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The Leisure Ability Model

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The Leisure Ability Model is one of the oldest, most widely used, and most often critiqued therapeutic recreation practice models. It is based on the concepts of internal locus of control, intrinsic motivation, personal causality, freedom of choice, and flow. The Leisure Ability Model uses these ideas as the basis for three components of service: treatment, leisure education, and recreation participation. These three areas of service supply the content for creating, developing, implementing, and evaluating therapeutic recreation programs that are based on client need. The overall intended outcome of therapeutic recreation services, as defined by the Leisure Ability Model, is a satisfying, independent, and freely chosen leisure lifestyle. Included in this review are noted strengths, weaknesses, and directions for future development.

KEY WORDS: *Leisure Ability Model, Leisure Lifestyle, Therapeutic Recreation Concepts*

The Leisure Ability Model the major reason that the Leisure Ability Model has received such extensive debate. In a time when many therapeutic recreation professionals want to cling strongly to a more medical or "therapy" model of service delivery, Peterson (1989) outlined

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Note 1: Unless otherwise noted, this discussion of the Leisure Ability Model stems entirely from the work of Carol A. Peterson and Scott L. Gunn, specifically in Peterson & Gunn (1984). The original authors have given permission to use this blanket statement rather than extensive internal referencing. Note 2: The authors would like to acknowledge Amanda McGowen, Illinois State University graduate research assistant, for her library retrieval assistance.

a strong "leisure" orientation. Peterson (1989) outlined the two options:

The leisure orientation implies that the ultimate outcome or guiding set of beliefs is related to leisure behavior, and the orientation draws on the existing body of knowledge related to leisure as its source and foundation. The therapy orientation, on the other hand, indicates change or improvement of functional behaviors as the desired end and draws from the medical, psychiatric, psychological, and human development body of knowledge. (p. 28)

In other words, the Leisure Ability Model was constructed with the belief that the end product of therapeutic recreation services for clients was improved independent and satisfying leisure functioning, also referred to as a "leisure lifestyle" (Peterson, 1981, 1989; Peterson & Gunn, 1984).

Leisure lifestyle is the day-to-day behavioral expression of one's leisure related attitudes, awareness, and activities revealed within the context and composite of the total life experience. (Peterson & Gunn, p. 4)

Leisure lifestyle implies that an individual has sufficient skills, knowledge, attitudes, and abilities to participate successfully in and be satisfied with leisure and recreation experiences that are incorporated into his or her individual life pattern. These participation and satisfaction levels ultimately speak to a person's quality of life and happiness. Csikszentmihalyi (1990) stated: "People who learn to control inner experience will be able to determine the quality of their lives, which is as close as any of us can come to being happy" (p. 2). In the leisure behavior and leisure theory literature, a number of concepts and findings exist that relate to a satisfying leisure lifestyle, quality of life, and happiness or satisfaction. Although

space is limited in this manuscript, several of these concepts will be discussed, including: (a) learned helplessness vs. mastery or self-determination; (b) intrinsic motivation, internal locus of control, and causal attribution; (c) choice; and (d) flow.

Rationale for Therapeutic Recreation Services

As a foundation for discussing the four concepts stated above, a rationale for the provision of therapeutic recreation services, according to the Leisure Ability Model, is needed. The rationale has been established through a logical set of assumptions concerning typical adult leisure behavior.

The first assumption is that every human being needs, wants, and deserves leisure. Leisure presents opportunities to try new behaviors, experience mastery, learn new skills, meet new people, deepen existing relationships, and develop a clearer sense of self. Leisure provides the context in which people can learn, interact, express individualism, and self-actualize (Kelly, 1990).

The second assumption is that many, if not most, individuals experience barriers to full and satisfying leisure. For example, some individuals may view leisure as wasteful; some may not know how to access information about leisure opportunities; some may lack skills in meeting new people or establishing meaningful relationships; some may have safety and welfare concerns that prevent them from entering leisure facilities; and some may feel they have inadequate discretionary money to spend on leisure. While many adults overcome these barriers or learn to compensate for their consequences, many are constrained from full and satisfying leisure experiences.

It then follows that many individuals with disabilities and/or illnesses may experience more frequent, severe, or lasting barriers compared with their non-disabled counterparts, simply due to the presence of disability and/or illness. For example, some individu-

als may experience difficulty with physical accessibility in recreation or tourist facilities; some may be addicted to substances that prevent their sober participation; some may have reduced physical endurance, coordination, or strength; some may have few skills due to lack of exposure to typical recreation and leisure opportunities; some may have difficulty making friends due to social isolation or societal attitudes; and some may have been unaware of leisure opportunities that are available to someone with their disabling condition.

Because they are likely to experience greater difficulty in full and satisfying leisure participation, many individuals with disabilities and/or illnesses need the additional help of a therapeutic recreation specialist to eliminate, reduce, overcome, or compensate for leisure barriers. A therapeutic recreation specialist who utilizes the Leisure Ability Model as the basis for service delivery helps reduce barriers to leisure involvement through the provision of treatment, leisure education, and recreation participation services. While the Leisure Ability Model through these three areas of service provides specific information on service delivery content and outcomes, its underlying basis stems from the concepts of: (a) learned helplessness vs. mastery or self-determination; (b) intrinsic motivation, internal locus of control, and causal attribution; (c) choice; and (d) flow. These four areas are so critical to the understanding of a leisure lifestyle that they will be reviewed according to their relationship to the Leisure Ability Model approach to therapeutic recreation service-delivery.

Learned Helplessness vs. Mastery or Self-Determination

Iso-Ahola (1980), a social psychologist, viewed therapeutic recreation as a means to aid individuals in achieving psychological satisfaction from their leisure participation. He provided a foundation from which other psychological constructs can be used to exam-

ine the leisure phenomenon, specifically those that relate to the concept of leisure lifestyle. The following quote is important to the understanding of theoretical underpinnings of therapeutic recreation service delivery.

[P]eople generally expect their leisure and recreation participation to be psychologically therapeutic. . . the term "therapeutic recreation" is restricted to the process whereby a person ("therapist") actively and intentionally strives to remove the psychological barriers hindering clients . . . from experiencing satisfactory leisure and recreation. Participation in free-time activities in itself is meaningless. The most important consideration is what the clients by themselves and with the help of a therapeutic recreation specialist are able to derive psychologically from their recreational involvement. (Iso-Ahola, 1980, p. 323)

A psychological construct that explains the leisure behavior of some individuals with disabilities and/or illnesses and relates to the delivery of therapeutic recreation services is that of learned helplessness. Learned helplessness is the perception by an individual that events happening in his or her life are beyond his or her personal control, and therefore, the individual stops trying to effect changes or outcomes with his or her life (Seligman, 1975). For example, if an individual in a treatment facility is told repeatedly that she cannot participate in a certain type of recreation activity ("You're too old to do that") or that she must participate in a certain way ("Let me do that for you"), she will eventually stop wanting to participate in that activity or participate in any other way. She will learn that the rules are outside of her control and someone else is in charge of setting the rules. Her ability to take a risk will be diminished and she will learn to be helpless. As such, learned helplessness be-

comes a significant barrier to an individual's freely chosen and self-determined leisure behavior. Iso-Ahola (1980) stated that it is "important to note that helplessness is learned through environmental encounters; it is not a result of inherited traits" (p. 328). In other words, learned helplessness may present a psychological barrier to full leisure participation and it may, conversely, be unlearned with the provision of well-designed services.

Many individuals with disabilities and/or illnesses experience learned helplessness. This could be learned during childhood when others did things "for" the individual, or through repeated exposure to settings where one learned to become a passive patient upon whom procedures were performed according to a routine. Learned helplessness robs the individual of a sense of mastery and self-determination. Iso-Ahola (1980) stated that learned helplessness can spread quickly from a specific instance to a more generalized sense of incompetence and lack of control.

After having experienced helplessness in one leisure activity, a person may firmly believe that he is abnormal, inadequate, and lacks basic skills in that activity. As a consequence, the person believes that he is handicapped to participate in this activity; and this belief may then generalize to personal performance in other areas of leisure behavior. The total repertoire of leisure behavior is therefore in jeopardy. If helplessness generalizes to total leisure and if leisure is important to the person, helplessness and depression may extend to one's work and in the worst case, to the entire life. (Iso-Ahola, 1980, p. 334)

Iso-Ahola (1980) noted that there are three consequences of learned helplessness: (a) a lack of internal motivation to escape the conditions that lead to the state of helplessness;

(b) a lack of cognitive understanding of personal effectiveness (i.e., that the individual can personally effect change); and (c) a heightened sense of emotionality (called post-traumatic stress disorder when repeated exposure to uncontrollable events is extreme).

The role of the therapeutic recreation specialist, in order to reverse the consequences of learned helplessness, is to assist the individual in: (a) increasing the sense of personal causation and internal control, (b) increasing intrinsic motivation, (c) increasing the sense of personal choice and alternatives, and (d) achieving the state of optimal experience or "flow." In theory, then, therapeutic recreation is provided to affect the total leisure behavior (leisure lifestyle) of individuals with disabilities and/or illnesses through decreasing learned helplessness and increasing personal control, intrinsic motivation, and personal choice. This outcome is accomplished through the specific provision of treatment, leisure education, and recreation participation services which teach specific skills, knowledge, and abilities, and take into consideration the matching of client skills and activity challenge.

Intrinsic Motivation, Internal Locus of Control, and Causal Attribution

The three concepts of intrinsic motivation, locus of control (Deci, 1975) and personal causation (Seligman, 1975) are intricately linked, and help to explain the basis for the provision of therapeutic recreation services. All individuals are intrinsically motivated toward behavior in which they can experience competence and self-determination. As such, individuals seek experiences of incongruity (that is, slightly above their perceived skill level) or challenges in which they can master the situation, reduce the incongruity, and show competence. This process is continual and through skill acquisition and mastery, produces feelings of satisfaction, competence, and control.

the individual has the orientation that he or she is responsible for the behavior and outcome he or she produces (Deci, 1975). Typically individuals with an internal locus of control take responsibility for their decisions and the consequences of their decisions. A typical statement might be "I am responsible for my leisure choices." An individual with an external locus of control may make the statement "It's your fault I didn't do this right" and will place responsibility, credit, and blame on other individuals. Obviously, an internal locus of control is important for the individual to feel self-directed or responsible, be motivated to continue to seek challenges, and develop a sense of self-confidence.

Personal causality or attribution implies that an individual believes that he or she can affect a particular outcome (Deci, 1975; Seligman, 1975). For instance, when an individual experiences success, that person can either attribute that success to personal effort (personal causality), or luck or chance (situational causality). An important aspect of the sense of accomplishment, competence, and control is the individual's interpretation of personal contribution to the outcome. Without a sense of personal causation, the likelihood of the individual developing learned helplessness (the feeling that external others are in control) increases greatly.

These three concepts relate to therapeutic recreation in that the ultimate goal of an individual's satisfying and independent leisure lifestyle entails being intrinsically motivated, having an internal locus of control, and feeling a sense of personal causality. In order to facilitate these perceptions, therapeutic recreation specialists must be able to design, implement, and evaluate a variety of activities that increase the person's individual competence and sense of control. In relation to leisure behavior, Peterson (1989) felt that this includes improving functional abilities, improving leisure-related attitudes, skills, knowledge, and abilities, and volun-

tion. Thus, the three service areas of treatment, leisure education, and recreation participation are designed to teach specific skills to improve personal competence and a sense of accomplishment. Csikszentmihalyi (1990) summed up the importance of these perceptions: "[I]n the long run optimal experiences add up to a sense of mastery—or perhaps better, a sense of participation in determining the content of life—that comes as close to what is usually meant by happiness as anything else we can conceivably imagine" (p. 4).

Choice

The Leisure Ability Model also relies heavily on the concept of choice. Inherent to and parallel with the concepts of intrinsic motivation, internal locus of control, and personal causality, choice implies that the individual has sufficient skills, knowledge, and attitudes to be able to have options from which to choose, and the skills and desires to make appropriate choices. Lee and Mobily (1988) stated that therapeutic recreation services should build skills and provide participants with options for participation. The Leisure Ability Model emphasizes content areas that help clients build skills in a variety of areas which, in turn, should allow them options for future independent leisure functioning.

Lee and Mobily (1988) extended the idea of choice when examining the notions of "freedom from" and "freedom to." Earlier in this article it was stated that many nondisabled individuals face barriers to their leisure experiences. Sometimes this becomes an "if-only" scenario. The individual feels that he or she would have more fun, "if only" he or she had more money, more time, fewer constraints, etc. These individuals express the need for more "freedom from" obligations and responsibilities. Individuals with disabilities however, often have the opposite, but equally important experience—needing "freedom to" participate. That is,

having the requisite skills to participate, knowing where and with whom to participate, being able to get to a recreation facility at one's own convenience, etc. "Freedom from" constraints and "freedom to" exercise options provide further a basis for the need for therapeutic recreation services to be provided to individuals with disabilities and/or illnesses.

Flow

A fourth, closely related concept is that of "flow" (Csikszentmihalyi, 1990). For a person to get into "flow" or to achieve "optimal experience," a number of elements must be present. Among the strongest of these are the match between the challenge presented by the activity and the skill level of the participant. When skill level is high and activity challenge is low, the individual is quite likely to be bored. When the skill level is low and the activity challenge is high, the individual is most likely to be anxious. When the skill level and activity challenge are identical or nearly identical (both low or both high), the individual is most able to achieve a state of concentration and energy expenditure that Csikszentmihalyi (1990) has labeled "flow."

The implications for service delivery to clients under the auspices of the Leisure Ability Model are great. In essence, it means that the therapeutic recreation specialist must be able to adequately assess clients' skill level (through client assessment) and activity requirements (through activity analysis) in order for the two to (at least roughly) approximate one another. Given Deci's (1975) theory of intrinsic motivation which includes the concept of incongruity, therapeutic recreation specialists may provide activities slightly above the skill level of clients in order to increase the sense of mastery. When this match between the activity requirements and client skill levels occurs, clients are most able to learn and experience a higher quality leisure. To facilitate this, therapeutic recreation specialists become responsible for compre-

ending and incorporating the: (a) theoretical bases (including but not limited to internal locus of control, intrinsic motivation, personal causation, freedom of choice, and flow); (b) typical client characteristics, including needs and deficits; (c) aspects of quality therapeutic recreation program delivery process (e.g., client assessment, activity analysis, outcome evaluation, etc.); and (d) therapeutic recreation content (treatment, leisure education, and recreation participation).

These areas of understanding are important for the therapeutic recreation specialist to be able to design a series of coherent, organized programs that meet client needs and move the client further toward an independent and satisfactory leisure lifestyle. Again, the success of that lifestyle is dependent on the client gaining a sense of control and choice over leisure options, and having an orientation toward intrinsic motivation, an internal locus of control, and a personal sense of causality. While based on these major precepts, the Leisure Ability Model provides specific content that can be addressed with clients in order to facilitate their development, maintenance, and expression of a successful leisure lifestyle. Each aspect of this content applies to the future success, independence, and well-being of clients in regard to their leisure.

Description of Components

The Leisure Ability Model contains three major categories of service: treatment, leisure education, and recreation participation. Each of these three service areas is based on distinct client needs and has specific purposes, expected behavior of clients, roles of the specialist, and targeted client outcomes. The overall anticipated outcome of therapeutic recreation service delivery is a satisfying leisure lifestyle, that is, the independent functioning of the client in leisure experiences and activities of his or her choice. Each of the three categories of service (treatment, leisure education, and recreation participation) contributes to enhancing the client's

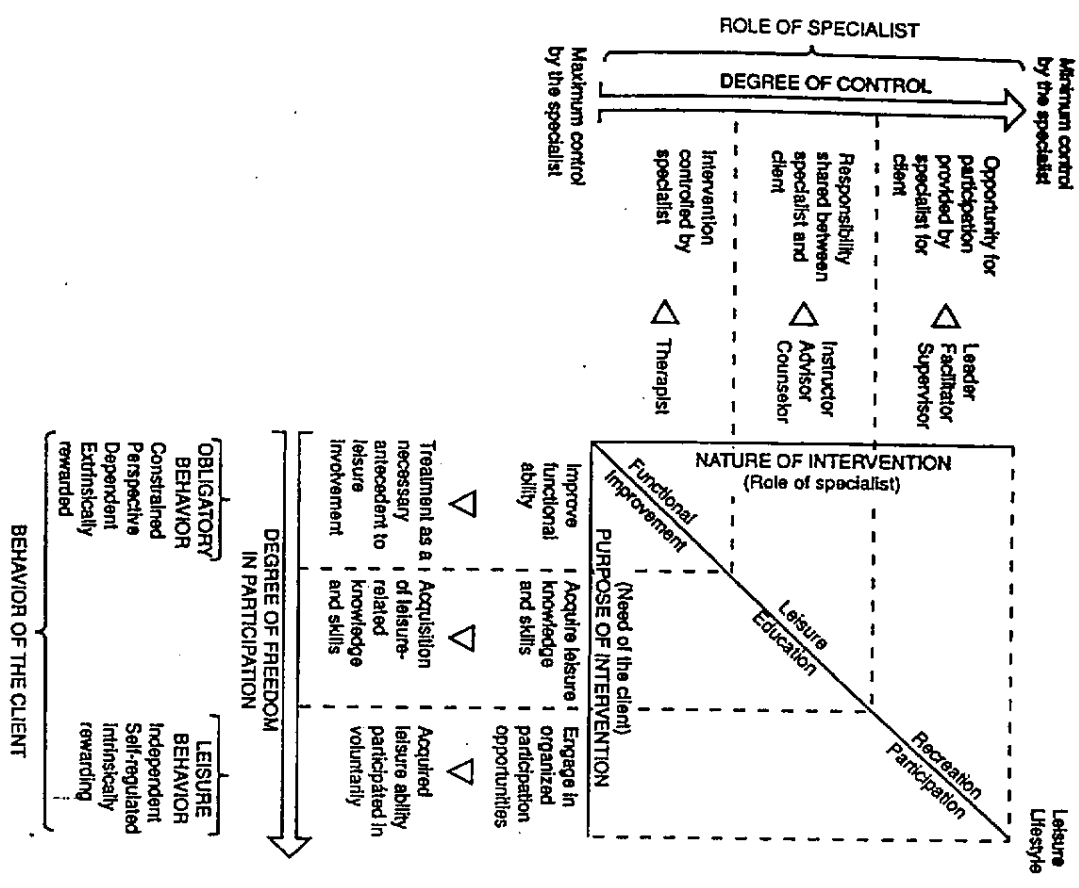


FIGURE 1. THE NEW LEISURE ABILITY MODEL

behavior toward achieving a positive and satisfying leisure lifestyle. Figure 1 displays the Leisure Ability Model.

Treatment Services

Treatment services are provided based on client deficits in four functional domains re-

lated to leisure involvement: (a) physical, (b) mental, (c) emotional/affective, and (d) social. Deficits in these areas prevent the client from participating fully in recreation and leisure activities; that is, they are prerequisite to the client's successful, daily involvement in lei-

sure. For the most part, the deficits represent

Therapeutic Recreation Journal

functional limitations that typical counterparts (individuals without disabilities and/or illnesses) would not experience. For example, a child with behavior disorders may have social skills deficits (hitting, kicking, scratching) to the degree that this individual cannot participate with others in a socially acceptable manner. Until these disruptive behaviors are minimized or replaced by appropriate social behaviors, the child will not be very successful in learning about or experiencing leisure. These deficits need to be improved, at least to an acceptable minimal level, prior to the client's involvement with others. Another example might be seen in a physical medicine unit with an individual with a traumatic/acquired brain injury. This individual may have severe limitations in attention span. Until this person's attention span can be increased, it will be difficult for the person to learn/re-learn recreation activities, especially those that involve rules, strategies, and specific modes of play. Treatment services help improve functional limitations that prevent the individual from improving their leisure-related awareness, knowledge, skills, abilities, and involvement.

During treatment services, the client generally has less control over the intent of the programs and is dependent on the professional judgment and guidance provided by the specialist. The client experiences less freedom of choice during treatment services than any other category of therapeutic recreation service. The role of the specialist providing treatment services is that of therapist. Within treatment services, the client has minimal control and the therapist has maximum control. The specialist typically designs the client's level and type of involvement, with considerably little input from the client. In order to successfully produce client outcomes, the specialist must be able to assess accurately the client's functional deficits; create, design, and implement specific interventions to improve these deficits; and evaluate the client outcomes achieved from treatment programs.

The ultimate outcome of treatment ser-

vices is to eliminate, significantly improve, or teach the client to adapt to existing functional limitations that hamper efforts to engage fully in leisure pursuits. Often these functional deficits are to the degree that the client has difficulty learning, developing his or her full potential, interacting with others, or being independent. The aim of treatment services is to reduce these barriers so further learning and involvement by the client can take place.

Leisure Education

Leisure education services focus on the client acquiring leisure-related attitudes, knowledge, and skills. Participating successfully in leisure requires a diverse range of skills and abilities, and many clients of therapeutic recreation services do not possess these, have not been able to use them in their leisure time, or need to re-learn them incorporating the effects of their illness and/or disability. Leisure education services are provided to meet a wide range of client needs related to engaging in a variety of leisure activities and experiences. "Leisure education is a process through which people go in order to become self-determining or independent in their leisure" (Howe, 1989, p. 207).

Leisure education has four components: (a) leisure awareness, (b) social interaction skills, (c) leisure activity skills, and (d) leisure resources. Leisure awareness services focus on the cognitive appreciation of leisure. Content in this area may include, but is not limited to: (a) knowledge of leisure, (b) self-awareness in relation to leisure, (c) leisure and play attitudes, and (d) related participatory and decision-making skills. It is felt that these four subcomponents represent areas of understanding that are needed to appreciate fully the importance of and need for leisure involvement. These four areas can be taught separately, or in combination, as the client's needs and abilities dictate. For example, the client may need assistance in identifying his or her strengths that can be

used for leisure, or need instruction in making decisions and taking responsibility for his or her leisure involvement. The relationship between this area and the previous discussion of internal locus of control, personal causality, and choice is obvious.

Social interaction skills include: (a) dual, (b) small group, and (c) large group social skills. Since much of leisure involvement is social by nature, acquisition and application of a variety of social skills in a diversity of settings appears to be important for clients to be able to function fully in their leisure time. Examples of social abilities that can be taught range from conversational skills, to assertion and empathy skills, to hygiene, grooming, and etiquette. Again, client deficits and needs determine which social skills become part of the leisure education instructional program.

Leisure activity skills include traditional leisure skills and non-traditional leisure skills. The intention of specifying these two categories, rather than other schematics of leisure activities, is to bring to the forefront the concept of a repertoire of diverse leisure skills in the largest sense. In order for a person to enjoy leisure fully, the individual should possess a wide range of activity skills—from organized and competitive skills to relaxing and contemplative skills—in alignment with his or her age, culture, preferences, lifestyle, and the like. This means that traditional leisure skills (for example, bowling and badminton) are taught simultaneously with non-traditional skills (for example, computer games and pet care), so that the individual can experience choice, personal freedom, and diversity in selecting leisure involvement opportunities.

Leisure resources include: (a) activity opportunities, (b) personal resources, (c) family and home resources, (d) community resources, and (e) state and national resources. Leisure resource programs are provided to individuals who may not have the knowledge or experience of locating opportunities for future independent leisure involvement. Lei-

sure resource information is an important link to help the client be able to connect with activities and opportunities in his or her home, neighborhood, community, state, and potentially, the nation. For example, leisure resource programs may teach a client how to use a telephone book for locating information about a certain activity, how to find tourist information about a specific destination, or how to use an ATM after banking hours. Leisure resource programs teach both the knowledge of the resource and skills about how to use the resource for future leisure involvement.

Each of these four areas (leisure awareness, social interaction skills, leisure skills, and leisure resources) represent content that is important to satisfying leisure involvement and may be areas of need for clients. The client begins to take a more participatory and involved role during leisure education programs, with a stronger personal responsibility for the outcome and future application of skills and knowledge. The role of the specialist during leisure education programs varies depending on the needs of the clients and the intent of the programs, but generally includes the roles of instructor, facilitator, and/or counselor. The specialist generally teaches clients new knowledge or skills, and aids them in discovering personal attitudes and values. The client is then responsible for applying this information for the improvement of his or her own leisure lifestyle.

The overall outcome sought through leisure education services is a client who has enough knowledge and skills that an informed and independent choice can be made for his or her future leisure participation. Leisure education means increased freedom of choice, increased locus of control, increased intrinsic motivation, and increased independence for the client.

Recreation Participation

Recreation participation programs are structured activities that allow the client to practice newly acquired skills, and/or experi-

ence enjoyment and self-expression. These programs are provided to allow the client greater freedom of choice within an organized delivery system and may, in fact, be part of the individual's leisure lifestyle. For example, after teaching clients the card game of Euchre in a leisure activity skills/leisure education program, the specialist may organize a holiday Euchre tournament in which clients can choose to participate, practice Euchre skills, and interact socially with other clients.

The client's role in recreation participation programs includes greater decision-making and increased self-regulated behavior. The client has increased freedom of choice and his or her motivation is largely intrinsic. In these programs, the specialist is generally no longer teaching or "in charge" per se. The client becomes largely responsible for his or her own experience and outcome, with the specialist moving to an organizer and/or supervisor role.

Client outcomes of involvement in recreation participation programs are highly individualistic. Outcomes may include areas such as: (a) increased ability to assume responsibility for personal leisure participation, (b) increased ability to make and follow-through with decisions regarding leisure involvement, (c) increased competence in leisure skills through practice and participation, and (d) increased sense of mastery through attainment and performance of skills.

Leisure Lifestyle

The concept of a leisure lifestyle is a very complex one. It is much more than a handful of activity skills and informational brochures. As noted by Iso-Ahola (1980), simply learning leisure activity skills does not create a satisfying, intrinsically motivating, or enjoyable leisure lifestyle. Leisure lifestyle means the client:

- has reduced major functional limitations that prohibit or significantly limit

- leisure involvement (or at least has learned ways to overcome these barriers);
- understands and values the importance of leisure in the totality of life experiences;
- has adequate social skills for involvement with others;
- is able to choose between several leisure activity options on a daily basis, and make decisions for leisure participation;
- is able to locate and use leisure resources as necessary; and
- has increased perceptions of choice, motivation, freedom, responsibility, causality, and independence with regard to his or her leisure.

These outcomes are targeted through the identification of client needs, the provision of programs to meet those needs, and the evaluation of outcomes during and after program delivery. A therapeutic recreation specialist designs, implements, and evaluates services aimed at these outcomes.

Examples of Utilization of Model in Practice

Numerous examples of applications of the Leisure Ability Model are located in Peterson and Gunn (1984). Based on the three major components of service, the text literally gives scores of practical examples of therapeutic recreation goals, programs, and anticipated outcomes.

Briefly, two case examples will be outlined here to illustrate the utility and flexibility of the Model. The first example involves young adults on a physical medicine and rehabilitation unit who have experienced traumatic spinal injuries as a result of automobile accidents, diving injuries, and gunshot wounds. The therapeutic recreation specialist has likely designed a program based on general client needs, as well as knowledge about the basic requirements for a satisfying leisure lifestyle. For example, treat-

ment programs might include activities that increase endurance, sitting or standing tolerance, and strength, as these skills are prerequisite to many leisure and recreation activities and are typical deficits of individuals with new spinal injuries. Leisure education programs may focus on: (a) self-awareness in relation to clients' new status; (b) learning social skills such as assertiveness, coping, and friendship making; (c) re-learning or adapting pre-morbid leisure skills; and (d) locating leisure resources appropriate to new interests and that are accessible. Recreation participation programs may involve practicing a variety of new leisure and social skills in a safe, structured environment. In designing and implementing these programs, the specialist builds in opportunities for the individual to exercise control, mastery, intrinsic motivation, and choice. The ultimate outcome would be for each client to be able to adapt to and cope with individual disability to the extent that he or she will experience a satisfying and independent leisure lifestyle, and be able to master skills to achieve flow.

A second example involves individuals diagnosed with depression in an outpatient clinic. The therapeutic recreation specialist, understanding the typical characteristics of individuals with depression and the features of a successful leisure lifestyle, conceptualizes, creates, implements, and evaluates programs that aid clients in developing satisfying leisure pursuits. For example, treatment programs may include working on the ability to make decisions as needed, and an exercise program to address loss of energy and frequent fatigue. Leisure education programs may focus on: (a) the identification of leisure barriers preventing individuals from enjoyable leisure; (b) learning social skills such as initiation and assertiveness; (c) learning new leisure skills that include physical exercise, leisure partners, and stress release; and (d) learning about local recreation facilities of interest to individual clients. Recreation participation programs (if provided on an outpatient basis) may include involve-

ment in a variety of activities that provide meaningful, healthy opportunities that provide a sense of competence, mastery, control, and choice. The targeted outcome would be for each individual to become competent in making decisions that result in healthy, satisfying leisure pursuits, both as an individual and with others.

Numerous other examples could be provided that would outline the purpose, process, and outcomes of the Leisure Ability Model. In practice, the development of program and diagnostic protocols addresses this need and provides standardized frameworks for the provision of services. Many professionals in therapeutic recreation, through the National Therapeutic Recreation Society and the American Therapeutic Recreation Association, are working currently on the development of standardized protocols that are based on the Leisure Ability Model.

Strengths of the Leisure Ability Model

One of the strengths of the Leisure Ability Model is its extensive use in the field of therapeutic recreation. Sylvester (1989) acknowledged that the Leisure Ability Model has played a significant role in the development of the field and "gave guidance to practice and impetus to professionalization" (p. 6).

Formed during a period when organizational stability was crucial, the [Leisure Ability Model] has served an important developmental function. By defining occupational roles and relationships, it has provided direction for such activities as ethics, research, standards, education, and credentialing, none of which can be pursued logically and credibly without at least the appearance of theory to guide them. (Sylvester, p. 5-6)

The Model has played an important role in

these professionalization functions. For example, the Leisure Ability Model is referenced in both the National Council for Therapeutic Recreation Certification's (NCTRC) 1997 certification examination content outline, and in the National Recreation and Park Association/AALR's Council for Accreditation educational accreditation standards. Despite its many critiques, the continued support and use of the Model speaks to its acceptability and utility in practice.

Another strength is the Model's flexibility. One level of flexibility is with the three components of service. Each component of service is selected and programmed based on client need. That is, some clients will need treatment and leisure education services, without recreation participation. Other clients will need only leisure education and recreation participation services. Clearly, services are selected based on client need. In addition, programs conceptualized within each service component are selected based on client need. The earlier two examples (traumatic spinal injuries and depression) illustrate this concept. While the examples outline programs in each of the three areas of service, each example illustrates specific content that differs based on client needs or deficits. These levels of flexibility allow the specialist to custom design programs to fit the needs of every and any client group served by therapeutic recreation. The ultimate goal of leisure lifestyle remains the same for every client, but since it is based on the individual, how the lifestyle will be implemented by the individual and what it contains may differ. As such, the content of the Leisure Ability Model is not specific to any one population or client group, nor is it confined to any specific service or delivery setting. Some authors, including Kinney and Shank (1989), have reported this as a strength of the Model.

Another strength of the Model lies in the overall targeted outcome of therapeutic recreation services; that is, successful, independently chosen leisure participation. This

focus on "quality of life" issues is more encompassing than a "functional gains" focus. Leisure Ability includes functional gains, but is not limited to that service area alone. Kinney and Shank (1989) reported on two upcoming shifts in health care. The first is that individuals in clinical settings, such as hospitals, are more "critically ill" and therefore, have little time or energy to devote to anything other than immediate medical needs. Second is the shift toward more community-based health settings, such as home health, where "the emphasis of service shifts to a more general 'quality of life' service as opposed to specific physical or behavioral interventions" (Kinney & Shank, p. 327). Austin (1997) also noted the shift to more community-based services, including schools. The Leisure Ability Model recognizes that client groups with diverse needs are served in a variety of settings, and it is able to address these varying needs through three areas of service.

Critiques of the Leisure Ability Model

Sylvester (1989) in a thesis about the need for philosophical debate and theoretical support in therapeutic recreation, noted that the Leisure Ability Model "is not a body of theoretical knowledge, nor has it generated the philosophical grounds upon which to erect one" (p. 6). Numerous authors in the field (cf. Compton, 1989; Gruver, 1994; Hemmingsway, 1987; Mobily, 1985a, 1985b; 1985c; Sylvester, 1985a, 1985b, 1987) have noted that several of the terms associated with the Leisure Ability Model and other models of therapeutic recreation service are ill-defined or lacking a philosophical bases. "The philosophy underlying these terms appear rather shallow and without firm foundation" (Compton, p. 488). In a sweeping statement about the whole of the profession, Sylvester (1989) stated "therapeutic recreation has not attended to its intellectual chores, preoccupying itself instead with im-mediate concerns of practice" (p. 6).

Ability Model on the basis that is espoused a leisure behavior orientation, instead of the therapy orientation. "A number of authors have objected to the [Leisure Ability Model], having observed that its all-encompassing approach is too broad and lacks the focus needed to direct a profession" (Austin, p. 147). Austin advocated an alignment of therapeutic recreation with allied health and medical science disciplines, rather than leisure and recreation professionals.

Sneegs (1989), while not directly critiquing the Leisure Ability Model, cautioned that examining and measuring the leisure behavior of individuals with disabilities and/or illnesses is difficult and fraught with multiple complexities. She presented several scenarios that illustrate that measuring or examining the leisure behavior of individuals with disabilities and/or illnesses is made even more difficult by the presence of the disability or illness, as well as other related methodological issues or constraints. However, according to Peterson and Gunn (1984, p. 25), "[n]ondisabled individuals were studied to determine components of successful leisure" for development of the Leisure Ability Model. Given that the Leisure Ability Model is based on non-disabled adult leisure behavior, then it may follow that there are inherent weaknesses in the conceptual underpinnings of 'normal, adult leisure behavior,' especially when extrapolated to individuals with disabilities and/or illnesses.

Since its conception, Peterson and Gunn (1984) have acknowledged the inherent limitations of the Leisure Ability Model. To paraphrase their words about the leisure education component of the Model:

All models have conceptual weaknesses. This is particularly true of a model that attempts to describe a phenomenon as complex as leisure and an area in which so little agreement related to definition exists. The [Leisure Ability Model] is thus subject to

tions. Nonetheless, its conceptualization and the resulting components and content have proven to be useful in the design of . . . programs for diverse populations in a variety of settings. (p. 25)

However, a number of strengths also have been acknowledged. These include continued and widespread use in the field; flexibility in meeting the needs of diverse client groups; and a focus on larger issues such as satisfaction, quality of life, and self-determination.

Future and Continued Development of Model

The Leisure Ability Model has stood the test of time, in a sense, by being used in the therapeutic recreation profession for nearly two decades. The Model continues to evolve as the profession develops further its knowledge base about the behavior, needs, and directions of individuals with disabilities and/or illnesses in relation to their leisure. Some changes in the Leisure Ability Model that are being made within the third edition of the Therapeutic Recreation Program Design text include a re-naming of the Treatment component to Functional Improvement. It is felt that Functional Improvement more closely reflects the actual content of this area. In addition, "treatment" is a rather generic term that implies a goal-directed intervention process that brings about behavioral change in the client regardless of content. So, for example, both Leisure Education and Recreation Participation services may, in fact, be "treatment" in that they may be goal-directed, and client outcome-driven.

A second change includes a re-conceptualization of the Social Skills sub-component of the Leisure Education Content Model. Rather than the former categorization of Dual, Small Group, and Large Group skills, the new content includes Communication

social Presentation. The third edition outlines the specific content under each of these. These areas were changed based on the current literature in the field, as well as the need for more client-directed content in this area. Both of these modifications were considered based on client need and evolving current practice.

However, more empirical research is needed to ground the Model in theory. All professionals in the field become responsible for providing the anecdotal and data-based research necessary to continue to support the Model. Through the efforts of scholars and professionals in the field, it is believed that this needed work will occur.

As such, other changes in the Model are much more difficult to predict. These changes will reflect the nature of health and human services which, at this writing, are going through a period of great turmoil and rebirth. It is likely that major areas more specifically addressing health and wellness will be added, as health care moves toward a more preventative and self-care model. These may include greater emphasis on stress management, health behavior management, and risk factor reduction. It is believed by these authors that health, wellness, and leisure are intricately enmeshed, and the roles they play in individuals' lives is of utmost importance. The relationship of these concepts to that of quality of life and life satisfaction needs to be further explored and studied.

Other societal changes, such as information and technology transfer, also will impact the profession and the models it supports. Changes in communication, entertainment, and information technologies (such as Web television, the Internet, and computer simulations) will greatly impact the lifestyle of many individuals and affect how they spend their leisure time. The concepts of "virtual time" and "personally controlled time" (such as when the individual determines when he or she will watch a program recorded on a VCR) will become pronounced

ing at work and being at leisure. All of these changes and more will impact the future of the Leisure Ability Model. It is the responsibility of all professionals within the discipline to test, support, dispute, and critique all models of service until greater working consensus is gained.

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