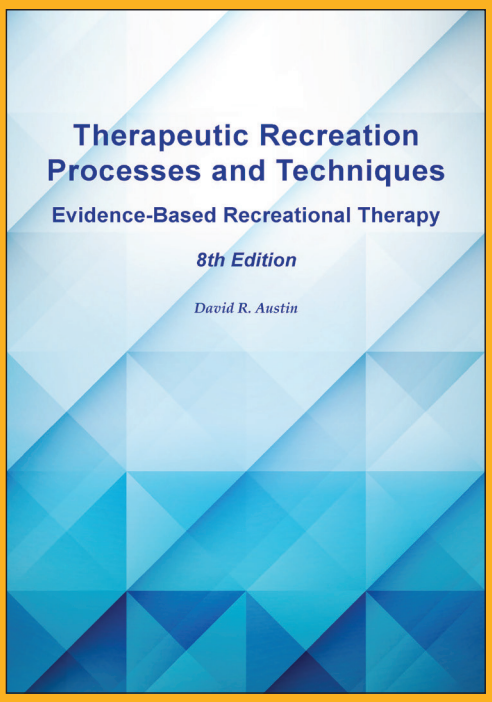
Student Resources

Therapeutic Recreation Process and Techniques: Evidence-Based Recreational Therapy, 8th ed.

by David R. Austin, PhD, FDRT, FALS



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SAGAMORE VENTURE

Tips for Reading and Learning From This Book

By David R. Austin

I indicated in the preface of the 8th edition of *Therapeutic Recreation Processes and Techniques: Evidence-Based Recreational Therapy* that the book is designed for students who want to:

- Gain understandings and skills to become confident and competent recreational therapists
- Gain a theory-based, empirically based, and client-based perspective for practice
- Be grounded in RT so they can clearly interpret the profession to others
- Develop into reflective, self-aware recreational therapists
- Have a book that is readable and easy to follow
- Have a book that can serve as a reference for completing an internship or for entering the profession as a full-time recreational therapist
- Prepare themselves for the NCTRC examination

As author of the 8th edition of *Therapeutic Recreation Processes and Techniques: Evidence-Based Recreational Therapy*, I have attempted to make you, the reader, the focal point of the book. Each chapter begins with a statement of the purpose of the chapter and key terms, followed by 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. These elements in every chapter provide a road map for learning and hopefully remove much of the mystery that sometimes accompanies and plagues instruction.

Effective Study Strategies

The best way to get the most out of *Therapeutic Recreation Processes and Techniques: Evidence-Based Recreational Therapy* and your course is to make sure you know the material. To do so there are strategies and "tricks" you can use. You just don't want to just put in time studying but you 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 do not try to do all your studying at night. You will want to 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.
- You will want to 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 you will want to 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 you instructor for clarification in class or during the instructor's office hours.
- To cement the information from the chapter into your mind, you should 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. You need to 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 like, "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

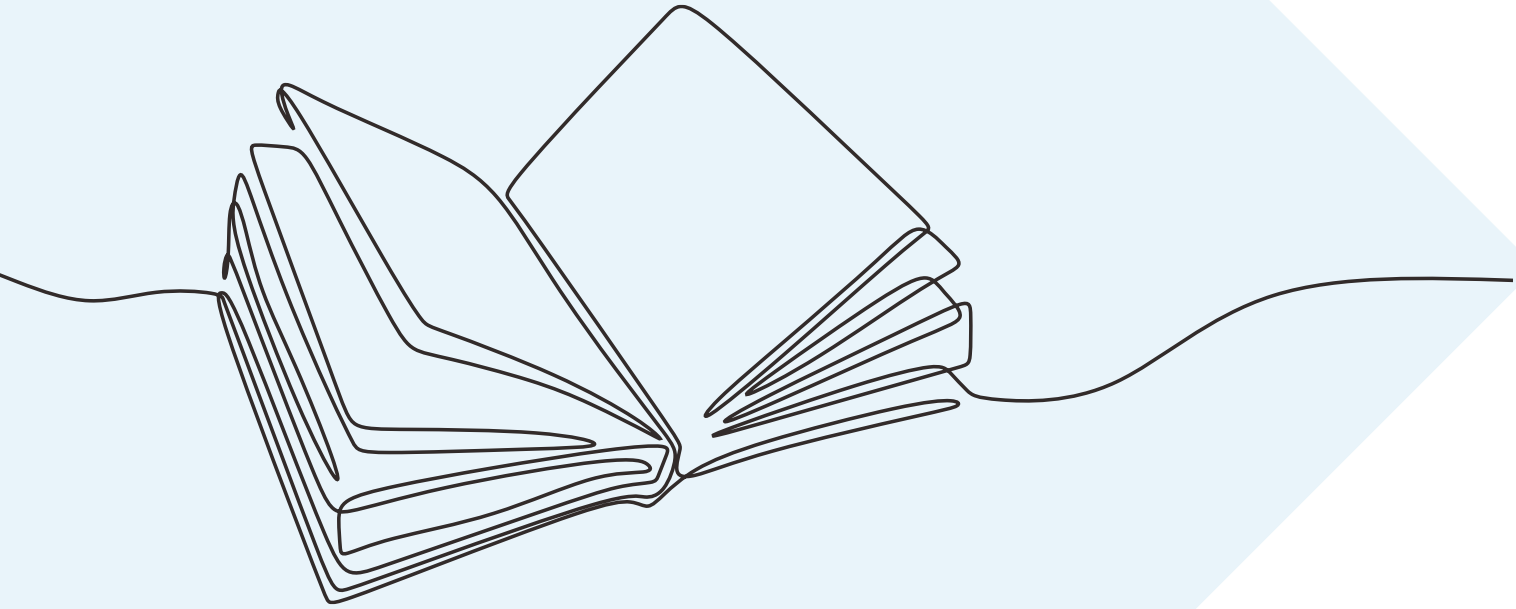
- Before a test, ask your instructor if there are any key concepts or topics you should be prepared for. Often instructors will voluntarily inform the class areas they should review to prepare for the test.
- Make sure to attend any pretest review sessions. These may be provided in class or outside of 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 using class notes, chapter learning objectives, reading comprehension questions, assignments, terms in the glossary, 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 put 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., is it short answer essay or multiple-choice) and to estimate the amount of time it will take for each segment of the test. For example, you will want to 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 he or she 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 got 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

- Make sure you 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 you 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 not have to look for you 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 fragmentary sentences.
- 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. Clink 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 instance, "Models of Practice: Leisure Ability Model" could be viewed when covering conceptual models in Chapter 4. "Professional Ethics" could be viewed when ethics are covered in Chapter 5. Two videos ("Effective Listening" and "Nonverbal Communication") relate to Chapter 6, the Communication Skills chapter. "Documentation and Behavioral Observation" might be viewed while covering Chapter 8. And The video "Clinical Supervision" could be viewed when covering Chapter 9, Clinical Supervision.
- Two resources for articles on recreational therapy are the *American Journal of Recreation Therapy* and *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 *Therapeutic Recreation Processes and Techniques: Evidence-Based Recreational Therapy*.
- 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, D. R., & B. P. McCormick. (2017). P*erspectives on Recreational Therapy*. Urbana, IL: Sagamore-Venture Publishing. 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 in the course and for the NCTRC exam.

Chapter 1: Basic Concepts

Helping relationships–In a helping relationship the helper, who is a trained practitioner, assists the client to meet a problem or need.

Theory–Theory is what the professional helper draws upon as a basis for action.

Objectives–Objectives state results that a person aims to achieve. Objectives are provided as learning aims at the beginning of each chapter.

Chapter 2: Theories and Therapies

Eclecticism–The utilization of approaches and techniques drawn from several sources.

Psychoanalytic Approach–Sigmund Freud's psychodynamic psychology that features the id, superego, and ego. All goal-directed behavior results from the interactions of these three systems according to Freud.

Ego Defense Mechanisms–Defense mechanisms function unconsciously to protect from a threat to the integrity of the ego or self-concept.

Transference–The process in which the client displaces thoughts, feelings, and behaviors on the psychoanalyst (counselor, therapist) even though the thoughts, feelings, and behaviors originally stemmed from a relation with another significant figure in the client's life.

Countertransference–Countertransference is the process when the therapist responds to the client as though the client were someone from the therapist's past.

Cathartic Notion–The idea that venting an emotion (e.g., aggression) can free the person from that emotion. (Venting of aggression is not supported by research, as aggression begets aggression).

Behavioral Approach–An approach based on the psychological theory of behaviorism that is concerned with bringing about changes in behavior.

Behavioral Therapy–Behavioral therapy is a term employed in psychiatric practice.

Behavior Modification–Behavior modification is a term typically used with groups other than psychiatric clients (e.g., persons with intellectual disabilities).

Classical Conditioning–The simple association of events that become linked when they occur together. Pavlov's famous dog study is often given as an example (Also known as respondent conditioning).

Operant Conditioning–Rewards function to reinforce behaviors, whereas negative outcomes tend to eliminate the occurrence of behavior. BF Skinner is often associated with operant conditioning (Also known as instrumental conditioning).

Positive Reinforcement–The idea of positive reinforcement is that people tend to repeat behaviors that provide rewards.

Negative Reinforcement–Negative reinforcement involves the removal of an aversive stimulus to increase the future occurrence of a desired behavior.

Reinforcers–While we often think of candy as a reinforcer, reinforcers are anything that reinforce behavior.

Shaping–A form of reinforcement or operant conditioning in which reinforcement is differentially applied to the responses that are made toward approximating a desired behavior. Eventually, the final form of the desired behavior is reached.

Chaining–Chaining involves linking one learned response with another to build a more complex response.

Modeling–Responses can be learned through modeling behaviors with either the learner seeing the model rewarded or the learner directly receiving a reward.

Premack Principle–The notion that naturally highly a preferred behavior can be used to reinforce less preferred behavior.

Response Deprivation Hypothesis–Either a highly preferred behavior or a less preferred (low-rate) behavior can serve as a reinforcer if the individual is deprived of his or her normal level of activity.

Humanistic Psychology–This humanistic perspective recognized 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. Humanistic therapists do not try to fix the client but instead help clients to make meaning out of their lives

Person-Centered Therapy–A growth-oriented therapy developed by Carl Rogers. The role of the helping professional is to be nonjudgmental and nondirective, providing an accepting atmosphere in which the client feels valued and cared for.

Gestalt Therapy–The goal of Gestalt therapy is to restore the personality to wholeness by helping clients to be free of external regulations (not assuming roles they feel others expect).

Transactional Analysis–Popularized by Berne's book, *Games People Play,* transactional analysis help people to understand themselves and how they interact with others.

Cognitive-Behavioral Therapy–Cognitive-behavioral therapy integrates cognitive therapy with behavioral therapy. The central notion is the interaction of how we think (cognitive), feel (emotions), and act (behaviors).

Cognitive Therapy (also known as cognitive-behavioral therapy)–Beck's cognitive therapy is based on the concept that people's cognitions influence the way they react to life situations. Maladaptive assumptions can underlie individuals' thoughts and beliefs and lead to dysfunctional behavior.

Rational Emotive Therapy–Ellis' therapy saw that people may engage in irrational thinking involving absolutes ("I must") or perfection ("I should") or other irrational beliefs leading them to inappropriate feelings.

Reality Therapy–Glasser's reality therapy deals with facing reality and taking responsibility for one's own needs. It helps the client to fulfill needs for love and belonging and to learn better ways to fulfill their needs.

Positive Psychology–Positive psychology concentrates on the positive side of persons instead of the negative. It is like 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. It focuses on what is going right, rather than what is going wrong with people.

Positive Emotions–Positive emotions include contentment and satisfaction experienced in the past, current feelings like happiness, flow, and sensual pleasures, as well as optimistic and hopeful emotions in anticipation of the future.

Flow–Csikszentmihalyi described flow as the positive effect of becoming so engaged in an activity that the participant becomes completely absorbed in the moment. The challenge of the activity exactly matches the skill required of the person.

Positive Traits–Positive traits include abilities we inherit (intellectual and athletic abilities), and strengths or virtues that we develop (moral traits that have to do with character).

Positive Institutions–Influences (e.g., social support) from the environment that cultivate abilities and strengths.

Family Therapy–Family therapy holds that people are best understood through assessing interactions between and among family members. Examples of goals for therapy include reducing stress in family relationships, improving communications among family members, and increasing emotional closeness of family members.

Multimodal Therapy–Multimodal therapy is personalistic and individualistic. Its basic premise is that clients are seen as being troubled by a number of specific problems that need to be treated using a multitude of techniques.

Constructivism–Under constructivism, therapy revolves around helping the client to understand his or her fundamental assumptions and how they came about. The goal of therapy is to alter these assumptions.

Feminist Therapies–Feminist therapies focus on understanding gender as both a cause and a consequence of women's experiences in a male-dominated culture.

Multicultural Perspective–This perspective centers around the importance of therapists being aware of themselves and their clients having been affected by multicultural factors such as gender, class, ethnicity, race, and sexual orientation.

Ecological Systems Perspective–The ecological systems perspective developed out of family systems theories that asserted individuals cannot be considered apart from their family relationship system. It enlarges on this notion by extending into larger social systems.

Chapter 3: Facilitation Techniques

Deep Breathing (Diaphragmatic Breathing)–Learning to breathe deeply and slowly in contrast to shallow and irregular breathing. Used as a relaxation technique.

Progressive Relaxation Training–A stress reduction intervention consisting of systematically tensing and relaxing various muscle groups.

Autogenic Training–Autogenic training is a form of self-regulation in which the trainee concentrates on certain physiological functions normally regulated by the automatic nervous system in order to teach their bodies to respond to verbal commands to achieve deep relaxation and reduce stress.

Guided Imagery–Guided imagery involves another person suggesting images that can affect us physiologically to bring about relaxation.

Biofeedback–Biofeedback training is a means for a client to gain awareness of and control over physiological func-

tions to increase relaxation and manage stress.

Mindfulness Meditation–Mindfulness meditation has been described as a moment-to-moment awareness of one's experience without judgment. It is being aware of one's moment-to-moment awareness without passing judgment so the person is not caught up in ruminating on any particular stimulus.

Yoga–Yoga is a mind-body practice composed of physical postures that focus on different parts of the body, breathing techniques, and meditation.

Tai Chi–Tai chi uses slow, smooth, graceful, flowing, and continuous motions that resemble a fluent dance.

Qigong–Qigong is a branch of traditional Chinese medicine that uses a system of simple, slow, gentle, and rhythmical exercises, breathing techniques, and meditation to stimulate the flow of energy from one area of the body to another.

Benson Technique–Developed by Dr. Herbert Benson, the Benson Technique follows a six-step process to bring about a relaxation response to counteract the physiological effects of stress on the body.

Self-Massage–In self-massage the individual learns to massage him- or herself to bring about relief from tension.

Physical Activity and Stress Reduction–Termed "nature's tranquilizer," almost any type of physical activity (e.g., walking, jogging, swimming) can act as a stress reliever.

Physical Activity–Physical activity is any body movement produced by the skeletal muscles that results in increased metabolic rate over resting energy expenditure.

Exercise–Exercise is a subset of physical activity in which movements are performed repeatedly over an extended period with a specific external objective (e.g., improve fitness).

Pilates–Developed by Joseph H. Pilates, Pilates is a system of low-impact exercises designed to place little stress on the body while building a strong "core," the center of the body, including abdominal and back muscles.

Stretching–Stretching is a means to loosen up muscles and eliminate muscle tension. Stretching is commonly employed with older adults and clients in rehabilitation programs.

Aquatic Therapy–Aquatic therapy uses the environment of water to reach treatment and rehabilitation goals.

Leisure Education–The term leisure education today is commonly used to encompass all educational enterprises, including leisure counseling, that involve learning about leisure-related information, values, attitudes, and skills.

Values Clarification–Values clarification assists individuals to explore their values and decision making regarding their values so they may explore important beliefs and principles by which they live their lives.

Bibliotherapy–Bibliotherapy uses reading materials such as novels, plays, short stories, booklets, and pamphlets to help clients become aware that others share problems similar to them and to help them to bring about insights.

Cinematherapy–Also termed cinema therapy, movie therapy, and video work, cinematherapy has the purpose of clients and therapists discussing themes and characters in films that relate to issues of ongoing therapy.

Horticulture Therapy–Horticulture therapy involves the use of plants, gardening, and nature as vehicles in therapy and rehabilitation programs.

Therapeutic Community–Therapeutic community are democratic, homelife communities used in psychiatric facilities and nursing homes based on the concept that the entire social milieu may be used as an intervention.

Humor and Laughter–Humor is a stimulus. Laughter is a physiological event. Laughter results from humor, which develops out of incongruity. Things that appear funny are generally unexpected, ambiguous, inappropriate, or illogical.

Laughter Yoga–Laughter yoga is a relaxation technique that combines laughter exercises with yoga breathing and stretching. It is based on the idea that if people go through the motions of laughing, real laughter will follow.

Aromatherapy–Aromatherapy is the art and science of using plant oils (termed "essential oils") in treatment.

Adventure Therapy–Adventure therapy uses experiential learning activities in the outdoors. The experiences during activities serve as vehicles for learning as participants reflect upon their experiences during group processing facilitated by the therapist.

Assertiveness Training–Assertiveness training helps people to become more assertive in social relationships. Sticking up for themselves reportedly makes people feel better about themselves, thus increasing self-esteem.

Social Skills Training (SST)–Many RT clients have deficits in social skills so they need to learn socially accepted behaviors that allow them to have effective interactions with others. SST involves the teaching of social skills through a planned and systematic method.

Cognitive Rehabilitation–Cognitive rehabilitation is an approach employed to help clients with acquired brain injury to assist them to restore functioning or compensate for cognitive disabilities.

Community Reintegration–Community reintegration (sometimes referred to as community integration) programs assist people with disabilities or illnesses to integrate into their communities by building skills to build social networks and become engaged in their communities (in their personal homes, groups homes, halfway houses, or long-term care facilities).

Animal-Assisted Therapy–Animal-assisted therapy is a goal-directed intervention that uses the animal-human bond.

Animal-Facilitated Therapy–Animal-facilitated therapy is not directed toward meeting specific treatment objectives. Programs involve animals but are casual and spontaneous without a focus on treatment goals.

Creative Arts–Creative arts include modalities such as music listening, writing therapy, journaling, knitting, poetry, storytelling, drawing, sculpting, painting, and even coloring in adult coloring books for creative expression.

Psychodrama–Psychodrama is a form of psychiatric treatment (that involves specialized training) from which recreational therapists can draw upon aspects such as role-playing.

Cognitive Stimulation Therapy (CST)–Cognitive Stimulation Therapy has taken the place of reality orientation (RO) for dementia that came under fire for being applied in a rigid, demeaning, confrontational, and impersonal manner that was insensitive to the needs of individuals. The approach of CST is sensitive, respectful, and person-centered that involves a wide range of enjoyable activities with the aim of stimulating thinking and memory.

Validation Therapy–Developed by Naomi Feil in the 1970s from her work with Alzheimer's-type dementia, validation therapy attempts to "validate" the feelings and needs underlying clients' perceptions, instead of constantly correcting them as had reality orientation. The basic premise for validation therapy is that there is a sense of reality or logic that underlies the behavior of even the most disoriented individuals.

Remotivation Therapy–Remotivation therapy is a small group approach used largely with elderly clients that employs a structured five-step approach in group meetings to help them by promoting self-esteem, awareness, and socialization by focusing on the clients' abilities rather than on their limitations.

Sensory Training–Sensory training attempts to maintain and improve the functioning of regressed patients through a program of stimulus bombardment directed at all five senses.

Reminiscence Therapy–Reminiscence therapy is typically conducted in small groups that meet at least once a week, in which participants are encouraged to recall and talk about past positive or happy events in their lives.

Chapter 4: The Recreational Therapy Process

Humanistic Perspective–This humanistic perspective recognized 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 like humanistic psychology in that positive psychology is focused on human strengths and optimal functioning rather than pathology. It promotes the provision of positive environments to promote change.

High-Level Wellness–Championed by Dunn and Ardell, high-level wellness is gained when we exist in a "very favorable environment" and enjoy "peak wellness." The client may achieve high-level wellness when we make the individual's environment as conductive to growth as possible.

Holistic Medicine–Holistic medicine treats the person, not the disease. It is concerned with the "whole person," encompassing all aspects of the person.

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

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). It is 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 if 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.

Strengths Assessment–Client strengths are identified during the assessment phase. 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).

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 RT intervention plan to meet the individual client's needs. The intervention plan serves as a "blueprint for action."

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 large number of facilitation techniques (e.g., adventure therapy, animal-assisted therapy, yoga, physical activities) are available to be used as interventions to facilitate change.

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?

Clinical Reasoning–RT assessment involves more than data gathering. A critical element in doing assessment is to scrutinize the information collected by means of clinical reasoning to arrive at clinical judgments, or diagnosis, that serve as the basis for action.

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.

Subjective Data–Subjective data is data gained from the client.

Objective Data–Objective data is data gained from sources other than the client.

Maslow's Needs Hierarchy–Maslow's Hierarchy contains five basic needs. At the bottom are physiological needs (thirst, hunger, etc.). Then come safety needs (physical and psychological security, protection from threat of danger, freedom from fear). The third level includes social needs (needs for belongingness and love). Next come self-esteem or ego needs (for self-respect, status, recognition). At the top of the hierarchy is the need for self-actualization.

Goals–Goals, or general objectives, 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.

Three Characteristics of a Useful Objective

1. Performance. It describes what the client is expected to be able to do.
2. Conditions. It describes the conditions under which the performance is expected to occur.
3. Criterion. It describes the level of competence that must be reach or surpassed.

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

Activity Analysis–Activity analysis is the process of systematically appraising what behaviors and skills are required for participation in a specific activity.

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.

RT Individualized Intervention Plan (IIP)–The IIP is a written document stating the client's strengths and a needs list from which goals are determined (with specific objectives specified for each goal). The program of interventions to reach the goals is stipulated along with a plan for evaluation.

Master Treatment Plan or Interdisciplinary Treatment Plan (Care Plan or Intervention Plan)–Most clinical settings have a comprehensive interdisciplinary plan to manage the care of each client.

Discharge Planning–Discharge planning involves making plans for the transition of clients being released from the care of an agency, rehabilitation center, hospital, or institution. Recreational therapy should play a role in discharge planning.

Theory–Theory provides the basis for practice. Theories embraced by members of a discipline reflect the assumptions and values held by its members and define the profession's nature and the purpose of its practice. Theory provides the lens through which practice is viewed.

Philosophy–Philosophy represents the beliefs on which theory rests. Our professional philosophies are made up of the values we hold and our beliefs about human nature.

Conceptual Models–Conceptual models serve a dual role of (a) addressing the central phenomena that define a discipline and (b) offer theories reflective of them to guide practice. Conceptual models traditionally provide diagrams to represent them.

Leisure Ability Model–According to Stumbo and Peterson, the purpose of the Leisure Ability Model is to enable persons with limitations to develop "a satisfying leisure lifestyle, the independent functioning of the client in leisure experiences and activities of his or her choice." The model has three components: functional intervention, leisure education, and recreation participation.

The Health Promotion/Health Protection Model–The overall mission of the model is to help people to enjoy the highest levels of health possible for them as individuals. The mission has two purposes. One purpose is health protection. Health protection is meeting threats to health by helping people to return to a steady state or regain their equilibrium following illness or disability. It also involves assisting persons with chronic illnesses and long-term disabilities to adaptively cope with their conditions to maintain their health to the highest level possible. The second purpose is health promotion. In health promotion people are helped to enjoy high-level wellness or the highest level of health the person can achieve.

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. EBP is a problem-solving approach that provides a means for healthcare professionals to make appropriate and effective clinical decisions when caring for clients. EBP 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 RTs 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 5: Helping Others

Self-Awareness–Self-awareness has been identified as a highly rated competency for recreational therapists and has been terms to be compulsory in caring professions. When people are self-aware, they are conscious of their

thoughts, feelings, beliefs, attitudes, and behaviors.

Self-Concept–Self-concept comprises all of the information, perceptions, beliefs, and attitudes we have about ourselves.

Physiological Needs–Physiological needs are those needs basic for survival (e.g., food, water, sleep, sex).

Safety Needs–Safety needs deal with being physically and psychologically safe.

Social Needs–Social needs are our needs for love and belonging.

Self-Esteem –Self-esteem involves our feelings of value and worth as a person.

Self-Actualization–Our highest need is for self-actualization or the need to move us toward reaching our highest potentials.

Values–Values represent our core beliefs that influence how we act in both our personal and professional lives.

Value-Free Professional–Once professionals were supposedly not allowed to hold values. This myth has ended as professionals today are seen to hold personal and professional values.

Professional Ethics–Professional ethics comprise a system of principles of behavior that govern professional conduct in terms of right and wrong in performing professional responsibilities. Professions, like recreational therapy, have written codes of professional ethics.

Beneficence–Beneficence is an ethical principle of professionals being obligated to employ high standards that maximize benefits to clients and to protect the well-being and interests of clients.

Nonmaleficence–Nonmaleficence is an ethical principle dealing with the obligation not to harm others or to "do no harm."

Client Autonomy–The ethical principle of client autonomy is allowing clients the right to be self-governing or being free to make choices that direct the courses of their lives.

Justice–The principle of justice directs professionals that clients should receive service without regard to client values, disposition, race, color, gender, age, sexual orientation, disability/disease, or social or financial status.

Fidelity–The ethical principle of fidelity deals with the concept of faithfulness and the practice of keeping promises.

Veracity–The term veracity relates to the practice of telling the truth.

Informed Consent–Informed consent involves the right of clients to be informed about their therapy to make autonomous decisions pertaining to it.

Privacy–Privacy is a fundamental right of individuals to control information or secrets that are not disclosed to others.

Confidentiality–Confidentiality requires nondisclosure of private or secret information about a client.

Social-Sexual Relations–Sexual relations between therapists and clients are seen to be unethical behaviors. The therapist should not exceed the bounds of the role of "professional friend" in a helping relationship.

Therapeutic Relationship–A therapeutic relationship means a trusting connection and rapport has been established between the client and therapist.

Culture–Culture refers to the values and beliefs shared by a group of people. Each person is influenced by values and understandings gained from his or her culture.

Diversity–Diversity is typically represented by different races, classes, ethnicities, affectional orientations, and so on.

Cultural Competence–Cultural competence in healthcare providers describes the ability to provide care to clients with diverse values, beliefs, and behaviors, including tailoring health care delivery to met the client's social, cultural, and linguistic needs.

Multiculturalism–Multiculturalism promotes the value of diversity. Although being an integral and recognizable part of the whole, diverse members of society can maintain their identities while residing in the mainstream of society.

Sexual Orientation–Sexual orientation was at one time used to refer to persons who were gay or lesbian. Today the often-employed acronym is LGBTQ+ referring to the lesbian, gay, bisexual, trans, queer/questioning, and others.

Burnout–Burnout describes the emotional and physical exhaustion experienced by professional working in healthcare that results from prolonged mental stress of the job. At its extreme, burnout can produce feelings of hopelessness, helplessness, and depression.

Chapter 6: Communications Skills

Communication Skills–Communication skills are abilities used to achieve a common or shared understanding using verbal and nonverbal means.

Five Elements in Communication Process

- Communicator – who
- Message – says what
- Medium – in what way
- Receiver – to whom
- Feedback – with what effect

KISS & KIP–KISS stands for "Keep it Short and Simple." KIP stands for "Keep it Positive."

Mental Set–A mental set is a frame of reference resulting from previous experiences that may bring about unintentional distortions in communications. Pitfalls might include stereotypes, fixed beliefs, negative attitude, lack of interest, or lack of facts.

Effective Listening–Effective listening is sometimes referred to as empathetic listening because the listener is not judgmental or critical while attempting to gain an empathetic understanding of the client's thoughts and feelings.

Minimal Verbal Responses–Minimal verbal responses are verbal cues such as "mmmm," "yes." "I see," and "uh-huh." Their purpose is to indicate interest without disturbing the client's communication.

Paraphrasing–Rephrasing the content of the message in slightly different words.

Checking Out–A verbal technique to confirm or correct perceptions or understandings. It is used to clear up confusion about perceptions about the client's behavior or to try out a hunch.

Clarifying–Admitting to the client that the therapist is confused about what was said and wishes to clarify.

Reflecting (on feelings)–Rephrasing the affective part of a client's message with the purpose of helping the client to understand his or her own feelings.

Interpreting–In interpreting something is added to the statement of the client to help the client understand his or her underlying feelings.

Confronting–Without being accusatory or judgmental, the confronting response challenges clients to examine discrepancies between what they say and their actions.

Informing–Conveying objective information to the client in order to inform but not advise him or her.

Summarizing–To bring together and condense important elements after a length of time. Often used to draw a session to a close.

Self-Disclosing–Self-disclosing is sharing personal information with the client about the helper's experiences, attitudes, or feelings with the intent of sharing with the client experiences, attitudes, or feelings similar to what the client has faced.

Focusing–Focusing allows priorities to be formed by asking the client what issues are most important and which he or she wants to focus on first.

Making Observations–Statements by the therapist on which he or she observes or perceives.

Suggesting–This is not telling the client what to do but encouraging the client to consider alternatives.

Closed Questions–Closed questions may be answered "yes" or "no" or with factual information.

Facilitative Questions and Statements–Facilitative questions and statements provide open-ended questions or broad openings to encourage clients to discuss their thoughts, feelings, and experiences.

Nonverbal Communications–Nonverbal communications are messages that pass between a sender and receiver that do not rely on the spoken word (e.g., voice tone or volume, rate of speech, body movement, eye contact, facial expression, hand gestures, touch).

Chapter 7: Being a Leader: Group Leadership Skills

Leadership–Leadership is a process of influence toward the attainment of a goal.

Autocratic Leadership–This leader makes all decisions and expects others to be obedient.

Democratic Leadership–Democratic leadership is shared leadership by involving others in decision making.

Laissez-Faire Leadership–The leader uses minimum control, so participants take on responsibility for decision making.

Overjustification Effect–An overjustification effect may occur when extrinsic rewards are continually given for intrinsic behaviors, changing a person's motivation from internal to external.

Controller Role in Groups–The controller exercises a high level of control over clients, making all decisions for the group.

Director Role in Groups–The director holds most of the power and leads the activities of the group but allows clients some latitude in making decisions.

Instigator Role in Groups–The instigator incites action on the part of the group and then withdraws.

Stimulator Role in Groups–The stimulator begins activities by stimulating interest on the part of those in the group and helps maintain interest.

Educator Role in Groups–The educator instructs clients in activities and social skills.

Advisor Role in Groups–The advisor provides counseling and guidance to group members.

Observer Role in Groups–The observer provides leadership by his or her presence and evaluates and reacts to client responses.

Enabler Role in Groups–The enabler role fits well into the laissez-faire style, in which the leader simply provides opportunities for participation in activities that clients determine.

Stages of Group Development

- Forming

- Storming
- Norming
- Performing
- (some add Termination)

Task Functions–Task functions in a group promote the work or task of the group.

Social-Emotive Functions–Social-emotive functions have to do with building the group or promoting group development.

Nonfunctional Behaviors (within groups)–Nonfunctional behaviors interfere with the processes of a group.

Modeling–Because observing others can play a large role in shaping behaviors, recreational therapists in leadership roles should be aware of their role in modeling positive behaviors.

Self-Disclosure–If group leaders use self-disclosure, they should keep in mind that it should only be used only when relevant and warranted to benefit group members. It cannot be assumed that it is always good to disclose.

Transference–The process in which a group member displaces thoughts, feelings, and behaviors on the group leader or another group member even though the thoughts, feelings, and behaviors originally stemmed from a relation with another significant figure in the client's life.

Countertransference–Countertransference is the process when the group leader responds to a group member as though the client were someone from the leader's past.

Coleadership–Coleadership involves two therapists leading a group. Recreational therapists should become aware of advantages and disadvantages of coleadership.

Phases in Conducting RT Group Activity Programs

- Warm-up Phase (or orientation phase)
- Experience Phase
- Wrap-up Phase (or cooldown phase)

Group Processing–Group processing activity participation with members of groups is a means through which those in the group learn about themselves and their interactions with others, gaining self-awareness that extends beyond the activity into their everyday lives.

Debriefing–Debriefing is a major group processing technique that occurs at the end of the session as group members reflect on their participation.

What? So What? Now What? (debriefing technique)

- What? Group members are asked to review what happened during the group activity with the intent of raising issues about positive behaviors and those behaviors participants may wish to change.
- So What? At this point, participants express what they have learned from the experience.
- Now What? The "Now What?" phase provides opportunities to talk about what group members will do with what they have learned as a result of their participation.

Chapter 8: Specific Leadership Tasks and Concerns

Documentation–Documentation is the process of obtaining, organizing, and conveying client health information in print or electronic format.

Charting–Charting is the concise, accurate, factual, documentation of occurrences and situations pertaining to a particular client. Charting is done in written form or electronically created.

Narrative Charting–Narrative charting provides a chronological account of the interventions performed, the client's responses to the interventions, and the client's status (e.g., changes in the client's condition).

Source-Oriented Charting–Source-oriented charting separates recordings according to source or discipline. Sections of the chart are designated for medical notes, nursing notes, RT or rehabilitation notes, and so on.

Problem-Oriented Records–The problem-oriented record is organized around the client's problems, rather than the source of information.

SOAP Notes–S stands for subjective data. O stands for objective data. A represents assessment. P is for plan.

Incident Report–An incident report is a tool that documents any event that may or may not have caused injuries to a person or damage to a facility or agency asset. It is used to capture injuries and accidents, near misses, property and equipment damage, health and safety issues, security breaches and workplace misconduct. Recorded should be facts, not opinions. Blame should not be apportioned for the incident.

Transtheoretical Model (TTM)–The TTM is an evidence-based model for understanding the stages that clients pass through: precontemplation, contemplation, preparation, action, and maintenance.

Motivational Interviewing (MI)–MI is based on the notion that clients are often ambivalent about change, and this ambivalence affects their readiness to change their behavior. MI is based on four guiding principles known as the acronym RULE.

RULE Principles

- **R**esist the righting reflex (resist the natural tendency to "fix" the client by imposing solutions).
- **U**nderstand and explore the client's motivation (help clients to make reason for change their own so are intrinsically motivated for change).
- **L**isten with empathy (use empathetic listening skills).
- **E**mpowering the client and encouraging hope and optimism (clients are helped to explore how to make differences in their health and then to understand that their plans are achievable, and they have to ability to bring them about).

Teamwork–Teamwork requires a high level of interdependence and shared responsibility among members who feel accountable to one another and who are committed to working together to achieve a defined purpose.

Advocacy–Advocacy involves a person making a reasoned argument to obtain something form those in power. It is often seen as the process of speaking for or acting in behalf of a person, an idea, a principle, a cause, or a policy. For example, recreational therapists may advocate for their clients or for their profession.

WHO–World Health Organization

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.

Self-Concept–The individual's overall beliefs and knowledge about himself or herself.

Self-Esteem–Self-esteem describes how favorably a person feels about themselves. It is the affective part of self-concept.

Social Comparison–Social comparisons are when people compare themselves to others and this feeds into their self-views.

Self-Handicapping–Self-handicapping is a term to describe actions when people arrange impediments that they can later use to blame for their poor performance (e.g., pulling an "all-nighter" to blame poor performance on an exam on a lack of sleep).

Self-Reported Handicap–The self-reported handicap occurs when there is no inhibiting factor but the individual makes up an excuse to their poor performance (claiming to be chronically ill as an excuse for poor performance).

Learned Helplessness–When humans start to believe that they have no control over what happens to them, they begin to think, feel, and act as if they are helpless. Learned helplessness occurs when an individual continuously faces a negative, uncontrollable situation and stops trying to change their circumstances, even when they have the ability to do so. Learned helplessness can lead to negative consequences, such as decreased problems solving, frustration, lowered self-esteem, or depression.

Psychological Reactance–Reactance is the opposite of helplessness. Instead of becoming helpless when facing a situation, persons experience reactance. They don't give up but instead are motivated to gain control over the situation.

Self-Fulfilling Prophecy–The "Pygmalion effect" in which expected behaviors become confirmed due to the actions of the perceiver. In short, "you get what you expect" in terms of others' behaviors because of your own actions toward them.

Loneliness–Loneliness is a distressing psychological feeling that accompanies the perception that an individual's social needs are not being met. It is more closely associated with the quality of relationships, rather than the numbers of relationships.

Social Support–Social support is the perception that persons in the person's social network are supportive of the individual in terms of meeting the individual's needs. When social support exists people feel others care about them and are willing to provide emotional, material, or information aid to them.

Social Facilitation–Social facilitation deals with the presence of others having an enhancing effect (facilitating a behavior) or a deteriorating effect (or an inhibiting effect on behavior) on them.

Social Learning Theory–Social learning theory emphasizes how behaviors are learned through observation. People observe others' behaviors and imitate them if they see them being rewarded or they do not behave in a certain way because they have seen others punished.

Self-Efficacy–Self-efficacy refers to an individual's belief in his or her abilities to execute behaviors necessary to do something. Self-efficacy reflects confidence in the ability to exert control over one's own motivation, behavior, and social environment. Low self-efficacy can lead people to give little effort or give up quickly if they are not having success.

Attributional Processes–We engage in attributional processes to explain the events that occur in our lives. These attributions (or explanations) have significant psychological consequences. Our reactions to emotional events, our self-regard, our judgments of ourselves and others, and our expectations of the future are all subject to the influences of how we explain events.

Internal Attributions–Making internal attributions places the cause of the event with us. The cause is perceived to be due to our personality, dispositions, abilities, or the amount of effect expended. For example, having done well on an exam, we might attribute our success to internal causes such as our intelligence or our preparation for the exam.

External Attributions–External attributions place the cause with the situation in which the event occurred. For example, if we did poorly on an exam, we might attribute our low performance on the exam items being "ambiguous."

Self-Serving Bias–The tendency to attribute successes to internal causes and to attribute failures to external causes is termed the self-serving bias.

Fundamental Attributional Error–The tendency to overestimate the role of personal dispositions and overlook situational causes is termed the fundamental attributional error. This can occur when therapists blame clients for unfortunate things that happen to them, while ignoring situational causes.

Chapter 9: Clinical Supervision

Clinical Supervision–Clinical supervision is a joint relationship between the supervisor and supervisee to assist the supervisee to develop and improve clinical skills while helping the agency to maintain the integrity of the agency's clinical program.

Strength-Based Clinical Supervision–Strength-based clinical supervision does not dwell on the negative but remains positive, attempting to recognize the supervisee's strengths. It does not ignore weaknesses but uses strengths to overcome weaknesses.

Skills Development Model (of Clinical Supervision)–The skills development model follows a teacher-student relationship as clinical skills are taught to the supervisee (e.g., skills in leading therapy groups, establishing therapeutic relationships, making diagnostic judgments, conceptualizing new cases).

Personal Development Model (of Clinical Supervision)–Here the relationship between the supervisor and supervisee resembles a counselor-client relationship in which the supervisor assists the supervisee to develop insights into himself or herself by examining his or her interpersonal relationship patterns and how he or she affects others. The supervisor also helps new supervisees learn to put the client's needs before their own and to deal with "shocking" subjects (e.g., child abuse, drug use, incest).

Integrative Model (of Clinical Supervision)–This model builds upon the skill development and personal development models and is used with advanced students and experienced therapists. It follows a mutual relationship between the supervisor and supervisee in which they share information about clinical practices and discuss clinical cases to determine strategies. Here the supervisee can control and structure of supervisory session.

Modalities for Clinical Supervision–Two primary modalities are used for conducting clinical supervision, individual and group meetings.

Triadic Supervision–In triadic supervision, two supervisees meet with one clinical supervisor.

Informed Consent–It is incumbent upon the supervisor to inform the supervisee of the supervisory relationship arrangement and to gain the supervisees consent. In general, supervisees need to be informed about any aspect of the supervisory relationship that could affect their willingness to participate.

Formative Evaluation–Formative evaluation is the continuous process of giving feedback that facilitates the skill development and professional growth of the supervisee.

Summative Evaluation–This is the formal type of evaluation that provides the supervisee an overall perspective of strengths, limitation, and possible areas for improvement. For a student intern, formal evaluations may occur at midterm and at the conclusion of the internship.

Chapter 10: Health and Safety Considerations

Seizure–When abnormal brain cells control movements of the body. Seizures vary significantly from very brief lapses of attention or muscle jerks to severe convulsions with unconsciousness.

Epilepsy–Epilepsy is the disorder 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.

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* are 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.

AEDs–Antiepileptic Drugs

Desired Effect (of AEDs)–The desired effect of an AED is to make the brain less apt to seize.

Side Effects (of AEDs)–All drugs may cause effects in addition to the desired effect for which they were prescribed. Common side effects of AEDs include somnolence, dizziness, unsteadiness, double vision, and behavioral changes.

Psychotropic Drugs–Drugs that have an effect on the psychic function of the client are collectively known as psychotropic drugs. The major classes of psychotropic drugs: antipsychotic, antidepressant, antimania, antianxiety, and stimulants.

Antipsychotic Drugs–Antipsychotic drugs are used in treating psychotic patients. The first of these was Thorazine (chlorpromazine) introduced in the 1950s. One side effect of Thorazine is that patients who take it become highly sensitive to sunburn.

Tardive Dyskinesia (TD)–TD is having movements you cannot control. It may result from taking antipsychotic medications.

Transfers–Examples of transfers include transferring a client from a bed to a wheelchair or from a wheelchair to a bed.

Mechanical Aids–Mechanical aids include items such as braces, crutches, walkers, and wheelchairs.

Chapter 15: Trends and Issues

Trends–Trends are developing tendencies that are taking RT 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 RT programs from the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

Conceptual Models–Conceptual models, sometimes referred to a practice models, provide the theoretical basis for RT as they serve to define and guide the practice of RT. Theory drawn from conceptual models furnishes explanations of concepts underpinning RT 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 assess 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 International Classification of Functioning, Disability, and Health (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 RT 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.