Student Resources

Recreational Therapy: An Introduction, 5th ed.

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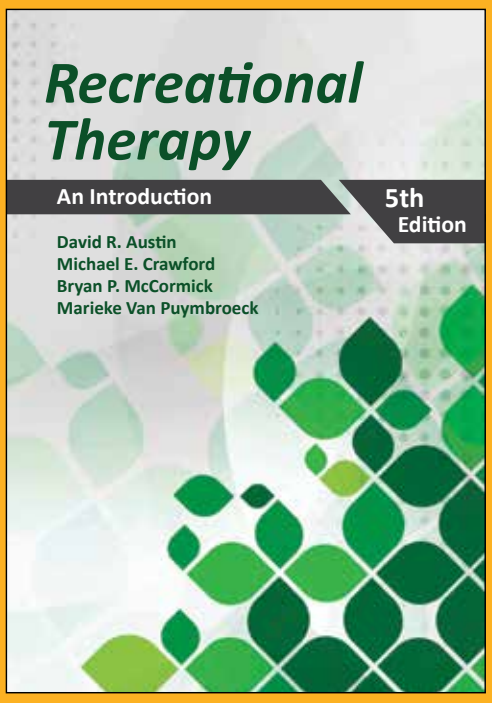

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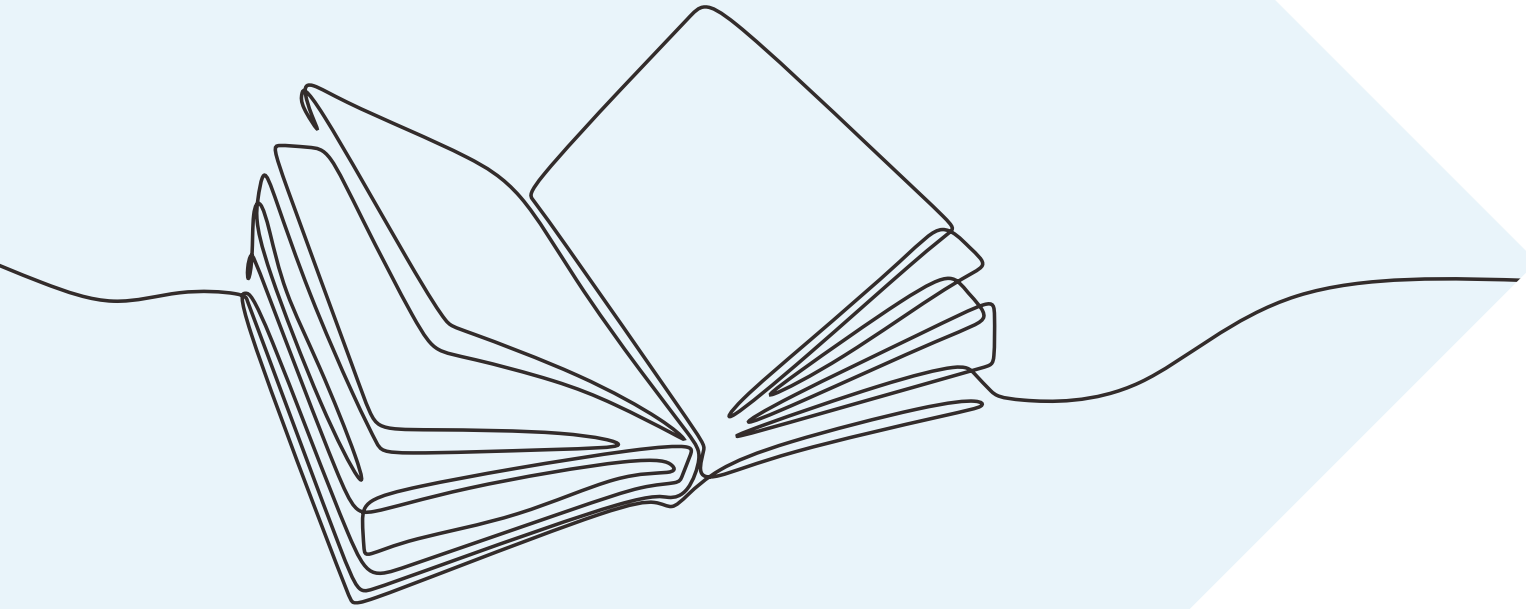
SAGAMORE VENTURE



Tips for Reading and Learning from This Book

The editors of the 5th edition of *Recreational Therapy: An Introduction* have attempted to make you, the reader, the focal point of the book. Each chapter begins with learning objectives for the chapter so you will know explicitly what you should learn from your reading. There are also reading comprehension questions at the end of each chapter that you can use to assess your understandings of material in the chapter.

There are three sections within the book. Section 1 covers the nature, purpose, history, and processes of recreational therapy. By the time you complete Section 1, you will have a good grasp of recreational therapy and what it takes to be a recreational therapist. Section 2 covers specific areas of practice. Covered in the chapters in Section 2 are practice areas such as behavioral health and psychiatric disorders, substance use disorders, pediatric practice, geriatric practice, and practice in physical medicine and rehabilitation. Each of these chapters follows a similar outline that includes not only learning objectives but also definitions of terms, current practices and procedures, and a case study to illustrate the actual application of the recreational therapy process (aka APIE process). Section 3 contains a chapter that covers management, consultation, and research from your perspective as a student. The final chapter introduces you to trends and issues found today in recreational therapy.

Effective Study Strategies

The best way to get the most out of *Recreational Therapy: An Introduction* and your course is to make sure you know the material. To do so there are strategies and "tricks" you can use. You not only want to put in time studying, but you also want to get the most out of the effort you put in. What follows are some ways for you to get the most out of your efforts:

Schedule Yourself

- One of the most basic rules is to not put off studying until the night before the test. On the first day of class, your instructor will likely give you a course syllabus. Examine it to see how many tests you will have and when they will occur. That way you will know when tests will be and how you will prepare.
- A good rule of thumb is to study two or three hours each week for every course credit. So if your course is a 3-credit-hour course, you should devote six to nine hours per week in study time. At the least, make sure you devote one hour of study time per credit hour each week.
- You'll need to establish a study schedule. When setting up your weekly schedule, don't try to do all your studying at night. Take advantage of time between classes, perhaps studying in the library or some other

quiet spot. The point is to not dibble away valuable study times. Of course, once you put your schedule into action, you may need to revise it if it is not working for you.

Read Your Assignments!

- Make sure you complete your assigned readings before going to class so that you will be able to actively take part in class discussions, perhaps posing questions to your instructor about things in the reading for which you need more clarity. Don't however assume that because you read over the assignment once that you grasped the content.
- Become an active reader. Before beginning reading a chapter, skim over it. Begin by reading over the objectives for the chapter. As you look the chapter over, note main points, headings, illustrations, and read the summary. Then as you read the chapter, highlight the most important passages and perhaps make notes in the margins to bring out important points.
- Be alert to bold or italicized print as authors use these to emphasize important points. Don't skip over tables or graphs as these often convey information better than written words. A good thing to do is to stop your reading after every subsection to ask yourself if you understand the material.
- Note anything you don't understand or don't agree with in the margins so you can ask your instructor for clarification in class or during the instructor's office hours.
- To cement the information from the chapter into your mind, review the chapter sometime after reading it and before you go to class. You can go over the reading comprehension questions at the end of the chapter and/or discuss the learning objectives for the chapter with someone, such as a classmate or your roommate.

Additional Effective Study Strategies

- Take accurate and concise lecture notes. Focus on the main points in the lecture. If the instructor writes something on the board or repeats an idea, it is likely important. Also listen for word cues such as "The three main components in writing an objective are…"
- Go over your notes to rewrite them for better organization and understanding. Don't wait too long to do this, as your notes may not make sense.
- Instructors tend to stress in class concepts they believe are the most important, so keep this in mind as these are likely to come up on tests.

Strategies for Preparing for Tests

- Before a test, ask your instructor if there are any key concepts or topics you should be prepared for. Often instructors will voluntarily inform the class areas they should review to prepare for the test.
- Make sure to attend any pretest review sessions. These may be provided in class or outside of class time.
- Don't study without breaks. Study for 30-45 minutes and then reward yourself with a break of 5-10 minutes, and when you do, get away from the table or desk where you are studying.
- Some students find it helpful to use a study group to prepare for tests, usually in groups of 4-6.
- To test your comprehension, get a study partner to ask you questions based on class notes, chapter learning objectives, reading comprehension questions, assignments, or study cards you have prepared. You can write the question on one side of the card and the answer on the other side.

Strategies for Taking Tests

- Begin by making sure you write your name on the top of the test sheet.
- Expect to have some anxiety, as students typically feel some stress when taking a test.
- To reduce stress, arrive early so you don't feel rushed and you can find a seat you desire.

- Answer easier questions first to reduce anxiety and gain confidence.
- Don't worry about others turning in their papers before you. They don't get extra points for getting in their papers before you!
- Listen attentively to any last-minute instructions given by the instructor.
- Once you have the test, skim it over before you begin answering. This will give you a sense of the structure of the test (e.g., short answer essay or multiple choice) and a chance to estimate the amount of time it will take for each segment of the test. For example, give more time to any questions with higher point values.
- You may wish to do a "brain dump" at the start of the test by writing down on a piece of paper facts or key ideas you are afraid you might forget so you'll have the information to refer to. You will probably want to ask your instructor if this is okay so they won't think you brought in a "cheat sheet."
- If the test is made up of both multiple-choice and essay items, begin by answering the multiple-choice items, as you may be able to gather information form those questions to use in your essays.
- Keep track of the time so you can pace yourself, but don't be a slave to the clock. Focus on the test.
- Use all the allotted time to take the test. You can go back over it to make sure you read the questions correctly.
- Never ever cheat! If you get caught, there could be terrible consequences and no honest person wants the reputation of being "a cheater."

Strategies for Multiple Choice Exams

- To begin, browse over the questions, noting those that seem easier with the thought of answering them first before taking on harder questions.
- Unless there is a penalty, give difficult items your best guess.
- Remember in answering a multiple-choice item you are looking for the best possible answer, not only a correct one.
- Having read the question carefully, don't read too much into it. Go with your first impression.
- Read each item as if it was a true/false question, eliminating all the answers that are false.
- Change your answer only if you have a very good reason, as your first impression is usually correct.
- Responses that employ absolute words such as "all," "always," or "none" tend to be wrong. On the other hand, responses that use "most" or "some" tend to be correct.
- "None of the above" tends to be a wrong answer. The person constructing the test probably couldn't come up with another choice to list.
- If two responses seem to be correct, "all of the above" is usually the correct answer.
- Choose the longer response if one is noticeably longer, because it is likely to be correct.
- When two of the choices are opposites, one of them is usually the correct answer.

Success with Essay Exams

- Read the directions carefully. Pay attention to whether you are required to address every question or only a specified number (e.g., "Answer two of the three questions").
- Know how many points each question is worth.
- Budget your time so you don't spend too much time on one question and run out of time to answer other questions.
- Scan the questions and choose the one you know the best to begin with. This allows you to get off to a good start and to build momentum.
- When reading each question, pay attention to keywords that tell you what to do. Follow them exactly. Common words in essay questions are compare/contrast, agree/disagree, describe/discuss, name/list,

trace, define, explain, illustrate, summarize, evaluate, and outline. Answer the question directly according to the keyword.

- Do not follow the impulse to read a question and begin to write immediately. Jot down key ideas. Formulate a thesis or concise statement that specifically addresses the question so you can outline your answer. You will want to think of facts or details that support the main point you want to make.
- Each paragraph in the essay should focus on one central idea followed by details (e.g., facts, dates, examples) that support it.
- Remember your main point and stick to it, referring back to it throughout your essay. Finish your answer with a brief conclusion statement that is a paraphrase of the introduction.
- Answer every question even if you are not sure about the answer. It is better to have written something than nothing and you may get partial credit for your answer.
- It can be helpful to the instructor grading an essay for you to note key ideas or keywords by underlining them. That helps the instructor to not have to look for your key points.
- Save some time at the end of the testing period to reread your essays to check for misspellings, errors in content, omitted words, and sentence fragments.
- Be sure your handwriting is legible. If your handwriting isn't clear, print instead.

Resources to Enhance Learning

- While not typically done, instructors occasionally make videos of their lectures available so students can view them. Often, online courses can be reviewed for a second time. Seeing a lecture or class session for a second time may be a good way to learn.
- Instructional videos are available at no cost via streaming from Indiana University Library's ScholarWorks program. Over 20 videos may be accessed. Type in Indiana University Recreation Therapy Videos into the search box. Look for Recreation Therapy Videos – IU ScholarWorks. Click on the link and a list of titles of the videos will appear. The videos can be a handy way to review information from the book. For example, an introduction to recreational therapy is provided by the video *To Serve a Purpose*. Three videos deal with course material on recreational therapy history. Other videos may provide topics for class papers.
- Two resources for articles on recreational therapy are the *American Journal of Recreation Therapy* and the *Therapeutic Recreation Journal*. Another source is the *Annual in Therapeutic Recreation* published by the American Therapeutic Recreation Association (ATRA).
- *Lessons Learned: An Open Letter to Recreational Therapy Students and Practitioners* (Sagamore Publishing, 2011) is a small book that offers many briefly written lessons about topics covered in *Recreational Therapy: An Introduction*.
- For more extensive information on tips and strategies on studying and for taking tests, you may wish to read Chapter 11, "How to Take and Pass Tests," in Austin and McCormick's *Perspectives on Recreational Therapy* (Sagamore-Venture, 2017). The chapter was the source for much of the material cited in this Student Resources publication.

Glossary of Terms

The Glossary of Terms does not follow the typical glossary format of alphabetizing the terms. Instead, terms for each chapter are presented in the order that they appear in each chapter. This approach makes it easier for students to locate and review terms as they read a chapter. Additionally, students may find the Glossary of Terms to be helpful in reviewing for tests.

Chapter 1: Introduction and Overview

Recreation

Recreational therapists understand recreation as voluntary activity that brings about positive emotions such as enjoyment, fun, and feelings of accomplishment and that has restorative properties vital to health restoration or for those with chronic conditions to manage their health status so they may enjoy the highest quality of life possible.

Leisure

Aristotle held "that leisure is the way to happiness and quality of life because it provides a means to self-fulfillment through intellectual, physical, and spiritual growth." Recreational therapists understand leisure as a phenomenon that provides the individual with perceived control; the opportunity to meet intrinsically motivated needs; and a means to actualize potentials, to flourish, and achieve high-level wellness.

WHO

World Health Organization

Health

"Health is a positive, balanced state of being characterized by the best available physical, psychological, emotional, social, spiritual, and intellectual levels of functioning at a given time, the absence of disease or the optimal management of chronic disease, and the control of both internal and external risk factors for both disease and negative health conditions." (Jones, 2000, *Talking About Health and Wellness with Patients*, p. 15, Springer)

International Classification of Functioning, Disability, and Health (ICF)

The WHO developed the ICF to create a new perspective for conceptualizing the health of persons with disabilities. Instead of having an emphasis on the person's disability, the ICF system is focused on the individual's level of functioning as an indicator of health. From the ICF perspective, functioning is the result of the interplay of body functions (physiological or psychological) and body structures (i.e., anatomical parts such as organs or limbs), as well as activities (i.e., executing a task or action) and participation (i.e., involvement in a life situation). The ICF

also accounts for environmental barriers and facilitators that impact the person's functioning and for personal factors.

Humanistic Psychology

This humanistic perspective recognizes the uniqueness of human beings to be self-directed, to make wise choices, and to develop themselves or realize their potentials or to become self -actualized. It takes a holistic view of the person, follows a developmental model rather than a medical model, and values a strength-based approach to health enhancement.

Positive Psychology

Positive psychology concentrates on the positive side of persons instead of the negative. It is similar to humanistic psychology in that positive psychology is focused on human strengths and optimal functioning rather than pathology. Its concern is with processes that contribute to the flourishing or optimal functioning of people, groups, and institutions.

Stabilizing Tendency

The stabilizing tendency is directed toward maintaining the "steady state" of the organism. It is the motivational tendency moving persons to counter excess stress (i.e., distress) to maintain their levels of health. When faced with excessive stress, persons engage in adaptive behaviors to regain their sense of equilibrium. They attempt either to remove themselves from the stress or to minimize the effects of the stressor. The stabilizing tendency is responsible for persons adapting to keep the level of stress in a manageable range to protect themselves from possible biophysical or psychosocial harm.

Actualizing Tendency

The actualizing tendency is a growth-enhancing force. The actualizing tendency is the motivational force behind achieving optimal health.

Prescriptive Activity

When individuals first encounter illness or disability, they often become self-absorbed and inactive and withdraw from their usual life activities, and experience a loss of control over their lives, leading to feelings of depression. To combat such feelings, the recreational therapist prescribes (i.e., recommends) clients reengage in activities even though they do not feel like taking part in them. The rationale for prescriptive activities is that clients must actively engage in life to overcome feelings of helplessness and depression and begin to establish control over the situation. Within prescriptive activities, clients begin to experience feelings of fun and accomplishment. They begin to make improvements and to regain a sense of independent functioning and control so they can move past prescriptive activities and engage in recreation experiences. In sum, prescriptive activities become a necessary prerequisite for clients who are demoralized and depressed to move on to voluntary participation in recreation activities that may lead to health restoration.

Health Protection

A means to restore oneself or regain stability or equilibrium following threat to health.

Health Promotion

To develop oneself through leisure as a means to obtain high-level wellness.

Health Protection/Health Promotion Model

Under this conceptual model, recreational therapy may be perceived to be a means to restore oneself or regain stability or equilibrium following threat to health (health protection) and to develop oneself through leisure as a

means to high-level wellness (health promotion). Thus, recreational therapy has the primary goals of (a) restoring health and assisting clients to cope with chronic conditions and disabilities and (b) helping clients to use their leisure in optimizing their potentials and striving for high-level wellness. Recreational therapy provides for the stabilizing tendency by helping individuals to restore health or cope adaptively with chronic illnesses and disabilities and for the actualizing tendency by enabling clients to use leisure as a means to personal growth. The Health Protection/Health Promotion Model reflects the full extent of recreational therapy practice. At one extreme of the continuum of service, the recreational therapist is assisting clients in poor environments to restore health. At the other extreme, the recreational therapist is helping clients achieve optimal health, or high-level wellness, in favorable environments.

Leisure Ability Model

The thrust of this conceptual model is on facilitating leisure experiences for persons with disabilities. The mission of the Leisure Ability Model is to help clients with limitations to develop "a satisfying leisure lifestyle, the independent functioning of the client in leisure experiences and activities of his or her choice" (Stumbo & Peterson, 2009, *Therapeutic Recreation Program Design*, 5th ed., p. 29, Pearson). The model has three major parts along a continuum. The first, functional intervention, deals with improving functional ability. The second is leisure education, which is focused on the client gaining leisure-related attitudes, knowledge, and skills. The third component, recreation participation, has to do with structured activities that give clients the opportunity to enjoy recreational experiences.

Inclusive Recreation

The term "inclusive recreation" is used to capture the full acceptance and integration of persons with disabilities into the recreation mainstream.

Special Recreation

The term "special recreation" describes programs for individuals with similarities to participate together in recreational experiences. Examples of special recreation programs include wheelchair sports, camps for children with disabilities, the Special Olympics, and the National Veterans' Wheelchair Games.

Recreational Therapy Process

The systematic recreational therapy process has traditionally been portrayed as involving four phases: assessment, planning, implementation, and evaluation. This process is commonly known by the acronym APIE drawn from the beginning letters of each phase and is often referred to as the "APIE process" (pronounced a-pie).

American Therapeutic Recreation Association (ATRA)

Professional membership society for recreational therapists in the United States.

Canadian Therapeutic Recreation Association (CTRA)

Professional membership society for recreational therapists in Canada.

National Council for Therapeutic Recreation Certification (NCTRC)

NCTRC was established in 1981 as a nonprofit organization dedicated to maintaining professional standards to protect consumers through the credentialing of well-qualified recreational therapists. The NCTRC grants professional certification to individuals who apply and meet established standards for certification, which include completing a bachelor's or master's degree in recreational therapy, or therapeutic recreation, and passing the national certification exam.

Chapter 2: The History of Therapeutic Recreation: A History of Two Professions

Therapeutic Recreation

"Therapeutic recreation" has been used as an umbrella term to encompass both the provision of recreation services for persons who are ill or have a disability and the use of recreation by recreational therapists as a modality to bring about health enhancement.

Dr. Phillippe Pinel

Pinel employed recreation within his humanitarian approach (termed moral treatment) in the treatment of psychiatric patients in France.

Florence Nightingale

Widely acknowledged to be the "mother of nursing," Nightingale emerged in the 19th century as a key figure in promoting the use of recreation in rehabilitation. Nightingale strongly advocated using recreation activities for patients in British military hospitals. Not until she employed recreation as a purposeful means to achieve health restoration did the potential for using recreation to bring about healthful outcomes begin to become accepted.

Dr. Benjamin Rush

Rush is known as the "father of American psychiatry." Rush, while superintendent of the Pennsylvania Hospital in Philadelphia, stressed the need for recreational activities as a part of the treatment of hospitalized psychiatric patients.

Boston Sand Gardens

The park and recreation movement in the United States grew out of the playground movement that is typically traced back to the development of the Boston Sand Gardens for the underprivileged children of Boston in the late 1800s.

Social Welfare Mission

The playground movement grew to become the park and recreation movement and ultimately expanded beyond its original concern for underprivileged children to a social welfare mission or general commitment for

serving disadvantaged segments of society. As time passed, however, park and recreation systems began to lose their focus on using recreation as a means to help disadvantaged persons, but instead adopted the perspectives "recreation for all" and "recreation as its own end."

American Red Cross Recreation Workers

Red Cross recreation workers became a common feature in military hospitals during World War I. Even greater developments in the use of recreation by the Red Cross in military hospitals would arrive during World War II. With World War II came vast acceleration in the use of recreation in military hospitals with more than 1,800 Red Cross recreation workers being employed to serve hospitalized soldiers.

Hospital Recreation Section (HRS)

Founded in 1948 as a special interest group within American Recreation Society, the HRS was comprised of hospital recreation workers who saw recreation as an end in itself and believed in the credo of "recreation for all." Those in the HRS believed that the right to recreation was something that all should enjoy, including those who were institutionalized, ill, or had a disability.

National Association of Recreational Therapists (NART)

Founded in 1952, NART was comprised of professionals who saw themselves as therapists who used recreation to ameliorate illnesses and aid in the rehabilitation of persons who were ill or had acquired a disability. Thus, to them, recreation was a means, not an end. As they termed it, recreation was "a tool for treatment."

National Therapeutic Recreation Society (NTRS)

The Hospital Recreation Section of the American Recreation Society (HRS/ARS) and the National Association of Recreational Therapists (NART) merged to form NTRS in 1966.

Therapeutic Recreation Journal (TRJ)

TRJ was established in 1966 by NTRS as a quarterly journal.

National Council for Therapeutic Recreation Certification (NCTRC)

NCTRC was established in 1981as the credentialing body for therapeutic recreation.

Certified Therapeutic Recreation Specialists (CTRSs)

Individuals who meet the standards of NCTRC and pass a national certifying exam become credentialed as Certified Therapeutic Recreation Specialists (CRTSs).

American Therapeutic Recreation Association (ATRA)

ATRA was founded in 1984 as an autonomous professional association. When NTRS was dissolved in 2010, ATRA became the single professional association representing the field in the United States.

Canadian Therapeutic Recreation Association (CTRA)

Canada established the equivalent of ATRA, which is the CTRA.

Leisure Orientation or Leisure Facilitation Philosophy

This philosophy of practice grew out of the traditions of the Hospital Recreation Section of the American Recreation Society. This philosophical position perceives leisure as an end, not a means.

Recreational Therapy Philosophy

This philosophy of practice grew out of professionals in the National Association of Recreational Therapists. Even though recreation offers fun and enjoyment to clients, it takes the approach of recreation as therapy that sees recreation as a means, not an end.

Recreational Therapy Profession

Today the U.S. Department of Labor and the U.S. Department of Education classify recreational therapy as a health care profession distinct from leisure professions.

Committee on Accreditation of Recreational Therapy Education (CARTE)

CARTE accredits university programs preparing students to enter the recreational therapy profession.

Chapter 3: The Recreational Therapy Process

Recreational Therapy Process (RT Process, APIE Process)

The RT process of assessment, planning, implementation, and evaluation (APIE) evolved over several decades. It is now used by recreational therapists everywhere as an organizing framework for providing individualized, contextualized, and prioritized person-centered care.

Assessment Phase (in the RT Process)

Assessment is the first phase in the RT process. A sound assessment identifies the client's health status, environment, needs, and strengths, as well as preferences. The assessment directs the planning phase by developing pertinent data about the client.

Clinical Reasoning

Clinical reasoning is a critical element for the recreational therapist in doing assessment. It involves scrutinizing the information collected to arrive at clinical judgments.

Naturalistic Observations

Naturalistic observations are made by recreational therapists in unstructured recreational settings (e.g., unstructured recreation by adults in a lounge or children in free play on a playground) where the natural environment is not manipulated or changed.

Specific Goal Observations

Specific goal observations occur in structured situations where the observer sets predetermined goals for the observation. For example, the therapist may observe the level of cooperation the client displays in a co-recreational game situation or how the client responds to frustration in an athletic contest.

Time-Interval Observations

In time-interval observations the recreational therapist observes these clients and records the frequency of client behaviors for predetermined times (e.g., 15 minutes, 30 minutes, or any period of the day). For example, the recreational therapist could record the number of aggressive acts occurring during a 1-hour period.

Standardized Observations (Standardized Instruments)

Standardized instruments may be criterion-referenced (measure achievement toward an established standard) or norm-referenced (to measure how the client performs in relation to others who are similar).

Reliability

Reliability deals with whether an instrument produces consistent results over time.

Validity

Validity answers the question of whether the instrument tests what it sets out to assess or its results are an accurate representation of what is being assessed. The instrument measures what it sets out to measure.

Open-Ended Questions

Open-ended questions are used to begin conversations. A general open-ended question is "Tell me about yourself."

Secondary Sources (of Assessment Information)

Secondary sources are sources of information not obtained directly from the client and may provide valuable information for the recreational therapist completing client assessments. Secondary sources include family members and friends, client medical records, social histories, progress notes, interdisciplinary teams, and visiting the client's home and community.

Strengths Assessment

Clients typically require the recreational therapist's help in identifying their strengths because their health concerns or a lack of self-awareness may interfere with the ability of a client to fully appreciate the strengths they possess. Strengths include a multitude of characteristics (e.g., persistence, determination, creativity, interpersonal skills, prior life successes), as well as social support (e.g., social networks, environmental resources) and recreational abilities (e.g., skills possessed in recreational activities).

Subjective Data

Subjective data are gained from the client.

Objective Data

Objective data are gained from sources other than the client.

Planning Phase (of the RT Process)

During this phase, priorities are set; goals are formulated; objectives are developed; programs, strategies, and approaches are specified; and means of evaluation are determined. When this phase has been completed, the recreational therapist and client have a personalized recreational therapy intervention plan to meet the individual client's needs. The intervention plan serves as a "blueprint for action."

Goals

Goals reflect sought outcomes that are directed toward satisfaction of the client's needs. Therefore, they are stated in terms of the client's behavior and describe proposed changes in the individual in broad terms.

Objectives

Objectives are developed to specify client behaviors related to reaching goals. Objectives enable clients to achieve goals and consequently are sometimes referred to as enabling objectives.

SMART Objectives

SMART objectives are Specific, Measurable, Attainable, Relevant, and Time lined.

Evidence-Based Practice (EBP)

EBP involves considering the latest evidence on interventions that represent best practice while considering the clinical expertise of the therapist along with client values and preferences.

Implementation Phase (of the RT Process)

The implementation phase is the action phase of the RT process. Implementation involves the recreational therapist and client executing the client's intervention plan. A number of facilitation techniques (e.g., adventure therapy, animal-assisted therapy, yoga, physical activities) are available to be used as interventions to facilitate change.

Therapeutic Activity

A basic tenet in the practice of recreational therapy is that the emphasis is always on the client, not the activity. The activity is only a vehicle; the end is bringing about therapeutic outcomes for the client. An activity is successful if clients derive therapeutic benefits.

Group Processing

Group processing involves clients discussing the dynamics of their activity participation to gain self-knowledge. It permits clients to discuss their participation in an activity, to learn from that discussion, and to extend their learnings to their everyday lives.

Debriefing

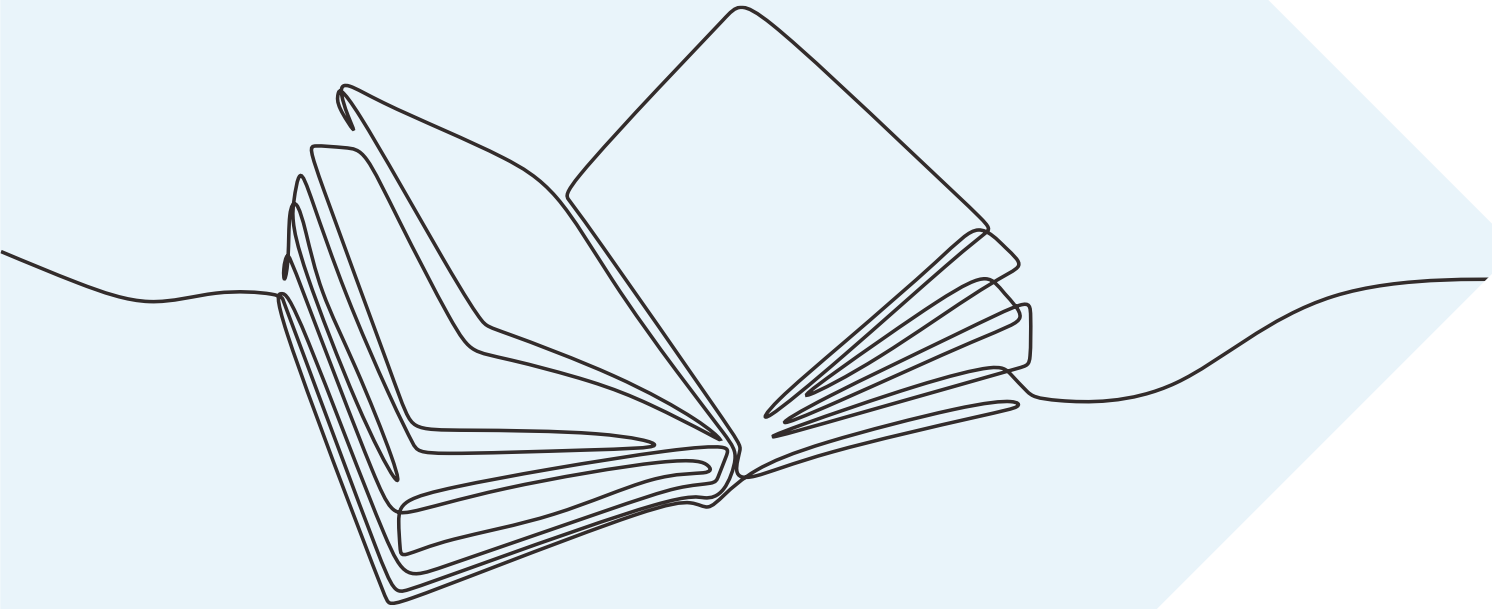
Completing group processing with clients following their participation in an activity is termed debriefing.

Evaluation Phase (of the RT Process)

Evaluation procedures assess progress toward obtaining stated client goals. The primary question to answer in the evaluation phase is, how did the client respond to the planned interventions?

An Alteration of the RT (APIE) Process

An alteration of the RT process, adding a "D" standing for documentation to the notation of APIE, has been presented by the ATRA Board to make the acronym read APIED.



Chapter 4: Behavioral Health and Psychiatric Disorders

Mental Illness

Mental illness "refers collectively to all of the diagnosable mental disorders. Mental disorders are characterized by abnormalities in cognition, emotion or mood, or the highest integrative aspects of behavior, such as social interactions or planning of future activities" (U.S. Department of Health and Human Services, 1999, p. 39).

Classification Manuals of Mental Disorders

Manuals of mental disorders are the Diagnostic and Statistical Manual of Mental Disorders (5th ed., American Psychiatric Association, 2013), known as the DSM-5, and the International Statistical Classification of Diseases and Related Health Problems (10th ed., World Health Organization, 2005), known as the ICD-10.

Schizophrenia Spectrum Disorders

Schizophrenia and related disorders are marked by psychotic features such as delusions, hallucinations, disorganized thought and speech, and disorganized or abnormal motor behavior.

Major Depressive Disorder

Major depressive disorder is identified by symptoms such as depressed mood, diminished interest in previously satisfying activities, significant change in weight, sleep disturbance, change in activity level, fatigue, feelings of worthlessness, diminished ability to concentrate, and recurrent thoughts of death (including thoughts of suicide).

Bipolar Disorder

Bipolar disorder is a mood and affective disorder in which a person experiences episodes of depression and/or mania.

Anxiety and Stress-Related Disorders

Anxiety and stress-related disorders are characterized by fear and anxiety associated with situations that are not currently dangerous. Fear and anxiety are out of proportion to the actual threat of the situation, and this is frequently the source of interference in functioning.

Anxiety and Fear

The DSM-5 distinguishes fear from anxiety, noting that fear is characterized by an emotional response to a real or imagined present threat, whereas anxiety is associated with a real or imagined threat in the future.

Behavioral Disorders

Behavioral disorders are principally identified through patterns of behavior that are dysfunctional and may or may not be distressing to the individual such as eating disorders, sleep disorders, and sexual dysfunction.

Personality Disorders

Personality disorders are characterized by patterns of experience and behavior that are markedly different from the expectations of one's culture and situation. Personality disorders listed by DSM-5 are antisocial, avoidant, borderline, narcissistic, obsessive compulsive, and schizotypal.

Serious Mental Illness

The term "serious" in the case of serious mental illness recognizes that the experience is pervasive, in both duration and impact, and affects multiple areas of functioning. The majority of persons characterized as having a serious mental illness have diagnoses of schizophrenia spectrum disorder or bipolar disorder; however, major depression and severe anxiety disorder may sometimes be included.

Transdiagnostic Approach

As opposed to categorical diagnoses, the transdiagnostic approach to behavioral health is one in which processes thought to lead to and maintain dysfunction are the target of intervention.

Recovery Orientation

Although symptom management remains a goal of recovery rehabilitation, it is understood within a larger context of improved life satisfaction, greater client empowerment, the development of natural social supports, and the development of hope. The recovery orientation recognizes service recipients as consumers who have considerably more say in the services they receive.

Integrated Care (in Psychiatric Rehabilitation)

This approach seeks to integrate general medicine with mental health services. This has resulted from the recognition that although mental health and physical health are strongly interconnected, their systems of services are often segregated.

Behavioral Activation (BA)

BA is a structured, brief psychotherapeutic approach used in the treatment of depression. BA has also been found to be an effective approach in treating posttraumatic stress disorder, anxiety disorders, and substance use disorders. The BA approach focuses on countering inactivity with pleasurable and meaningful activity.

Social Skills Training (SST)

As impairments in interpersonal function are seen in many psychiatric disorders, providing SST is appropriate. The general approach in using SST involves cognitive and educational approaches to develop knowledge and skills related to interpersonal interaction.

Clinical Status Outcomes

Clinical status outcomes are directly related to the symptoms of a disorder. Recreational therapy has been shown to effectively reduce clinically relevant outcomes such as stereotypic self-talk, rumination, hallucinatory behavior, and inappropriate behavior among adults in inpatient treatment.

Functional Outcomes

Functional outcomes include areas such as general tasks and demands; work and educational functioning; self-care; domestic life; interpersonal functioning; and participation in community; social; and civic life.

Comprehensive Evaluation of Recreation Therapy (CERT)

The CERT assessment instrument has three areas of assessment related to recreational therapy: general, individual performance, and group performance.

Chapter 5: Substance Use Disorders

Substance Use Disorders (SUD)

Formerly known as substance abuse. The DSM-5 lists criteria for substance use disorders.

Addiction

"Addiction" is the preferred term for persons who experience compulsive use of drugs despite serious health and social consequences. These users engage in a pattern of behavior characterized by overwhelming involvement with a drug and securing its supply regardless of adverse consequences. Addiction is often chronic in nature; it disrupts circuits in the brain that are responsible for reward, motivation, learning, judgment, and memory.

Dependence

Dependence signifies the changes that happen in the body after extended use of alcohol or other drugs, which produces tolerance.

Withdrawal

Withdrawal is the temporary physical and/or psychological symptoms that occur when use of the drug is stopped abruptly.

Depressants

Slow normal brain function; cause drowsiness; produce a calming effect; slurred speech; confusion; poor concentration. Alcohol is a depressant.

Stimulants

Speed up motor activity; elevate mood; increase heart rate, respiration, blood pressure, energy, and alertness; may cause feelings of excitability, euphoria, paranoia, agitation, and hostility. Amphetamines, cocaine, caffeine, nicotine, ecstasy, Adderall, and Ritalin are examples.

Opioids/Narcotics

Quick, intense feeling of pleasure followed by a sense of well-being and calm; decreases pain, causes lethargy, lack of motivation, drowsiness, slow pulse. Examples are Heroin, morphine, codeine, opium, fentanyl, Carfentanil, Oxycodone, Hydrocodone, and Demerol.

Hallucinogenics/Psychedelics

Alter perceptions, feelings, sense of time; may cause auditory, visual, and tactile hallucinations; may cause panic, paranoia. LSD, PCP, mescaline, psilocybin, peyote, marijuana in larger doses, and inhalants are examples.

Detoxification (Detox)

Refers to getting drugs or alcohol out of a person's system. Clients who have just been admitted for detoxification (detox) to rid their body of the drug will begin to go through physical withdrawal. Although symptoms of withdrawal vary based on the substance of use, typical reactions include anxiety, tremors, muscle pain, nausea, vomiting, sweating, and hallucinations.

Antabuse

Medication that makes users sick if they drink alcohol.

Naltrexone

Medication that blocks the rewarding effects of alcohol and reduces cravings.

Methadone, Suboxone, and Naltrexone

Medications for opiate addiction that work by reducing symptoms of withdrawal, reducing the cravings for the drug, and blocking the effects of the opiates.

Milieu Therapy

All aspects of the treatment environment contribute to the client's care including group and individual psychotherapy, support groups, interactions with all staff, social skills development, and vocational rehabilitation, social services, occupational therapy, and recreational therapy as provided.

Twelve-Step Support Groups

Voluntary fellowship open to anyone who walks into a meeting; based on recognition that sobriety and recovery depend on support of others; run by members, no professional staff; includes acceptance, surrender, and active involvement.

CAGE-AID Questionnaire for Alcohol and Drug Use Screening

A screening tool that uses the questions: 1. Have you ever felt you should Cut down on your drinking or drug use? 2. Do you get Angry when people criticize your drinking or drug use? 3. Do you feel Guilty about your drinking or drug use? 4. Do you need an Eye-opener to get started in the morning?

Flow

Flow is a state of optimal psychological arousal resulting from intrinsically motivated participation in activities where the challenges posed by the activity and the skills of the individual are ideally matched. The concept of flow was made popular by Csikszentmihalyi.

Chapter 6: Autism

Autism Spectrum Disorder (ASD)

Autism (ASD) is a complex neurobiological condition affecting the ways an individual processes and responds to information and sensory stimuli, which may create a "restricted repertoire of activities and interests" as well as impairments in social and communication skills.

ASD is diagnosed in early childhood or in early adulthood. No single etiology is known; however, it is currently understood as a complex compilation of nature (genetics) and nurture (environment), affecting both the central nervous system and the digestive system. ASD is a lifelong, pervasive condition, with a current prognosis of (1) not having a cure, (2) requiring lifelong management (treatment/services), and (3) not being progressive in nature (does not worsen over time).

Purpose of Recreational Therapy

When serving individuals with ASD, the recreational therapist is to assist in the development, maintenance, and expression of a healthy leisure lifestyle while also focusing on improving physical, cognitive, social, emotional, and environmental functioning. Through education, as well as maintaining and expanding upon the strengths of the individual to improve functioning in multiple domains, recreational therapists help the individual become an informed self-advocate. Further, recreational therapists want individuals with ASD to be confident in who they are and what they can do to be able to become self-actualized.

APIE or RT Process

The RT process is the cyclical, dynamic, systematic process of assessment, planning, implementation, and evaluation.

Validity

Validity means that tools used during assessment and evaluation measure what they intended to measure.

Reliability

Reliability means that tools used during assessment and evaluation will consistently measure what they intended to measure.

Interdisciplinary and Collaborative Treatment Approaches

An interdisciplinary and collaborative approach to serving individuals with autism and their families places all professionals, as well as the client, at an equal balance, focusing on shared decision making. It is unrealistic to think that one treatment approach and/or professional can provide all the necessary services to address every need for each client.

The health care needs of people with ASD are complex and require a range of integrated services, including health promotion, care, rehabilitation services, and collaboration with other sectors such as the education, employment, and social sectors.

Assistive Technology, Assistive Devices, and Adaptive Equipment

The terms "assistive technology," "assistive device," and "adaptive equipment" may be defined in very different ways. Nonetheless, what they all have in common is the purpose of enabling people to remove the barriers they face due to having specific functional limitations.

Persons with ASD use many types of assistive technology, assistive devices, and adaptive equipment for communications and social functioning. Common assistive technology used by persons with ASD include, but are not limited to, (a) low-tech modalities and techniques (e.g., blinking/physical movement systems, sign language, yes–no system of gestures, storyboards, paper and writing utensils) and (b) high-tech modalities and techniques (e.g., braille, photos, augmented alternative communication [PECS, DynaVox, communication boards], computers), and (c) "fidgets" and other sensory supports.

Chapter 7: Intellectual and Developmental Disabilities

Intellectual Disability (ID)

Intellectual disability refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, telling time, or handling social interactions appropriately. Intellectual disability originates before age 18 and may result from physical causes as in the case of autism or cerebral palsy or from nonphysical causes such as extreme environmental deprivation, lack of stimulation, and adult responsiveness (American Psychiatric Association, 2013).

Developmental Disability (DD)

Developmental disability describes a group of conditions that express themselves during periods of time within which key developmental milestones typically are achieved. Development disabilities represent a broad umbrella of specific conditions such as cerebral palsy, ADHD, vision and hearing impairments, autism, and intellectual disabilities.

Idiopathic

Having unknown cause.

Mild Intellectual Disability

This category includes roughly 85% of persons with an intellectual disability. In many cases, these persons are able to live independently with a minimal level of support, although they may need assistance with major life decisions and help with tasks such as finances, shopping, and transportation.

Moderate Intellectual Disability

This category includes about 10% of persons with intellectual disabilities. Persons at this level may have problems with appropriate social skills. They require regular support for self-care activities in terms of instruction, reminders, and performance cues. A typical residential setting would be a group home with 24/7 staffing.

Severe Intellectual Disability

This category includes 3% to 4% of theintellectual disability population. Communication skills frequently are challenging, often receptive vocabulary is greater than expressive, and survival word training is emphasized. The incidence of comorbidities in terms of physical and sensory impairments is much higher, leading to the need for high vigilance for safety. Housing is usually a residential center (or group home) with high staffing ratios.

Profound Intellectual Disability

This category includes just 1% to 2% of the intellectual disability population. These persons usually require 24-hour care and are highly dependent upon other persons for all aspects of daily routine. High comorbidities with physical and sensory impairments are typically present. Many persons in this category are deemed "medically fragile" and may be tube fed and/or require ventilator assistance with breathing and 24/7 nursing support.

Rosa's Law

In October 2010, President Obama signed a bill known as Rosa's Law, which requires the terms "mental retardation" and "mentally retarded" be stricken from federal records and replaced with the DSM-5 APA term "intellectual disability."

Readiness Skills

Readiness skills represent the cognitive and social abilities necessary for instruction to be received. Therefore, attention span, impulse control, eye contact, listening skills, and sequential memory abilities may represent generic abilities that need to be developed prior to or at least simultaneously with leisure skill development. Other maladaptive behaviors may need to be diminished, or even eliminated, such as self-stimulatory behaviors or unnecessary vocalizations.

Leisure Education Programs

Leisure education programs may include a number of components to ensure that individuals are prepared to be successful in leisure. The goal of leisure education is to help clients achieve the greatest degree of self-initiated leisure choices that are chronologically age appropriate.

Least Restrictive Environment (LRE)

LRE is part of the Individuals with Disabilities Education Act (IDEA). IDEA says that children who receive special education should learn in the least restrictive environment. This means they should spend as much time as possible with peers who do not receive special education.

Over time, many professionals have equated LRE with inclusion-only programming. The important aspect is providing activities that help persons grow and reach their developmental potential. This does not mean exclusive programming in inclusive settings; it means matching levels of support with needs in the most appropriate environment to facilitate growth, learning, and appropriate care.

Normalization

Normalization is a process of helping individuals with developmental disabilities to live as "normal" a life as possible for that individual. Using the principle of normalization, recreational therapists help provide clients with as normal a rhythm of life as possible.

Equal Education Act (PL 94-142)

Since the original authorization of the Equal Education Act (PL 94-142) in 1975, recreational therapy has been listed as a related service. Recreational therapy is a related service (optional), not a direct service (as are physical therapy and occupational therapy).

Task Analysis

Task analysis is used to break down the whole, or gestalt, of the skill into separate parts. The parts are then introduced, usually in a meaningful sequence, and eventually all the parts are "married together" to produce the total skill.

Activity Analysis

Activity analysis is the procedure for breaking down and examining an activity to find inherent characteristics (physical, cognitive, affective, and social) that contribute to program objectives.

Chapter 8: Epilepsy

Epilepsy

Epilepsy is the disease associated with spontaneously recurring seizures. Epilepsy is characterized by the transient occurrence of abnormal brain activity that produces a rapid discharge of intercellular electrical activity that causes seizures. Epilepsy is not only defined as an abnormality of the brain that results in epileptic seizures but as a disease characterized by neurobiological, cognitive, psychological, and social consequences, including stigma.

Seizures

Seizures vary significantly from very brief lapses of attention or muscle jerks to severe convulsions with unconsciousness.

Partial or Focal Seizures

These seizures result from abnormal activity in only one area of the brain. They fall into two categories. One is partial or focal seizures that occur without any loss of consciousness. These seizures were once termed simple partial seizures. They may alter emotions or change the way things look, smell, feel, taste, or sound to a person. Partial or focal seizures may also involve involuntary jerking of a part of the body (e.g., an arm or leg) and spontaneous sensory symptoms (e.g., tingling, dizziness, flashing lights). The second category includes focal or partial seizures with impaired awareness. This category was once referred to as "complex partial seizures." These seizures involve a change or loss of consciousness or awareness. The person may stare into space and not respond normally to the environment or may perform repetitive movements, such as hand rubbing, chewing, swallowing, or walking in circles.

Generalized Seizures

Generalized seizures involve all areas of the brain. Generalized seizures do not start in one isolated body site but rather involve several sites or entire body areas such as the trunk or the extremities. There exist six types of generalized seizures. *Absence seizures* (previously known as petit mal seizures) involve staring into space or subtle body movements (e.g., eye blinking, lip smacking). These seizures may take place in clusters and cause a brief loss of awareness. *Tonic seizures* cause stiffening of the muscles. Because they usually affect muscles of the back, arms, and legs, they may cause the person to fall. *Atonic seizures*, also known as "drop seizures," bring about a loss of muscle control that may cause the person to suddenly collapse or fall down. *Clonic seizures* involve repeated or

rhythmic jerking muscle movements, usually affecting the neck, face, and arms. *Myoclonic seizures* typically appear as sudden brief jerks or twitches of the arm and legs. The final generalized seizures are *tonic-clonic seizures* (once termed grand mal seizures). This type of seizure is what many people think of when they visualize a seizure. It is the most dramatic type of seizure because it can result in an abrupt loss of consciousness, body stiffening and shaking, and sometimes loss of bladder control or biting the tongue.

Anti-Seizure Medication for Epilepsy

There is no cure per se for epilepsy, but it generally can be controlled with medication. Up to 70% of persons with epilepsy can become seizure free with the appropriate use of anti-seizure medication.

Stigma

Stigma was defined by Goffman as "an attribute which is deeply discrediting." Unfortunately, stigma is a major issue for people who develop epilepsy.

Comorbidities

Comorbidity is the presence of one or more additional conditions co-occurring with (i.e., concurrent with) a primary condition. Common comorbidities in epilepsy are psychiatric disturbances, intellectual disability and developmental delay, and obesity.

PWE

Persons with epilepsy

AEDs

Antiepileptic drug therapy. AEDs do not cure or correct epilepsy but rather offer a method of preventing future seizures.

Desired Effects (of AEDs)

The desired effects of AEDs are to make the brain less prone to seize.

Side Effects (of AEDs)

Common side effects of AEDs include somnolence, dizziness, unsteadiness, double vision, and behavioral changes.

Purpose of Recreational Therapy (with PWE)

Recreational therapists who work with persons with epilepsy typically are focusing on a secondary diagnosis (e.g., developmental disability, psychiatric or physical disability), psychological issues associated with epilepsy (e.g., depression, anxiety), or specific needs related to lifestyle modifications and leisure activity choices.

Sudden Unexpected Death in Epilepsy (SUDEP)

In rare cases, epilepsy is fatal. The incidence of sudden unexpected death in epilepsy (SUDEP) ranges from 0.9% (93 cases per 10,000 persons per year) to 1.2% in different studies.

Chapter 9: Geriatric Practice

Ageism

The term "ageism" was coined by Robert Butler, a geriatrician, to describe the prejudice and discrimination against older adults.

Geriatrics

Geriatrics deals with the health and disease problems in old age and the medical care and treatment of aging people; the comprehensive health care of older persons; and the well-being of their informal caregivers.

Gerontology

Gerontology is the study of the aging process and individuals as they grow from midlife through later life, including the study of physical, mental, and social changes; the investigation of the changes in society resulting from our aging population; the application of this knowledge to policies, programs, and practice.

Health Disparities

If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Older Adults

Older adults or "older persons" may reflect aging as a continuum: young-old (65–74), old-old (75–85), and oldest of the old (85 and above), suggesting that differences exist between groups, although these differences are not definitive.

Chronic Health Conditions

Chronic health conditions generally are incurable, worsen over time, and endure over many years. Examples are hypertension (high blood pressure), arthritis, heart disease, cancer, and diabetes.

Dementia

The symptoms of dementia may vary, but two of the following core mental functions must be significantly impaired to be considered dementia: (a) memory, (b) communication and language, (c) ability to focus and pay attention, (d) reasoning and judgment, and (e) visual perception. Alzheimer's disease is the most common type of dementia, accounting for 60% to 80% of all dementias.

Roles of the Recreational Therapist (in Geriatric Practice)

The roles of recreational therapists in geriatric practice include *expert clinician* (the expert clinician uses the RT process of assessment, planning, implementation, and evaluation as a basis for practice), *trainer and educator* (train and educate service-learning, practicum, and internship students in best practices, as well as train and educate administrators, staff, and family members about recreational therapy), *consumer of evidence* (use evidence-based practice in making clinical decisions), and *supervisor and manager* (this role includes supervisory and managerial responsibilities such as organizing multiple projects, motivating staff, coaching individual persons and teams, assessing individual skills and weaknesses, hiring and developing staff, fostering accountability and ownership, delegating responsibility, prioritizing tasks, earning trust and respect, and communicating with peers and superiors).

Home Care

Home-based services typically are provided on a fee-for-service basis.

Medical Home

Medical home is a model or philosophy of primary care that is focused on caring for an individual's health conditions by providing comprehensive and continuous medical care to patients with a goal to obtain maximal health outcomes. Key philosophical components are patient-centered care, comprehensive care and coordinated care, accessible care, and a commitment to quality and safety.

Adult Day Services

Adult day services are a specialized service for older adults who due to illness or disability require assistance in a supervised and therapeutic environment. They allow individuals to continue to live at home and avoid placement in a nursing home.

Continuous Care Retirement Communities

As persons age and health status changes, their increasing needs may be accommodated by continuous care retirement communities. Independent living is for healthy adults who can reside independently in single-family homes, apartments, or condominiums. Assisted living is made available when older adults need help with everyday activities. When required, skilled nursing services are provided. Many continuous care retirement communities are now offering specialized memory units for persons who need care due to Alzheimer's disease or related dementias.

Memory Units

Memory units are provided for persons who need care due to Alzheimer's disease or related dementias.

Assisted Living

The Assisted Living Federation of America defines assisted living as a long-term care option that combines housing, support services, and health care, as needed. Many older adults who reside in assisted living need support with meals, housekeeping, medication management, mobility, and incontinence.

Nursing Homes

The highest level of care for older adults, outside a hospital, is provided by a nursing home. Nursing homes provide custodial care and a high level of medical care. Care is supervised by a licensed physician, and a nurse and other medical professionals are on the premises. Skilled nursing care is available on-site, usually 24 hours a day.

Palliative Care

The National Institute of Health defines palliative care as providing treatment for a patient's discomfort, symptoms, and stress of serious illness. Symptoms can include, pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, problems with sleep, and any side effects from medical treatment.

Hospice Care

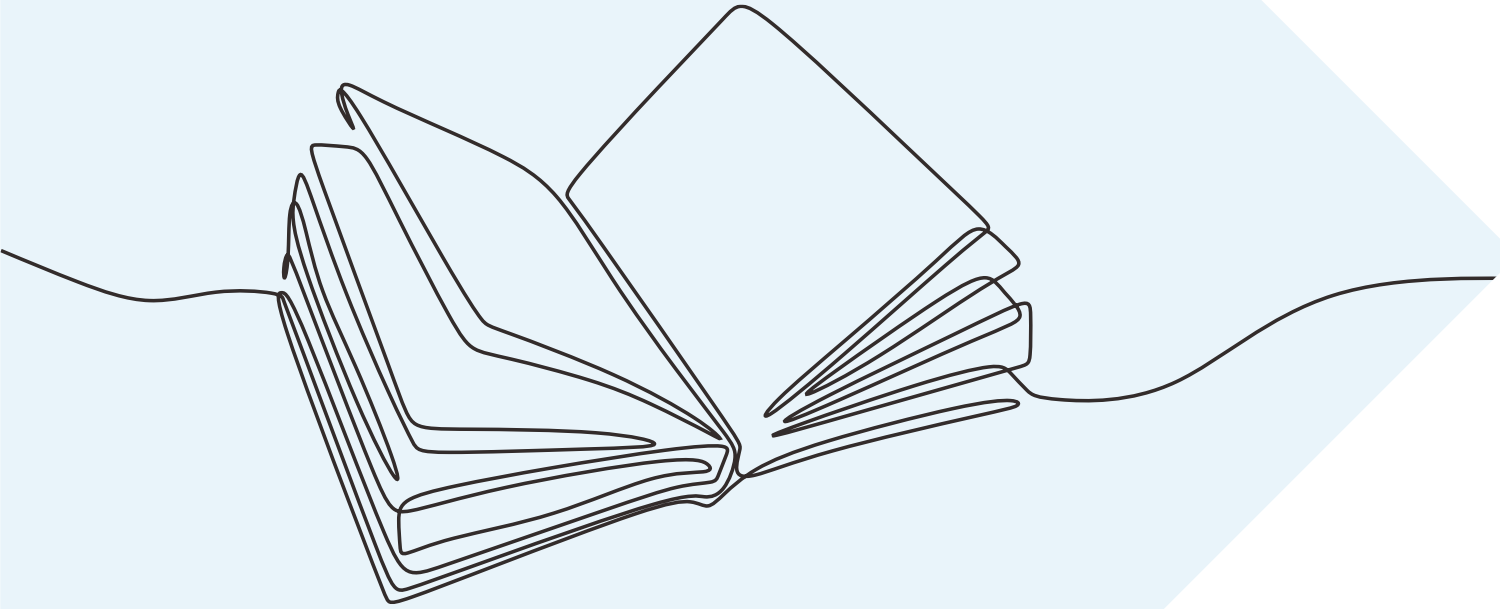
Hospice care is provided at the end of life and includes palliative care. The difference is that the individual may receive palliative care at any time. The improvement in the individual's quality of life and comfort is the goal of these services.

AGHE

Academy of Gerontology in Higher Education

AGHE's Program of Merit (POM)

The AGHE reviews health-related professional preparation programs in order to award the POM designation. This designation provides the AGHE "stamp of approval," which can be used to verify program quality to administrators, to lobby for additional resources to maintain a quality program, to market the program, and to recruit prospective students into the program.



Chapter 10: Pediatric Practice

Pediatric Disability

"A [pediatric] disability is an environmentally contextualized health-related limitation in a child's existing or emergent capacity to perform developmentally appropriate activities and participate, as desired, in society" (Halfon et al., 2012, p. 32).

Developmental Disabilities

Developmental disabilities are disorders that present at birth or prior to age 18 and result in the child not meeting developmental milestones. Developmental disabilities include learning disabilities, cerebral palsy, muscular dystrophies, spina bifida, spinal muscular atrophies, specific speech articulation disorder, autism spectrum disorder, and genetic and chromosomal disorders.

Psychiatric Disorders

Psychiatric disorders include anxiety disorders, attention deficit hyperactivity disorder (ADHD), conduct disorders, depressive disorders, oppositional defiant disorder, tic disorders, reactive attachment disorder, and nonsuicidal self-injurious behavior.

Blood and Immune System Disorders

Common blood and immune system diseases include sickle cell anemia, anemia, hemophilia, and acquired immune deficiency syndrome (AIDS).

Diabetes

Diabetes occurs when blood glucose (blood sugar) is too high. Two types of diabetes exist: type 1 and type 2. Type 1 diabetes (formerly called juvenile diabetes) occurs when the body cannot produce insulin. Type 2 diabetes typically occurs due to poor nutrition and obesity.

Cardiovascular and Respiratory Disorders

The cardiovascular and respiratory systems are unique in that they work collectively to make sure that oxygen is received by the organ tissues. The human body, made up of numerous cells, must work collectively to achieve "health." The respiratory system exchanges carbon dioxide and oxygen through breathing, whereas the cardiovas-

cular system is responsible for transporting blood and other substances throughout the body. Diseases include rheumatic heart disease, Kawasaki disease, asthma, and cystic fibrosis.

Musculoskeletal Disorders

Congenital and acquired illness and injuries that fall under musculoskeletal include clubfoot, hip dysplasia, scoliosis, and sustained injuries.

Cancer

Common cancers in children include the following: leukemia, lymphomas, neuroblastoma, brain tumors, osteosarcoma, and rhabdomyosarcoma (RMS).

Visual Impairments

Visual impairment describes vision loss, whether the person has partial or complete vision loss, whereas blindness indicates limited vision and complete blindness indicates no visual perception, including light. Visual impairments that are less common include the following: strabismus, congenital cataracts, retinopathy of prematurity, retinitis pigmentosa, coloboma, optic nerve hypoplasia, and cortical visual impairment.

Hearing Impairment

The following are broadly defined and common categories of hearing impairment: Postnatal hearing impairment is a temporary loss of hearing after birth but may be pervasive and progressive over time. Permanent childhood hearing impairment (PCHI) is the ongoing and consistent loss of hearing. Nearly 50% of PCHI is related to genetic factors.

Purpose of Recreational Therapy (in Pediatrics)

The general purpose of recreational therapy within pediatric settings is to encourage the most appropriate developmental process possible.

The Pediatric Treatment Network

The Pediatric Treatment Network, through ATRA, is a group of pediatric recreational therapy professionals dedicated to best practices in working with children and adolescents.

Equine-Assisted Therapy Programs

The modality of equine-assisted therapy consists of a variety of interventions including therapeutic riding, equine-assisted learning, hippotherapy, and equine-assisted psychotherapy (counseling) that can benefit pediatric clients.

Learned Helplessness

Learned helplessness occurs when an individual is exposed repeatedly to situations in which they have little control over the outcomes of events and learn to become helpless in responding. Children with disabilities may develop learned helplessness due to the negative impact of having a specific diagnosis that is out of their control, from others doing tasks for them, or from continuous protection from negative outcomes.

Chapter 11: Physical Medicine and Rehabilitation Practice

Physical Medicine and Rehabilitation (PM&R)

PM&R is a setting in which recreational therapists treat individuals who are recovering from physical injuries, both traumatic (e.g., from an accident) and nontraumatic (e.g., from a surgery).

Cerebrovascular Disease

Cerebrovascular accident (CVA), or stroke, is a blockage or rupture of the blood vessels that supply blood to the brain, most often caused by a blood clot. A CVA causes damage to the brain and is considered a nontraumatic brain injury. CVAs are usually classified as Left CVA or Right CVA. A Left CVA means that the clot occurred on the left side of the brain and impacts functioning on the right side of the body, as well as causes difficulty in language, and usually results in slow and cautious movements and behaviors. A Right CVA indicates that the clot damaged the right side of the brain and typically leads to physical problems on the left side of the body, as well as impulsive behavior and visual impairments.

Traumatic Brain Injury (TBI)

A TBI is caused by an external force to the brain. A penetrating TBI is caused by something that is able to penetrate the brain, such as shrapnel from a missile, and an injury that does not penetrate the brain is called a closed head injury.

Spinal Cord Injury (SCI)

A SCI may be classified as incomplete or complete. An incomplete SCI results when the injury to the spinal cord does not result in its complete severing and some motor or sensory function remains below the level of injury. A SCI is considered complete when the spinal cord is completely severed and no function or sensation remains below the level of injury. An additional classification in SCI has to do with the level at which the injury occurred. These classifications are tetraplegia (injury at the cervical spine, C1, to thoracic spine, T1), paraplegia (thoracic spine, T2, to sacrum, S5), and spinal fracture (injury to bone around spinal cord but not to the spinal cord).

Paraplegia

Persons with paraplegia have feeling and movement of upper extremity. Those with the level of injury in the T1-T12 region are likely self-care independent, use a manual wheelchair, and have potential for minimal mobility depending on level of injury. Those with their level of injury in the lumbar are very likely to be self-care independent and may be able to ambulate for greater than 150 feet with or without assistive device.

Amputation

Amputation, or the loss of a limb(s), may occur as a result of trauma, infection, vascular disease, secondary complications from a chronic health condition, or congenital disorder.

Neuromuscular Disorders

Neuromuscular disorders cause changes to voluntary muscles by impacting the nerves that control them. When these nerve cells are impacted and become unhealthy or die, changes or wasting in the muscles and nervous system result. Many health conditions fall in this category, including amyotrophic lateral sclerosis (ALS), Parkinson's disease (PD), and multiple sclerosis (MS).

Amyotrophic Lateral Sclerosis (ALS)

Commonly called Lou Gehrig's disease, ALS is a progressive degenerative disease that impacts the brain and spinal cord nerve cells. As the motor neurons (nerve cells that are located in the spinal cord) die, the brain is no longer able to initiate or control the movement of muscles.

Parkinson's Disease (PD)

This neuromuscular disease usually impacts persons over age 50, although younger persons may get it as well. Early on, the symptoms of PD are difficult to pinpoint. The symptoms most often associated with PD are tremor or trembling of the upper extremities, legs, jaw, or face; stiffness or rigid movements in the limbs or trunk; slow movements; and problems with balance and coordination.

Multiple Sclerosis (MS)

This neuromuscular disease also is progressive and is caused when the covering of the spinal cord and brain are damaged. When the covering is damaged, lesions are formed that cause the individual limitations in functioning, depending on where the lesion is located. Several forms of MS exist, including relapsing–remitting (periods of symptoms and periods without new symptoms) and progressive (where symptoms increase over time).

Joint Replacement

In joint replacement, a damaged joint is replaced with an artificial joint that is implanted in the body.

Role of the Recreational Therapist (in PM&R)

Recreational therapists may work on functional outcomes and psychosocial well-being simultaneously by engaging the patient in enjoyable activities that increase functional skills. In PM&R settings, a major role may be to work with patients in community reintegration to assist individuals in reentering the community with the new level of ability.

Complementary and Integrative Health

Complementary health interventions are non-traditional interventions that are employed in addition to (or complement) traditional medicine interventions. If a non-traditional intervention is employed instead of traditional medicine interventions, this is referred to as "alternative medicine." Integrative medicine is the combination (or integration) of traditional and non-traditional interventions.

Chapter 12: Military Service Members

The U.S. Armed Forces

The U.S. Armed Forces consists of five main branches of service (Air Force, Army, Coast Guard, Marines, and Navy), as well as National Guard and Reserves components.

Veteran

The term "veteran" refers to service members who have been discharged from military service.

Blast Injuries

"Blast injury" is an overarching term that includes injuries from explosions of artillery, mortar shells, mines, booby traps, aerial bombs, improvised explosive device (IEDs), and rocket-propelled grenades. Blast injuries include categories of physical injuries such as limb loss, bone fractures, sensory impairments, burns, spinal cord injury (SCI), crushing injuries, brain injury, and polytrauma.

Brain Injury

Any injury to the brain may affect a person's physical, cognitive, and emotional/psychological functioning, with distinct differences based on the severity of the injury (classified from mild to severe). Both closed and open brain injuries are prevalent during war. Closed brain injuries are likely to result from concussive injuries from blast waves or impact injuries that do not penetrate the skull. Open, or penetrating brain injuries, are likely to occur from shrapnel from bombs, artillery, or other outside objects that break through the skull and damage the brain. Depending on the severity of damage to the brain, complications may include seizures, loss of consciousness, spasticity, and loss of physical functioning such as balance and functional strength, loss of memory, problems with attention span, anxiety, and depression.

Spinal Cord Injury (SCI)

SCI is common among injured service members and generally results from vehicular accidents, blasts, and gunshot wounds that damage the spinal cord. These injuries result in paresis (i.e., incomplete impairment) or paralysis (i.e., complete impairment) below the level of injury and may affect muscular and sensory/sensation and functioning. Injuries in the thoracic or lower region of the spine often result in paraplegia (i.e., impairment in two extremities, typically the trunk and legs), whereas injury to the thoracic or higher region of the spine often results in tetraplegia (i.e., impairment in all four extremities).

Limb Loss

Limb loss is a common injury. The causes of amputation often include traumatic injury from a gunshot or bomb that causes immediate amputation or leads to further complications that result in medical amputation. Limb loss includes amputation of the leg above or below the knee and amputation of the arm above or below the elbow.

Polytrauma

Polytrauma is defined by multiple injuries. Polytrauma is a combination of injuries that affect at least two body regions, in which one of the injuries was life threatening and resulted in multiple impairments or disability.

Emotional/Psychological Injuries

Mental health conditions are a common injury associated with service members, especially those who have served in the Global War on Terrorism (GWOT), and include posttraumatic stress disorders (PTSD), major depressive disorder, schizophrenia, bipolar disorder, and substance use disorder.

Posttraumatic Stress Disorders (PTSD)

PTSD is a serious issue among injured service members, as many experience traumatic events during their military service. The *Diagnostic and Statistical Manual* identifies four symptom clusters for PTSD: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity.

Substance Use Disorders

Substance use is a common and easily accessible way for all service members to cope with the stressors of military service. Unfortunately, substance use disorders may develop quickly and may persist long after a deployment has ended.

Other Threats to Health

In conjunction with more typical combat-related injuries (e.g., brain injury, PTSD), many injured service members are living with other medical conditions that are a direct outcome of their military experiences. For example, Agent Orange was an herbicide used frequently during Vietnam to kill vegetation that was associated with health problems.

Age-Related Health Conditions

Older service members may experience health conditions associated with advanced age, such as changes in cognitive functioning, physical functioning, and social interaction patterns. These include conditions such as visual and hearing impairments, mobility issues, stroke, dementia, delirium, depression, arthritis, and cardiovascular disease.

Secondary Aging

Secondary aging refers to environmental and behavioral factors, such as stress, smoking, and unhealthy lifestyle behaviors, that further contribute to the primary or biological aging process.

Complementary and Alternative Medicine (CAM)

Complementary medicine is a group of diagnostic and therapeutic disciplines that are used together with conventional medicine. Alternative medicine is when these approaches are used instead of traditional medicine. CAM is becoming a leading approach to care with veterans.

Adaptive Sport

In addition to the physical functioning improvements that come from any physical activity, involvement in adaptive sports has been found to create and strengthen social and emotional/psychological functioning of injured service members. Evidence has indicated that involvement can enhance subjective well-being, contribute to the development of determination and inner strength, and improve perceptions of disability.

Outdoor Recreation

Of the outdoor recreation activities that may be implemented with service members, fly-fishing and river running (e.g., rafting, kayaking) have been the most researched in regard to emotional/psychological and social functioning. Benefits associated with these outdoor recreation services include increased sense of camaraderie, opportunities for reflection and reconciliation of memories, a more positive outlook on treatment and life post-treatment, increased confidence, development of new skills, and the chance to reconnect with others and nature.

Nature as Therapy

Facilitated interactions with nature and programming in natural settings for veterans are becoming more popular and more evidence based. From a strengths-based approach to care, nature-based interventions and programs can be created and individualized according to the veteran's interests and needs.

Focus on Military Families

Camps and retreats provide an ideal setting for recreational therapists to work with service members and their families on issues such as problem solving, decision making, anger management, financial management, relationship (re)building, and spending time together, among others. These settings are invaluable in their ability to remove the family from a stressful home environment for a small period of time to allow important family recovery work to occur in a safe, accepting, and often restorative natural environment.

Chapter 13: Corrections

Corrections

"Corrections" is a broad term used by federal and state criminal justice systems that refers to the network of agencies that supervise individuals on probation, parole, rehabilitation, or incarceration.

Jail

"Jail" is the term used to describe a facility of confinement that is managed by local law enforcement and is intended to house adults for confinement.

Prisons

Prisons are long-term facilities that confine individuals, usually felons, with sentences of more than 1 year and are run by the state or federal government.

Minimum-Security Prisons

Minimum-security prisons are designed to confine prisoners while also providing as much freedom as possible in a confined setting.

Medium-Security Prisons

Medium-security prisons are built to minimize the possibility of escapes and to limit violence.

Maximum-Security Prisons

Maximum-security prisons are designed to highly restrict the freedom of all prisoners and visitors to prevent the possibility of escape and violence.

Parole

Parole is when an individual is conditionally released from incarceration after completing their sentence and placed under supervision for a set period of time.

Recidivism

Recidivism is the tendency of a convicted individual to reoffend and return to prison.

Forensic Units

State hospitals often offer secure forensic units that serve individuals that have been remanded for treatment by court order.

Juvenile Facilities

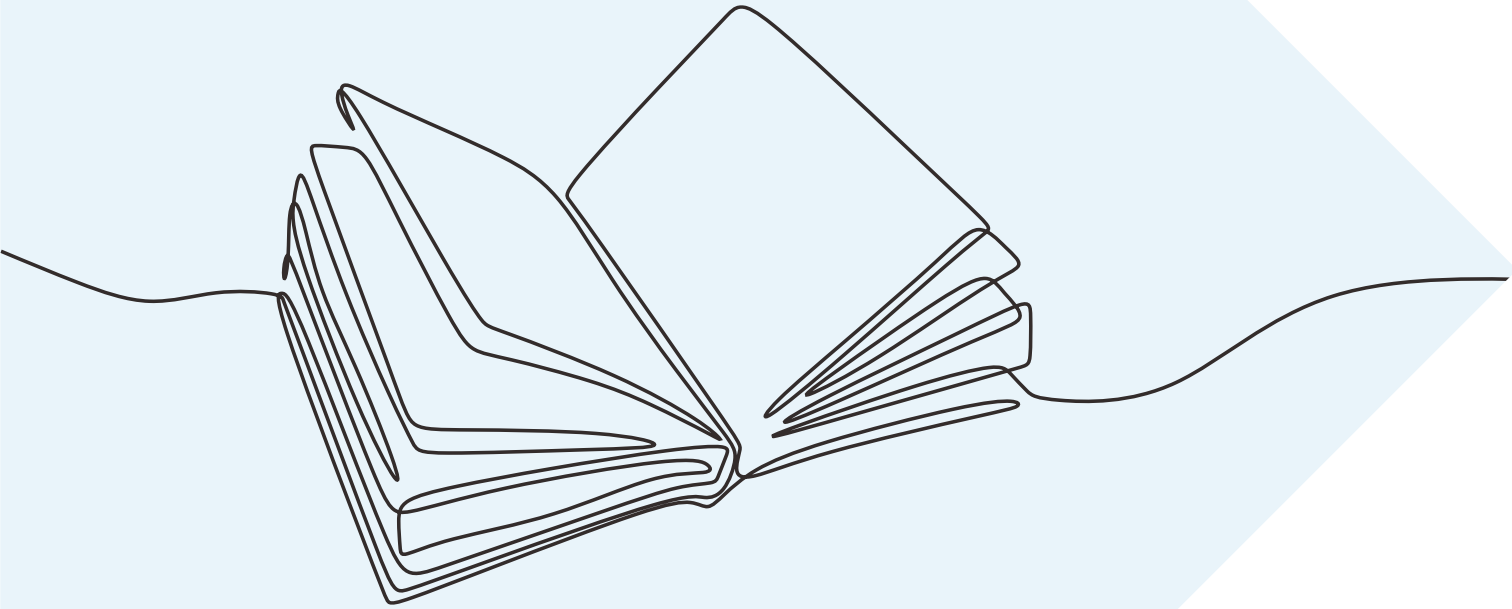
Juvenile facilities can also be known by a variety of additional names, including youth detention facilities, reformatories, juvenile detention facilities, and juvenile hall. Juvenile facilities are designed to provide support and rehabilitation to young offenders (anyone under the age of 18) in a space away from the public and adult offenders.

Outcome-Based Treatment (in Corrections)

Outcome-based treatment is a main trend in the profession of recreational therapy within correctional settings. Recreational therapy professionals need to make sure their program is not a diversional activity, but that they are providing intentional recreational therapy services that focus on functional outcomes and skill development.

Secondary Traumatization (STS)

STS is a trauma-related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.



Chapter 14: Workplace Influences and Professional Growth

Management

"Management is considered a discipline and a process. Management, as a process, uses both interpersonal and technical aspects through which objectives of an organization (or part of it) are accomplished efficiently and effectively by using human, physical, financial, and technical resources. The management role is dedicated to facilitating the work in the organization through one's own efforts and the efforts of others." (Grohar-Murry & Langan, 2011, *Leadership and Management in Nursing*, p.148, 4th ed., Pearson Health Science)

First-Line Managers

In recreational therapy management, managers are often first-line managers because they provide treatment services and are responsible for human resources issues in the department, including the oversight of recreational therapy staff, interns, and volunteers. Managers of recreational therapy departments oversee not only human resources, such as recreational therapists, but also nonhuman resources, such as equipment, supplies, and space or work areas available to staff members.

Clinical Supervision

Clinical supervision is a dynamic process in which a clinical supervisor works with recreational therapists to identify their strengths and weaknesses in clinical practice. The purpose of clinical supervision is twofold: to help develop the professional skills and strengths of the recreational therapist and to enhance client care via enhanced skills.

Consultation

Consultation involves a process in which a consultant, a professional with specialized knowledge, works with an individual or group seeking that knowledge. The purpose of consultation is for the consultant to help the client enact change in the agency.

Research

Research is defined as a systematic and well-planned process that allows the researcher to gather information about a phenomenon.

Evidence-Based Practice

Evidence-based practice uses research as a prime source of evidence. It should be noted that while research is the key source of evidence, where research does not exist recreational therapists may have to turn to other sources of evidence, such as case studies and reports, the experiences of clinicians and clients, and expert opinion.

Chapter 15: Trends and Issues

Trends

Trends are developing tendencies that are taking recreational therapy in new directions. They indicate emerging changes.

Issues

Issues involve problems or concerns over which two opposing points of view often exist.

Recreational Therapists

Recreational therapists are health care providers who plan, direct, deliver, and evaluate recreation-based interventions for individuals with illnesses and/or disabling conditions. They provide research-informed interventions that are based on client assessments and targeted client outcomes. (ATRA)

Committee on Accreditation of Recreational Therapy Education (CARTE)

Accreditation of university professional preparation programs is now provided by CARTE. Established in 2010, CARTE receives authority to conduct the accreditation of university recreational therapy programs from the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

Conceptual Models

Conceptual models, sometimes referred to as "practice models," provide the theoretical basis for recreational therapy as they serve to define and guide the practice of recreational therapy. Theory drawn from conceptual models furnishes explanations of concepts underpinning recreational therapy practice and serves to guide the actions of recreational therapists.

Evidence-Based Practice (EBP)

There are three principal elements in EBP: (1) valid evidence on which to base interventions; (2) practitioner's expertise and judgment; and (3) client characteristics, values, and preferences.

Patient-Reported Outcomes Measurement Information System (PROMIS)

Created by the National Institutes of Health (NIH), PROMIS provides practitioners free access to validated measures for use with children and adults in the domains of global health, mental health, physical health, and social health.

NIH Toolkit

The National Institutes of Health headed an initiative to create a toolbox for assessing neurological and behavioral functioning. This set of measures assesses function in cognitive, emotional, motor, and sensation domains.

Positive Psychology

Positive psychology came about late in the 20th century as a response to the perception that psychology had been embracing a disease and medical model. Rather than being focused on pathology, positive psychology is concerned with human strengths and optimal functioning.

International Classification of Functioning, Disability, and Health (ICF)

The World Health Organization developed the ICF to provide a common language for functioning, disability, and health. The ICF model is focused on functioning, not disability.

LGBTQ+

LGBTQ+ stands for Lesbian, Gay, Bisexual, Trans, Queer/Questioning, and others.

Entry-Level Degree

The bachelor's degree has remained the entry-level degree for the recreational therapy profession.

Master Clinician

The term "master clinician" can be used to designate individuals with training to practice at a higher level than traditionally prepared recreational therapists.