Textbook Conceptualizations of Therapeutic Recreation: A Discourse Analysis

by

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Abstract

There has been ongoing debate in therapeutic recreation (TR) regarding the role of recreation as a means to an end, or as an end in itself since the field emerged in the early 1900s. The roots of the field are in both hospital and community recreation, and despite numerous attempts over the last century, there has been no clear commitment to either the 'means to an end' or 'end in itself' conceptualization of TR. The purpose of the study was to understand how therapeutic recreation practices are constructed and reproduced in TR textbooks, with attentiveness to hidden discourses. Using constructivism as a guiding paradigm and critical disability studies as a conceptual framework, a discourse analysis was conducted on two popular TR textbooks. A multi-step approach was used to find textbooks used in recent TR undergraduate education, and the two texts with the highest frequency of use were selected for analysis. These were Stumbo, N. J., & Peterson, C. A. (2009). *Therapeutic recreation program design: Principles and procedures* (5th ed.), New York, NY: Pearson, and Anderson, L., & Heyne, L. (2012b). *Therapeutic recreation practice: A strengths approach*, State College, PA: Venture Publishing, Inc. The introduction chapter(s) of each text were analysed, as this was where the author's conceptualization of TR was explained. The language of each textbook was deconstructed to expose the social structures and ideologies behind the assumptions and implicit meanings in the text. Analysis took place at a word, sentence, paragraph, and entire text level, in order to capture both small and over-arching episodes of meaning. Using a critical disability studies framework, respective thematic distinctions arose from each textbook: individual responsibility for health, professionalization of TR, and the medicalization of recreation; and being in relationship, disability as diversity, and solution focused. Conceptual differences between the two texts included the role of TR practitioners, the goals of TR services, and the qualities of those who access TR services. One conceptualization of TR had a medical, deficit orientation, while the other focussed on strength utilization. The two different

conceptualizations discovered in the texts highlights the existence of a divided field. However, also implied is that both conceptualizations have existed for this long because there are valid applications to both. A single perspective of TR may not be enough to capture the complexity of the field. Further research is needed to determine long-term leisure outcomes of either conceptualization, while reflexion of the field is needed to determine if accepting both conceptualizations is a viable way to unify the field.

Preface

Chapter 4 of this thesis has been submitted for publication as M. Ciesieslski and D. L. Goodwin, Hitting the books: Textbooks as cultural artifacts of a splintered field. I was responsible for the data collection and analysis as well as the manuscript composition. D. L. Goodwin was the supervisory author and was involved with concept formation and manuscript composition.

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CHAPTER 1
INTRODUCTION

The following is a paper-based thesis, completed as part of a master's degree in the faculty of Kinesiology, Sport, and Recreation, at the University of Alberta. Following the introduction chapter is a comprehensive review of the literature that pertains to my study. Chapter three contains a description of the research paradigm and methodology used in this study, as well as a detailed description of the methods. The research paper is presented in chapter four. My thesis closes with reflexions on the importance of the findings within the context of the literature, as well as a discussion of the limitations of the study.

From the first beginnings of therapeutic recreation (TR) in the 1930s to the present day, recreation therapists or therapeutic recreations specialists (TRS) have had a broad scope of practice (Austin, 2004; James 1998a). TR practitioners work within a variety of settings to increase participation in and access to recreation and leisure opportunities across the physical, emotional, cognitive, social, and spiritual domains (Alberta Therapeutic Recreation Association, 2020b). A TR practitioner may work in settings such as rehabilitation, addictions and mental health, acute care, community and home care, adult day programs, continuing care, and private practice (Alberta Therapeutic Recreation Association, 2020a). A typical day may consist of team meetings, patient/client[1] screening and assessment, individual and group therapy, supervising therapy assistants and volunteers, administration, family meetings, and planning and/or facilitating large recreation programs (Hutchinson et al., 2006).

Depending on the context and geographical area in which a TR practitioner works, there may be variations in job title; in addition to recreation(al) therapist and TRS, TR practitioners may work as recreation directors, recreation managers, diversional therapists or activity directors (Wozencroft et al., 2009). Sometimes these titles are linked to level of education.

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[1]'Patient' is a common term in clinical contexts, while 'client' or 'participant' is typical in community settings (Anderson & Heyne, 2012b). This may not be reflective of individual practitioner preferences or institutional guidelines.

Today, TR practitioners generally require a bachelor's degree to be considered a 'Recreational Therapist' or 'Therapeutic Recreation Specialist' (Austin, 2004). Registration and licensure are necessary in some provinces and states. Canada and the USA each have their own federal TR association, with many regional organizations throughout both countries.

Recreation and leisure are at the centre of TR practice. The difference between the terms is not always clear in the literature. However, when a distinction is made between the terms, recreation is generally seen as a non-work activity (e.g., knitting), while leisure is a "a much larger concept" that encompasses such things as emotional, psychological, social, and physical dimensions (Edwards, 1974, p. 26)

Leisure as an End in Itself

Leisure can be a difficult term to concretely define, but four key concepts highlighted in the TR literature are (a) leisure having intrinsic value, (b) connection to happiness and quality of life, (c) emphasis on freedom, and (d) utilizing one's strengths and capabilities (Hutchinson et al., 2006; Mobily, 2015a; Stumbo & Peterson, 2009; Sylvester, 1985). In addition to the four concepts above, engagement in leisure may lead to health or functional benefits. For example, if someone considers running to be an aspect of their leisure, their physical health will likely improve while engaging in leisure. However, these benefits are not the motivation for leisure engagement, because leisure is "good for its own sake" (Sylvester, 1985, p. 10).

The intrinsic value of leisure surpasses the basic needs of health, and is instead linked with the holistic concept of quality of life. Csikszentmihalyi (1990) believed that quality of life is determined by how individuals feel about themselves and what happens to them through experiences, such as leisure. TR researchers define quality of life as the holistic and subjective feeling people have about their overall state of being (Shank & Coyle, 2002). Quality of life is multi-dimensional (physical, emotional, cognitive, social, spiritual), as is TR (Alberta Therapeutic Recreation Association, 2020b). Quality of life is further related to life satisfaction, happiness, morale, and well-being (Janssen, 2004). Hutchinson et al. (2006) argued that an

often over-looked, but nevertheless, essential, part of the TR practitioners' job is to foster enjoyable experiences, because enjoyment of activities will lead to improved quality of life. Improvements to quality of life do not necessitate functional improvements, therefore, neither does increased leisure engagement (Sylvester, 1985).

Freedom – including freedom to choose activities and freedom from obligation – is an essential part of leisure (Kleiber et al., 2011; Mobily, 2015a; Sylvester, 1985). Mobily (2015a) argued that when people do not have freedom when engaging in activities, leisure cannot occur. Sylvester (1985) pointed out that oftentimes in therapy, an activity is chosen (prescribed) for an individual to complete. TR involving activity prescription is therefore at odds with achieving leisure experiences (Sylvester, 1985). However, a newer approach in TR is to use 'strengths-based' practice in order to foster leisure experiences (Anderson & Heyne, 2012a; 2012b). Participant choice is an essential part of strengths-based TR practice. The strengths-based approach originated in the field of social work and was more recently adopted in TR (Weick et al., 1989). The focus in strengths-based practice is what participants would like to engage in and achieve, highlighting the free choice and self-efficacy aspects of leisure (Anderson & Heyne, 2012b). For example, a TR practitioner may discover that a participant dreams of going sailing again after an injury. The practitioner would then work with the participant to realize this goal by finding grants and accessible equipment, coordinating with other supports, practicing sailing skills with the participant, and creating a plan for the day (Anderson & Heyne 2012b). Although a recreational activity (sailing) is involved, the activity of sailing has the potential to become a leisure experience, because it is something the participant has freely chosen, is intrinsically motivated to participate in, and truly enjoys. This example highlights a conceptualization of TR in which leisure and the participant's choices guide the TR plan from a strengths-based perspective that "intentionally include environmental approaches as well as approaches that focus on the individual participant" (Anderson & Heyne, 2012b, p. 130). Strengths-based practice and TR will be further explored in the literature review.

Recreation as Therapy

Another conceptualization of TR is to use recreational activities as therapy, or means, something "that contributes to the attainment of an end" (Sylvester, 1985, p. 9). Recreation is a tool to improve specific functions; drawing from a deficit reduction approach, functional outcomes are prioritized over leisure engagement (Austin, 2014; Mobily, 2015a). Recreational activities are specifically chosen by the TR practitioner to reduce an assessed deficit in the individual, regardless of patient preferences (Mobily, 2015a). To contrast with the above example of sailing as a leisure experience, sailing may be prescribed by a TR practitioner to a participant to improve various functions, for example physical strength, balance, or agility. Although the participant may enjoy the activity, reducing perceived deficits is the prescribed reason for engagement in the activity, not their enjoyment. TR researchers point out that activity *prescription* is incongruent with the ideas of leisure, such as free choice, enjoyment, and intrinsic motivation (Hutchinson et al., 2006; Mobily, 2015a; Sylvester, 1985). However, there is ample evidence from TR researchers for the functional improvements that engaging in recreation can provide, such as improving grip strength (Buettner et al., 1996), physical fitness (Saposnik et al., 2010), and Mini Mental State Examination scores (Buettner, 2012).

Austin (2014) wrote that TR practitioner must focus on using recreation a therapeutic tool with a goal of functional improvement in order to distinguish themselves from recreation practitioners and align with other allied healthcare practitioners (physiotherapists, occupational therapists, speech-language pathologists; Sylvester, 1985). Other allied healthcare fields tend to be dominated by a medical perspective, with a focus on improving function and reducing deficits (Mobily, 2015a; Sylvester, 1985). As TR practitioners have reported feeling under-valued in the healthcare realm, some practitioners see imitation of more valued fields as a way to gain respect (Anderson & Bedini, 2002; Anderson et al., 2005; Briscoe & Arai, 2015; Sylvester, 1985).

The two conceptualizations of TR, strengths-based practice to optimize leisure, and (recreation) therapy as a means to reduce deficits, are demonstrative of the diversity of the field

of TR. Researchers have shown that there are benefits to participants who receive either type of TR interventions, and in some areas of practice, both conceptualizations of TR have been successfully incorporated. For example, in stroke rehabilitation, researchers found that while some therapists focused heavily on physical function (White et al., 2007), patients also expressed enjoyment of recreational activities, both as therapeutic and diversional activities (Luker et al., 2015). However, some TR researchers are postulating that those governing the organizational bodies of TR are largely promoting only the deficit reduction side of TR, leaving the focus on leisure behind (Dieser, 2005; Mobily, 2015a; Sylvester, 2015a).

The tensions between the two conceptualizations of TR leaves those who educate future TR professionals in the middle of an unresolved question of what should be included in post secondary curricula. The authors of the American Therapeutic Recreation Association's (ATRA) task force on higher education has recently reported "that the most current and pressing need in higher education is to improve the quality and consistency of the bachelor's degree" (Hawkins et al., 2018, p. 4). Mobily (2015a) and Dieser (2013) have previously voiced their concerns about implementing standardized curriculum in TR, worrying that a standardized curriculum would lack cultural sensitivity, and default to a medical focus on increasing function.

van Puymbroeck et al. (2010) suggested that the future of TR will be determined by the curriculum provided by TR faculty to students in their degree granting programs. Part of this curriculum will be influenced by the textbooks used in teaching undergraduate students, as textbooks represent a "surrogate curriculum, that is, a reflection of a sometimes undocumented curriculum" (Venezky, 1992. p. 437). Although a textbook may be chosen as the best fit for a course, the textbook will likely contain ideas that are not represented in the curriculum, and vice versa. Because of this, the 'surrogate curriculum' of textbooks does not exactly mirror the needed or desired curriculums of the courses in which they are used. Venezky (1992) noted that a single set of curriculum guidelines could be represented by an infinite number of textbooks, "each with its own interpretation of the guidelines" (p. 437). Therefore, even if a standardized

curriculum was enacted in TR, there will still be wide diversity in what students learn, dependent partly on the instructor's choice of textbook.

Some researchers suggest that textbooks fail to promote multiple perspectives on issues of importance to the areas of study and their use may actually weaken critical thinking skills and the ability to reflect critically on what one has learned (Errington & Bubna-Litic, 2015). Part of the reason that textbooks may limit the development of critical thinking skills could be that textbooks are often largely uncritical reproductions of previous textbooks (Paul, 1988). Errington and Bubna-Litic (2015) also explained that textbooks tend to contain historically fixed perspectives presented as fact, with little room for alternative points of view, limiting the need for students to critically assess what they are reading. Venezky (1992) noted that textbooks tend to contain socially conservative ideas in order to appeal to as wide of audience as possible. Textbooks that contain potentially inflammatory ideas are unlikely to sell well, and are hence censored by publishers (Errington & Bubna-Litic, 2015; Venezky, 1992).

Part of what students learn from textbooks may be through the latent or hidden curriculum the texts contain. Hidden curriculum reflects the meanings and values of society, and the specific field one is studying (Cowell, 1972; Venezky, 1992). This latent information is unlikely to be overtly recognized by either teachers or students, but nonetheless will affect the student's future practice (Cowell, 1972). Through both the potential limits to critical thinking and the hidden curriculum, students may accept ideas through textbooks without reflection. Examining textbooks can therefore provide insight into both what students may learn from them, and how the texts reflect society at large. At a time when the professional and educational future of TR is heading for change, an examination of TR textbooks can shed light on both where the profession has been, and where it might be headed. The purpose of the study then, is to understand how therapeutic recreation practices are constructed and reproduced in TR textbooks, with attentiveness to hidden discourses.

CHAPTER 2
LITERATURE REVIEW

Sylvester (1985) wrote that TR practitioners have spent the greater part of the last century trying to establish a professional identity, or perhaps, a cohesive professional identity. Establishing a professional identity is challenging in TR because of the diversity of the field, from the range of setting TR practitioners work in, to the populations with which they work. The roots of the field are also varied. The field of TR originated in two areas; recreation as rehabilitation in veteran hospitals and community recreation movements for social justice, which eventually converged together, although not seamlessly (James, 1998a, 1998b; Mobily & Dieser, 2018).

The diversity of the field has led to two main conceptualizations of TR. One is that TR practitioner should support the creation of leisure experiences, utilizing an individual's strengths and desires. The other is that recreation should be used as therapy for functional improvements and deficit reductions. Each conceptualization will be discussed below, followed by a discussion of the factors that support the prevalence of one conceptualization over the other. Finally, literature pertaining to education in TR will be reviewed and discussed in light of the divergent conceptualizations apparent in the field.

Leisure and Strengths-Based Practice

The focus of strengths-based TR is to utilize a participant's strengths to foster leisure experiences and improve quality of life (Anderson & Heyne, 2012a; 2012b). The heart of strengths-based practice is the development of a caring relationship between practitioner and participant, and a commitment from the practitioner to help others recognize and utilize their strengths (Weick et al., 1989). Strengths-based practice was initiated in the field of social work by those who were concerned about the negative effects that problem focussed practice was having on participants, namely, that focussing solely on problems was too narrow a focus to create real, positive, lasting change in an individual's life (Weick et al., 1989). Focussing on what

an individual could not do was no more successful in improving the quality of their life than focussing on what they could do (Weick et al., 1989). Weick et al. (1989) presented to the field of social work the concept of focussing on a person's personal *and* community strengths and resources (over of their diagnosis or problems). The concept has transferred to TR, where practitioners expressed similar concerns about deficit-focussed practice (Anderson & Heyne, 2012a; Mobily, 2015a).

In the strengths-based approach, TR practitioners consider the holistic quality of life of participants rather than just specific functions (Anderson & Heyne, 2012a; 2012b). The development of partnerships between participant and practitioner is important, as is the happiness and enjoyment of the participant (Hutchinson et al., 2006). Free choice is considered an integral aspect of leisure, so the participant's choice of activities is incorporated as much as possible into the TR intervention (Anderson & Heyne, 2013; Kleiber et al., 2011). Rather than activities being prescribed by the therapist, choices are made jointly between the participant and therapist, with a focus on the participant's strengths and interests (Anderson & Heyne, 2012b, 2013; Hutchinson et al., 2006). Participants become experts in their own lives alongside TR practitioners, and TR practitioners work to create accessible community opportunities for recreation rather than focus strictly on reducing individual deficits. With this in mind, as long as 50 years ago, it was recognized that TR practitioners may go beyond focusing on the so-called shortcomings of their participants and create inclusive opportunities for recreation. The responsibility of the TR practitioner is "to reorient social and physical environments that handicap individuals via discriminating attitudes, architectural practices and approaches to transportation" (Witt, 1977, p. 40).

The Social Model of Disability

Witt's (1977) work was ahead of its time, as the social model of disability was only just being developed at the time he was calling for TR practitioners to challenge environmental barriers (Shakespeare, 2006). The social model of disability was established as a rejoinder to the

medical (individual) model of disability, in which disability was viewed as an individual problem that medical intervention could ameliorate (Oliver, 1990). In the 1970s, the Union of the Physically Impaired Against Segregation published a document in the United Kingdom that laid the foundation for the social roots of disability, calling disability a "situation, caused by social conditions" and that social change was required to reduce the imposition of disability (UPIAS, 1976, p. 3). Oliver (1990) expanded upon the idea that disability emanated from socially imposed conditions and created the social model of disability.

In the social model, disability is recognized as being socially constructed, meaning that 'being disabled' is defined by humans, rather than being a natural phenomenon (Crow, 1996; Haegele & Hodge, 2016). While there are multiple forms of the social model, or "social-contextual approaches" (Shakespeare, 2006, p. 54) the basis of these models is that disabled people are oppressed by an inaccessible society, not by their impairments (Withers, 2012). Another tenet of the social model is that impairments are differentiated from disabilities, impairments being tangible differences in a person's body, for example, someone may have the impairment of not having legs, but only be disabled when faced with a set of stairs (Oliver, 1990). Disablement occurs when people are excluded from areas of life such as "employment, housing, education, civil rights, transportation, negotiation of the built environment, and so forth" (Thomas, 2014, p. 10). When the tenets of the social model are applied to TR, the goal is full inclusion in the areas of leisure, via a reduction in social and environmental barriers (Anderson & Heyne, 2013; Witt, 1977). Sylvester (1985) highlighted that while a TR practitioner may reduce impairments using recreation, this is not the same thing as reducing disabling factors of the environment in order to foster leisure.

Critiques of the social model revolve around the idea of impairment and a homogenizing of the disability experience (Crow, 1996; Oliver, 2013). Those critical of the social model claim that its proponents "deny the body" (Shakespeare, 2006, p. 51), or a denial that impairments do cause problems and pain for those who experience them. Oliver (2013) agreed that there are

limitations to the social model; however, he argued that through its singular focus on disability as a result of social conditions, a united front is created among disabled people to fight for political and social change. A strengths-based approach in TR does not deny the existence of restrictions or problems related to impairment, but the focus is not on 'fixing these problems' at an individual level. Instead, participants are asked what they can and want to do for leisure, and change is focused on an interactional environmental level (Anderson & Heyne, 2013).

Recreation to Reduce Deficits

Under the deficit-reduction conceptualization of TR, TR practitioners focus on using recreation to reduce impairments and functional limitations (Mobily, 2015a). Functional intervention is often seen as preliminary step in the TR process, based on a popular TR practice model, the Leisure Ability Model (Stumbo & Peterson, 1998, 2009; see Appendix A). The model presents a progression of therapy and functional improvement to counselling and leisure education to resource provision and recreation participation. The initial focus on functional intervention is part of a stepping-stone therapy program, requiring patients to first improve their individual skills, and eventually transfer these skills to an independent leisure practice (Stumbo & Peterson, 2009).

At the functional intervention stage, the focus is predominantly on creating individual change (Mobily, 2015a). A TR practitioner may choose an activity which they think will be fun or enjoyable for the 'patient'; however, therapeutic goals are prioritized over enjoyment. Hutchinson et al., (2006) presents a case study in which a patient is prescribed the task of beading in order to work on fine motor skills, despite a stated dislike of such activities. Although the patient's fine motor skills did show improvement, the patient did not enjoy the activity and had no desire to continue with beading as a leisure activity. Oliver (1990) noted that a focus on functional limitations is a defining feature of what he called the "individual model" or medical model of disability (p. 1). Mobily (2015a) also considered deficit reduction TR to fit within a medical model of disability, due to the focus on individual functioning interventions.

The Medical Model of Disability

The medical model of disability arose in the 19th century as healthcare providers focussed increasingly on linking specific symptoms of patients with specific biological causes (Fisher & Goodley, 2007). Once the biological cause of ill health is found, physicians and other healthcare practitioners can set about fixing it (Fisher & Goodley, 2007). The medical model is popular among both healthcare practitioners and patients as it is "effective in fighting disease and treating pain" (Filc, 2004, p. 1276). Individual biological factors are the main focus of the medical model, and social factors that may contribute to disability are a secondary consideration (Filc, 2004). As such, interventions are focussed primarily on creating individual change, rather than social change. Individuals are responsible for their health, therefore, experiencing disease or disablement may be seen as a result of 'bad habits' of the individual rather than a result of social or environmental factors (Filc, 2004).

For those practicing under the medical model "the goal is to restore the disabled person to a state that is as near normality as possible" (Oliver, 1990, p. 4). The idea of being normalized – able to emulate what is considered normative functional ability – may be attractive to many people with impairments because people with nondisabled bodies are able to attain numerous benefits not awarded to people with impairments (van Amsterdam et al., 2015; Scully, 2010), but it is not without controversy. Problems regarding one's self-worth and overall mental health may result if normative function is touted as the best outcome of therapy and not achieved (McRuer, 2002; Scott, 2015). People undergoing rehabilitation, and their therapists, may have the compulsion to achieve the ideal body (the normate), leading to adherence to a function-focussed, deficit-reducing conceptualization of TR. The medical model is apparent in Austin's (2002) perspective on TR, as the author states that the "primary aim of…*recreational therapists* was not the provision of a recreation experience, but the use of activities to ameliorate pathology and, ultimately, to rehabilitate the individual" (p. 277).

The medical model remains the dominant model in most of Western healthcare (Filc, 2004). Illich et al. (2011) suggested that in the last century, the importance of 'health' has risen in conjunction with the authority of physicians, and other health professionals. They wrote that as the dominant profession in society changed from the clergy to the law to medicine, "robes remained, but changed from red to black to white" (Illich et al., 2011, p. 62). The dominance of physicians has had far reaching effects across both society and healthcare specifically. Allied healthcare professionals may imitate physician practices in order to share in the prestige and respect granted to physicians (Filc, 2004). Illich et al. (2011) explained that physicians (and allied healthcare professionals) have worked to create dominance by deeming particular experiences as health problems in need of intervention, and then establishing exclusivity over the treatment, such as physicians' largely exclusive ability to prescribe medications. If TR practitioners can establish leisure as their exclusive domain to provide interventions in, they may achieve more prestige in both healthcare and society.

Shifting Toward Medicalization

TR Organizations

Mobily et al. (2015) argued that there has been an increasing focus on the deficit reduction form of TR, even as the social model of disability has become more broadly known and accepted. To understand this focus, it is important to look back at the history of TR. As previously mentioned, TR grew out of both 'hospital recreation' and 'community recreation' practices (James, 1998a; Mobily & Dieser, 2018). These different streams of early TR were represented in the USA by a multitude of organizing bodies, eventually resulting in two national organizations: the National Therapeutic Recreation Society (NTRS) and the American Therapeutic Recreation Association. The NTRS reflected the 'leisure as an ends' side of TR, while the American Therapeutic Recreation Association came to represent those who desired TR to be a clinical, therapeutic practice (Mobily et al., 2015). However, in 2010 the NTRS was dissolved, leaving the American Therapeutic Recreation Association as the only governing body

for TR in the USA. Some argue that the American Therapeutic Recreation Association did not expand to include the views of those with a less medical mindset, but rather has increasingly promoted a deficit reduction conceptualization of TR, as reflected in their definition of TR (Mobily et al., 2015). Recreational Therapy is:

> Treatment services designed to restore, remediate and rehabilitate a person's level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. (American Therapeutic Recreation Association, 2017, para 2)

This definition places individual illnesses/conditions as the cause of activity limitations and is also void of any reference to leisure or quality of life (Mobily, 2015a). Similarly, the Canadian Therapeutic Recreation Association (CTRA) defines TR as "a health care profession that utilizes a therapeutic process, involving leisure, recreation and play as a primary tool for each individual to achieve their highest level of independence and quality of life" (CTRA, 2019, para 3). The deficit reduction conceptualization of TR is in contrast to a CTRA definition from just two years earlier:

> Therapeutic recreation is a profession which recognizes leisure, recreation and play as integral components of quality of life. Therapeutic Recreation is directed toward functional interventions, leisure education and participation opportunities. These processes support the goal of assisting the individual to maximize the independence in leisure, optimal health and the highest possible quality of life. (CTRA, 2017, para 3-4).

The latest definition from the CTRA highlights TR as a *health care* profession, and leisure, recreation and play are no longer integral components of quality of life but *tools* of a *therapeutic process*. The shift toward medicalized TR is apparent in Alberta as well. When Alberta Health Services mandated an increased focus on rehabilitation across the healthcare system, the Alberta Therapeutic Recreation Association sent a document out to all members

outlining function as a key health outcome, and the ways in which recreation therapists can promote function (Alberta Therapeutic Recreation Association, 2017). The first goal in the document was to "Integrate the rehabilitation philosophy throughout the healthcare system to improve patient and system outcomes" (p. 3) with deliverables given as 'function' being included in clinicians reports and charting, and incorporated into all care plans. Other parts of the document were focused on 'marketing' of TR as a valuable partner in community rehabilitation settings, on equal footing with other allied health therapists.

Processes of Professionalization

The professionalization of TR, including the creation of a regulatory college for practitioners, has been a main theme in the Alberta Therapeutic Recreation Association for at least the last decade (Alberta Therapeutic Recreation Association, 2019). TR practitioners in Alberta are not alone in their belief of a need for professionalism of the field. TR practitioners across Canada and the USA strive for increased professionalization and autonomy (Sylvester 2002). Sylvester (2002) wrote that a profession is characterized by three fundamental features:

> (1) specialized training in a field of codified knowledge, usually acquired by formal education and apprenticeship, (2) public recognition of a certain autonomy on the part of the community of practitioners to regulate their own standards of practice, and (3) a commitment to provide service to the public which goes beyond the economic welfare of the practitioners (p. 314-315).

Sylvester's (2002) ideas can be recognized in the rationale Hebblethwaite (2015) presented for TR professionalization, including ensuring minimum entry-level standards, advancement of the field, and protection of people who receive TR services. Hebblethwaite (2015) further wrote that professionalization is a way to protect those who access TR services, for example from unqualified practitioners who may cause psychological harm.

There has been a recent push to standardize and elevate undergraduate TR education, in order for practitioners to gain profession-specific "knowledge that is 'exclusive', 'profound',

'inaccessible' or 'not easily understood' by lay persons" (Siegrist, 2002, p. 12154). However, TR authors point out that a by-product of increasing professionalism has been an increasing adherence to the medical model of disability through a focus on creating, promoting and using standardized, evidence-based interventions to reduce assessed deficits (Carbonneau et al., 2015, Dieser, 2013; Mobily et al., 2015). Mobily (2015a) argued that efforts to professionalize TR have fallen into a trap of self-promotion. As medically-based TR gains traction in Canada, "leisure programmes with disabled persons provided for intrinsic reasons and enjoyment are branded as out of touch, unprofessional, or less important than physician ordered and 'medically necessary' recreation therapy" (Mobily et al., 2015, p. 49). Sylvester's (2002) third tenet of a profession – service to the public beyond the economic welfare of the practitioners – has largely been forgotten in the efforts to ensure that TR is seen as an economically viable profession (Mobily, 2015a). The American Therapeutic Recreation Association has published guidelines indicating that recreational therapy must be comprised of prescribed therapeutic activities (not merely recreational or social outlets), in order that TR is consistent with the Centre for Medicare and Medicaid Services in the USA and, therefore, eligible for healthcare funding (Mobily, 2015a).

Concerns about the processes of professionalization have also been noted in Canada. TR practitioners in Quebec struggle with the specialization of TR in their currently highly diverse recreation field and prefer general recreologists over recreational therapists (Hebblethwaite, 2015). Eastern Canadian and Albertan TR practitioners worry about the professional divide that is being created as only TR practitioners with university degrees in TR are able to achieve advanced TR certification, while other, two-year diploma holding practitioners are excluded from certification and therefore, job opportunities (Dieser, 2013; Sullivan, 2015). For example, the recent decision by the Alberta Therapeutic Recreation Association to restrict new professional memberships to those with degrees was promoted as a way to advance the profession, but will leave diploma-holders without a professional organization (Alberta Therapeutic Recreation Association, 2016).

Issues of Respect and Prestige

Some TR authors have suggested that the motivation behind professionalization is not to better serve those who access TR, but rather to address a perceived lack of respect for the field of TR by healthcare colleagues (Dieser, 2013; Mobily, 2015b). TR practitioners have reported difficulty interacting with colleagues in physical therapy and occupational therapy because they did not feel they were considered to be legitimate healthcare professionals (Anderson & Bedini, 2002; Anderson et al., 2005). The TR practitioners' perception may be accurate. Harkins and Bedini (2013) found that a majority of allied health professionals and administrators in North Carolina thought TR training was not rigorous, and it would be easy for other disciplines to provide TR services. Another example of disciplinary overstepping was apparent in a study by Kolanowski et al.'s (2011). In the study, recreation interventions for people with delirium and dementia in long-term care settings were based on research completed by researchers affiliated with the American Therapeutic Recreation Association and the National Therapeutic Recreation Society. However, research assistants with no TR education carried out the intervention, sidestepping the professional qualifications of a TR practitioner because the activities "require no special expertise to implement" (Kolanowski et al., 2011, p. 6). Austin (2002) worried that without respect for TR as a unique profession, the profession will cease to exist, and the field has resultantly embraced a medicalized form of TR in order to stop this from happening. Siegrist (1990) suggested that 'social esteem' and expert status are integral aspects of professions.

Incompatibilities Between TR and the Medical Model

Mobily et al. (2015) argued that medicalized TR has contributed to the negative construction of disability. Recreation is viewed as 'therapy' to 'fix' people with impairments, which negatively impacts the integrity of recreation and leisure experiences (Hutchinson et al., 2006; Mobily et al., 2015; Sylvester, 1985). When recreation activities are prescribed to an individual, two fundamental aspects of leisure, freedom and enjoyment, are removed (Kleiber et al., 2011). Sylvester (1985) pointed out that even if a TR practitioner prescribes a recreational

activity that an individual enjoys, using it for treatment decreases enjoyment, and it may no longer be thought of as leisure, even when the treatment is over. Devine and Dattilo (2000) found that people who believed there was something wrong with them (i.e., they needed to be fixed) did not feel socially accepted, further leading to poor experiences in recreational activities.

Practicing individualized deficit reduction TR may also lead to missed opportunities to foster social inclusion (Mobily et al., 2015). TR practitioners have the potential to create environmental and socially rich opportunities through their work, ultimately fostering inclusion of disabled people into society. TR practitioners may advocate for access to community recreation programs that are not constrained by physical accessibility, ability, or finances, creating opportunities for disabled people to build relationships through shared enjoyment of activities. The increased social inclusion may even extend to other areas of life, such as work (Mobily et al., 2015). Sylvester (1985) pointed out that TR practitioners have the unique ability among healthcare professionals to foster the expressive side of humanity, transcending compartmentalized treatment to achieve leisure engagement that uplifts a person's whole being. An opportunity for social inclusion and the ability to grow as a human being risks being lost if functional improvements become the only focus in TR.

Therapeutic Recreation Practice

Research into the practices of TR has revealed that there is confusion about what it means to be a recreation therapist, and that context plays an important role in how TR is carried out (Briscoe & Arai, 2015; Reid et al., 2013; Wozencroft et al., 2009). There is a lack of consensus among TR practitioners over whether a strengths-based or deficit reduction conceptualization should guide the field; and what it actually means to practice from either perspective. Sylvester (2015a) noted that the field of TR has been socially constructed, that is created by people. Because of this, there is not a fundamentally correct way to practice TR. However, a lack of critical thinking and reflexion has the potential to put the field at risk (Sylvester, 2015a). Mobily (2015a) wrote about the "bad habit of chasing health care fads" (p.

60) that has plagued TR, limiting the ability of those in the field to develop a sense of professional self. The tension between leisure as an end and recreation as a means has resulted in some authors and researchers becoming deeply entrenched in 'their' views, while TR practitioners are caught in the middle, prey to the culture of the institutional context in which they are practicing.

Briscoe and Arai (2015) engaged recreational therapists in "relational reflective practice" (p. 196), asking them to reflect on their practice and relationships between themselves and clients. The therapists indicated an overt resistance to the medical model, saying that they believed that the medical model is viewed negatively by TR practitioners. However, language that reflected the medical model was often used by these therapists; for example, participants discussed clients in terms of their medical history and diagnoses, placed importance on cognitive assessments, and utilized an expert-client relationship instead of aiming for partnerships with clients. Briscoe and Arai (2015) connected this use of the medical model with the (clinical) setting the therapists worked in, and the medical-model dominant educational institutional settings in which they were students. Without the opportunity to engage in the relational reflective processes, TR practitioners work in silos where they may struggle to feel valued, "unfortunately though…our way of asserting ourselves [TRS] has been in a claim to the medical model" (Briscoe & Arai, 2015, p. 196). As well, the discrepancy between the therapists eschewing the medical model overtly, while in many ways practicing from it, highlights the tensions that TR practitioners face in their work.

While Briscoe and Arai (2015) found practitioners overtly rejected the medical model, other researchers reported that practitioners overtly support the medicalization and reduction of deficits in order to be more respected by and compatible with other allied healthcare professionals (Reid et al., 2013; Wozencroft et al., 2009). Some practitioners were reported to prefer the term "Recreation Therapist" over therapeutic recreation specialist because it sounds similar to physical therapist and occupational therapist. In a study from British Columbia, a

combination of medical and social models of disability were reported in TR practice. The same TR practitioners who preferred the title recreation therapist as a symbol of "achievement and professionalism" and used recreation as a way to improve function were also found to have values which pointed to what the researchers called a humanist disposition, illustrated by themes of "self-determination", "benevolence" and "inclusion and rights" (Reid et al., 2013, p. 82).

Wozencroft et al. (2009) suggested that adherence to the assumptions of the medical model or social model in TR practice may be highly dependent on context. The authors proposed a medical model/clinical settings and social model/community settings dichotomy as an explanation. However, context was one of five themes identified as affecting terminology preference, the other four being: consistency with other allied health professionals, certification, unity, and respect and credibility (Wozencroft et al., 2009). Wozencroft et al. (2009) concluded that although TR practitioners may desire unity for the field, a desire to be seen as an equal part of the healthcare team may overshadow the drive for unity. Those TR practitioners who work in clinical settings, with other allied healthcare members who use the medical model, may be most likely to also use the medical model, as a way to 'fit in' and be respected.

The perception that the medical model is more valued within healthcare than the social model was further apparent in Leblanc and Singleton's (2008) study which found that practitioners were interested in using research mainly to justify practice and demonstrate the efficacy of TR, in order to maintain or expand their services. The participants also noted that they were stressed because a lack of time and standardized tools in TR meant they were unable to document changes in clients in the same way as physical or occupational therapists. Comparing TR with other therapies which are traditionally rooted in the medical model is problematic as objective assessments and outcomes are not necessarily used in TR interventions. Thus, Leblanc and Singleton (2008) concluded that TR practitioners are faced with the choice of continually doing research designed to justify the strengths-based approach of

TR, or modifying their practice to be compatible with other allied healthcare disciplines – but at the risk of losing important relational aspects of their practice. Sylvester (2015a) did not advocate for one side of TR to become dominant, but rather that TR practitioner spend the time at an individual and organizational level to reflect on what effect each conceptualization of TR will have on the field going forward.

Education in TR

Post-secondary educational institutions are looked to for leadership in TR. Educators are seen as determiners of future directions in TR, as they determine the conceptualization of TR that is being taught and how it is interpreted in the classroom against increasing professionalization of the field (Dieser, 2013; Muzio et al., 2013). Siegrist (1990) wrote that "institutions of advanced knowledge" are one place within which processes of professionalization unfold (p. 177).

Certification and the Tyranny of Standardization

The National Council for Therapeutic Recreation Certification (NCTRC)[2] was established in the 1980s in the USA to provide a credentialing organization for TR practitioners. Sylvester (2015b) suggested that limiting the TR profession to only those who can be certified through NCTRC would increase the ability of those certified to work alongside other certified allied health professionals who receive funding for their services. However, the NCTRC is viewed by some practitioners as a main factor in the increased use of deficit reduction TR and, correspondingly, the promotion of the medical model (Dieser, 2013; Mobily, 2015a; Sullivan, 2015). The NCTRC's board of directors do not support the 'leisure as an end' conceptualization of TR, going as far to state that "Recreational therapists should not be confused with recreation workers, who organize recreational activities primarily for enjoyment" (NCTRC, 2019, para 5). Instead, TR is described as a systematic process to treat and maintain "physical, cognitive,

[2]For the educational requirements of the NCTRC, see Appendix B.

social, emotional and spiritual functioning" (NCTRC, 2019, para 4).

After the NCTRC was introduced, the emphasis on standardized education in TR intensified, in order that students could pass the NCTRC exam. The American Therapeutic Recreation Association's (ATRA) task force on higher education has recently set out to improve the quality and consistency of TR bachelor degree-granting programs (Hawkins et al., 2018). Mobily (2015a) said that TR is falling into a "tyranny of standardization" (p. 64). He noted that TR curricula in the USA have become inflexible and uniform across different schools, ensuring that all future practitioners are taught the same ideas to meet NCTRC standards, irrespective of unique cultural differences and ideology present across the country. A narrow definition of the role of TR (i.e., only deficit-based) may exclude practices that are traditionally associated with TR in different geographical areas. For example, Dieser (2013) asserted that TR practices which involve an individual's family and wider community – highly prevalent in the Latino communities of Southern USA – are excluded by the NCTRC's individualist interpretation of the TR practitioners' scope of practice.

Cultural differences widened as NCTRC was adopted in Canada in 2009 – Canada is widely known for having a multicultural ideology, compared to the "melting pot" ideology of the USA (Dieser, 2013). Dieser (2013) (unsuccessfully) promoted the use of a Mosaic Certification Framework in Canada, instead of joining the NCTRC, to reflect the diversity of Canadians and TR practices across the country (see Appendix B for a comparison between the proposed Mosaic Certification Framework and the NCTRC). Although TR practitioners in countries such as Japan rejected the assimilating notions of American TR (Nishino et al., 2007; Yoshioka, 2016), many researchers believe Canadian TR practitioners are in danger of losing their diversity as they attempt to match the TR standards of the USA (Dieser, 2013; Carbonneau et al., 2015; Hebblethwaite, 2015; Mobily, 2015a; Sullivan, 2015). For those TR practitioners utilizing a strengths-based approach, following the American conceptualization of TR (encompassing both the NCTRC and the American Therapeutic Recreation Association) is concerning.

Concerns about the NCTRC are amplified in Quebec, which is significantly linguistically and culturally distinct from the other Canadian provinces and the USA. The linguistic differences are problematically exemplified by the NCTRC's refusal to provide the NCTRC exam in French, despite French being one of Canada's two official languages (Hebblethwaite, 2015). Culturally, the medical model used by NCTRC is of especially high concern in Quebec, as there is resistance to even using the term "therapeutic recreation" due to its medical-model connotations (Carbonneau et al., 2015). Instead of the medical model, recreologists – their preferred name for Recreation Therapist or Therapeutic Recreation Specialists – focus on people's optimal leisure lifestyle, rather than trying to reduce their limitations (Carbonneau et al., 2015). Therapeutic benefits of recreation are recognized in Quebec, but "meaningful social participation is fundamental amongst all recreation practitioners" (Carbonneau et al., 2015, p. 9). There is no separate professional association for TR in Quebec, instead, TR and other recreation and leisure-based professions meet as a unified, but diverse group as the Quebec Association of Activity Professionals (QAAP) (Hebblethwaite, 2015). An NCTRC oriented TR profession in Quebec that is focussed specifically on medically defined recreation 'therapy', would be in direct opposition to the foundation of the QAAP (Hebblethwaite, 2015).

Canadian Therapeutic Recreation Education

TR practitioners in Newfoundland and Labrador (NL) are concerned about how adopting the NCTRC standards has changed the direction of recreation in their provinces. Sullivan (2015) found that their concerns were related to the educational requirements and financial cost of becoming Certified Therapeutic Recreation Specialists (CTRS) through the NCTRC program. As previously mentioned with the Alberta context, a further divide is created between TR practitioners with degrees and practitioners with two-year diplomas, as only those with a degree can become certified. Dieser (2013) reported that in both NL and Alberta, approximately half of TR practitioners hold diplomas, and there are concerns that the establishment of CTRS as the minimum to practice in either province will both leave out many talented practitioners, and

instead of promoting unity, further divide the field.

Dictating the educational requirements needed to become a TR practitioner also limits perspectives evident in TR. For example, Sullivan (2015) stated that in NL, there is a single university that provides the courses needed for the standards set out by the NCTRC (Memorial University), a single CTRS at the university (Sullivan) who can supervise students, and for the most part, a single employer of TR practitioners in the province (Eastern Health). While she addressed the educational side of this as a logistical concern (i.e., being unable to take sabbatical as students will not have access to another CTRS professor to supervise their practicums), this also leads to a single professor teaching from a framework of strict guidelines to meet NCTRC examination requirements which limits the diversity of ideas to which future practitioners are exposed. If the increasing professionalization of TR is decreasing the diversity of ideas in Canadian TR, Sylvester's (2015a) fear of an uncritical acceptance of one form of TR as 'correct' may hold true. As standardization of curriculum is being promoted by both the American Therapeutic Recreation Association's Higher Education Task Force and those involved with the NCTRC, a single set of ideas about TR may be taught to future practitioners, potentially reducing the opportunity to be exposed to a diversity of ideas and the opportunity to reflect upon these learnings.

Hidden Curriculum in Therapeutic Recreation

Carbonneau et al. (2015) suggested that the task of reconciling the social model-based TR with the medical model-based TR currently promoted by NCTRC and American Therapeutic Recreation Association should fall to educational institutions in both the preparation of future practitioners and needed professional development of current practitioners. van Puymbroeck et al. (2010) further suggested that the future of TR will be determined by the curriculum provided by TR faculty to students in higher education.

The curriculum is made up of both formal and informal teachings, as well as the hidden curriculum (Cowell, 1972). Hidden curriculum was first defined in 1972 by Cowell as "that which

the school teaches without, in general, intending or being aware that it is taught" (p. iv). Hidden curriculum is in contrast to the formal curriculum – what is written down on syllabi and planned course objectives. The hidden curricula are indicative of organizational cultures and the ideological underpinnings and expectations of professional fields (O'Donnell & Hafferty, 2014). Students absorb the culture, beliefs, and behaviours of a field, and establish professional identities (Cowell, 1972; Hill et al., 2014).

Hidden curriculum can come from the personal beliefs, attitudes, and values of faculty, the professor's choice of textbook, and the types of internship placements available. Dieser (2011) refuted van Puymbroeck et al.'s (2010) assertion that little research has been done in the area of hidden curriculum in TR, as much of his own work is related to exposing the White, individualist teachings that underlie TR teachings and practices. However, Dieser (2011) does highlight a need for researchers to use 'strong sense' critical thinking skills to evaluate the hidden curriculum in TR post-secondary institutions. To be considered strong critical thinking skills, they must evaluate all beliefs about TR, not just defend one's own beliefs (Dieser, 2011), aligning with Sylvester's (2015a) ideas about problematizing all aspects of TR instead of uncritically adhering to a single set of beliefs.

TR and Textbooks

All TR practitioners attend post-secondary institutions before entering the field, therefore, TR education can be examined as a starting point for how TR practitioners develop ideas about the profession. One tool of TR post-secondary educators is textbooks. Venezky (1992) wrote that textbooks exist as both "a *cultural artefact* and as a s*urrogate curriculum*" (p. 437, emphasis original). Textbooks are cultural artefacts because they reflect the time and culture in which they were created, including the content, the physical materials used to create the book, the publisher, and the design and typography of the book (Venezky, 1992).

Textbooks function as a surrogate curriculum because, although they are generally chosen to reflect the formal curriculum of a course, they also contain latent or undocumented

information which students will learn in addition to the manifest information they contain (Venezky, 1992). Venezky's (1992) ideas of the latent curriculum in textbooks is similar to Cowell's (1972) hidden curriculum. The latent curriculum is "a series of secondary messages, transmitted on top of the manifest curriculum through commission or omission" and is reflective of the values of the dominant culture (Venezky, 1992, p. 438). Previous researchers have examined textbooks for promotion of ideologies related to social issues, such as gender (Cassese & Bos, 2013), culture and language learning (Karim & Haq, 2014), and patriotism and militarism (Lachman & Mitchell, 2014). In research of secondary education geography textbooks, Bednarz (2004) found textbooks to be "cultural artefacts, related to and reflective of the education system" (p. 224).

Analysing TR textbooks, including the latent/hidden curriculum present, is one way to develop an understanding of what TR students learn in post-secondary education. Analysis of textbooks can provide insight into what is officially stated as the purpose of TR, and conceptualizations of the field that underlie professional practice. Just as hidden curriculum has been documented to play a role in forming the identity of future doctors (O'Donnell & Hafferty, 2014), depictions of different TR goals and practices in textbooks may influence how TR students come to understand their field. Although it is clear that there are multiple conceptualizations of TR, it is not clear how and what TR practitioners learned about these conceptualizations. Further research into TR education is needed, especially in light of the increasing push toward standardized TR education (Hawkins et al., 2018).

It is essential to understand what is currently being taught, and the consequences for the field of TR, in order to move forward in a way that allows both those who practice TR, and those who access it, to flourish. TR textbooks may provide part of the information about what is currently being taught (and learned). With the knowledge of the ongoing debates within the field of TR, the blending of conceptualizations happening in TR practice, and the idea of the latent/hidden curriculum that can be present in educational contexts, there is a need for

reflexion on TR discourses present in textbooks. Therefore, the purpose of my study was to understand how therapeutic recreation practices are constructed and reproduced in TR textbooks, with attentiveness to hidden discourses.

CHAPTER 3
METHODOLOGY

Ontological and Epistemological Assumptions

A research paradigm is a collection of beliefs, values and techniques shared by an academic community (Markula & Silk, 2011). A paradigm is used to guide research decisions, from the questions asked, the research approach, choice of method, data analysis strategies, interpretation of findings, and ethical concerns (Markula & Silk, 2011). Paradigms form the basis of how the researcher understands knowledge and reality. The components of a paradigm ascribe to a specific ontology, epistemology, and methodology. This research will be conducted within the constructivist paradigm, which is defined by a relativist ontology, a transactional/subjective epistemology, and a hermeneutic and dialectical methodology (Guba & Lincoln, 1994).

The ontological basis of a research study comes from what the researcher believes is the nature of reality and truth (Markula & Silk, 2011). Ontologies can be broadly categorized into three different interpretations of reality: one true reality, relativism, and multiple realities (Markula & Silk, 2011). Research conducted within the constructivist paradigm is based on the assumption that reality is relative (Guba & Lincoln, 1994), meaning that "individuals construct multiple meanings of reality" and will experience and interpret situations in different ways without one way being more correct or 'true' than another (Markula & Silk, 2011, p. 33).

A relativist ontology aligns well with the belief that society and its institutions have been socially constructed. Proponents of the constructivist paradigm suggest that social constructivism "is the process by which individuals construct their personal knowledge about reality" (Russo, 2005, p. 25). The meanings we attach to experiences are not arbitrary or inherent, but created because of social interactions, especially through the use of language (Russon, 2005). Researchers positioned in this paradigm therefore have the ontological belief that there are many different experiences or constructions of what reality means (Guba &

Lincoln, 1994; Markula & Silk, 2011). The goal of this research is not to uncover an objective, specific, or universal conceptualization of TR within TR textbooks, but rather to examine the differences among textbooks and situate the findings within our ideologically driven social context.

An epistemology encompasses "how one knows the world and relationship between the knower and the known" (Markula & Silk, 2011, p. 25). In the constructivist paradigm researchers use a transactional/subjective epistemology: research is influenced by the researcher, and research results are created through an interaction between the researcher and the research participants (Guba & Lincoln, 1994; Markula & Silk, 2011). The researcher acknowledges that knowledge is subjective, experienced, and created. Researchers must reflect deeply and critically on what they see and hear throughout the research process, in order to understand how their influence affects the data collection, research participants and analysis of the data. Reflection in this type of research is a "meaning-making process that moves a learner from one experience into the next with deeper understanding of its relationship with and connections to other experiences and ideas" (Rodgers, 2002, p. 845).

The methodological question of "How can the inquirer (would-be knower) go about finding out whatever he or she believes can be known?" is answered in constructivism using a hermeneutic and dialectical approach (Guba & Lincoln, 1994, p. 109). The hermeneutical aspect is reflected in the belief that knowledge is gained through the researcher's interpretation, rather than the researcher discovering objective truths (Guba & Lincoln, 1994). The interpretations that the researcher makes come from interactions between the researcher and the researched (Guba & Lincoln, 1994). To use a dialectic approach, the researcher then compares and contrasts constructions of meanings (both their own, and what arises in the research process) in order arrive at a construction that is "more informed and sophisticated than any of the predecessor constructions" (Guba & Lincoln, 1994, p. 111).

Conceptual Framework

In qualitative research, a theoretical framework allows the researcher to focus on specific aspects of a phenomenon under study, guiding everything from choice of research questions to interpretation of data (Kelly, 2010; Tavallaei & Talib, 2010). Research on any phenomena can be approached from multiple angles, so theory helps the researcher to focus on what they would specifically like to understand, and how they will interpret their findings (Tavallaei & Talib, 2010). Theory can play a role in clarifying and bringing transparency to researcher preconceptions, thereby providing a richer more complex understanding of the phenomenon beyond what would be possible based on the researcher's own perspectives and experiences (Tavallaei & Talib, 2010). Therapeutic recreation textbooks contain a vast amount of information that could be interpreted in many different ways. The theory of critical disability studies was used as a conceptual framework for this study to guide the analysis and organize the findings (Sandelowski, 1993). Using critical disability studies as a theoretical framework enabled me to focus on the aspects of the selected texts that could best answer my question, as well as provided me with a framework to analyse and present my findings.

Critical disabilities studies is a field in which disability is a viewed as "both a lived reality in which the experiences of people with disabilities are central to interpreting their place in the world, and as a social and political definition based on societal power relations" (Reaume, 2014, p. 1248). Critical disability theory (CDT) comes from the evolution of disability studies and the diversification of critical social theory (Meekosha & Shuttleworth, 2009). Disability studies emerged as a field in the 1970s, and it has expanded continually, partly due to the growing visibility of disabled people in the community and disability movements (Meekosha & Shuttlewoth, 2009). Disability studies have a multi-disciplinary nature, as disciplines from the social sciences to architecture and engineering have taken on disability studies' perspectives (Meekosha & Shuttleworth, 2009). Critical disability studies is a rejoinder to what Meekosha and Shuttleworth (2009) deem the "cooption…of disability studies" (p. 49), referring to things

such as university courses which are titled 'disability studies', but actually support the medical model. Essential to critical disability studies is a challenge to the view that disability needs to be remedied through medical intervention, and instead can be explored through social, political, cultural, and economic lenses (SDS, 2016).

Critical theory was originally developed as an alternative to liberalism and 'traditional theory' which is used to objectively examine the world (Hosking, 2008). Critical theorists challenge the dominant ideology of liberalism on a number of fronts (critical race and feminist theorists, for example). Pothier and Devlin (2006) suggested that disability may pose an even more fundamental challenge to liberalism than other oppressed populations because a core assumption of liberalism is that disability is equated with misfortune and abnormality. They characterized CDT as a way to develop "an understanding of disability that focusses on genuine inclusiveness" (p. 2). A main goal of CDT is to force change from a society dominated by ableism to a barrier-free society (Pothier & Devlin, 2006). Going beyond merely working with disabled populations, the specific focus of those in critical disability studies is on achieving social justice for disabled people through examination (deconstruction) of how the approaches to and assumptions and ideologies of disability have been constructed (Vehmas & Watson, 2014).

Hosking (2008) described the seven tenets of CDT as: "the social model of disability, multidimensionality, valuing diversity, rights, voices of disability, language, and transformative politics" (p. 5). These tenets are explained in Table 1 (below). Although I am not bringing a critical perspective to my study (discourse analysis), because CDT is a broad theory with multiple articulations, adhering to the tenets described by Hosking will bring depth to the description and interpretation of the findings.

CDT is an appropriate lens to examine TR textbooks with as it fits with both my epistemology and research approach. When critical theories are applied, the researcher and the researched are considered to have an interactive relationship, consistent with the subjective epistemology that will be used in this study (Hosking, 2008). As well, a "primary concern of

critical disability theory is an interrogation of the language used in the context of disability" (Pothier & Devlin, 2006, p. 3), hence it provides a good fit for bringing deep reflexion to the discourses present in TR textbooks.

Table 1

The Seven Tenets of Critical Disability Theory

CDT Tenet	***Explanation***
The social model of disability	• Society disables people with impairments • Change must occur at a societal level before the oppression of disabled people is lifted
Multidimensionality	• A reminder that disabled people are not a homogenous group with identical needs and experiences • The lives of disabled people are affected by their gender, race, sexual orientation, and social class, among others
Valuing diversity	• Rather than privilege single ways of looking and behaving, CDT promotes equality across a diverse human experience
Rights	• CDT embraces legal rights for disabled people as an indispensable way to promote full inclusion in society
Voices of disability	• CDT promotes listening to and valuing the stories of disabled people
Language	• Language affects how people are labelled and described • Language carries ideological implications
Transformative politics	• Emphasis is placed on linking theory and practice to create change

(Modified from Hosking, 2008)

Critical disability theory has been used in a range of other allied health professions to examine the ways in which 'helping professions' play a sometimes-contradictory role in the lives of disabled people. Meekosha and Dowse (2007) suggested that while social workers have the power to create opportunities related to housing, employment, and independent living for disabled people, they are often constrained by the "medical and rehabilitative discourses of disability" (p. 169) which, through education and socialization, heavily influence their understanding of disability and the focus of their work. Similar contradictions are found in

occupational therapy, wherein the goals at a professional level may value disability rights, but the practices of individual therapists may be ideologically constrained to a specific type of functionally-based rehabilitation. Ferguson (2009) also discussed the 'power' speech-language pathologists have in comparison to their 'patients' and the fundamental challenge this makes to the goal of equality between disabled and non-disabled people – highlighting the idea that to have a 'helping profession' someone must be in need of 'help'. From my own experience, I expected the issues and ideas brought forth through a critical disability studies lens of allied health professions would be apparent in the field of TR, and the texts that I analysed in my study.

Method

Research Approach

I investigated my research question using an interpretive discourse analysis (DA) research approach (Heracleous, 2006). Discourse analysis is the "study of language-in-use" (Gee, 2010, p. 8), with discourse being recognized as more than just text and speech, but rather language and its contexts. Wodak and Meyer (2009) asserted that to study discourse is to study language as a social practice, by connecting a discursive event with the situations, institutions and social structures which frame it. Within discourse analysis, "interpretive approaches conceptualize discourse as communicative action that is constructive of social and organizational realities" (Heracleous, 2006, p. 2). Some forms of discourse analysis focus on the content of the discourse being studied, while other forms use a linguistic approach to examine the structure of the language itself, and how this is used to make meaning within certain historical, social, and political conditions. The second form will be used in this study.

Discourse analysis is meant to explain how language works, in order to understand it. Gee (2010) argued that language is a social practice and is always political. Language is, in itself essentially meaningless; "it is through the shared, mutually agreed-on use of language that meaning is created" (Starks & Trinidad, 2007, p. 1374). Further, the mutually agreed upon

meaning of language is grounded in power, history, and ideologies, making it far from a neutral system of signs (Amerian & Emsaili, 2015). Discourse analysis can be used to describe how language works in order to understand the piece of language, and in using it, I will be able to illuminate the forces behind language use and the social issues to which these forces are connected (Gee, 2010). Importantly, as TR has contested meanings and multiple conceptualizations of practice, I will examine the function of discourse in TR textbooks, and connect the discourse to the society in which it is situated. Using DA to examine the TR textbooks fits with the constructivist paradigm of this study, as both DA and constructivism share an assumption that research, discourse and society are "inherently part of and influenced by social structure, and produced in social interaction" (Van Dijk, 2001, p. 352). Using DA, combined with the conceptual framework of critical disability studies, one can deconstruct a piece of text (language) to expose the social structures and ideologies behind the assumptions and implicit meanings of the text (Rudman & Dennhardt, 2015).

Textbook Selection

The textbooks were selected using a multi-source process that enabled me to select two texts that are both popular in undergraduate TR courses, and also highlight different perspectives of TR. First, an internet search using the search engine Google was conducted to find syllabi from undergraduate TR classes being taught in Canada and the USA within the past five years (2014-2019). This search identified the textbooks endorsed by TR instructors (see Appendix C). Second, the website 'Amazon.ca' was searched for textbooks using the terms "therapeutic recreation", "recreation therapy" and "recreational therapy" (See Appendix D). In doing so, the textbooks still in print were identified. These search strategies provided information on which TR textbooks are currently used in instructional settings and purchased by those in the field.

The textbooks were selected using purposeful, criterion sampling, consistent with Fairclough (2012) who asserted that when using DA, data selection must be selective and match

the research problem and objectives. Textbooks were included if they appeared in both a course syllabus and on the website Amazon.ca and were published within the past 15 years (2004 and later), to ensure relevancy. Textbooks were excluded if they were (a) an edited book, rather than sole or co-authored as edited books have chapters around a singular topic by multiple authors, (b) a study guide or manual, or (c) focussed on a specific aspect of TR, such as management or assessment. The search revealed six texts, and the two most identified in the course syllabi were selected (see Appendix C). The textbooks chosen and analysed were Anderson, L., & Heyne, L. (2012b). *Therapeutic recreation practice: A strengths approach*, State College, PA: Venture Publishing, Inc., and Stumbo, N. J., & Peterson, C. A. (2009). *Therapeutic recreation program design: Principles and procedures* (5th ed.), New York, NY: Pearson.

Upon examination of the two textbooks, it was determined that the books differed from each other in numerous ways (see Appendix E). Stumbo and Peterson's (2009) text is the fifth edition of this text, with the first being published over forty years ago. The ideas contained in this textbook are considered foundational to the philosophical underpinning of the American Therapeutic Recreation Association (James, 1998b). Anderson and Heyne's (2012b) textbook is much newer and, due to the focus on strengths-based practice, contains different ideas about TR than the Stumbo and Peterson (2009) text. As it is apparent from reviewing the literature that there is more than one conceptualization of TR, it was important that the texts selected reflected this diversity, in order to understand how the activities of TR are constructed and reproduced. Because of the diversity present in the above two textbooks, further textbooks were not added to the study. As well, because discourse analysis was used to analyse the texts, a small sample ensured I could avoid "getting bogged down in too much data and not being able to get the linguistic detail" needed (Potter & Wetherell, 1987, p. 161). The introductory chapter or chapters were analysed in this work, as this was where the authors explained their conceptualization of TR. A research ethics certificate was not required to conduct this research as no human participants were involved.

Data Analysis

The selected excepts from the textbooks were analysed following the processes of discourse analysis (Gee, 2010; Rudman & Dennhardt, 2015; Wodak & Meyer, 2009). Rudman and Dennhardt (2015) emphasized that critical discourse analysis does not have a fixed or singular method and cannot be conducted according to a set of rules. Discourse analyses are conducted by "emphasizing hermeneutic, iterative journeys of discovery by (re)reading individual texts in and of the whole and their social context" (Heracleous, 2006, p. 10). DA is guided by theory, with importance being placed on coherence across ontology, epistemology, methodology and the analysis (Rudman & Dennhardt, 2015). Wodak and Meyer (2009) suggested that the method for each DA must be customized to suit the theoretical underpinnings of the study.

A mixture of linguistic levels have been used in recent DA research in the area of disability. Micro-level analysis, such as vocabulary choice, can be very indicative of which model of disability an author uses, such as in Stamou et al.'s (2016) DA of disability Facebook groups. When examining policies for rehabilitation in Norway, Røberg et al. (2017) used a 'textured' approach to analyse "words, the constructions of sentences, and longer statements" (p.60) to examine discourses related to different models of disability. The textbooks were examined at a combination of levels, including the word, sentence, paragraph, and chapter level, following Van Dijk's (1982) writing on 'episodes.' Episodes do not have a specified length or linguistic unit attached to them, but are rather intuitively chosen and defined throughout discourses by the researcher as selections of the discourse that fit together to make meanings, similar to how one may have 'episodes' in their own life, ranging from a single memory to entire years (van Dijk, 1982). Flexibility in the analysis process enabled me to capture meaning and context across the texts and connect my findings to the social settings they occur within.

Gee (2010) proposed seven 'building tasks' which are used in language to construct reality. Each of these building tasks has a corresponding discourse analysis question, as outlined

in Table 2. Gee's (2010) seven questions can be answered using episodic analysis (Van Dijk, 1982), for example, a single word may indicate technical jargon, while an entire chapter may contribute to establishing identities. I applied the seven DA questions to my reading of the TR textbook chapter excerpts.

Table 2

The Seven Building Tasks of Language and Discourse Analysis Questions

Building Task	Discourse Analysis Question
Significance	How is this piece of language being used to make certain things (in)significant?
Practices	What practice (activity) is this piece of language being used to enact?
Identities	What identity is this piece of language attributing to others, and how does this help the speaker or writer enact their own identities?
Relationships	What sort of relationship(s) is this piece of language seeking to enact?
Politics (the distribution of social goods)	What perspective on social goods is this piece of language communicating (i.e., what is being communicated as "normal", "good", "right" etc.)?
Connections	How does this piece of language connect or disconnect things; how does it make one thing relevant or irrelevant to another?
Sign Systems and Knowledge	How does this piece of language (dis)privilege specific sign systems (e.g., technical language vs. everyday words) or different ways of knowing and believing (e.g., science vs. the humanities)?

(Modified from Gee, 2010, p. 19-20)

DA enabled me to examine how authors used language to create different meanings of TR and connect these different meanings to prevailing ideologies of disability. With DA I was able to examine what the authors of the specific textbooks were portraying (saying), how they suggested TR practitioners practice (doing), and how practice can shape the identity of future TR practitioners (being) (Gee, 2010). I also connected the semantic and grammatical choices of the textbook authors to the social contexts in which they are situated. The DA research approach enabled me to examine how TR is conceptualized in TR textbooks, and how these

conceptualizations are connected to societal factors such as professionalization, perspectives of disabled people, and the organization of healthcare.

Rudman and Dennhardt (2015) suggested using an individualized analysis sheet to ensure theory is adhered to, and ensure transparency of analysis, which will increase the quality of the study. The discourse analysis sheet is presented in Table 3. Using the three question categories suggested by Rudman and Dennhardt (2015), analysis questions were created from concepts and ideas brought forth in the literature review.

Table 3

Discourse Analysis Questions

Question Category	Analysis Questions
Questions informed by theory (Critical Disability Theory)	a. Which model of disability is being used? b. Are impairments and disability differentiated? c. Is there a focus on 'fixing' disability? d. Are health and disability mutually exclusive? e. Are changes to society proposed? f. Are environments or individual characteristics considered disabling?
Questions informed by the research question	a. How is TR conceptualized in the text? b. What is the purpose of TR? c. When is recreation an activity vs a therapy? d. How does TR fit into healthcare?
Questions informed by linguistic tools	a. What terms are used for people who access TR services? b. What terms are used for TR practitioners? c. Which adjectives and pronouns are used? d. What qualities are linguistically assigned? e. What social relations are constructed? f. What technical language is used? g. What is being made significant, and how? h. What is being communicated as 'good' or 'normal'?

To complete the data analysis, I started with an open read of the texts, noting down parts of the texts that could potentially answer the above analysis questions, and my research question. This was followed by a close reading, using the analysis sheet as a guide to deconstruct both the overt content and the hidden curriculum present in the texts (Rudman & Dennhardt,

2015). Attention was paid to both *what* was being said, and *how* it was being said, referring to Gee's language building tasks (Table 1) to examine the linguistic choices of the authors. Using Gee's (2010), building tasks, I asked myself questions about how salient features of the text were used to construct the activities of TR. This was not a linear process, as features of the discourse were identified and then questions from both Table 2 and 3 were used to prompt analysis and understanding, returning to both the text and the questions multiple times throughout the process. Small data units (e.g., single words) were significant in different ways than when they were part of larger data units (e.g., sentences or paragraphs), and such were included in multiple data analysis questions. Key findings from the texts were organized together and given descriptive labels. As the analysis process went on, the key findings and their corresponding labels were changed multiple times: combined with other data, split into more labels, or re-labelled as new concepts emerged. I turned to the tenets of CDS to reflexively think further about the labels. The results were then organized and presented.

Research Rigour

Qualitative researchers face challenges related to theoretical cohesion, methodological transparency, and data and analysis representation (Greckhamer & Cilesiz, 2014). To aid in the completion of rigorous qualitative research, Tracy's (2010) "Big-Tent" criteria for rigorous qualitative work were used, in addition to criteria more specific to DA, as outlined by Greckhamer & Cilesiz (2014) and Antaki et al. (2003). Tracy suggested that the eight criteria outlined in her paper can be universally used in different combinations for all qualitative work, hence making these appropriate criteria for my qualitative study. The criteria are summarized in Table 4 below, followed by the strategies I used to address each criterion.

Beyond Tracy's (2010) universal qualitative research criteria, Greckhamer and Cilesiz (2014) offered four challenges of conducting quality discourse analysis: (a) systematic and rigorous analysis, (b) transparency of analysis, (c) substantiation of claims with evidence, and (d) representation of analysis process and results. These challenges correspond with

Table 4

Criteria for Excellent Qualitative Research (Tracy, 2010)

Criteria	Description	Relevance to this paper
Worthy Topic	• Relevant • Timely • Significant • Interesting	• Topic has been identified by TR researchers as an area needing further exploration • Higher education in TR is under review by the American Therapeutic Recreation Association • TR practitioners in Alberta are currently working to become professionalized
Rich Rigor	• Theoretical constructs • Data and time in the field • Sample(s) • Context(s) • Data collection and analysis processes	• Theoretical coherence between the sample selection, data collection, and data analysis • Data collection and analysis process based on discourse analysis and critical disability theory
Sincerity	• Self-reflexivity about subjective values, bias, and inclinations of the researcher • Transparency about the methods and challenges	• Reflexion on my biases and assumptions using a log of thoughts/decisions during the analysis process, and asking for bias checking from thesis supervisor and colleagues
Credibility	• Thick description, concrete detail, explication of tacit knowledge, and showing rather than telling • Triangulation or crystallization • Multivocality • Member reflections	• Provided thick description and enough context and detail that readers are is able to draw their own conclusions from a piece of text, rather than divorcing an idea from its context and *telling* the reader what to think.
Resonance	• Aesthetic, evocative representation • Naturalistic generalizations • Transferable findings	• Results of my study will be transferable to other research in the field of TR, and similar fields.
Significant Contribution	• Conceptually/theoretically • Practically • Morally • Methodologically • Heuristically	• Established a connection between Critical Disability Theory and therapeutic recreation, contributing to theoretical knowledge in TR. • Add a discourse analysis to the TR literature
Ethics	• Procedural ethics • Situational and culturally specific ethics • Relational ethics • Exiting ethics	• Being an ethical researcher, by engaging in reflexivity (research log, checks for bias by other readers) and transparent practice by outlining my research methods and steps taken to analyse date and draw conclusions
Meaningful Coherence	• Achieves what it purports to be about • Uses methods and procedures that fit its stated goals • Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other	• Research question was embedded in personal experience and TR literature • Discourse analysis literature was used to select relevant data (discourses) • Followed previously used and promoted steps for discourse analysis • Discussed the finding within the context of theory and the literature.

Antaki et al.'s (2003) work on the shortcomings of DA, and each challenge, as well as strategies used to overcome it, will be described below.

Systematic and Rigorous Analysis

Antaki et al. (2003) discussed how simply summarizing data or spotting discourse features in a text is not sufficient to call the work a discourse analysis. Greckhamer and Cilesiz (2014) suggested that "applying systematic analysis methods and conducting rigorous analyses grounded in epistemological and theoretical assumptions of discourse analysis aids in establishing the trustworthiness" (p. 425) of the research. Greckhamer and Cilesiz (2014) suggest using a framework for analysis, such as Gee's (2010) seven discourse analysis questions (see Table 1). The discourse analysis questions were used during the analysis process as a framework to establish connections between what was being said in the text, how it was being said, and why this was significant to my research question.

Transparency of Analysis

Not only must the analysis be conducted in a systematic way, it is important that the analysis process is communicated with transparency to enhance trustworthiness (Greckhamer & Cilesiz, 2014). Antaki et al. (2003) suggested that taking sides and conducting circular analysis (identifying features because they fit a certain idea, and then fitting them back into that same idea during analysis) are two potential shortcomings of DA; presenting the analysis process transparently can show that these shortcomings are not present. Greckhamer and Cilesiz (2014) suggested that chronicling the analysis process is an important step to achieve as much transparency as possible. Care was taken in this work to outline the steps taken during data analysis, as well as explaining how conclusions were drawn from the results and interpreted through reflexion on the tenets of CDS. Part of being transparent is researcher reflexion, or "self-awareness, honestly, and genuineness, with her/himself, the research process, and the readers" (Zitomer & Goodwin, 2014, p. 201). To engage in reflexivity, I used a log book to note my own biases and assumptions during the analysis process, as well as using peer-checking:

having others read my work and reflecting on the feedback from my supervisor regarding preconceived notions found in my work. The personal and professional background I bring to this work is outlined in the section on Positionality (Zitomer & Goodwin, 2014).

Substantiation of Claims with Evidence

Greckhamer and Cilesiz (2014) suggested that there are two types of evidence important in DA: "(a) evidence of a systematic and rigorous analysis process, and (b) evidence of the substantive basis of results" (p. 427). The first type of evidence can be shown through a transparent and systematic analysis process, as described above. The second type of evidence pertains to the inclusion and presentation of data, often in the form of quotations from the discourse. The researcher must avoid over-quoting a piece without explanation or taking quotations out of context to fit them to a pre-conceived idea (Antaki et al., 2003). Greckhamer and Cilesiz (2014) suggested that researchers choose data that is "particularly poetic, concise, or insightful" (p. 436) given the need to balance the amount of data that can be included in a paper with the need for space for interpretations and conclusions from the data. I chose data to present in my paper that were particularly impactful, as Greckhamer and Cilesiz (2014) suggested, by focussing on data that were representative of the larger views of the textbook authors, as well as data that required a multi-level analysis to truly understand what was being said. Answering the discourse analysis questions (Gee, 2010) ensured that I had sufficient evidence from the text for ideas which enabled me to avoid overuse of quotations without explanation or using circular reasoning. Quotations were provided with enough context that readers can draw their own conclusions from a piece of text, rather than divorcing an idea from its context and *telling* the reader what to think (Tracy, 2010).

Representation of Analysis Process and Results

Representation can be challenging in DA because the non-linear analysis and interpretation processes may not be easily captured by the standards of a traditional research report (Greckhamer & Cilesiz, 2014). As mentioned above, "a key tool is laying out a study's

conclusions instantiated by prototypical quotes from the data" (p. 435-436). Quotations of what is present in the data anchors the researcher's interpretations; it is also important to represent omissions from the data which may be used to create lopsided arguments in the author's favour (Greckhamer & Cilesiz, 2014). Critical disability theory, and the processes of discourse analysis, as outlined by Gee (2010) and Rudman and Dennhardt (2015) were used to highlight omissions in the texts, which was a vital part of understanding and explaining my interpretations of the discourse. Representation of results was based on the systematic analysis of both what was and was not present in the texts. A shortcoming related to representation of the results is the idea of false survey, or "treating one's findings as if they were true of all members of the category" (Antaki et al., 2003, pp. 36). Results from conducting a discourse analysis are specific to the analysed data, and not meant to be generalizable to the world at large (Antaki et al., 2003), therefore, I presented the results from my research without generalizing the findings to, for example, all TR textbooks or all TR authors. As I used a relativist ontology to guide this work, I did not make generalizations from my analysis, and rather recognized that my work is one interpretation of a specific data set.

Positionality

A discourse analysis is highly interpretive work, and the subjective epistemology used in this work created the opportunity for me as researcher, to both influence and be influenced by the research process. As a practicing recreation therapist and graduate student, I have the opportunity to sit in two worlds – that of the front-line service provider, and that of the birds-eye-view researcher. Working in the field of TR while researching TR gave me insider insight into the field in ways that would not otherwise have been possible – carrying out the activities of TR, attending Alberta Therapeutic Recreation Association conferences and chapter meetings, participating in TR practice meetings, and access to many informal conversations with other recreation therapists and allied healthcare colleagues. This 'insider knowledge' and experience of TR has brought a sense of authenticity to my research. On the other hand, my closeness to the

field makes the need for reflexion on my own ideas about TR all the more prominent. I have never been a participant of TR, so a gap or 'betweenness' (Grimaldi et al. 2015, p. 135) exists between myself as the researcher. and the topic being researched. Practicing reflexivity is necessary to open the 'betweenness' into a space to question dominant truths (Grimaldi, 2015).

Another world that I participate in is that of disability sport. I coach para-athletes in the sport of track and field. Although I am non-disabled, the experience of coaching in the para world, in addition to the strong relationships between myself and my athletes, has provided me with invaluable insight and the opportunity for reflexion on how I experience the world as a non-disabled person, and how this impacts my coaching, work, and research. In addition to being non-disabled, my experience as a White, middle class woman have also affected the research. Milner (2007) suggested that the "varied positions, roles, and identities [of researchers] are intricately and inextricably embedded" in the research process (p. 389), and such the various parts of my identity have undoubtedly flavoured this research project.

CHAPTER 4

RESEARCH PAPER

Hitting the books: Textbooks as cultural artifacts of a splintered field

Abstract

Therapeutic recreation (TR) presents two conceptualizations of recreation, recreation as rehabilitation and recreation as community wellness. Textbooks are cultural artifacts used for passing disciplinary knowledge to students. The study purpose was to understand how TR practice is constructed and reproduced in textbooks, with attentiveness to hidden discourses. Selected chapters from two highly subscribed TR textbooks in Canada and the USA underwent a discourse analysis (Stumbo & Peterson, 2009; Anderson & Heynes, 2012). Using a critical disability studies framework, respective thematic distinctions arose: individual responsibility for health, professionalization of TR, and the medicalization of recreation; and being in relationship, disability as diversity, and solution focused. The respective authors' TR assumptions of either ameliorating deficits or building on existing strengths led to differing TR goals, varied practice contexts, and distinctive positions on relationship building - creating divergent discourses and discord at a cost to the field and those utilizing its services.

Hitting the books: Textbooks as cultural artifacts of a splintered field

Therapeutic recreation (TR) has been a healthcare field in Canada and the United States since the 1930s, with ever increasing educational requirements needed to practice under the title of 'Recreational Therapist' (James, 1998a, 1998b). TR has two origins, recreation as rehabilitation in veteran hospitals and community recreation to enhance wellness. They eventually converged, although not seamlessly, resulting in two conceptualizations of TR practice (a) a hospital-based deficit reduction approach whereby recreation is a tool to reduce individual deficits and/or improve specific functions (James, 1998b), and (b) a strength-building approach associated with community recreation to improve overall quality of life (James, 1998a, 1998b; Mobily, 2015a; Mobily & Dieser, 2018). Both conceptualizations have uneasily coexisted, leading to both philosophical and professional challenges for practitioners (Mobily & Morris, 2018). In an American Therapeutic Recreation Association task force report on the educational requirements for entry-level TR practice, it was stated that the "most current and pressing need in higher education is to improve the quality and consistency of the bachelor's degree in RT/TR." (Hawkins, Craig, & Anderson, 2018, p. 415).

Deficit Reduction

One conceptualization of TR is engagement in recreation to 'normalize patient' behaviour and produce functional outcomes (Hutchinson et al., 2006; Mobily, 2015a). As people become 'patients' within a healthcare context, disability can be viewed as a tragedy and personal problem. This medical model of disability is the prominent model for understanding disability in healthcare in Canada and the USA, supported by research, technologies, and practices devoted to minimizing or curing disability (Shakespeare, 2006; Withers, 2012). It is understandable then that within a healthcare context, TR specialists use recreation as a tool for the "amelioration of problems through assessment and prescribed interventions" to address a "person's deficits, illness, disability, poor functioning, or other negative state" through individualized functional change (Anderson & Heyne, 2013, p. 91). Under this 'deficit-based' medicalization of recreation,

often as part of an interdisciplinary medical team including physical and occupational therapists, TR specialists' notions of enjoyment, fun, and relationship building become of secondary importance to functional improvement. Little regard is given to social factors that may also impact function (Filc, 2004; Mobily et al., 2015; Withers, 2012). Recreation becomes a treatment, which can overshadow recreation as a restorative and enjoyable way to spend time.

Strengths-Based Practice

A second conceptualization of TR is known as a 'strengths-based' or a 'strengths-building' use of recreation (Anderson & Heyne, 2012a)[3]. Under this approach, recreation becomes a means for improving subjective feelings of wellness and quality of life (Shank & Coyle, 2002). The users of TR services become 'participants' rather than 'patients' with the intrinsic benefits of recreation taking precedence over it being a tool for functional change (Mobily & Morris, 2018). A social model of disability becomes the base for professional action as social influences on the disability experience are considered (Anderson & Heyne, 2012a). Disabled people introduced the social model in response to the prominent medical model which individualized disability. Under the social model, disability is considered to be socially constructed, meaning that 'being disabled' is defined by humans, rather than being a natural reflection of the diversity of the human condition (Withers, 2012). Three tenets of the social model of disability are (a) disabled people are an oppressed social group, (b) there is a difference between impairments people have and the oppression they experience, and (c) disability is caused by social oppression (Shakespeare & Watson, 2001; Withers, 2012). A social model perspective challenges the notion that impairment is synonymous with illness in need of being cured (Barnes, 2012). Recreation becomes a means to enhance engagement in community activities and overall wellbeing.

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[3] Strengths-based therapeutic recreation practice is based on the "Flourishing Through Leisure: An Ecological Extension of the Leisure and Well-Being Model" (Anderson & Heyne, 2012a, p. 19), which is an extension of the Leisure and Well-Being Model developed by Carruthers and Hood (2007) and Hood and Carruthers (2007).

Therapeutic Recreation Practice

Although the aims of TR professional practice through the lenses of the medical and social models of disability have been presented in the literature as somewhat dichotomous, in actual practice the lines are much less clear. Briscoe and Arai (2015) found that TR practitioners looked down on the medical model, and yet they discussed people by diagnosis and medical history, assessment-based deficits, and maintaining an expert-patient distance. Briscoe and Arai connected the medical model tendencies to the clinical setting in which the therapists worked and the medical-model dominant educational programs under which they were certified.

Reid et al., (2013) also found contradictions in expressed ideology and professional practice. Using a survey, the TR specialists revealed that they based their identity on knowledge of recreation/leisure, the desire to help others, a passion for leisure, and holistic, person-centred, and strengths-based approaches. Yet, they preferred the job title 'Recreation Therapist' rather than TR specialist because it sounded more clinical. The 'therapists' were also approximately three times more likely to see 'recreation as a therapeutic means to an end' rather than an 'end in itself' (Reid et al. 2013).

A lack of respect for TR within healthcare is a concern for many TR specialists (Briscoe & Arai, 2015; Wozencroft et al., 2009). Feeling illegitimate in the healthcare world stems from a confusion of as to whether to promote recreation as a therapeutic tool or a service for holistic wellbeing and enjoyment (Mobily & Morris, 2018). This confusion may be due, in part, to acquiescing to the practice models of other allied health professionals (Reid et al., 2013; Wozencroft et al., 2009). As allied health professionals typically practice from the medical model, some TR specialists see adherence to this model as a solution for legitimacy in healthcare (Briscoe & Arai, 2015). TR specialists may also be pursuing increased respect through increasing professionalization standards and educational requirements (Mobily et al., 2015).

The Role of Textbooks

Bednarz (2004) found textbooks to be "cultural artifacts, related to and reflective of the education system" (p. 224). Textbooks reflect the knowledge landscape of a field and are a mainstream way of passing information on to students (Errington & Bubna-Litic, 2015). Because all TR practitioners attend post-secondary institutions before entering the field, TR textbooks overtly and covertly influence professional identity development (O'Donnell & Hafferty, 2014). Reliance on a single source of written knowledge in undergraduate courses, such as textbooks, limits access to alternative viewpoints (Bednarz, 2004), and the development of critical thinking skills in students (Errington & Bubna-Litic, 2015). This may contribute to what Sylvester (2015) fears is the push for an uncritical acceptance of a single conceptualization of TR.

van Puymbroeck et al., (2010) suggested that the future of TR will be determined by the curriculum provided by TR professors to students in higher education. Professors' selection of reading materials is not value free. Students often learn organizational culture and practices, and establish professional identities through hidden curriculum, especially in the healthcare realm (Hill et al., 2014). Cowell (1972) first defined the hidden curriculum as "that which the school teaches without, in general, intending or being aware that it is taught" (p. iv). Hidden curriculum can come from the personal beliefs, attitudes, and values of professors, their choice of textbooks, and the type of practical placements available. Analysing textbooks is one way to uncover educators' conceptualization of TR and explore the hidden curriculum, especially given "the extent that instructors rely on textbooks to structure (and even streamline) course development" (Cassese & Bos, 2013, p. 214).

Our aim was to understand the ways textbooks, as educational tools and cultural artifacts, portray conceptualizations of TR. Therefore, the purpose of the study was to understand how therapeutic recreation practices are constructed and reproduced in TR textbooks, with attentiveness to hidden discourses. Key areas addressed included the described

role of the TR specialist, support for a functional or recreation-based definition of TR, underlying disability models, and assumptions about people who access TR services.

Conceptual Framework: Critical Disability Theory

Critical disability theory (CDT), the conceptual framework for the study, facilitated the interpretation of the findings (Collins & Stockton, 2018). In critical disabilities studies, disability is a viewed as "both a lived reality in which the experiences of people with disabilities are central to interpreting their place in the world, and as a social and political definition based on societal power relations" (Reaume, 2014, p. 1248). To Meekosha and Shuttleworth (2009), applying CDT is foundational for critical reflexion on the history of disability studies. As such, Hosking's (2008) seven elements of CDT ["the social model of disability, multidimensionality, valuing diversity, rights, voices of disability, language, and transformative politics," (p. 5)] were points of reflexion during the analysis and interpretation of the findings. CDT was an appropriate lens to examine TR textbook discourse as a "primary concern of critical disability theory is an interrogation of the language used in the context of disability" (Pothier & Devlin, 2006, p. 3).

Methodology and Method

The constructivist research paradigm framed the research, comprised of a relativist ontology, a transactional/subjective epistemology, and a hermeneutic and dialectical methodology (Kivunja & Kuyini, 2017). These constructs convey multiple meanings of reality without one objective true interpretation, and that knowledge generation involves researcher interpretations. Social constructivism "is the process by which individuals construct their personal knowledge about reality and, in doing so, create their own reality" (Russo, 2005, p. 25) Our goal was not to uncover an objective, specific, or universal conceptualization of TR within TR textbooks, but rather to examine the discourses held within textbooks and situate the findings within ideologically driven social contexts.

Research Approach

Discourse analysis (DA) is the "study of language-in-use" (Gee, 2010, p. 8), and how

language works within social practices. Language is political, grounded in power, history, and ideologies (Amerian & Emsaili, 2015). Researchers using DA connect the language of texts with social contexts to highlight the values of speakers and writers, making it a well-suited approach for connecting discourses in current TR textbooks to TR practices (Cheek, 2004; Gee, 2010; van Dijk, 1993).

Textbook Selection

Six TR textbooks used in 15 different educational institutions were identified using a purposeful, criterion sampling strategy, as data selection in DA must be selective and match the research problem and objectives (Fairclough, 2012). Textbooks for review were included if they appeared in a university course syllabus (from Canada or the USA) available via Google, were in-print on the website Amazon.ca, and were published within the past 15 years (2004 - 2019). Excluded textbooks were edited textbooks, study guides or manuals, or those focusing on a specific aspect of TR (e.g., management or assessment). The two most subscribed textbooks were selected for inclusion in the study, as they provided a representative sample of current TR discourse (see Appendix C). The texts were Stumbo and Peterson, (2009), *Therapeutic recreation program design: Principles and procedures* (5th ed.), and Anderson and Heyne (2012b), *Therapeutic recreation practice: A strengths approach*. To understand the authors' conceptualizations of TR, the preface and introductory chapters were analysed.

First published in 1978, the Stumbo and Peterson (2009) textbook was used in 11 courses in 10 of the 15 institutions identified. The fifth edition "features an improved organization that guides you through the theory and practice of therapeutic recreation programming in a way that fully prepares you to work effectively in the industry" (Stumbo & Peterson, 2009, back cover). There are 16 chapters in the textbook; selected for analysis were the *Preface* (pp. xi-xiii) and Chapter 1, *Conceptual Foundations*: *The Basis for Service Development and Delivery* (pp. 1-26).

The Anderson and Heyne (2012b) textbook is a first edition textbook assigned in 6 courses, in four of the 15 institutions identified. The authors commit to reflexion on the field of TR and a strengths-based model of practice, including creating societal change. The textbook has 13 chapters. Selected for analysis were Chapter 1: *Introduction to Therapeutic Recreation Practice: A Strengths Approach* (pp. 3-10) and Chapter 2: *Paradigm Shifts – A Sea Change in Health and Human Services* (pp. 11-25).

Quality of the Research

Four criteria guided the conduct of quality discourse analysis (a) systematic and rigorous analysis, (b) transparency of analysis, (c) substantiation of claims with evidence, and (d) representation of analysis process and results (Greckhamer & Cilesiz, 2014). A *systematic and rigorous analysis* occurred by presenting coherence across the research paradigm, conceptual framework, research approach, methods used (Rudman & Dennhardt, 2015), and acknowledging a subjective epistemology (Antaki et al., 2003). The *transparency of the analysis* involved following and documenting discourse analysis processes using a textured analysis of words, phrases, and longer statements using a discourse analysis question sheet (Gee, 2010; Røberg et al., 2017). Although the authors are experienced qualitative researchers, they completed the analysis through the lenses of white, non-disabled, straight, cisgendered females with professional practice in therapeutic recreation, Para sport, and adapted physical activity.

The *substantiation of the claims made* transpired by locating the research question in the literature as a needed area for exploration. Direct quotations supported the findings. The tenets of Critical Disability Studies provided points of reflexion in the interpretation of the findings. The *representation of the analysis process and results* occurred by researcher reflexion on documented logbook entries and peer debriefing. A limitation of the representation of the analysis rests with the examination of only two textbooks. However, this enabled an in-depth analysis of textbooks that ultimately presented two different conceptualizations of TR.

Data Analysis

Seven discourse analysis questions were used to guide analysis: how is language used to construct significance, practices, identities, relationships, politics, connections, and sign systems and knowledge? (Gee, 2010). Although there is no formulaic way to conduct discourse analysis (Cheek, 2004); Rudman and Dennhardt (2015) suggested using an analysis sheet to promote transparency of the analysis and use of theory. The analysis sheet contained four sections: the above mentioned discourse analysis questions (Gee, 2010; e.g., what TR practice is language being used to enact?), questions informed by Critical Disability Theory (Hosking, 2008; e.g., which model of disability is being used?), questions informed by the research questions (e.g., how are the goals of recreation therapy described in the text?), and questions informed by linguistic tools (Rudman & Dennhardt, 2015; e.g., how are subjects within the texts presented?).

The analysis starting with an 'open reading' of the selected texts (Rudman & Dennhardt, 2015, p. 146), noting interesting features. Using the analysis sheet, a closer reading of concepts and ideas led to exposure of explicit and implicit assumptions (Rudman & Dennhardt, 2015). The analysis continued with attention given to *what* was said, *how* it was said, and overt and covert meanings of language choices (Rudman & Dennhardt, 2015). Preliminary themes were then generated, and then finalized with supporting quotations.

Results

The authors of the textbooks adhere to distinct conceptualizations of the goals of TR, context of practice, the role of practitioners, and TR specialists' relationship with service users. The themes generated from Stumbo and Peterson's (2009) textbook are based in a medical model understanding of disability, most applicable to clinical contexts. As knowledge experts, the role of TR specialists is to prescribe function-enhancing recreational activities. The themes generated from the Anderson and Heyne (2012b) textbook are based in a strength-based social model of disability, more relevant to community contexts. TR specialists focus on participants strengths, and build relationships to collaboratively problem solve opportunities for meaningful

leisure engagement (see Table 5). The findings are presented for each textbook in turn.

Table 5

Summary of Themes

Therapeutic Recreation Program Design: Principles and Procedures. Stumbo & Peterson, 2009	Therapeutic Recreation Practice: A Strengths-based Approach. Anderson & Heyne, 2012
Individual Responsibility for Health	Being in Relationship
Professionalization of Therapeutic Recreation	Disability as Diversity
Medicalization of Recreation	Solution Focused

Therapeutic Recreation Program Design: Principles and Procedures (Stumbo & Peterson, 2009)

Individual Responsibility for Health

The concept of 'health' and individual responsibility for being 'healthy' is a prominent discourse of Stumbo and Peterson (2009). They linked lack of health and disability to self-imposed lifestyle shortcomings in physical, emotional, and social wellness. Using a secondary resource, they stated, "**Wellness** is an approach to personal health that emphasizes individual responsibility for wellbeing through the practice of health-promoting lifestyle behaviors (Hurley & Schlaadt, 1992)" (Stumbo & Peterson, 2009, p. 2, emphasis original). They further identified 38 barriers to leisure, 35 of which focused on an individual's lack of skills or "inability to" personally engage in normative wellness behaviours (p. 11). Of the individually focused barriers, seven (20%) pertained to physical health, including deficits in physical coordination, decreased mobility, disability, limited physical ability, and fatigue. Twenty six (74%) of the barriers pertained to emotional and psychological health, including fear of entering new settings, lack of motivation, fear of rejection, inability to manage stress, lack of knowledge and experience with

leisure, and refusal to take responsibility for leisure. Two of the individually focussed barriers focussed on (6%) to social health: inappropriate social skills and lack of leisure partners[4].

Only three barriers focused on social or environmental factors including time (real or perceived) available for leisure, lack of financial means, and lack of reliable transportation. The barrier discourse squarely placed perceived wellness deficits on the individual, with any resulting change in function (disability) being a personal responsibility. The implicit (hidden) message is that the purpose of TR is to promote individual change (deficit reduction) in order to meet normative standards of functional ability through prescribed recreational activities, rather than identifying and addressing social, cultural, or environmental inhibitors to recreation participation. Although Stumbo and Peterson (2009) stated that "the relationships between health, wellness, and life functioning are important, and must take into consideration a person's cultural, social, and historical background" (p. 12), the mention of factors external to the individual seems disingenuous given the predominance of person focused barriers. Framing disability as an individual responsibility implicitly supports the medical model of disability and healthcare contexts as the domain of TR practice.

Professionalization of Therapeutic Recreation

The deficit-based understanding of disability (medical model), one that places responsibility for perceived deficits on individuals due to poor choices or other internal processes, creates the need for health-based interventions and a professional identity based on exclusive knowledge, interventionist practice, and the evaluation of progress toward normalized function and health. Stumbo and Peterson (2009) stated:

> The focus on a satisfying and health producing leisure pattern is exclusive to therapeutic recreation services, but it's vitally complementary to the overall health and rehabilitation mission of most health care in human service agencies….Development, maintenance,

[4] See Stumbo and Peterson (2009, p. 11-12) for a complete explanation of the barriers.

> and expression of an appropriate leisure lifestyle for individuals with disabilities and/or illnesses can be established as an area of human need and thus an area for professional service. Therapeutic recreation has been established as the professional field of service that fulfills this need. (p. 12-13)

The use of the term *exclusive* suggests a unique knowledge base and profession, distinct from other health professions. The word *appropriate* supports the notion of professional knowledge and practice based in a hierarchical identity of expert. The implicit (hidden discourse) assumption is that disabled people are not able to develop, maintain, or reach *appropriate* or normative expressions of a recreation without professional intervention. The dependence on health professionals created by the 'disease therapy cycle' perpetuates the idea that disabled people are in constant need of therapy, a need which also solidifies the existence of therapists.

If experts perceive that disabled people are in need of leisure supports due to normatively imposed standards of leisure, there will be need for TR. The use of the term c*omplex* to describe how leisure can improve quality of life beyond enjoyment or participation, further conveys a connection between a definable unique and professional (expert) knowledge base and a return to wellness by those with perceived deficits. The discourses of complexity and comprehensive services promotes a hierarchy of expertism and professional territorialism. For disabled people, this means their knowledge of an appropriate leisure lifestyle, quality of life, and enjoyment are perceived to be of little significance. Within the healthcare system, TR is positioned as a legitimate and recognizable profession, as only they have the knowledge to design appropriate and comprehensive leisure services, implying that unqualified others may cause harm.

Medicalization of Recreation

Stumbo and Peterson (2009) open Chapter 1 with a statement about the medical model:

> It views health as being at the opposite end of the continuum from disease, illness, and/or disability, and focuses on functional ability, morbidity, and mortality (Larson, 1991). In this view, if an individual had a disease, disability, and/or illness, he or she was not capable of being healthy (p.1).

From this discourse, the notions of health and disability are mutually exclusive with disability being synonymous with a poor quality of life. A focus on enhancing functional ability to improve quality of life medicalizes recreation as a tool of TR and is a key aspect of The Leisure Ability Model[5], created to guide TR practice (Stumbo and Peterson, 1998). The first stage of the model is "Functional Intervention" (p. xi) which is "a necessary antecedent to leisure involvement…improved functional ability…[given] deficits in the four functional domains related to leisure involvement: (a) physical, (b) mental, (c) emotional/affective, and (d) social" (Stumbo & Peterson, 1998, p. 88). TR specialists enact their professional privilege and expertise, introducing a hierarchical relationship that can negate individuals' desires, preferences, and lived knowledge. The implicit (hidden discourse) assumption is that disability implies illness due to deficits in functional ability, and recreation as therapy can restore wellness and quality of life.

The locus of control for functional deficits and a return to wellness, a symbol of a higher quality of life, rests with the privileged knowledge and interventionist activities of TR specialists. Stumbo and Peterson (2009) purport that the lives of disabled people can be enhanced through *appropriate* and *comprehensive* intervention – beyond what the individual may feel is *enjoyable:*

> The improvement of the quality of an individual's life through focus on the leisure component is much more complex than the provision of enjoyable activity or the delivery of some segmented therapy utilizing activity as the medium. Therapeutic recreation calls

[5] The three progressive stages of the Leisure Ability Model are functional intervention, leisure education, and recreation participation. See Stumbo & Peterson (1998) for a full description of the model.

> for a thorough understanding of the leisure lifestyle concept and the design of appropriate and comprehensive services that can be used to intervene in the lives of people in an influential and positive way. (p. 14)

When TR is specialist (expert) driven, recreation becomes a medical tool to facilitate individual, functional change.

Therapeutic Recreation Practice: A Strengths Approach (Anderson & Heyne, 2012b)

Being in Relationship

Anderson and Heyne (2012b) based their textbook on a strength-based approach to practice that aligns with a social model of disability. Participants *and* their surrounding environments are the focus of interventions as the authors "see therapeutic recreation as identifying family, cultural, neighborhood, and community resources to support people in achieving their goals" (p. 3). They describe the approach as one in which "goals and interventions are driven by aspirations identified by the person, and we judge our success in the helping relationship by whether those goals are met", valuing and acknowledging life experiences before implementing a goal-oriented plan (p. 12). The authors further portray the TR role as a *helping* one, with the implicit (hidden) discourse of being 'in relationship' through altruism, connection, and regard for one another - rather than discourses of chronic need, decreased choice, or benevolence.

The language in Anderson and Heyne's (2012b) textbook reflects a further commitment to relationship building. The authors stated:

> How we talk and write about the participants with whom we work in therapeutic recreation can show respect, positivity, and accuracy. Language can instill hopefulness and a sense of possibility, or it can instill a sense of "handicaptivity," damage, and hopelessness. (Anderson & Heyne, 2012b, p. 21)

In using the terms *participant* or *people* they distance themselves from the identity

discourses of 'patient' which "conveys helplessness, disease, and a strong linkage to the medical, deficit-based model" (Anderson & Heyne, 2012b, p. 22). They additionally recommend language that is "action-oriented, engaged, positive, sensitive, and accurate" (Anderson & Heyne, 2012b, p. 22), such as using a person's name, rather than diagnosis, such as "the hip replacement in Room 4" (p. 21). The implicit (hidden message) is that language is a social phenomenon that reflects, shapes, and influences our behaviors and relationships with others.

Disability as Diversity

Anderson and Heynes (2012b) believe that disability is not a negative state of being, and instead "of seeing disability as damage, **we see disability as a variation in the human condition**" (p. 20, emphasis original). The idea of disability as diversity is a rejection of ableistic notions that define disability as a negative state, something that needs to be changed or cured. They reject using assessments designed to decrease diversity as "the focus of assessments is to find needs and problems…and interventions are designed to address problems or deficits" (p. 3). Viewing disability as a variation rather than a deficit, relieves the pressure to change or 'fix' function and "the ability to embrace life as disabled person can flourish…[as people can] live full lives in their homes and communities, without having to gain 'prerequisite skills' in 'stepping stone' rehabilitation or therapy programs" (Anderson & Heyne, 2012b, p. 20). Anderson and Heyne (2012b) suggested that people should not have to 'practice' leisure in specialized settings before being allowed to participate in mainstream settings, rather, the community needs to be modified to enable inclusive programming. The implicit (hidden message) is that disabled people do not have to prove themselves able before participating in their leisure of their choice, as all forms of participation are valuable. Anderson and Heyne (2012b) described the TR specialist role as being active in supporting communities to include everyone, rather than change individuals to fit into existing (exclusionary) settings.

Solution Focused

Anderson and Heyne (2012b) discussed the idea of a 'sea-change' occurring in both TR and general healthcare. They see current practice as being problem-oriented, rather than solution focussed, a difference they define as: "Solutions are what people *want* to have happen, versus problems, which are what people *don't want* to have happen" (p. 4). The authors believe that the traditional western healthcare problem-oriented approach can be disrupted by embracing a strengths-based solution approach. Inherent in the strengths approach is viewing participants as experts in their own lives. Pursuing personally chosen TR goals gives meaning to interventions that are 'solution-focussed' (barrier removing) rather than 'problem-focussed' (deficit based). TR specialists work at "building community capacity to include people with disabilities across all domains, from work to school to recreation" (Anderson & Heyne, 2012b, p. 19).

Supporting communities to include everyone, rather than change individuals to fit into existing communities, provides a critical and practical way to create social change. To TR specialists using a strengths approach, participants are viewed in the context of their family and cultural communities to generate shared solutions. According to Anderson and Heyne (2012b), commitment to strengths-based TR practice begins with a shift away from specialist-perceived *patient* need to solutions based on asking *participants* what they would like to achieve. They seek an expansion of a deficits-based approach in TR to also include community resources and client choices and strengths. TR specialists utilize the person's strengths and resources to support them in achieving their aspirations, over a singular focus on ameliorating deficits to meet TR specialist prescribed outcomes.

Discussion

The two most subscribed textbook authors defined the field of TR for use by instructors and their students using their own conceptualizations of TR, in distinctly different ways. The themes developed from the discourse analysis highlighted distinctions across the goals of TR,

the context of practice, the role of practitioners, and relationship building.

Goals of Therapeutic Recreation

Stumbo and Peterson's (2009) conceptualization of TR has parallels with the medical model, such as the connections between disability and illness, positioning TR specialists as disciplinary experts, being members of clinical health teams, situated in hospital contexts, and returning people to normalized function. As a self-promoting allied healthcare profession, the medicalization of recreation brings prestige and respect in healthcare contexts as recreation becomes means for restoring health (Filc, 2004; Mobily, 2015a). The disability discourse of reduced function, poor health, and reduced quality of life creates and sustains the need for TR intervention. The authors' position supports Illich et al.'s (2011) contention that medical science focusses on health, not as one pillar of a good life, but as the very definition of what constitutes a good life. Further aligning disability with illness (lack of health), defines people as patients in need of medical intervention to restore them to normality (Oliver, 1990). The hegemony of the medical model, and TR under this model, defines disability as an individual problem, making the discourse difficult to disrupt (Filc, 2004; Sylvester 2015). The role of social, cultural, and political barriers to inclusion, the lived knowledge of disability, and being in collaborative relationship when setting goals, is secondary to prescriptive healthcare interventions to ameliorate, rehabilitate, and normalize pathology (Austin, 2002).

Anderson and Heyne (2012b) provided a powerful alternate discourse, one based in a firm belief that disability is not an inherently negative state of being, but rather a natural variation of the human condition (Shogan, 1998). With the assumption that impairment is part of human diversity, the goal of TR practice becomes engagement in choice filled and enjoyable recreation as part of a socially rich good life (Kleiber et al., 2011). Participant strengths and resources are foundational as TR specialists support disabled people's recreation and leisure aspirations.

A distinction between the respective textbooks rests with the (not so) hidden message

that the actions of TR specialists are done to, rather than done in dialogue with, disabled people (Bricher, 2000). People tend to act on the best of intentions, yet there is a professional responsibility to reflexively critique the assumptions upon which those intensions are based and their consequences on others (Briscoe & Aria, 2015; Goodwin & Rossow-Kimball, 2012; Sylvester, 2015).

Context of Practice

A dichotomization of TR contexts could be drawn along the lines of medical model/clinical and social model/community settings (Mobily & Dieser, 2018; Wozencroft et al., 2009). Stumbo and Peterson (2009) positioned TR specialists alongside clinical therapists (e.g., occupational therapy, physical therapy), seeking respect and prestige for the field (Briscoe & Arai, 2015; Wozencroft et al., 2009). Justifying professional status on a deficit view of disability arguably perpetuates a negative construction of disability (Filc, 2004; Illich et al., 1977). As suggested by Meekosha and Dowse (2007), rehabilitative and medical discourses of disability minimize a broader extension of the community as a legitimate platform for TR practice, or bring a medicalized mindset beyond acute care settings, potentially devaluing community resources. A restriction of context in turn constricts the identity of service users to a singular dimension of disability, ignoring a multitude of other factors (i.e. race, gender, socio-economic status) which will affect a client's ability to engage in leisure (Hosking, 2008). Presenting a community focused conceptualization of TR, Anderson and Heyne (2012b) challenged a clinical focus saying that the "medical model and medical professionals have lost the monopoly once held over medical and health knowledge" (p. 21). They promote disabled people as knowledge holders and valued their input and strengths in the shared development of leisure interests. Access to the community is a main focus, and community resources are utilized even within institutional settings. With a viewpoint that decouples disability and the assumption of medical need, Anderson and Heyne (2013) presented discourse for TR based on a desire for accessible community recreation (Hutchinson et al., 2006).

Role of Practitioners

According to Stumbo and Peterson (2009), a TR specialist's job is to bring about normalizing functional change for patients. (Mobily, 2015a). Other recreational outcomes, such as enhanced self-esteem, skill development, social engagement, enjoyment, or overall mental health are secondary to a focus on functional change (Scott, 2015). TR specialists become gatekeepers to the meaning of prescribed recreation activities based on normative standards of function. As Oliver (1991) pointed out, the hidden discourse of hierarchical and "dependency creating relationships" traps professionals as gatekeepers of care for those in perceived need, promoting mutual dependency, that while career satisfying, reduces motivation to bring about social change (p. 91). TR specialists have the potential to become "professional disability parasites" (Bricher, 2000, p. 783), advancing their own professional legitimacy and careers while being unwilling to create social change and equity. For disabled people, an identity of dependency can lead to disempowering feelings of inadequacy and negative self-perceptions as they serve the needs of those who need to care (Bricher, 2000; Scott, 2015).

Anderson and Heyne (2012b) believe that TR practitioners can be part of disability discourse that replaces the dichotomy between able/disabled with a continuum of strengths, promoting acceptance and diversity. They uphold collaborative relationships based in supported participant control, decision making and aspirational activities over independence in daily activities (Bricher, 2000). It is of note that while the authors commit to the strengths-based approach, they may be underrepresenting the physical and emotional struggles disabled people face in entering community recreation contexts (Shakespeare, 2006; Withers, 2010).

TR Specialist Relationships with Service Users

For Stumbo and Peterson (2009) the TR specialist is an expert, upholding the view that disability is a problem needing medicalized solutions. The authors create a hierarchy of need based on a professionally imposed power dynamic reflected in the value laden language of TR specialist and unknowledgeable patient (Bricher, 2000). Resulting is a discourse of privileged

professional knowledge that defines the 'patient' by labels and disability, removing individuality, choice, voice, efficacy and perhaps even impart insult through dismissal of preferences (Hosking, 2008; Evan, 2004).

Anderson and Heyne (2012b) place importance on alliances and shared knowledge between the participant (embodied knowledge) and the TR specialist (education and professional experience). Space is created to hear the participants' voice (Hosking, 2008). Anderson and Heyne (2012b) suggest that the relinquishment of professional power creates opportunities for collaboration and relationship building. They critically reflected upon the unexamined use of the medical model and a hierarchical professional stance. Sylvester (2015) warned of the dangers of losing critical and alternative voices in TR and asked those in the TR profession to critically re-examine the ideas that are foundational to the field. Anderson and Heyne (2012b) presented a vastly different conceptualization of TR to the medical model rhetoric common to healthcare settings and suggested that TR is not reliant on medically based legitimatization. They present a discourse of relationship building aimed at increasing leisure, enjoyment, and socially rich community recreation engagement (Kleiber et al., 2011).

Conclusion

The tension between recreation as a tool or an end in itself has existed since the field's beginnings nearly a century ago, and continues today (James, 1998b). We are aware that the writing of this paper may be reinforcing a false dichotomy, making artificial enemies of instructors, students, and practitioners who find themselves on either the healthcare or community contexts sides of TR (Kubler LaBoskey, 1998). And yet, explicit and implicit (hidden) lines have been drawn. To incorporate a broad and encompassing view of TR, dialogue between TR leaders, professionals, and disabled people needs to occur. The negative perceptions of healthcare practice by some, and the lack of perceived rigor in community practice by others, reinforces a medical versus social dichotomy that is occurring outside of disability discourse and disability groups (Bricher, 2000). Therapeutic recreation needs disability studies, especially

when there is a significant potential to cause harm to disabled people through the use of medicalized TR (Evans, 2004).

Instructors pass along their conceptualization of TR as they know it to their students, while working to improve the quality of TR degree granting programs and the preparedness of their students (Hawkins et al., 2018). Errington and Bubna-Litic (2015) claimed that textbook use may limit the development of critical thinking skills, and in combination with the concept of hidden disability discourses, students may adopt unintentional and unexamined assumptions. Generating space for students to discuss the future of TR while stepping away from their immediate learning, may spark reflexive questions that challenge the dichotomizing discourse in TR (Kubler LaBoskey, 1998). The emerging questions may focus less on which approach (medical model/clinical practice, social model/community participation) is 'best' or 'correct' to one of "how expertise is exercised [and] how such concepts are applied" (Evans, 2004, p. 3) to therapeutic recreation.

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CHAPTER 5
CONCLUSION

Therapeutic recreation is a field characterized by different, and perhaps competing, conceptualizations of professional practice. These different conceptualizations affect the field from the practice level to the organizational level (including the NCTRC), as the governing leaders address educational reforms and standardization policies (Hawkins et al., 2018). This study was designed to create an understanding of how the activities of TR are constructed and reproduced in TR textbooks, with sensitivity to what is being transferred to students. The tension surrounding TR was brought to light, as well as reflections on the 'why' behind the different conceptualizations of the field. As the two textbooks analysed in this study provide very different conceptualizations of TR, it follows that students learning from either book would learn and internalize very different ideas about what it means to be a recreational therapist.

The confusion and tension in professional practice resulting from a lack of a single conceptualization of TR may abet the argument that TR practitioners must commit to a single conceptualization in order for the field to move forward. However, I question the wisdom of a narrow, fixed view of TR. The 'recreation as a means' and 'recreation as an end' sides have existed in TR for nearly a century, and more recently have been documented in the literature (Buettner et al., 1996; Janssen, 2004, Luker et al. 2015, Saposnik et al. 2010). TR practitioners face diversity in both contexts and individuals, for example the differences are vast between clinical versus community settings, or between working with someone who lives with a congenital impairment compared to someone with newly acquired injury. Aa single perspective of TR does not capture the needs of disabled people and why they might access TR, however the conceptualization of TR by Stumbo and Peterson (2009) promotes a medicalized view of TR which places responsibility for wellness and leisure ability on the individual, rather than focus on creating change at a broader (societal) level. This view reinforces ableist norms, and is incongruent with the social model of disability, which is presented by Hosking (2008) as a

model for transformative change for disabled people. A medicalized view of TR reinforces professional identities and promotes interventionist practice that devalues diversity by prescribing recreational activities which privilege normative functional ability, while at times devaluing the preference of the person. This is not to say that clinical-based TR professionals do not ever incorporate client choice or include community resources in their practice, but expert knowledge and functional changes are prioritized.

Anderson and Heyne (2012b) seek to *expand* on a deficits-based approach to TR, acknowledging that one conceptualization should not supplant the other, but rather extend the continuum of care and service. They promote a way to practice TR that creates opportunities to enhance personal strengths to achieve inclusion in recreation activities, beyond the clinical context. They also ask TR students and practitioners to embrace a broad vision of TR, one that values diversity of human experiences, involves the desires of their clients, and seeks to remove barriers to participation.

Reflexion on how we think about, promote, and teach TR is necessary because, according to proponents of Critical Disability Theory, TR practiced without giving voice to and valuing the diversity of disabled people causes significant harm to disabled people (Hosking, 2008). Reflexion in TR will enable practitioners to think critically about the parts of TR ideology and practice that contribute to the negative construction of disability (Briscoe & Arai, 2015). TR specialists are at risk of imparting harm when professional needs are valued *above* those of the TR service users. Some professionals, especially those leading current governing bodies, have been criticized for promoting deficit-based practice in order to raise the prestige of the profession (Dieser, 2013; Mobily, 2015b; Sylvester, 2002). The message underlying deficit-based practice is that disabled people need to change to fit into society, which is a message that marginalizes, silences, homogenizes, and removes resources from disabled people. A conceptualization of TR that does not address the need for change (social and legal) at a societal level, promotes a return to normative functioning without be in relationship with the person

about their goals and challenges (e.g., socio-economic status, gender, race), uses language that removes dignity and personhood, and disengages with the politics surrounding the construct of disability, is one that creates and sustains hierarchies of knowledge, influence, position and is detrimental to the wellbeing of disabled people.

A challenge to recreation therapists will be to recognize the impacts of the different conceptualizations of TR while keeping the needs of participants at the center of their practice. For example, participants may have functional goals, and Stumbo and Peterson (2009) provide a useful framework to achieve these. On the other hand, Anderson and Heyne (2012b) provide tools to recognize the participants' strengths and focus on relational solutions rather than problems. There is overlap between the conceptualizations, such as the special training and knowledge of TR practitioners which is present in both. In my professional experiences, TR practitioners move between the conceptualizations fluidly, although at times uncritically, in day-to-day practice.

Sylvester (2015a) asked TR practitioners to use resources to create dialogue and opportunities for critical thinking. I believe that the textbook authors could, in future editions of their works, position their conceptualization of TR within the broader field, thereby acknowledging the breadth of the field and that TR education needs to reflect the context in which it is practiced as our understanding of disability and our role in its construction matures.

Elevating the medically-based ideas of TR from the hidden curriculum to the manifest curriculum in TR textbooks would be one way to promote discussion and reflexion of the effects of the medical model on those who access TR services. When ideas that stem from the medical model are not openly discussed in texts, readers may absorb these ideas without the opportunity for critical thinking (Errington & Bubna-Litic, 2015). This clinical mindset may then seep into practice, also without critical thought to its application, which is a disservice to both participants who may be construed as in ongoing need of therapy or help, and practitioners, who may unintentionally benefit from this construction. If practitioners are provided the tools and time to

practice reflexion, TR practice may continue to be reconstructed, in a way that best serves both participants, and practitioners.

Limitations

The findings presented were based on specific chapters within two TR textbooks. This is a limitation as the perspectives of only two sets of authors were included in this research, leaving out many others. The texts themselves were also quite different in that one has undergone multiple editions since its first publication in the 1980s, while the other is a much newer, first edition text. However, the texts are both currently used in undergraduate TR education in Canada and the United States of America. Although not intentional, the two selected texts also stood as exemplars of quite different conceptualizations of TR. Delimiting the study to the review of two textbooks may reflect a somewhat dichotomous view, rather than the full range of the discourses surrounding how TR is conceptualized.

Antaki et al. (2003) provided several shortcomings which can be prevalent in discourse analysis. One potential shortcoming is over or under analysis of the discourses. I hope I have provided readers with enough context to draw their own conclusions. Another potential limitation in discourse analysis is "taking sides" (Antaki et al., 2003, p. 1). Research conducted from a subjective epistemology is value laden, which brings authority to the knowledge claims advanced, but also the risk of confirming preconceived notions about the phenomenon of interest. For this reason, I have explained my paradigmatic and researcher position in the completion of the work (Greckhamer, & Cilesiz, 2014). I also tried to recognize and reflect on my assumptions, which included asking for peer feedback regarding preconceived notions found in my work. One of the conceptualizations of TR resonated more with my personal beliefs and TR practice which was reinforced through my reading of the textbooks through a lens of critical disability theory. Although there were similarities among the texts, using CDT highlighted the potential harm that a deficit-based approach may cause in TR. I also acknowledge that these texts represent just two of many conceptualizations of TR. This work was not meant to be

generalizable to encompass all TR textbooks but opens the door to future research which could be conducted on how TR is conceptualized in other discourses.

Future Research

The findings from this research adds to a limited body of research about TR, at a time when researchers with the NCTRC are looking to restructure TR education in North America, and when TR practitioners in Alberta are trying to gain professional status. As the purpose of my research was to understand how therapeutic recreation practices are constructed and reproduced in TR textbooks, an expansion of this work to analyse entire textbooks, and to include more textbooks, would lead to an expanded understanding of the discourses currently present in TR undergraduate education. A study that examines what students actually learn from both the manifest and hidden curriculums in texts would also be helpful in guiding curricular changes.

Another next step would be to research how different ideas about TR affects practitioners' identify and practice, and those who access TR services. Although I tried to avoid presenting one conceptualization of TR as better than the other, I did infer that a strengths-based approach in TR may lead to better long-term leisure outcomes for disabled people than a deficit-reduction practice with short term aims of return to function. The examination of long-term leisure outcomes of strengths and deficit-based approaches would be an interesting area for future research, and the evidence from this research could help to provide a legitimacy to the profession that practitioners are often worried is lacking.

The perception of TR practitioners regarding the use of deficit and strengths-based approaches is also an avenue that needs further research. Do practitioners who use a deficit-based approach actually feel more respected in the workplace? How do practitioners who use a strengths-based approach resolve (or not) tension with medically-based colleagues? Are practitioners aware of which conceptualization they use, and if so, how do they make decisions about which conceptualization from which to practice? Deepening our understanding of what

TR practitioners currently know and how they practice can guide reflexion regarding what practitioners do not know, or do not do. If the tension between a deficit-based and a strengths approach is ever to be settled, a much more thorough understanding of its implications for students, professionals, and participants must be developed.

Final Reflections

What does it mean to be a recreation therapist? This question has been in the back of my mind for at least five years as I worked in the field of TR and completed this research. Having worked as a recreation therapist in rehabilitation, long-term care, acute care, and most recently, community mental health settings, I have yet to arrive at a clear conclusion as to the meaning of TR, although it is clear to me that a non-reflexive deficit-based approach to TR can impart and sustain harm to disabled people. The thread connecting my professional practice across settings was a firm belief that engaging in leisure was of vital importance to quality of life, no matter the setting or the people I supported. I came to the realization that I cared far more deeply about enhancing quality of life through enjoyable leisure experiences than strict adherence to normalizing function. I had never heard the term 'strengths-based practice' (Anderson & Heyne, 2012a) in my undergraduate degree, but as my research and reflexion unfolded, the term resonated with me in profound ways. The idea of supporting someone to recognize and utilize their strengths and resources, to accomplish their own aspirations was a meaningful idea to me. As an emerging professional faced with many uncertainties working in a multitude of temporary positions, aligning my practice with a strengths-based approach enabled me to settle, enabled me to know who I was, and what I wanted to accomplish in my work.

As I am finishing writing my thesis in the midst of the Covid-19 pandemic, I had further opportunity to ponder the meaning of TR. I have been splitting time between my regular job as a recreation therapist for a housing first program, and working at an isolation shelter for people experiencing homelessness and Covid-19 symptoms. I had the opportunity to keep a diary of my

time at the shelter for the University of Alberta NewTrail magazine (Spring 2020), with a sample below:

COVID Dispatches: On the front lines at an emergency shelter

Day #1

8 A.M. I check in at the Expo Centre, which is now an emergency shelter for vulnerable people experiencing COVID-19 symptoms. It's relatively quiet, which I'm OK with as I have to learn a totally new electronic medical record system.

12:30 P.M. I deliver lunch to patrons of the shelter. "Let me put this on your coffee table," I joke with one of the men as I place his food on his box of belongings. I clean my face shield for at least the 10th time today.

4 P.M. As the nurses do shift reports, I cover their station, handing out cigarettes, books, coffee and word-search puzzles. And de-escalate complaints.

Day #2

9 A.M. One of the attending doctors discovers I am a recreation therapist and asks if I can run a bingo. I inwardly groan and then start brainstorming how to make it work, along with other activities you can do with groups in isolation.

11 A.M. Staff from another agency show up to learn the procedure in case they need to bring clients here. I super-appreciate their work, but I have to put on full personal protective equipment before talking to them, which means I need to clean it all, again, and sanitize my hands, again.

12 P.M. First admission of the day! Chance that I did something wrong: very high. In my defence, I learned an entire new medical record system yesterday.

Day #3

8 P.M. I remind someone to wear their mask. They get angry and stomp on their crack pipe, sending glass all over the floor.

10 P.M. Phew! Just finished moving people to a different hall and cleaning all their cots. It's hot — the face shield over the mask just locks in the heat.

11 P.M. As more people are sleeping, I find a minute to chat with one of the nurses. We talk about how worried we are about our clients. We know that clients are going to end up getting sick, and feel helpless in trying to stop this.

Although I was working at the isolation shelter as a support staff, rather than a recreation therapist, I realized that I could not just stop practicing TR. I advocated for a projector for movies, and ran around with crossword puzzles and colouring supplies in between

cleaning. I chatted with the patrons as I delivered their meals and tried to learn a little bit about their lives (the stories those folks can tell…). I tried to deliver moments of humanity and enjoyment – which to me are the heart of TR. The folks at the isolation shelter and my regular clients have often experienced trauma to an extent that is almost incomprehensible. I have no illusions that painting a birdhouse is going to 'fix' this. However, going hand-in-hand with surviving trauma is incredible strength and resiliency, and I hope that by using the fundamentals of strengths-based TR, I am able to remind people of their strengths and use recreation and leisure as a way to build upon them.

Did my attachment to a strengths-based perspective flavour this research? Of course. I used a subjective epistemology, and the interpretations of the works analysed are wholly my own. However, my work was also transactional, meaning that that although my own beliefs and values influenced the work, I was also influenced through its completion. As I looked into the history of TR and traced its path to the present day, I was able to locate myself in the field. I realized that I was far from alone in my confusion over what exactly it means to be a recreation therapist. As I examined the textbooks central to this study, I was able to understand what it was about some longstanding, and highly respected TR discourses that made me uncomfortable, and how the medical model of disability had seeped into my education and influenced my practice. I was also able to understand the allure of wanting TR to fit into healthcare, of wanting to be taken seriously. However, researching strengths-based practice gave me the confidence to *not* fit into the healthcare framework of emphasizing normalized function, and being a part of a shift toward recognizing that there is more to leisure than the functional ability to engage in it.

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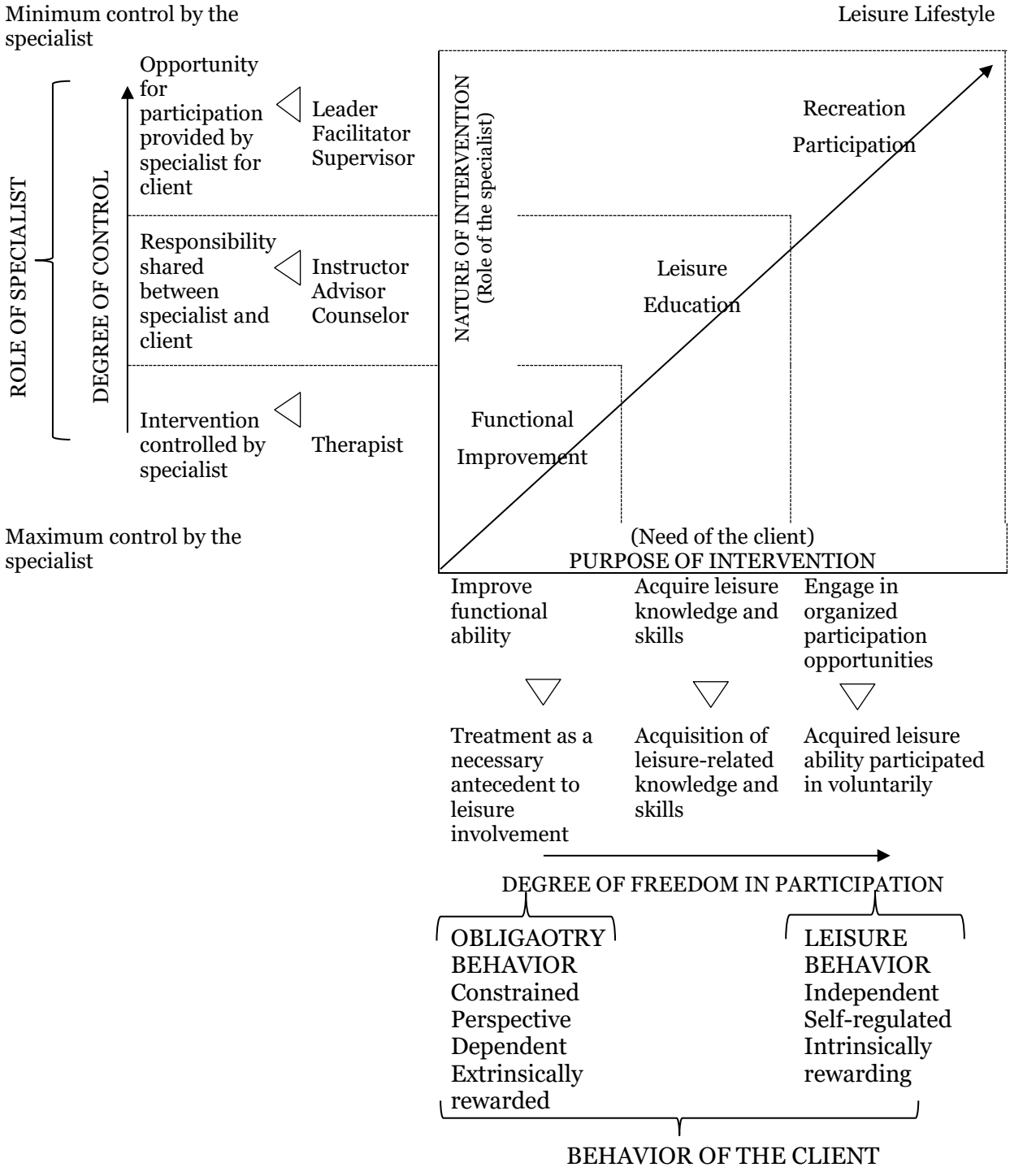
Appendix A

Leisure Ability Model (adapted from Stumbo & Peterson, 1998)



Appendix B

Requirements of the National Council for Therapeutic Recreation Certification (NCTRC) and the Mosaic Certification Framework (MCF)

Table 6

Requirements of the National Council for Therapeutic Recreation Certification (NCTRC) and the Mosaic Certification Framework (MCF)

Certification	NCTRC	MCF
Course Requirements	• A minimum of five courses in TR, with suggested topics being: assessment, TR processes, and advancement of the profession • Supportive course work in anatomy and physiology, abnormal psychology, and lifespan development • Three general recreation courses • Remaining coursework must be done in the content areas of the social sciences and humanities	• Three uniform, Canada-wide, classes: 1. Foundations of TR 2. TR Program Design 3. TR Intervention and Facilitation Techniques • Universities in each Canadian province/ territory would develop diverse support coursework that reflects the strength of their universities, faculties, and communities • Coursework in multiculturalism that reflects the strength of each geographical region
Practicum Requirements	• Completion of a minimum 14 week / 560-hour internship supervised by a CTRS	• All internships would have a specific multicultural obligation.
Credentialing Process	• Completion of the above and passing of the NCTRC Exam	• To be created by the CTRA in collaboration with the provinces and territories • Different credentials based upon scope of practice and education level

(Dieser, 2013; NCTRC, 2016a, 2016b)

Appendix C

Textbooks Used in TR Classes in North American Post-Secondary Institutions

Table 7

Frequency of In-print Textbooks Used in 31 Therapeutic Recreation Courses in 15 Canadian and USA Post-Secondary Institutions, 2014-2019

Textbook	Post-Secondary Institution (n)	Total Courses
Stumbo, N. J., & Peterson, C. A. (2009). *Therapeutic recreation program design: Principles and procedures* (5th ed.). Englewood Cliffs, NK: Prentice-Hall.	• Brigham Young – Idaho Campus (1) • George Mason University (1) • Ithaca College (2) • Pittsburgh State University (1) • Shaw University (1) • State University of New York Cortland (1) • Texas State University – San Marcos (1) • University of Alberta (1) • University of Lethbridge (1) • University of Wisconsin-Milwaukee (1)	11
Anderson, L., & Heyne, L. (2012). *Therapeutic recreation practice: A strengths-based approach*. State College, PA: Venture.	• Brigham Young – Idaho Campus (3) • Ithaca College (1) • Texas State University (1) • University of Lethbridge (1)	6
Carter, M. J., & Van Andel, G. E. (2011). *Therapeutic recreation: A practical approach* (4th ed.). Long Grove, IL: Waveland.	• Calvin College (1) • George Mason University (1) • Southern Illinois University (1) • University of Southern Maine (1) • University of Wisconsin-Milwaukee (1)	5
Dattilo, J., & McKenney, A. (2011). *Facilitation techniques in therapeutic recreation* (2nd ed.). State College, PA: Venture.	• Florida International University (1) • Pittsburgh State University (1) • State University of New York Cortland (1) • University of Lethbridge (1)	4
Austin, D. R. (2009). *Therapeutic Recreation processes and techniques* (6th ed.). Champaign, IL: Sagamore.	• George Mason University (1) • Shaw University (1) • Southern Illinois University (1)	3
Shank, J., & Coyle, C. (2002). *Therapeutic recreation in health promotion and rehabilitation*. State College, PA: Venture.	• State University of New York Cortland (1) • University of Wisconsin-Milwaukee (1)	2

Appendix D
Therapeutic Recreation Textbooks Listed on Amazon.ca

- Anderson, L., & Heyne, L. (2012). *Therapeutic recreation practice: A strengths approach*. State College, PA: Venture Publishing, Inc.
- Austin, D. R. (2009). *Therapeutic Recreation processes and techniques* (6th ed.). Champaign, IL: Sagamore.
- Carter, M. J., & Van Andel, G. E. (2011). *Therapeutic recreation: A practical approach* (4th ed.). Long Grove, IL: Waveland Press, Inc.
- Dattilo, J., & McKenney, A. (2011). *Facilitation techniques in therapeutic recreation* (2nd ed.). State College, PA: Venture Publishing, Inc.
- Shank, J., Coyle, C., (2002) *Therapeutic recreation in health promotion and rehabilitation*. State College, PA: Venture Publishing, Inc.
- Stumbo, N. J., & Peterson, C. A. (2009). *Therapeutic recreation program design: Principles and procedures* (5th ed.). New York, NY: Pearson.

Appendix E

Textbook Details

Table 8

Details of the Textbooks Analysed

Features	Strengths Approach	Program Design
Authors	Lynn Anderson & Linda A. Heyne	Norma J. Stumbo & Carol A. Peterson
Title	*Therapeutic Recreation Practice: A Strengths Approach*	*Therapeutic Recreation Program Design: Principles and Procedures*
Publication	2012	2009
Current Edition	1st	5th
Publisher	Venture Publishing, Inc	Pearson
Publisher Description	*Therapeutic Recreation Practice: A Strengths Approach* is divided into three main sections. In Part One, a foundation of the strengths approach is introduced. Part Two is the mainstay of this book. This section looks at the application of the strengths perspective to the therapeutic recreation process: assessment, planning, implementation, and evaluation. Part Three of the book helps readers as professionals establish and maintain themselves as strength-based therapeutic recreation specialists.	*Therapeutic Recreation Program Design* uses the most up-to-date information and powerful study tools to help students learn how to synthesize different elements of therapeutic recreation into one cohesive program. The Fifth Edition features an improved organization that guides students through the theory and practice of therapeutic recreation programming in a way that fully prepares them to work effectively in the industry. The book has been thoroughly updated to include the latest government/ organization regulations, and more client examples have been woven through each chapter to give students practical illustrations of the theories presented in the text.
Total Chapters	16	13
Chapters Analysed	1: Introduction to Therapeutic Recreation Practice: A Strengths Approach (pp. 3-10), 2: Paradigm Shifts – A Sea Change in Health and Human Services (pp. 11-25)	1: Conceptual Foundations: The Basis for Service Development and Delivery (pp. 1-26)