A Practitioner Critique of the Self-Determination and Enjoyment Enhancement Model

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"We are asleep with compasses in our hands" (W. S. Merwin in Kehl, 1983). This observation was recently applied to therapeutic recreation (TR), "Where in the world are we going?" (Compton, 1997). Compton urged "more relevance to the human agenda" (p. 49) stating that the ultimate test of the profession is "what works for people" (p. 47). A practice model can remediate a profession's confusing identity by giving direction and focus to professionals and their publics. The Self-Determination and Enjoyment Enhancement Service Delivery Model (Dattilo, Kleiber, & Williams, 1998) values unique and cherished components of the leisure experience for therapeutic work. This model might awaken and redirect therapeutic recreation (TR) practice to a calling and future as "existential therapists" (Richter & Kaschalk, 1996). While debate continues, that calling might be articulated through this model: caring for people by facilitating enjoyment and self-determination in their individual quest for a meaningful existence. Therefore, Dattilo et al. (1998) might reconsider modifying and/or adding components.

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to their very psychologically-based model based on the following points:

1. Reselect a definition of TR that better coheres the model’s components if the goal of medicine, and the purpose of TR practice, is self-transcendent healing.

2. Pursue the self-suggested expansion to an ecological perspective. Enhance the ethical grounding of the model by studying the expression of service delivery among pioneering culture change models. For example, person-centered and resident-directed approaches emphasize life-planning and environments of enjoyment.

3. Incorporate new and revised philosophical recommendations for TR such as a shift from functional to existential outcomes.

This critique analyzes the model by examining these three areas including examples of how practice could be guided by outcomes based on this model. The critique is completed with suggestions for the future development of the model.

**A Confounding Definition of TR in the Model’s Presentation**

Under the heading ‘‘The Purpose of TR’’, Dattilo et al. (1998) quoted a definition widely embraced by ATRA and NTRS. This definition utilizes language that aligns TR with a medical model, and which has been used formally to influence public policy.

‘‘. . . the purpose of TR is to treat ‘physical, social, cognitive and emotional conditions associated with illness, injury, or chronic disability’ through the use of a variety of interventions’’ (p. 260). This definition uses language that is prescriptive rather than collaborative (‘‘to treat’’), places emphasis on pathology and disability before the person (‘‘treating conditions’’), and certainly does not seem to incorporate enjoyment.

Mobily (1996) affirmed the integrity and soundness of Dattilo and Kleiber’s (1993) original theoretical proposal of the experience of leisure as self-determination and enjoyment. Publication of their original paper caused Mobily to acknowledge a humble and profound reconsideration of TR as a means/ends debate. While Mobily formerly articulated and supported TR as an instrumental tool for therapeutic change (1985a, 1985b), he has now detailed scientific and conceptual evidence that supports the facilitation of leisure as an end in itself, with a definitive place in health care. ‘‘Leisure activity in clinical settings is a right that is implemented as an activity, and that may need adaptation, accommodation, or facilitation by the therapeutic recreation specialist’’ (Mobily, 1996, p. 67). Yet the current presentation of the Self-Determination and Enjoyment Enhancement Model (Dattilo et al., 1998) appears to be confounded by an attachment to functional improvement, rather than clear insistence on the primacy of leisure as self-determined enjoyment through healing enactment. ‘‘While there are other agendas for TR specialists, teaching people, regardless of the type and degree of disability, to create environments conducive to enjoyment is consistent with that purpose’’ (Dattilo et al., 1998, p. 260). This impression may be due to the authors’ choice of the above definition of TR that subordinates, rather than elevates, the leisure experience as an end in itself.

Reference to this definition as a foundation for a TR practice model contradicts emerging consciousness about service delivery because it socializes students and professionals to study and ‘‘treat’’ disease or incapacitation outside the context of the person experiencing it. A definition of TR that focuses on functional restoration and cure may not be appropriate for persons who are most likely to receive TR services. People with chronic illnesses or conditions (e.g., brain injury, developmental disability, addiction, mental illness) learn to live with debilitation and must integrate it into daily life in a posi-
A contemporary goal of medicine "must be healing rather than curing disease" by shifting to a model that "focuses explicitly on the human experience of illness": "Healing involves restoring, or preserving a sense of equanimity and personal integrity in the face of the many and varied disturbances in living that are necessarily caused by illness" (Toombs, 1995, p. 13). This is a transcendent goal, not a functional goal, that attends to the person's individual and fluctuating meanings of debilitation which affect their daily activities and relationships. Self-determination and enjoyment enhancement are strategies for living with a disordering condition, and therefore are worthy paths in their own right for relieving suffering as the central goal of healing. CARF affiliates Richter and Kaschalk (1996) offered a revised practice definition, "Therapeutic recreation is about purpose and meaning, those things that make life worth living in the first place. The future of therapeutic recreation, therefore, rests primarily in existential outcomes" (p. 87). Would Dattilo, Kleiber, and Williams (1998) reselect this definition of TR which is broader and more focused on meaning-making as the purpose of TR? This approach might clarify ambiguities and animate their complex theoretical approach by enacting illustrations that guide practice distinctively.

Practice perspectives may be changing across professions thanks to disability activists (Shoultz, 1997) heralding the slogan, "See the person, not the disability." Self-advocates warn that defining health exclusively in terms of ideal standards of functioning only exacerbates the person's diminished self-worth and loss of purpose (Toombs, 1995). The Self-Determination and Enjoyment Enhancement Model underscores the necessity to view individual circumstance as a hallmark of self-determination. The participant's personal story as self-perception becomes paramount in determining meaning and values. "Lived experience" accounts represent a growing literature, research, and education agenda in disability culture (Kleinman, 1995; Spaniol & Koehler, 1994; Toombs, Barnard, & Carson, 1995). These self-reported accounts of persons with disabilities portray their bodily experience of suffering as a form of self-expression and response, and are forms of moral or political commentary. "Lived experience" accounts allow health care professionals to come "experience near" (Kleinman, 1995) to subtle nuances of living with a disability, or demoralizing conditions like battering. Thus, practice models based on lived experience become "action-sensitive" (Van Manen, 1990), oriented to the individual's situation rather than the pathology of the disability. Also, "lived experience" turns attention to environments because one's sense of "lived space" affects the way a person feels—excited, bored, or vulnerable. "We may say that we become the space we are in" (Van Manen, 1990, p. 102).

Incorporating an Ethically Grounded Ecological Approach

Health care practice models are evolving that modify environments for living in an individual life context. These models incorporate the same components as the Self-Determination and Enjoyment Enhancement Model, where the renewed purpose might be "what works for people" (Compton, 1997, p. 47). A criticism of Dattilo et al.'s (1998) presentation is that the practice exemplars and theoretical sources tend to exclusively focus on the contexts and literature of developmental disability, in addition to psychology. This model may have unprecedented application across TR settings. Comparing emerging practice models among wider settings may reinforce the model's profession-specific relevance, and enlarge its micro perspective to a macro perspective. The following examples of alternative models of service
delivery illustrate this contemporary ecological approach:

• **The Eden Alternative** commits to the "Human Habitat" by facilitating an environment where residents give care, rather than just receive it, as they nurture pets, plants, and children. Edenizing emphasizes "variety and spontaneity" since unpredictable events occur in the Human Habitat daily. According to Principle #6, Eden also, "De-emphasizes the programmed activities approach to life and devotes these resources to the Human Habitat" (Thomas, 1996; Lifespan, 1997, p. 47).

• **Person-Centered Planning (PCP)** focuses on life planning and empowerment instead of viewing a person as a deficit needing treatment. Proponents of person-centered planning offer sensitive suggestions for practitioners’ thoughtful process such as, (a) "Ask the question, ‘What is your dream?’; (b) do the planning in a participant’s favorite place such as a restaurant or garden; and, (c) have living plans that change with the person" (HFD News, June 1998, p. 6).

• **The Regenerative Community** envisions "a multigenerational community as a sacred place in which love is the great healer" (Lifespan, 1997, p. 42). This model exemplifies the Dattilo et al. (1998) component of "emphasizing inherent rewards" related to self-determination through deliberate restoration of a meaningful role to residents as elders. This model transforms the nursing home into "a living system in which each person’s needs and contributions makes the community what it is and what it is becoming" (Lifespan, p. 42).

• **Inclusion as a Human Right** (not a model or program but a birthright/daily experience), facilitated through tools titled CIRCLES, MAPS, or PATHS, is "about embracing humanity and figuring out how we are going to live WITH one another in the challenging years to come" (Pearpoint & Forest, 1996, p. 6).

All of these models spring from an ethical perspective that prompts changing manners of service delivery where practitioners are mindful of care as moral action.

If TR specialists are health and human service professionals, they have an obligation to "restore the [participant’s] humanity" (Kestenbaum, 1982, p. 18) which has been compromised by illness, disability, or demoralization such as abuse or homelessness. This perspective may be a more accurate description of the vocation of therapeutic recreation than is "treating conditions". While there are recommended therapist strategies to evoke the participant’s self-determination in the Self-Determination and Enjoyment Enhancement Model, (make adaptations, appraise challenge, make choices, make decisions), the authors give only passing attention to the "ethics of enjoyment". "Restoring participants’ humanity" via self-determination and enjoyment could ground the model in an ethical frame. Such a grounding supports the morality of facilitating self-determination and enjoyment enhancement with the recommended alternative definition of TR (Richter & Kaschalk, 1996) that may better suit the model's intent and components.

### Recommendation for A Philosophical Shift to Existential Outcomes

Interdisciplinary colleagues Richter and Kaschalk (1996) observed TR’s role insecurity and offered a rehabilitation perspective which clearly resonates with the Dattilo et al. (1998) practice model:
Some members of the profession are looking at the profession solely as a means that is, as a tool to accomplish a specific therapeutic end, such as achieving better hand-eye coordination or proficiency in activities of daily living. As such, they fail to recognize that therapeutic recreation has a very singular and unique importance of all the professions in rehabilitation. Therapeutic recreation is the only discipline that actually stands as an end, not just a means. It is the only discipline seeking the person’s “want to’s”, not just the “have to’s.” It is a goal in itself, not just a stepping stone to something else. (p. 86)

Richter and Kaschalk (1996) recommended that the therapeutic recreation specialist be viewed as “the existential therapist” who “can help people realize that what remains when they face disability and treatment is a life worth living” (p. 87). They acknowledged the enormous difficulty of uncovering a participant’s motivation and meaning in life because these are individually constructed, and one must create and discover meaning as life unfolds in the moment. Dattilo et al. (1998) have explicated intrinsic motivation in their text and tables and noted that it is independent of level of ability; this supports an existential approach.

Richter and Kaschalk (1996) cautioned against “the mistake of the profession in embracing the medical model”; they implored TR not to “ride the coattails of medicine in the wrong direction” by staying in the clinic rather than moving to the community, or becoming mindless “diversion therapists” who engender pseudo-enjoyment (p. 87). Dattilo et al. (1998) have explicated genuine enjoyment, including principles of flow, as a distinctive feature of TR practice that requires thoughtful facilitation of the perception of manageable challenge. The authors have succinctly and theoretically illustrated what might inhibit enjoyment for the TR participant. This implies an existential approach focused on the participant’s changing human experience and personal meanings of challenge (e.g., restoring mobility may not be as important as learning to compensate or accommodate with a scooter or wheelchair).

Richter and Kaschalk (1996) emphatically criticized the therapeutic recreation specialist who seeks credibility by “copying other therapies’ approaches” (p. 87) as functional outcomes. Dattilo et al. (1998) present functional improvement as a developmental byproduct of growth-inducing enjoyment which is self-motivated. This is the area where their model may blunt the profession’s moral opportunity for alleviating suffering by subordinating the healing properties of delight and amusement to functional improvement. Their discussion of functional improvement is not as well explicated as other components of the model.

Richter and Kaschalk (1996) urged that the field “must keep its horizons broad” (p. 88) by transcending the medical model, and by embracing the psychosocial and psychoeducational focus on ability, advocacy, and capacity, along with stamping out stigma. Dattilo et al. (1998) have explicated precise strategies for enhancing participants’ choice making and articulation of preferences as antidotes to the marginalizing experience of disability stigma. They should reconsider their discussion of functional outcomes because embracing these idealized standards of normalcy are problematic as a professional response that may actually intensify feelings of failure and loss of control (Toombs, 1995). Illness is a paradoxical situation where the notion of autonomy must be minutely and individually negotiated. Participants may need the skill to be vulnerable at the same time they aspire to be as self-determining as possible.

Four examples will illustrate how this model could be applied by a therapeutic re-
reation specialist if its focus were extended toward the existential outcomes that so complement its already existing framework. All of these practice examples reverberate with [emphasized] elements of the proposed Self-Determination and Enhancement Enjoyment Model (see Figure 2, Dattilo et al., 1998, p. 263).

Example 1. The true story of “Steve” puts person-centered planning into a recreational context to illustrate the Self-Determination and Enhancement Enjoyment Model if its authors agreed to an existential approach. Steve has a developmental disability and is a resident of a boarding home. When his care planning team asked him his life goals, he told them he wanted to be an airline pilot. Instead of disregarding Steve’s dream in a minute focus on his functional limitations, the team inquired about the source of Steve’s desire. Was it the power implied in being a pilot? Steve responded that he just wanted to fly a plane (focus on internal standards). The outcome of this “restoration of Steve’s humanity” reveals how the team acted existentially to give Steve his desired self-determined experience of enjoyment:

The solution was to purchase a flight simulator software for the computer, and Steve was able to vicariously experience flying a plane. He loved it, and particularly enjoyed [emphasis added] the spectacular crashes he could stage and walk away from unscathed. Steve is probably thinking about his next life goal now. (HFD News, June, 1998, p. 6)

Example 2. The content of existential outcomes is about making sense of a situation, discovering what is at stake in living, making sense of suffering, and making sense of being human (James & James, 1991). Christopher Reeve “made meaning” as a surviving actor whose “strength” continues to be expressed in speech as craft, “Severed nerves in your spinal cord can’t be healed by a positive attitude, but Dana is my medication” (Fox, Dougherty, Brown, Adato, & Bensimon, January, 1996, p. 62). Reeve affirmed his identity by appraising challenge realistically and making self-aware choices, “I am going to direct. I am actually going to write a book. I am going to give speeches around the country” (CNN, February 21, 1996). Reeve revitalized by savoring the continuity of family leisure and emphasizing its inherent rewards, “. . . our number one activity was eating frozen yogurt and watching the Rangers . . . that we can continue (NBC, December 26, 1995). Reeve articulated the paradox of transcending his broken body with his healed spirit through connecting relationship as he attributed recovery to his wife, “Ninety-nine percent was Dana, and one percent was the fact that I’m very determined” (NBC, December 26, 1995). A therapeutic recreation specialist operating under the Self-Determination and Enjoyment Enhancement Model, who wanted to “make meaning” with Reeve as a participant, would engage him on an existential level. She would facilitate his passion for living as a film director and actor (i.e., invest his attention) and facilitate adjustment to injury through his craft (e.g., facilitating his story as a script through videotape or audiotape via his self-aware choices and making adaptations). She would also enlist his family as healing colleagues since they are his self-acknowledged intrinsic motivation! In this way she would align with standards of practice by involving significant others in planning. Yet she might interact from a broader existential perspective rather than working on the functional outcomes that all his other therapists are already attending to.

Example 3. A therapeutic recreation intern at an agency serving adults with physical disabilities helped staff provide feeding and assistance with the noon meal as a central social activity. She persuaded another
intern that feeding and serving in a standing posture was "acting on" participants (instrumental helping) but that sitting and eating with them, facilitating assistance at the same time, was "being with" them (recreation of one's social self as an end in itself). Together, the interns persuaded the TR staff to change practice to a truer communal experience of enjoyment in this activity. This intern may be deliberately using the Self-Determination and Enjoyment Enhancement Model to facilitate a leisure experience which supersedes a functional intervention of nutrition as an activity of daily living. This scenario illustrates that functional outcomes are met at the same time an existential perspective humanizes the activity and interaction.

Example 4. Kimberly was a research participant (Murray, 1997b) who made a journal of her hospitalization for amputation and pylon training complicated by diabetes. Much of her journaling was self-directed but was reviewed with her therapeutic recreation specialist who provided art materials and digital photographs of her rehabilitation activities. Journaling for Kimberly became an existential outcome where she revitalized her biography as a woman with an amputation. She "made sense" of her experience through the leisure activity of journaling, which she had never done before (Murray, 1997a). "The simple act of recording in a journal what is happening in an illness experience, including feelings and reactions, and reviewing it with a witness (i.e., a therapeutic recreation specialist) makes hidden meanings visible" (Nealon, 1993, p. 91), and that such activity may be liberating (self-determining) because it enlarges self-understanding. Therefore, journaling may be enjoyable self-directed leisure activity with an existential outcome of meaning making. Kimberly's description of her experience provides evidence that journaling her hospitalization was a self-determined and enjoyment enhancement experience:

Kimberly's spontaneous description of flow while drawing her pylon contradicts Bullock's (1998) rejection of flow as a possible participant experience. Whereas flow may not resonate with the tenets of the Leisure Ability Model (Bullock, 1998, p. 101), it may indeed resonate as an outcome of the TR process in the Self-Determination and Enjoyment Enhancement Model, especially as an experience of investment of attention. Kimberly's sense of time was altered when she journaled. This example illustrates existential outcomes articulated as "therapeutic" by the participant if one's practice were guided by a revised Self-Determination and Enjoyment Enhancement Model.

If practice were guided by the Leisure Ability Model (Stumbo & Peterson, 1998), the activity of journaling might be used instrumentally for a deliberated functional outcome (e.g., adjustment to disability, enhancing memory) for treatment or leisure education components of practice. However, if
the specialist were addressing the recreation participation component, journaling might become an existential outcome of enjoyment and self-expression with "increased self-regulated behavior . . . motivation is largely intrinsic" (Stumbo & Peterson, 1998, p. 91). By comparison, in the Health Protection/Health Promotion Model (Austin, 1998, p. 111), journaling might be instrumental as a "stabilization experience" (e.g., a person with memory loss journals with a time diary for orientation, a functional outcome as a means). Or, journaling might be substantive as an "actualization experience" (journaling to celebrate personal growth, an existential outcome as an end in itself)). Austin related that, while practice model authors might portray interventions and outcomes as distinct for interpretive clarity, a participant can experience both functional and existential outcomes at the same time within a given recreational activity. Austin suggests that while "the majority would be directed toward health restoration, some may be aimed at the provision of growth experiences . . ." (1998, p. 115). The authors of the Self-Determination and Enjoyment Enhancement Model might clarify whether they are predisposed to an outcome emphasis based on (a) the title of their model, and (b) the philosophical perspectives in this critique and in emerging literature (Richter & Kaschalk, 1996). This discussion and comparison among models extends the means/ends debate in TR (Sylvester, 1997). The Leisure Ability Model and the Health Protection Model appear to place greater emphasis on a functional outcomes approach with the title of the second more indicative of leisure subordinated to therapy as the purpose of TR practice.

These examples show how a therapeutic recreation specialist might be keenly aware of how a practice model guides the facilitation of healing activity. These examples also illustrate that the specialist must be extremely invested and skilled in therapeutic relationship, as well as sophisticated in theoretical understanding of the TR process defined by a practice model. Graphic illustration of the Self-Determination and Enjoyment Enhancement Model (see Figure 2, Dattilo et al., 1998, p. 263) suggests actions by the therapeutic recreation specialist (e.g., assessing skill, making adaptation, reducing distraction). The description of the model implies the roles of advocate (championing choice and self-direction), teacher (e.g., teaching activity skills), and facilitator (e.g., conducting debriefings and helping to estimate and facilitate a level of challenge). Yet a profound question for a practice model intent on facilitating self-determination is whether the therapeutic recreation specialist, or any health professional, has the capacity to help any participant form acts of self-recognition. This depends on the helper’s "ability to grasp, cognitively and affectively, the predicament and the feelings of another" (Charon, 1995, p. 40).

Future Development of the Self-Determination and Enjoyment Enhancement Model

This model could provide decidedly new direction for TR (existential outcomes) at the same time it cherishes the unique healing tradition of facilitating the experience of leisure. The authors might consider the following recommendations:

- Use an alternative definition of TR that better complements the model (Richter & Kaschalk, 1996).
- Enlarge the psychological perspective with an ecological focus on environments of enjoyment.
- Vary practical illustrations of the model’s components with a wider selection of settings and populations.
- Shift or add a focus on existential outcomes which no other practice model
has demonstrated, and which honors the enlightened calling of TR as a vocation and profession. Embracing the functional improvement component might appeal to therapists committed to treatment, with professionalization of the larger discipline of TR into a narrowed vision of "recreational therapy" (ATRA & NTRS, n.d.). However, the authors’ might influence TR's therapeutic work toward a broader existential frontier; the Pew Health Professions Commission (December, 1995) calls for the superb generalist who is less focused on treatment and more focused on health, prevention, and quality of life for persons living with chronic illness and demoralization.

• In regard to theoretical perspective, this model may be skewed as a psychological presentation. The model did not address psycho-spiritual dimensions of participants who also have to navigate the culturally sanctioned ideals of their families and communities. Such ideals may also conflict with self-determination. Given that living with a debilitating condition is an individually experienced and unpredictable process, especially in estimating human capacity for transcendence, the model seems too neatly interventionist especially in its graphic presentation (see Figure 1 and Figure 2, Dattilo et al., 1988, p. 259, 263):

Studies of psychological . . . aspects of illness are often designed to uncover conditions which can be manipulated by professionals to assist in the patient’s recovery. This is consistent with an emphasis on doing for, rather than being with the patient, that characterizes many relationships in health care. . . . The processes of reconstructing life meanings and adjusting lifestyles to incorporate the demands of illness must often go on outside the professional’s control. The professional is called to witness and support these reconstructive efforts, rather than to initiate or direct them. (Bernard, 1984, p. 76)

Frankl (1969) noted that the main concern of personhood is to fulfill a meaning and actualize values. Therefore, self-determination is not mere adaptation of the environment, nor mere reduction of "maladaptive attributions" that can be globally "fixed" by therapists. That is why this psychological model cannot remain untouched by philosophical dimensions of making meaning with individual participants.

• Further delineate the roles of the therapeutic recreation specialist in the model. Graphic presentations of the model are difficult to interpret in role delineation. The roles of witness and support may supersede roles of diagnosis and intervention for this model. The model is strongly focused on activity; if the goal becomes making meaning with existential outcomes, the therapist will not only need to know what to do with participants, but how to be with them. That will require an elaboration of empathy.

As for therapists, educators, and students reviewing this practice model, it may be time to grow beyond competence, (as a technician who manipulates functional improvement), to presence (Nachmanovitch, 1990, p. 21), (as a helper who facilitates environments of enjoyment), by listening to the participant’s story first and fully. It is important to compare all the practice models and to "care to confront" their authors and critiques. It is important to reflect on one’s own biography in TR, and to reconsider and choose what shapes personal theoretical beliefs in follow-
ing a practice model. “It’s quite possible to be so influenced by the ideals and commands of your neighborhood that you don’t know what you really want and could be” (Campbell, 1988, p. 143). If the purpose of TR is not helping people finding meaning through self-determination and facilitating environments of enjoyment, then, what is the calling and future of TR as a distinctive practice?

References


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