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Understanding Cross-Ethnic Interactions When Using Therapeutic Recreation Practice Models

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The purpose of this qualitative study was to investigate how Certified Therapeutic Recreation Specialists utilize therapeutic recreation practice models to manage cross-ethnic interactions in therapeutic recreation programs. The following four salient themes emerged from the data: (1) awareness and struggle of diversity issues; (2) awareness of limited diversity training; (3) importance of family and spiritual involvement; and (4) implementation of Euro-North American universal notions across culture. Future directions regarding cross-ethnic therapeutic recreation practice are provided.

KEY WORDS: *Cross-Cultural Interaction, Diversity, Ethnicity, Therapeutic Recreation Practice Models*

Despite the increased literature regarding cross-cultural and diversity issues in therapeutic recreation (Allison & Smith, 1990; Beveridge, 1998; Dieser & Peregoy, 1999; Fox & van Dyck, 1997; Getz, 2000; Peregoy & Dieser, 1997; Sylvester, Voelkl, & Ellis, 2001), there still is a dearth of research investigating cross-cultural and diversity issues in therapeutic recreation practice. In particular, there has been almost no research directed toward exploring diversity in therapeutic recreation practice models. To this end, Dieser and Peregoy underscored the pervasive lack of attention that authors of therapeutic recreation practice models have placed on embracing and understanding multicultural and diversity issues:

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> . . . in a special series issue in 1998, the *Therapeutic Recreation Journal* dedicated the second, third, and fourth quarter journals to discourse regarding therapeutic recreation service models. Although fifteen articles were written (a total of 122 pages), only three sentences by McCormick (1998) were directed toward multicultural concerns. (p. 56)

The purpose of this paper is to increase understanding of diversity issues in therapeutic recreation practice. In particular, this study investigates how Certified Therapeutic Recreation Specialists™ (CTRS) utilize therapeutic recreation practice models to manage cross-ethnic interactions in therapeutic recreation programs. To help bring clarity to the study reported in this paper, the following section will provide a brief literature review regarding therapeutic recreation practice models, diversity, and ethnicity.

Literature Review

Therapeutic Recreation Practice Models

Therapeutic recreation practice models guide therapeutic recreation specialists in the process of intervention (Bullock & Mahon, 2000). That is, a practice model provides a framework for selecting, sequencing, and organizing therapeutic recreation programming (Bullock, 1998; Bullock & Mahon, 2000). Practice models provide professionals with a framework for thinking—models shape the observations professionals make, the questions they ask, and the answers they provide (Freysinger, 1999). Although there are several therapeutic recreation practice models, the following section will explain the Leisure Ability Model and the Health Protection/Health Promotion Model.[1]

The Leisure Ability Model

Peterson and Stumbo (2000) articulated a three-phase model to help guide and design the practice of therapeutic recreation. The first phase, functional intervention, focuses on the improvement of functional abilities through recreation and leisure activities. The second phase, leisure education, concentrates upon the development of skills, attitudes, and knowledge related to leisure participation. The last phase, recreation participation, focuses on acquisition of activity-based services to foster participation in recreation experiences as an expression of a leisure lifestyle. The leisure ability model strives for the development of independent leisure, which ". . . entails being intrinsically motivated, having an internal locus of control and feeling a sense of personal causality" (Stumbo & Peterson, 1998, p. 86).

The Health Protection/Health Promotion Model

Austin (1996, 1998, 1999) designed the Health Protection/Health Promotion model with the goal of optimal health, which is defined as self-actualization. Austin (1996) posited that as clients move toward optimal health, they exercise greater choice until they move to the point at which they experience self-actualization.

In the first phase, prescriptive activities, therapeutic recreation specialists prescribe activities to assist clients in regaining a sense of control over their lives. During this phase therapeutic recreation specialists activate clients by providing direction and structure for activities. In the second phase, recreation, the actualization tendency of clients begins to grow as the client gains a sense of mastery via experiencing recreation activities. In this stage, therapeutic recreation is used as a treat-

[1] Later in this paper, when the research findings are explained, the reader will have a better understanding why the Leisure Ability Model and the Health Protection/Health Promotion are the only two models explained in the literature review section. In short, five of the six research participants, who participated in the study, reported that they utilized the Leisure Ability Model and the other research participant combined the Leisure Ability Model and the Health Protection/Health Promotion Model.

ment modality. During the last phase, entitled leisure, self-actualization (optimal health) occurs due to self-directed leisure activities. The Health Protection/Health Promotion model encourages self-determination and independence to foster self-actualization.

Dimensions of Cultural Diversity

Cultural diversity refers to the recognition of differences among cultures and the implications of these differences with the goal of cross-cultural understanding (Henderson, 1995). Although culture has been defined in multiple ways (Kroeber & Kluckholn, 1952), in this paper culture is defined broadly as a set of attitudes, values, beliefs, and behaviors shared by a group of people (Corey, 1991; Matsumoto, 1996; McDermont & Varenne, 1995).

There are numerous dimensions of diversity (Allison, 2000; Matsumoto, 1996), although most people usually identify with a core culture or dimension (Gudykunst, 1998; Stryker, 1987). That is to say, people have a core cultural identity and simultaneously belong to differing cultures, thus making them multicultural beings. An individual's multiple cultures include primary and secondary dimensions of cultural diversity. Primary dimension of diversity includes cultural characteristics that are usually, but not always, obvious when first meeting someone, such as ethnicity, gender, and race (Allison,). Secondary dimensions of diversity include cultural characteristics that are usually, but not always, obscure when first meeting someone, such as religious beliefs, educational level, and socioeconomic status (Allison,). For example, an individual may have a core cultural identity based upon ethnicity (e.g., African-American), but simultaneously have cultural identities affiliated with upper-middle class, female, academic cultures. Additionally, another person may have a core cultural identity premised upon religion (e.g., Baptist Christian), but simultaneously may have cultural identities affiliated with middle class, blue-collar, African-American cultures.

Within the scope of this paper, the cultural dimension that is examined is ethnicity. Ethnicity includes a shared sociocultural or ancestral heritage that includes the biological, cultural, social, and psychological domains of life (Buriel, 1987; Pedersen, 1994). Minority refers to smaller or fewer in number within a larger group (Soukhanov, 1992, cited in Dattilo, 1999). In this paper, ethnic minority is defined as groups of people who share a sociocultural or ancestral heritage who are fewer in number than White Euro-North American people (e.g., First Nation People).

Methods

This qualitative investigation asked Certified Therapeutic Recreation Specialists™ how they utilize therapeutic recreation practice models to manage cross-ethnic interactions in therapeutic recreation programs. To accomplish this research objective, semi-structured interviews were conducted. These interviews attempted to describe the world from the research participant's point of view and to uncover understanding of their lived realities in therapeutic recreation practice. To this end, the researcher used a conversational approach to interviewing (Ellis, 1998; Kvale, 1996). A conversational interview gives the researcher an opportunity to learn about experiences, feelings, and thoughts of research participants in a semi-structured format. Carson (1986) outlined two aspects of conversational interviews. First, a conversational interview illustrates a mutual questioning of a common topic between a researcher and a research participant. Second, conversations are not linear, rather they are discursive. Thus, to gain understanding, the researcher may need to address contradictions in a tactful manner.

The primary criterion of eligibility to participate in the study was that a therapeutic recreation specialist: (1) must have utilized a therapeutic recreation practice model while working with a client from an ethnic minority culture; (2) the therapeutic recreation special-

ist resided in Canada[2]; and (3) the therapeutic recreation specialist was certified via the National Council for Therapeutic Recreation Certification.

After securing names of potential research participants from various therapeutic recreation membership directories in Canada (e.g., Alberta Therapeutic Recreation Association, Atlantic Canadian Society for Certified Therapeutic Recreation Specialists, Canadian Therapeutic Recreation Association), fifteen participants were identified as eligible to participate in the study. Of these fifteen potential research participants, nine therapeutic recreation professionals felt they could not participate in the study. Four of the nine participants who did not participate in the study disclosed that they had not worked recently with a client from an ethnic minority background. The other five research participants who declined to participate in the study reported that they did not feel comfortable volunteering in the proposed study due to the delicate nature of ethnicity. Hence, the study reported in this paper had six research participants. Table 1 presents descriptive information regarding the six research participants.

The research interviews occurred over the telephone, were recorded on audio tape, and then transcribed verbatim with the research participants' written consent. Interviews ranged from one to three hours in duration. The interviews consisted of open-ended questions but were flexible to allow a conversation to occur during the course of the interview. To develop trust and comfort, interviews began with broad introductory-type questions (Kvale, 1996) related to therapeutic recreation and then shifted to more focused questions pertaining to understanding the participants' experiences in using therapeutic recreation practice models to manage cross-ethnic interactions during therapeutic recreation practice. Table 2 provides an example of questions included during the semi-structured interviews.

[2] Because the primary researcher was affiliated with a University in Canada, it made pragmatic sense to have research participants reside in Canada.

To analyze and interpret the data, three steps were adapted from Miles and Huberman (1994). First, concepts and ideas were noted in the interviews. This was ongoing and began after the completion of the first interview. Within minutes after each interview a contact summary form was completed (contact summary forms were adapted from Miles & Huberman, 1994, p. 53). This process consisted of documenting the main issues and themes that were underscored in the interview, summarizing information aligned to differing questions or conversational topics discussed, and articulating new or remaining questions that could be considered if another interview was conducted. Revisiting the interviews through the transcripts and tapes was critical to identify ideas and concepts.

Second, clustering of concepts and ideas occurred until there was a consistent theme. Clustering began after the second interview and continued throughout the remaining interviews. Two strategies were used to cluster themes. First, the creation of word documents occurred in which words were created around certain themes. Second, theme modeling—placing quotes under corresponding theme headings—took place. This process of clustering has also been termed as a constant comparison (Creswell, 1994; Glaser & Strauss, 1967; Lincoln & Guba, 1985).

Third, analysis was facilitated via comparisons and contrasts. During data collection and analysis, it became apparent that there were constant themes in comparable and contrasting manners. For example, when research participants were aware of diversity issues (constant theme), some participants embraced diversity (sub-theme) while other research participants avoided or reduced diversity concerns (contrasting sub-theme).

The trustworthiness of data collection and analysis was addressed by using three strategies. First, after the tapes were transcribed verbatim, the documents were sent to each research participant for feedback and to check for accuracy in transcription (Miles & Huberman, 1994). All six research participants reported that

Table 1.

Descriptive Information of Research Participants

Research Participant (Pseudonyms)	Gender and Ethnic Background of Research Participants (CTRS)	Employment Facility	Ethnic and Gender Background of Client that Research Participants (CTRS's) Were Working With
Betty	Female European Canadian	Adult transitional care unit from medical (rehab) to long term placement (e.g., nursing home)	African-Canadian adult male
Bob	Male European Canadian	Adult physical rehabilitation	Native-Black adult men and women
Karen	Female European Canadian	Residential treatment facility for people with substance dependency	Micmac First Nation female adolescent
Myra	Female European Canadian	Adult transitional care unit from medical (rehab) to long term placement (e.g., nursing home)	Elderly Japanese Canadian female
Nancy	Female European Canadian	Adult long term care setting	African-Canadian adult male
Sally	Female European Canadian	Community school program for at-risk adolescent women	African-Canadian female adolescent

the transcriptions were accurate. Second, a five-member peer review process provided an external check of the research process (Creswell, 1998; Lincoln & Guba, 1985; Merriam, 1998). Third, the researcher reflected and clarified researcher biases throughout the research study by journaling (Creswell; Merriam). Because qualitative research is self-conscious raising for the researcher (Ellis, 1998), journaling allowed personal reflection on the research process (e.g., clarifying biases) and documented interpretations of the research.

Findings and Discussion

In order to ground conversational interviews with theories, scholarship, and practice, the research findings and discussion section in this paper are merged (Creswell, 1998; Strauss & Corbin, 1990). The results that follow present the most salient and consistent themes: (1) awareness and struggle of diversity issues; (2) awareness of limited diversity training; (3) importance of family and spiritual involvement; and (4) implementation of Euro-North American universal notions.

Awareness and Struggle of Diversity Issues

A prominent theme among all participants was an awareness of and struggle with understanding diversity issues. As Betty explained with genuineness and honesty

Table 2.

Examples of Questions Included in the Understanding Cross-Ethnic Interactions When Using Therapeutic Recreation Practice Models in Therapeutic Recreation Practice Interview

1. Can you please tell me a little about your job as a TRS at the facility you work at? For example, what is your role as a TRS?
2. Can you give me a brief description of what you think the purpose of therapeutic recreation is?
3. When you agreed to be part of this study, I believe you mentioned that you follow a model of therapeutic recreation practice. Could you describe the model of practice that you currently use?
4. Describe how you have used the _____(name of the TR model)_____ with clients?
5. Can you take a couple of seconds and think of a specific client who is from an ethnic minority culture that you have interacted with via the _____(name of the TR model)_____? Describe to me your thoughts, feelings, and observations when you think about this specific experience?
6. Why did you use the _____(name of the TR model)_____ with this person?
7. Did you have to modify or adapt the _____(name of the TR model)_____ in any way when working with this client? And if so, how did you go about adapting _____(name of the TR model)_____ with this client?

> I guess I'm struggling because I'm choosing this individual [client], and he just happened to be Black. What I struggle with is that I didn't feel his treatment, or even his family involvement was any different than someone who wasn't Black . . . I'm aware that they're from a different ethnic background, but the individuals that I've worked with certainly have been Canadian-born, have lived and grown up in our city, and from the short amount of time with this individual, he was here about two, three months maybe, I didn't seem to have to look at his ethnic background in order to develop a treatment plan.

Likewise, Bob also struggled with how to manage cross-ethnic issues. In an insightful manner, Bob disclosed that he did not want to impose his values on clients who were from ethnic minority backgrounds.

Dealing with the Diversity Struggle

Although all of the research participants were struggling with diversity issues, they dealt with the struggle in two different ways: some embraced diversity while others avoided or reduced the complexity of diversity. Karen, who worked at a residential treatment facility for people with chemical dependency, embraced diversity by supporting her client's involvement with First Nation healing and spiritual ceremonies (e.g., drumming activities). In contrast to Karen, some of her treatment team colleagues perceived the clients' involvement in First Nation ceremonies as secondary and irrelevant for treatment. For example, certain treatment team members felt that utilizing spiritual Elders and other First Nation resource professionals was problematic to treatment.

> Karen: He [First Nation counselor who specialized in First Nation perspectives

of chemical dependency] came to talk to the clients and I had a very negative response from the treatment team because what came out of his discussions with the clients, the treatment team didn't really like . . . It's fear, of, that maybe, another way isn't; like maybe my own way isn't the best way, or isn't the only way.

Interviewer: Sure, sure. And, I think also, and I'd be curious how you respond to this, I think there's also fear in giving up the expert title?

Karen: You bet!

Although Karen was not sure why a First Nation paradigm to treatment was important to First Nation clients, she definitely believed that First Nation treatment activities (e.g., drumming, sweat lodge ceremony) benefited her clients. Waldram (1997), a medical anthropologist, articulated how symbolic healing during First Nation spiritual ceremonies is critical to overall health: "Although technology can rid one of disease, 'healing' can only occur where the medical system is interpretable between the healer and patient" (p. 71). Waldram underscored how contemporary biomedicine has constructed a system of treatment that is premised upon the assumption that the mind and body are separate biological entities, which is a foreign and confusing paradigm to many First Nation people.

Myra, who worked with an elderly Japanese woman, also embraced diversity. However, Myra went beyond supporting ethnic-oriented leisure activities—Myra changed her professional role as an "expert" to a "learner" or "student." In Myra's initial interaction, her client was unresponsive to interventions and refused to eat:

> She [the client] had suffered a CVA [cerebrovascular accident], and there was a big problem with her not wanting to eat, and just having lost all motivation to do anything, and the family, who was able to converse with her in Japanese . . . had said she had a death wish . . . I thought, what can I do in my activities that would stimulate her to want to eat? So I got this idea; she loved sushi and used to be an incredible sushi maker . . . So I said, all right, well, let's have her teach me, this little English Anglophone, how to make sushi. And that was my approach with her. It worked . . . it just stimulated her senses.

Some of Myra's treatment team colleagues also changed their roles to become learners rather than experts, and learned about Japanese culture. For example, Myra reported that the music therapist went to the library to learn how to play Japanese music notes.

While Karen and Myra embraced diversity, other research participants avoided the complexity of diversity and reduced it to idiocentric notions.[3] Nancy, who clearly was struggling with the complexity of diversity reduced the complexity to an individual level:

> Nancy: I would struggle with everyone, always wondering if I was doing the right things . . . It's not so much a cultural thing; it's a who is this person and how can I best meet their needs and reach the therapy sessions [objectives]
>
> Interviewer: The thing I'm hearing over and over is that you take a very individualized approach to clients.
>
> Nancy: Right!

Although an individualized and person centered approach is advocated by many therapeutic recreation scholars and practitioners (Austin, 1997; Bullock & Mahon, 2000; Carter, Van Andel, & Robb, 1995; Peterson &

[3] Idiocentric is defined as individualistic tendencies observed at the individual level (Matsumoto, 1996).

Stumbo, 2000), such an approach is premised upon Euro-North American values of individualism and lacks appreciation of culture. Sue and Sue (1990) argued that

> Such terms as "person-centered" or "person-blame" indicate a focus on the individual. Those who hold a person-centered orientation (a) emphasize the understanding of a person's motivation, values, feelings, and goals, (b) believe that success or failure is attributable to the individual's skills or personal inadequacies, and (c) believe that there is a strong relationship between ability, effort, and success in society. In essence, these people adhere strongly to the Protestant ethic that idealizes "rugged individualism." On the other hand, "situation-centered" or "system-blame" people view the sociocultural environment as more potent than the individual. (p. 143–144)

There were other examples of eliminating and reducing the complexity of diversity to an idiocentric level. For example, Sally wondered aloud "How can rec therapy be used to eliminate some of those barriers, be it, you know cultural differences, language differences, all of those things?" Further, when asked about therapeutic recreation programming from an ethnic perspective, Sally repeated that she does not "single anyone out" or make special arrangements. That is, instead of recognizing and embracing differences, Sally wanted to eliminate diversity by treating everyone as the same (standardized approach).

Although standardization is often used as a strategy to deal with diversity, it is antithetical to the needs of people from ethnic minority backgrounds because it creates an inflexible system that responds unfavorably to anything unusual or different (Cox, 1994; Dahl, 2000). Further, reducing cultural, political, and social realities to an individualized level hides social variables (e.g., colonialism, economic, racism) and follows a White Euro-North American individualistic model of treatment (Sue & Sue, 1990; Waldram, 1997). A standardized and idocentric approach shifts responsibility away from social institutions that support dominant worldviews (Wearing, 1998; Witt, 1991).

Awareness of Limited Diversity Training

A profession's commitment to diversity is reflected in the extent to which diversity training is embraced and communicated through training programs (Bedini & Stone, 2000; Peregoy, Schliebner, & Dieser, 1997). This point was explicit as research participants clearly explained that training programs lacked diversity training. Nancy sharply criticized the scant attention to diversity issues in her undergraduate degree program and the content areas embraced by the National Council for Therapeutic Recreation Certification (NCTRC). Similarly, when asked whether her training prepared her to work with clients across differing cultures, Myra also highlighted the lack of diversity training:

> When I [was] preparing for the certification exam, there's so much emphasis that's put on the Peterson and Gunn model [Leisure Ability Model] that, I mean, like that's what we studied all of the time . . . that was the model that you were questioned on over and over again.

Karen also explained that there was limited discussion of diversity issues in training programs. When asked to think back to her formal training in therapeutic recreation and asked if any course work focused on diversity issues, Karen noted "No . . . I never took a class within a broader class. I never took a class on diversity or anything like that." Karen then questioned aloud whether therapeutic recreation practice models could be used cross-culturally.

To this end, survey research also suggested there is scant attention directed toward learn-

ing and understanding diversity issues in therapeutic recreation (Peregoy et al., 1997) and graduate-level leisure curriculums (Dieser & Peregoy, 1998) at the university level. Likewise, there is little attention oriented toward developing cross-cultural or diversity knowledge and skills in the National Council for Therapeutic Recreation Certification Standards booklet (NCTRC, 1999).

Cultural Assessment

To help therapeutic recreation specialists understand and navigate through diversity issues, Dieser and Peregoy (1999), building upon the work of McFadden (1993), argued that cultural assessments and histories should be included in therapeutic recreation practice models and in formal therapeutic recreation education. All of the research participants, when questioned about cultural assessments, commented that a cultural history or assessment was not included in their educational or employment settings. Furthermore, respondents were ardent about learning how to facilitate a cultural assessment. For example, Betty stated:

> There is relevance to it [cultural history/assessment], or to asking questions in relation to their ethnic background, and it would be, I think, the importance is how those questions will be asked . . . As I look back to this family [client and clients' family] I think there were more issues ethnically that could have been addressed that might have met even more of his needs.

Similarly, Karen noted that ". . . I would say that it [cultural assessment] is an area that needs to be looked at because we deal a lot with . . . Black culture and Micmac [First Nation people]."

Moreover, all six research participants speculated that a cultural history or assessment may highlight diversity-oriented antecedents to leisure constraints and barriers. In particular, Betty, Karen, Myra, and Nancy reported that in indirect non-planned conversations regarding the client's ethnicity they discovered that (1) White culture was a constraint to leisure pursuits for clients from ethnic minority backgrounds and (2) people of ethnic minority backgrounds had differing leisure experiences. In conversing about her client's past leisure, Betty explained how her client lived in a predominantly Black community and speculated that a cultural assessment regarding leisure experiences was needed for her to gain an accurate understanding of her client (e.g., Black community activities, racism). When speaking about constraints to leisure, Karen noted how her client, who was from a First Nation culture, felt uncomfortable in leisure and lifestyle pursuits in a predominantly White community:

> Interviewer: So she [client] responded that she felt uncomfortable being a Micmac [First Nation culture] woman going into a town site of predominantly White people?
>
> Karen: . . . for sure . . . because there are so many issues with the Micmac people going to the school in the town. There was so much racism and this kind of thing going on.

Nancy also addressed how cultural awareness via a cultural assessment would also provide pertinent and relevant data regarding dimensions of diversity beyond ethnicity, such as religion, gender, and nationality.

Importance of Family and Spiritual Involvement

Ample research suggests that for people who embrace collectivistic values (e.g., African-American, Asian-Americans, First Nation people), large group and family involvement in leisure is paramount (Baas, Ewert, & Chavez, 1993; Carr & Chavez, 1993; Carr & Williams, 1993; Chavez, 1992, 2000; Stamps

& Stamps, 1985; Walker, Deng, & Dieser, 2001). In the present study, a salient theme was that family and spiritual involvement was paramount. Betty recounted in great depth how religion and family were important to her client:

> Betty: ... religion was a very important part of his [client's] life, and his family was very religious ... sometimes because he couldn't get to church anymore, they would bring in a small portion of the church choir, which happened to be gospel music ... And the other two individuals that I worked with [who were also African-Canadian] ... Again the family members would arrange to have someone from their church come in to sing gospel music.

Karen disclosed that although she typically does not include family in therapeutic recreation programming, family involvement was included with her First Nation client due the strong relationship that her client had with family. Nancy, who worked with a male client who was African-Canadian, also observed that there was strong family involvement during therapeutic recreation programming.

> Nancy: ... the family has, they're very involved as volunteers within the program.
>
> Interviewer: More so, than, would you say, typical?
>
> Nancy: Oh, absolutely!

Betty and Myra also disclosed that the clients they worked with who were from ethnic minority backgrounds were more family-oriented than Euro-North American White families.

Implementation of Euro North American Universal Notions

One of the most notable themes among the research participants was to begin describing the purpose of therapeutic recreation in broad and generic terms. All six research participants explained that the purpose of therapeutic recreation was to increase quality of life, life skills, wellness, or personal meaning in life.

However, as the researcher explored the meaning of these broad terms, it became obvious that for all six participants the purpose of therapeutic recreation was to facilitate and implement Euro-North American universal notions of personal choice, individual autonomy, selfhood, intrinsic motivation, and independence. In response to a probe regarding the meaning of quality of life, Myra explained that

> Myra: ... so I try to keep this whole leisure lifestyle approach; it's a continuation, it doesn't stop.
>
> Interviewer: Now, with the leisure lifestyle you just mentioned, Peterson and Gunn, in their [Leisure Ability] model refer to a leisure lifestyle as having leisure behaviors, independence, intrinsic rewarding activities, being self-selecting and self-regulating. Do you generally follow that, or not?
>
> Myra: Yes I do, but I, because of the abilities of a lot of my patients, they will never quite get to an independent state in most cases, especially a lot of my cognitive impaired individuals, who are coming out of CVA or traumatic brain injury, where they will need constant assistance. I see their independence where they're able to participate.

Although Myra realized that independence was impossible for many of her clients to achieve, her ultimate purpose for therapeutic recreation intervention was to increase independence. Betty, who also used the Leisure Ability model, responded almost identically to Myra in explaining the meaning of quality of life "... ultimately, we want them [clients] to be as intrinsically, you know, self-regulating,

self-initiating, and we're doing a lot of things in that regard with them."

Perhaps the most salient description that encapsulates the axiom that research participants are using Euro-North American universal terms to explain the purpose of therapeutic recreation came from Bob. He explained that the purpose of therapeutic recreation was to develop "Just normal leisure lifestyle habits. Also, for an opportunity to continue to develop and to, you know, personal development. Also, it's an opportunity for self-expression, those type of things." For Bob, normal leisure lifestyle habits consisted of intrinsic motivation and self-expression.

Iyengar and Lepper's (1999) research clearly illustrated that intrinsic motivation is cherished by Euro-North American people but is less relevant for people from socially interdependent cultures, such as Asian people (Matsomoto, 1996) or First Nation people (Waldram, 1997). In this regard, there has been scant attention directed toward a cross-cultural understanding of leisure or intrinsic motivation (Chick, 1998; Mannell & Kleiber, 1997). Recent scholarship and research suggested that the definition of leisure across differing ethnic cultures may vary widely (Chick; Fox, 2000; Walker et al., 2001).

On a surface level, describing the purpose of therapeutic recreation in terms of personal choice and development, individual autonomy, selfhood, and independence may not seem problematic; it may even seem like the correct way to explain therapeutic recreation. These are fundamental assumptions rooted in the Leisure Ability Model (Peterson & Stumbo, 2000), the Health Protection/Health Promotion models (Austin, 1996, 1998, 1999) and psychologically-oriented leisure theory (Mannell & Kleiber, 1997; Neulinger, 1981). However, as some leisure professionals and scholars have highlighted (Dieser, 1999, 2000, 2002b; Dieser & Peregoy, 1999; Fox & van Dyck, 1997) terms such as personal choice, self-actualization, individual autonomy, and independence are notions that are premised upon Euro-North American White individualistic-oriented cultures which are not universal.

Additionally, recent research and scholarship in cross-cultural psychology posited that individualistic and self-oriented concepts such as personal development, personal control, and intrinsic motivation are not universal notions; rather, they are values associated with White Euro-North American individualistic cultures (Choi, Nisbett, & Norenzayan, 1999; Heine, Lehman, Markus, & Kitayama, 1999; Iyengar & Lepper, 1999; Rose, 1998). Moreover, cross-cultural scholars have argued that self and internal-oriented concepts, such as self-actualization, self-esteem, and independence may not be appropriate wellness variables for people who embrace collectivistic values (Choi et al.; Heine et al.; Iyengar & Lepper; Matsumoto, 1996). LaFromboise, Trimble, and Mohatt (1990) suggested that because American Indian people believe that mental health is spiritual and community-oriented in nature, conventional psychological and social services that foster "a clinical mentality that emphasizes action and a sense of responsibility to individual clients ... over a service orientation to the larger community ... are indeed inappropriate for service deliveries in Indian communities" (p. 317).

In this regard, providing interventions that are premised upon dominant Euro-North American values can cause harm to clients who do not embrace individualistic notions (Dieser, 2002a).[4] For example, in American Indian and First Nation communities the tensions that result from the pull of the dominant culture (e.g., individualistic values) and tribal expectations to maintain traditional values (e.g., collectivistic values) can lead to drug and

[4] Interventions that are premised upon Euro-North American individualistic notions are outstanding interventions for people who embrace individualistic values. In regard to Euro-North American individualistic culture, therapeutic recreation scholars have developed solid models of practice. The next step is to develop models and interventions that help people from diverse cultures who do not embrace individualistic values.

alcohol dependency, truancy, school failure and suicide (Red Horse, 1982; Shore, 1988; Waldram, 1997).

Conclusion

The qualitative study reported in this paper underscored the voices of six Certified Therapeutic Recreation Specialists who resided in Canada. The data uncovered suggestions regarding how to manage cross-ethnic interactions, such as including cultural activities into therapeutic recreation practice, involving family in therapeutic recreation programming, and learning about diversity from clients. However, this study clearly illustrates some problematic aspects of cross-ethnic therapeutic recreation interactions. In short, idiocentric tendencies and following Euro-North American notions which describe the purpose of therapeutic recreation and quality of life in terms of personal choice, individual autonomy, selfhood, and independence are problematic, because these approaches and their philosophical framework follow the dominant discourse of Euro-North American individualism. Likewise, attempting to avoid or reduce the complexity and struggle with diversity does nothing to help clients who are from ethnic minority backgrounds.

However, it is clear that the people who participated in this study were competent professionals in many facets of professional practice. For example, all of the research participants understood how to implement the Leisure Ability Model and to follow the therapeutic recreation process. To help therapeutic recreation specialists develop awareness, knowledge, and skills to work with clients from diverse ethnic backgrounds university curriculums, workshop and conference sessions, and NCTRC content areas need to devote greater attention toward cross-ethnic and diversity issues. In short, therapeutic recreation training programs need to teach potential professionals about ethnic diversity. Beyond training, partnerships between ethnic and professional organizations need to be developed (Dieser & Wilson, 2002; Herberg & Herberg, 1995).

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