training	3.60 (0.67)	Leisure Education	3.56 (1.17)
Problem Solving	3.44 (0.78)	Exercise	3.53 (1.09)	Stress Management	3.41 (0.76)	Behavior Modification	3.43 (1.24)
Exercise	3.41 (0.68)	Arts & Crafts	3.53 (1.09)	Resocialization	3.40 (0.77)	Resocialization	3.38 (1.17)
Community Reintegration	3.32 (1.01)	Community Reintegration	3.36 (1.39)	Reality Orientation	3.22 (0.86)	Reality Orientation	3.35 (1.34)
Self-Esteem	3.26 (0.83)	Music	3.33 (1.26)	Cognitive Retraining	3.21 (0.86)	Stress Management	3.29 (1.29)
Music	3.21 (0.92)	Problem Solving	3.31 (1.21)	Behavior Modification	3.20 (0.85)	Group Therapy	3.27 (1.48)
Parties	3.17 (0.89)	Sports	3.21 (1.21)	Therapeutic Community	3.20 (1.01)	Sensory Stimulation	3.17 (1.45)
Sports	3.17 (0.91)	Self-Esteem	3.09	Group Therapy	3.08 (1.15)	Cognitive Retraining	3.13 (1.31)
ADL Skills	2.89 (0.91)	ADL Skills	2.98 (1.24)	Sensory Stimulation	3.04 (0.99)	Reminiscence	3.12 (1.46)

Chart 1



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