Therapeutic Recreation Programs in a Physical Rehabilitation Setting

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Introduction

With the growing number of head injury survivors and the improved management approaches that have led to a significant increase in the survival rate for traumatic spinal cord injury (SCI) in the United States today, we have an increased need for specialized rehabilitation services. These rehabilitation services continue to multiply as the prevalence of SCI survivors and incidence of head injuries increases. In the Dallas/Fort Worth Metroplex area there are five freestanding rehabilitation facilities, of which three have been developed or enlarged during the last three years. These facilities are complemented by six rehabilitation units at local multi-service hospitals. The metroplex currently has a population base of three million.

Current figures support the increase both in incidence, prevalence and facility development. The National Head Injury Foundation (1988) estimates that 700,000 head injuries occur each year, of which 2,000 are left in a "persistent vegetative state." By comparison SCI is a low incidence injury with approximately 7,800 spinal cord injuries each year (National Spinal Cord Injury Association, 1988). Figures for SCI are felt to be significantly under-reported due to numbers not including deaths before hospitalization or those with secondary deficits. The larger SCI numbers are those in terms of prevalence with 220,000 current SCI survivors in the USA.

With the traditional purpose of rehabilitation shifting, under the increasing need for services, from preparation for employment to include preparation of disabled persons to function up to potential in all aspects of living, the role of recreation is requiring more attention. Therapeutic recreation (TR) has emerged in rehabilitation settings from the time when Howard Rusk and the New York Rehabilitation Institute was the paradigm of the profession to the point...
today where TR is providing direct service in almost all rehabilitation facilities.

The development of recreation services within a rehabilitation setting has brought forth many discussions concerning the exact role and function of the services which many felt to be ambiguous when covered by the early definition of TR (Peterson and Gunn, 1984:2). Some proponents believe the services are treatment oriented and thus directly contribute to the total rehabilitation process. Others contend that the role of recreation in treatment settings is purely diversionary, enabling individuals to relax or recreate despite disability or the treatment situation.

The underlying issue centering around the narrow treatment versus pure recreation question is one of developing an underlying philosophy regarding the recreation programs available in specific rehabilitation settings. In the late 1970s models developed by Gunn and Peterson (1978) and Witt and Compton (1979) aided the formation of a suitable position statement for each TR department. By using an approach such as the Gunn and Peterson model, recreation is seen as a planned, purposeful intervention with the goal of improving the individual's quality of life.

Dallas Rehabilitation Institute (DRI) is a 120-bed specialist hospital comprising extensive in-patient and outpatient services. Disease category services are available to a large number of disabilities including spinal cord injury, head injury, stroke, arthritis, amputations, pain management and other orthopaedic or neuromuscular dysfunctions. The average daily patient census for the last six month period is 66 with the highest percentages of disability falling to SCI, stroke and head injury.

We have a small recreation department with four full-time staff members. These consist of three Certified Therapeutic Recreation Specialists (CTRS) and a Wheelchair Sports Coordinator. Due to the administrative commitments, only two of the CTRS’ are involved in patient contact on a full-time basis. Our primary service focus is with the two larger areas of SCI and head injury, although these do overlap with orthopaedic and stroke services. For the purpose of this presentation we will discuss the services offered to the SCI and head injury areas.

Our departmental philosophy is one that corresponds with the Leisure Ability approach (Peterson & Gunn, 1984) and is directly linked to the principle of normalization as expressed by Wolfensberger (1972). This being "the use of methods and settings which are valued and familiar, to offer each person life conditions and opportunities which are at least as good as those of the average citizen, and as much as possible to enhance and support each person's behavior, status and reputation." We also focus on mitigating the effects of devaluation. Devaluation occurs when a person is seen as being different and the differences are socially significant and negatively valued. Initial trauma and the rehabilitative setting often precipitate devaluation in the in-patient. Although all three elements of the Leisure Ability Model are present in our programs, we focus on functional activities that occur during the latter stages of leisure education and recreation participation. With the title of "Recreation and Leisure Services," we are able to educate patients, staff and the community to the role of our department. This is increasingly necessary as the department is still evolving (three years old) and is moving away from the bonds that tied it in with occupational therapy.

Each CTRS is fully involved within the process of rehabilitation and the interdisciplinary team, which includes physicians, nurses, behavioral medicine, speech, occupational and physi-
cal therapists, case managers and nutritionists. In the area of quality assurance, initial assessments, progress notes, update staffings and discharge evaluations are ever increasing in importance and the CTRS is fully involved in each stage. Of particular importance is the utilization of the recreation and leisure service’s discharge packet, which contains re-entry information - both community specific and general resources.

Head Injury Services

With evidence suggesting that cognitive impairments and psycho-social aspects of head injury far exceed physical complications, the area of recreation and leisure services reflects the importance of addressing these needs through direct programming. Fazio and Fralish (1988) conducted a study, the first nationwide survey into existing recreation and leisure education programs in post-acute head injury facilities. The results, which indicated an improvement in basic social skills and community reintegration were the major goals of the TR department, show the importance of the recreation process in successful community reintegration. The National Institute of Handicapped Research (1982) reported data from major head injury research projects that further reinforces the leisure "disuse" problems.

The elements of leisure knowledge and skill acquisition and participation are of major importance within the DRI head injury program. Individuals who are at a low level of cognitive function (as reported by the Rancho Los Amigos scale) are involved in therapy programs such as pet therapy, which focus on the visual and tactile senses and may introduce basic socialization through a "friendly" or recognized approach. As the stages of recovery progress with the individual, the treatment techniques focus upon increasing awareness and attaining purposeful and appropriate responses toward self, activities at hand and the environment. The range of activities that may be included at the level (Rancho levels may be IV through VI) include participating in a recreation center based aquatics program working with specific goals, through to hospital-wide patient activities such as cook-outs, outdoor games and community recreation trips, where the individual is observed and specific areas addressed.

At the cognitive levels VII and VIII the individuals are included in the stage III advanced head injury group unless excluded by criteria such as physical management problems. This group is developed to meet the needs of high level head injury individuals. The program is highly structured with activities planned to coincide with activities the individual will encounter after leaving the hospital setting. Recreation takes on a specific role in this stage III group. This may be seen by addressing one of the discharge goals, which is displaying the ability to plan, initiate and participate in a wide range of recreational and leisure activities. Leisure education during this stage is regarded as a broad category of services that focuses on attitudes, knowledge and the development of skills necessary for greater community independence. Included here is training involving accessible facilities that are community wide, to instruction on locating programs and following up on visits.

Due to improved research into the long term outcome after head injury (Brooks, et al., 1987), treatment implications concerning post-rehabilitation are becoming addressed. Such developments include cognitive remediation, transitional living communities and specialized problem-specific re-entry programs. Recreation is being seen to have an increasing role post-discharge as research (NIHR, 1982) is showing those having a non-work role had associated leisure time and cognitive problems in comparison to those working.
At DRI the cognitive remediation program has utilized recreation and leisure services in a program being sponsored by the Texas Rehabilitation Commission. The cognitive remediation trainees were involved in an outward bound course developed to focus on problematic areas of dysfunction. The goal of the program is to examine if the skills learned in a generalized highly structured environment in which risk taking (perceived, not actual) and interpersonal communication were stressed.

Spinal Cord Injury (SCI) Programs
In-Patient Programs
The in-patient SCI population at DRI interacts primarily with the Certified Therapeutic Recreation Specialist responsible for the SCI group and to a lesser degree the wheelchair sports coordinator. Support is also available from the other two members of the department. Programs offered to the in-patient SCI population focus on three areas: Community Reintegration Therapies (CRTs), functional activities and leisure education.

Consistent with the Principle of Normalization, CRTs are designed to expose the patient to once-familiar activities that should become, once again, a familiar part of their lifestyles. A CRT outing can be as "routine" as a trip to the local shopping mall or it can be as stimulating as going to a rock concert. Although the outing itself is important, any CRT has a number of other benefits not immediately apparent to the in-patient. At DRI the nature of the CRT is determined by the in-patients who are going on the outings. Therefore the in-patient initiates his or her own recreational activity. In-patients experience both the physical and attitudinal barriers they are likely to face when re-entering the community but at a time when there are resources available to mitigate the initial problems of community re-entry in a positive environment. Finally, CRTs have a positive impact on some of the problems of devaluation by taking the patient out of the institutional environment. Functional activities include interaction with the patient during physical and occupational therapies. An example of the implementation of DRI's team approach to patient care occurs during the physical therapy department's inpatient mobility class. As part of scheduled physical therapy, patients who have attained a threshold level of function in their wheelchairs are placed in an advanced mobility class that meets three afternoons during the week.

The advanced mobility class concentrates on techniques such as advanced recovery for when the person loses control of the chair, stair climbing and "wheelies" for curb negotiation. For one afternoon per week the mobility class concentrates on sports activities, which are directed by the Recreation and Leisure Services Department. The objective of these activities is to improve functionality through sport. This is achieved by helping to develop the in-patient's proprioceptive model of his new environment, human and wheelchair, and developing motor skills to improve day-to-day functionality. This is achieved by playing sports that are dynamic and require movement of the wheelchair at an intensity that cannot be achieved in the normal hospital environment. Some sports are played competitively such as wheelchair football, floor hockey and, of course, basketball; some are undertaken recreationally such as slalom and badminton.

During these activities other aspects of leisure education are also stressed. These include good exercise habits (stretching before the activity and "cooling down" after); and resource information dissemination, namely informing the in-patient of what sporting activities are available and how to start participating after discharge.
Leisure education at DRI covers many areas, I will focus on sports as that is my area of expertise. During the initial rehabilitation process the new SCI patient is made aware of the wide range of sporting activities available to the wheelchair user. The department makes available a wide range of videotapes that include the "conventional" wheelchair sports, basketball, track and field, etc., and also includes some not-so-obvious activities such as hang gliding, four-wheel racing and sailing. At this stage the emphasis is placed on future possibilities and that life's pleasures are not over. During rehabilitation this is re-emphasized through the mobility class and in-patient interaction with members of DRI's community-based wheelchair sports program. Upon discharge the patient receives a comprehensive discharge packet which includes resource information on local and national sports organizations, wheelchair sports magazines and DRI's wheelchair program. Upon discharge the patient is therefore aware of some of the recreational opportunities available and is encouraged to join the community wheelchair sports program.

Out-Patient (Community) Programming: The DRive
The Dallas Rehabilitation Institute emphasizes the development of the whole person. The community wheelchair sports program, The DRive, is an extension of that philosophy and is committed to positively impacting the lives of the wheelchair population in the Dallas/Fort Worth Metroplex. Within the able-bodied environment, well-structured sports programs inculcate many benefits to the participant. These benefits include: improved social skills, improved leadership abilities, improved health and an overall sense of well being. Participation in sporting activities is encouraged to the point that, for example, with a few exceptions, sports participation is a required part of the undergraduate curriculum at universities. For the wheelchair population, sports activities are a valuable tool that should be used to promote these benefits within as large a section of the wheelchair user population as possible.

The DRive wheelchair sports program attempts to provide sports opportunities to the local wheelchair population, where possible in a "mainstreamed" environment to promote the development of physical, psychological and social skills that will enhance the life-style of the participant. In order to do this, emphasis is placed on the recreational side of the activity spectrum rather than the athletic side. This allows for a higher number of participants in the programs and stays away from the intimidating elitism that is prevalent in all sports, not just the wheelchair variety.

The community-based wheelchair sports program allows for easy entry into the sports environment by way of the bi-weekly fitness and conditioning class. The class has a deliberately relaxed feel, is non-competitive and is self-paced. However, it is stressed that participation in the other programs is desirable but not mandatory. From this starting point other recreational programs are made available such as self-defense, softball, football and basketball. We also include close-ended clinics for easy introduction to sports. Activities covered in these clinics include tennis and sit-skiing. This is not to say that competitive athletics are not addressed within the program but they are promoted as a continuation of our overall programming goals. The wheelchair sports program also assists in education and advocacy by having staff talk at area schools, universities and local government meetings. The program supports area research as a resource for athletic contacts and of course improves the visibility of DRI in the area.
Conclusion

Within the recreation and leisure services department of DRI a number of different programs exist. Each one, however, conforms to the philosophical framework delineated within the department. It is hoped that the role of the department will increase as we educate peers, patients and the community to the benefits of therapeutic recreation. This education should lead to increased support, in terms of funding and other resource allocations, for both current in-patient and developmental out-patient programs.

References


Compton, D. and P. Witt, A Philosophical Statement of the National Therapeutic Society, a Branch of the National Parks and Recreation Association, 1979.


