A Critique of the "Optimizing Lifelong Health Through Therapeutic Recreation" (OLH-TR) Model

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According to a professor I had as a graduate student, models are metaphors. They suggest likenesses and paint pictures of abstract concepts and intangible processes. Hence, models assist us in making abstract concepts concrete or "real." Models provide us with frameworks for thinking. They shape what we see, the questions we ask, and our answers to those questions. He further indicated to us that it does not matter whether models are true, rather their value rests on whether they are useful in understanding some phenomenon or process. In contrast, theories, which are based in models, gain their value from their truthfulness. That is, theories are to be tested, refuted, and/or supported. While this professor's discussion of models and theories was grounded in a discussion of research, his understanding of models and theories is one that informed my reading of the Wilhite, Keller, and Caldwell (1999) therapeutic recreation (TR) practice model.

Since graduate school, a major focus of my research and teaching has been on recreation and leisure in relation to lifespan development and age. It is for this reason that I was asked to comment on the Wilhite et al. (1999) model. It is important to state up front that I come to this reflection as one who is not, and has not been, engaged directly with the field of therapeutic

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recreation (TR) since my days as an undergraduate student. Through professional association memberships, conferences, and periodicals/journals, I have continued to be aware of the issues and debates that have occurred in TR. However, I have very much been on the periphery of these discussions. Hence, the following observations and comments are those of a relative outsider to the field of TR. Given my interest in and knowledge of leisure in relation to lifespan development, I hope that my outsider status does not obviate the usefulness of this critique.

In what follows, I discuss both the reactions I have to the proposed model and questions that the model raises. These questions are not necessarily criticisms of the model itself. The questions raised are about how models are and are not used, how they do and do not inform our research and practice. The comments and questions I have about the model seem to group under four issues or categories. The four categories are as follows: (a) the lack of specification of concepts or terms, (b) the emphasis on the individual and adaptation, (c) the lack of a life course perspective, and (d) the use of Baltes and Baltes' (1990) concept of "selective optimization with compensation." Before I discuss these issues I will provide a brief overview/summary of the Wilhite et al. model and my general reactions to it.

Overview of the Model

Wilhite et al. (1999) ground the development of their model in a discussion of assumptions about TR, health enhancement, reform in health and human services, and a life course perspective. According to the authors, TR service delivery assumes that a need exists for intervention with the intention of altering individuals' "personal and/or leisure functioning (Wilhite & Keller, 1992). Early leaders . . . conceptualized the desired outcome or result of TR intervention along a hierarchical-continuum of care where achieving higher order client needs presupposes the achievement of needs at lower levels. The Individual's needs determine the level of care . . . " (p. 98–99). The authors also note that early on the potential of TR to optimize lifelong health and well-being through an emphasis on health enhancement was noted by some (Austin, 1997). However, "prevention and health promotion have received limited attention to date and have been concerned primarily with reducing secondary disability and higher health care costs . . . " (p. 99). The authors feel that TR services may be well suited to address health enhancement needs, but guidelines and research in support of this are lacking. It is for this reason, as well as (a) the reforms occurring in health and human services and (b) the dynamic or temporal nature of illness, disease and disability, that the authors propose "a non-linear model of TR, that is grounded in a life course perspective which merges health enhancement and self-care approaches" (p. 99). This model is called the "Optimizing Lifelong Health through Therapeutic Recreation" (OLH-TR) model. The model is based on a description of the process of successful aging (selective optimization with compensation) presented by Baltes and Baltes (1990). According to the OLH-TR model, health enhancement/promotion is and should be a goal of TR. The way for therapeutic recreation specialists (TRSs) to realize this goal is by working with TR clients as educators and/or facilitators in the process of selecting, optimizing, compensating, and evaluating healthy leisure lifestyles.

I would evaluate the OLH-TR model as proposed by Wilhite et al. as somewhat useful in its current state and as having the potential to be very useful. The model provides a starting point, but needs development. This was acknowledged by the authors, themselves, who briefly discussed several weaknesses that need to be addressed. The issues I discuss below are intended to provide some additional direction for this development. Further, and again as the authors recognize, theirs is but one model and given the diversity of the TR field, multiple models may well be necessary. But it is not only for that reason that

multiple models are useful. In addition, the models that have been proposed and critiqued in the *Therapeutic Recreation Journal* special series (including Wilhite et al.'s in this issue) vary in globality and specificity and focus on somewhat different aspects of TR service delivery. They are perhaps more complementary than competitive. For example, the OLH-TR model proposes a very specific process of decision-making or adaptation with which TRSs can facilitate or teach their clients so that they may achieve or maintain optimal health and well-being. The Leisure Ability Model (Stumbo & Peterson, 1998), on the other hand, identifies psychological characteristics and processes that contribute to the development of "a satisfying, independent, and freely chosen leisure lifestyle" (p. 82). It does not address just how TRSs can change the psychological functioning of individuals or the process of adaptation.

Furthermore, what TR is (e.g., its intent, goals, and methods) changes over time and so models of TR service delivery will change over time. As clearly illustrated in the presentations of the Wilhite et al. (1999) and Austin (1998) models, TR does not exist separate from changing economies, medical and health care delivery systems, technological development, political agendas, and social attitudes. For example, Wilhite et al.'s argument for the adoption of a health enhancement role by TR is based in changing notions of treatment and rehabilitation and necessary lengths of stay which have been influenced by changes in reimbursement by both public and private health insurers. At the same time, just because models are not timeless does not obviate the need for them. Models are needed to make concrete or real the culture and sub-cultures of TR, including the values, beliefs, customs, practices, norms, and languages of TR. Models also allow the development and testing of, and disagreements over, theory and practice. With these thoughts in mind, let me proceed with several issues that arose as I critiqued the OLH-TR model.

Issue #1: Lack of Specification of Concepts and Terms

Throughout the introduction, the subsequent discussion of health enhancement, and the presentation of the model, the authors use the terms health, health enhancement, and healthy leisure lifestyle without discussing what these concepts mean. As the authors themselves note, explication of these concepts is needed to operationalize the model. Clarity of concepts is essential for the model to be useful. Models present the assumptions (values and beliefs) behind our explanations of human behavior and practices, what it is we do. Models provide the framework or worldview and become the norm guiding practice and research questions. For example, without an understanding of what is meant by health or healthy leisure lifestyle, who is "in need of" or "having need for" TR services cannot be identified. In other words, until there is some understanding of and agreement/disagreement on the meaning of these concepts the goals of TR remain vague, how/what to "do" is unclear, and the impact of TR cannot be measured. Further, the ethical or value dimensions of TR service delivery will be given short shrift. These dimensions need to be rigorously discussed by researchers, practitioners, and clients of TR.

In addition, the model indicates that the role of the therapeutic recreation specialist (TRS) is that of educator and facilitator. At this stage in its development, however, the model does not explicate what those terms mean. For example, in discussing the process of Selecting, the authors state that "(a) TRS could help this individual work through the process of selectively focusing attention on one goal." In talking about Optimizing, the authors assert that "(t)hrough education, the TRS can assist in this process of knowledge acquisition". How a TRS can do these things and on what basis has yet to be explained.

Issue 2: The Emphasis on the Individual and Adaptation

As has been noted of the previous models presented in this special series (e.g., Lee, 1998; Murray, 1998), there is a tendency in the OLH-TR model to focus on the individual and individual change. Even though the authors acknowledge the role of the environment (e.g., families, communities, and health care providers) in constructing disability and "recovery," the model is essentially individualistic. It is the individual who needs to adapt and the individual who has choices. It is up to the individual (with the assistance of the TRS) to make choices for healthy leisure lifestyles. One of the tensions the field of recreation and leisure as a whole faces, and TR particularly, is reconciling how to think about concepts (i.e., leisure, recreation, development, health) that have been defined in North America and western cultures as essentially psychological and/or biological phenomena/processes with the fact that humans are social beings. Individual experiences cannot be separated from socio-cultural and historical contexts. We construct the meanings of our lives in interaction with our environments.

For example, the authors state that . . .

> "An ultimate goal is to *facilitate the adoption of healthy leisure lifestyles* that prevent or minimize the impact of disabling or dysfunctional conditions, or secondary consequences for those persons who already experience a chronic or disabling condition, while promoting optimal health and well-being . . . *individuals must be prepared to alter leisure choices, or find substitutes, when necessitated, by changing personal and environmental characteristics* across the life course. Thus, healthy leisure lifestyle includes a flexibility that enables individuals to make *continuous accommodations to internal and external changes.* A central task of the TRS is to help *facilitate these adjustments* while still allowing for maximum client choice, control, and preservation of selfhood (Baltes & Baltes, 1990)" (emphasis mine) (p. 102).

While the concepts of "healthy leisure lifestyle" and "optimal health and well-being" are not clear, there seems to be a paradox here. That paradox is that individual choice, control and preservation of selfhood comes with increasing acceptance of externality and adaptation to the external environment. It seems that a characteristic of human beings that is both one of our greatest strengths, as well as one of our greatest weaknesses, is our ability and/or willingness to adapt, cope, and accommodate. While I cannot argue against the fact that flexible people are probably easier to get along with and may well be happier people, I do not think that social change will occur, nor social inequities disappear, if we only adapt or accommodate. Perhaps we need to rethink our notions of health and aging and include resistance and argumentativeness, instead of adaptation and accommodation, as indicators of health and optimal well-being (see also Freysinger, 1990)!

The model does not necessarily advocate for accommodation and adaptation but its emphasis on the individual and description of TR as an individual process centers the individual, not social institutions, cultural norms, and historical contexts, as the concern of TR. At issue is whether health and healthy leisure lifestyles are personal troubles or public issues (Mills, 1959). Again, with explication of some of the concepts and processes that make up the model, this emphasis may shift. For example, the authors' discussion of independence, dependence, and interdependence, as well as the relationship among these three, needs to be expanded. Interdependence is not just the middle ground between dependence and independence but a process of mutuality that struggles to survive in a culture that thinks dualistically and an economic system that punishes dependence (Rodeheaver, 1987; Rodeheaver & Datan, 1985).

A very significant contribution that this or any other model of TR could make would be to incorporate contexts, the politics of health, and a critical perspective into their development. I believe that these are issues of practice. If they are not emerging in inductive research it may well be due to the questions we do (or do not) ask. If they are not raised by deductive research then it is likely due to the models and theories that monopolize our field and frame our studies.

Issue 3: The Lack of a Life Course Perspective

The presentation of the model as incorporating a life course approach is somewhat confusing or misleading. My understanding of life course is that it addresses some kind of age-related phenomena. As currently described the OLH-TR model is not grounded in age. The authors do indicate in their discussion of a life course perspective that illness, disease, and/or disability "are ongoing, dynamic processes" and that "(o)ver the life course, people may become aware of changes in their resources. . . . " Their model is also a modification of Baltes and Baltes' (1990) concept of selective optimization with compensation, which they maintain describes a process of successful aging. While I can see that the process of TR they describe is dynamic and temporal, the relationship of the model to age or some age-related process is not developed. Yet, developing the model in this way may be useful. For example, the notion that the process of selective optimization with compensation is "an on going, lifelong process that intensified in later life" remains to be tested. It seems to fit with research examining changes in achievement motivation across the course of life. That is, research suggests that as individuals move from adolescence to young and middle and later adulthood there is a shift from internality to externality and from emergent to continuing motivation (Kleiber, 1985). Similarly, the notions of dependence, independence, and interdependence are not only age-related issues that have biological, psychological, socio-cultural, and historical dimensions, but also gendered issues that, if explored, would strengthen the model's usefulness.

Issue 4: The Use of the Concept of "Selective Optimization with Compensation"

The OLH-TR model is a variation on Baltes and Baltes' (1990) concept of selective optimization with compensation. As the authors note, this concept was developed to explain a process of "successful aging." The context for the development of this concept is important for assessing its utility for the delivery of TR services.

Three explanations of the process of aging have dominated the field of gerontology in North America. These are disengagement theory, activity theory, and continuity theory. Whether or not these "theories" describe the process of "successful" aging, the theories did emphasize (and "normalize") the different ways that people experience aging as they move into later life.

Specifically, these theories provide different explanations for changing participation in roles, relationships, and activities in late life. One of the things research has documented is that with increasing age, individuals tend to reduce the range or number of roles and activities in which they are involved. The rate of this reduction varies by individual. We know that it is dependent on a variety of factors such as functional health, well-being, economic resources, companions, opportunities, transportation, etc. However, a common interpretation of this shrinking of involvements has been that "you can't teach an old dog new tricks" or "old people are stuck in their ways." In other words, a reduction in involvements with advancing age was seen as a problem and one that resided in old people or was a negative part of being old. What Baltes and Baltes asked us to do was reframe the issue. Rather than a reduction in activity being seen as a

problem and just a part of biological aging, it should actually be seen as a very adaptive (and hence, "smart") strategy. They reframed the gradual constricting or elimination of roles, relationships, and activities as a process of being selective in how one expends one's energy in order to optimize performance (and abilities). In doing so individuals compensate for losses that chronological aging brings. In other words, reductions in involvements are both an indication of knowing one's self and an intelligent way to cope with changes in physical and mental functioning and societal opportunities. It appears that more recent writings by Baltes and colleagues on this concept may develop it in directions of which I am unaware (i.e., I did not have access to the in press writings referenced by Wilhite et al.). However, available work on this concept suggests that while not necessarily restricted to adaptation, accommodation and not resistance is desirable (Baltes & Baltes, 1990). Whether this is what TR sets as a goal for itself needs to be discussed in light of what both research and practice tell us about the outcomes of such accommodation on both a personal and societal level.

Further, I am not sure of the utility of separating into distinct stages a holistic or integrated process. Wilhite et al. suggest that they had difficulty themselves doing this, hence, the overlap in their description of selecting, optimizing, compensating, and evaluating. My reading of the concept, "selective optimization with compensation," is that it refers to a process of adaptation whereby individuals optimize their functioning (and opportunities) by being selective. This selectivity allows for compensation for changes or losses, and hence, allows one to attain or maintain a sense of integrity. To separate the concept into distinct parts seems arbitrary and antithetical to the concept itself. The concept is a useful one as a whole. To burden TRSs with deciding just what is selection vs. optimization seems unnecessary.

Finally, Wilhite et al. add another step, evaluation, to this process for therapeutic recreation. It is at this stage that the TRS can assist clients in deciding "whether continuing a certain activity is desirable . . . . At this time, reexamination of the elements of selecting, optimizing, and compensating is required so that a healthy leisure lifestyle may be recreated" (p. 103-104). Hence, it appears that in evaluating previous choices that were made in selecting, optimizing, and compensating, the question of what a healthy leisure lifestyle is will have to be addressed. The model will be more useful when it directly confronts and addresses that question. Research, inductive, deductive and critical, is needed to develop that part of the model.

Conclusion

The OLH-TR model begins to construct a framework for the delivery of TR services or the practice of TR. It raises as many questions as it answers. There are three general issues that I suggest need to be addressed. These are (a) the under-specification of terms and concepts, (b) an over-emphasis on the individual and adaptation, and (c) the lack of a life course perspective. It was also suggested that the context for the development of Baltes and Baltes' (1990) concept of "selective optimization with compensation," which describes a process of successful aging, needs to be considered when evaluating the usefulness of this concept as the process of TR. Research is needed to help answer questions raised by these issues and to further develop the model.

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