Conceptual paper

Therapeutic Recreation, the International Classification of Functioning, Disability, and Health, and the Capability Approach

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Abstract

A major development in health care, The World Health Organization's *International Classification of Functioning, Disability and Health* (ICF) has been embraced by therapeutic recreation. One of the outstanding features of the ICF is its bio-psycho-social approach, which integrates the medical model and the social model. The purpose of this discussion is to enhance therapeutic recreation's association with the ICF by introducing the capability approach, a social framework that has been favorably associated with the ICF. Recommendations include greater attention to social justice in therapeutic recreation to make it more compatible with the principle of holistic care inherent in the ICF and the capability approach.

Keywords: *Capability approach, disability rights, International Classification of Functioning, Disability, and Health, social justice*

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The World Health Organization's (WHO) *International Classification of Functioning, Disability and Health* (ICF) is a major development in health care, providing a "conceptual basis for the definition, measurement and policy formulations for health and disability" (World Health Organization, 2002, p. 2). The ICF expands the focus of health care from clinical diagnosis, treatment, and medical outcomes to how people with health conditions are actually able to live in their communities. Responding to its unified, systematic, and holistic approach to health care, professions, including psychotherapy (Peterson, 2005), social work (Welch-Saleeby, 2007), and occupational therapy (Stamm, Cieza, Machold, Smolen, & Stucki, 2006), are adopting the ICF. The ICF has also been embraced by therapeutic recreation, evinced by the endorsement of professional organizations (Van Puymbroeck, Porter, McCormick, & Singleton, 2009), a textbook devoted entirely to the ICF and therapeutic recreation practice (Porter & burlingame, 2006), and a growing number of articles, chapters, and presentations on the subject. Furthermore, the *Commission on Accreditation of Allied Health Education Programs Standards and Guidelines for Accreditation of Educational Programs in Recreation Therapy* (2010) includes "Knowledge of the World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF) as a method of assessing individual functioning and the impact of activity limitations and restrictions to participation in life activities, independence, satisfaction and quality of life" (p. 14). Although the impact of the ICF on therapeutic recreation has not been determined yet, its emergence is salient.

Responding to the prolonged problem of treating illness and impairment in isolation of the individual's environment, one of the most outstanding features of the ICF is its attention to the social dimension of health. Under the medical model, individuals could successfully complete treatment according to medical criteria, only to fail upon returning home because they could not participate in their communities. For example, a person sufficiently recovered by medical standards from a spinal cord injury might still be unable to access vocational and recreational opportunities due to environmental factors, such as architectural barriers and discriminatory attitudes. The ICF seeks a solution to the problem by approaching health and disability in terms of how individuals with impairments actually live in society. One of its main attributes, then, is a bio-psycho-social approach, which integrates the medical model (disability is attributable to the individual) and the social model (disability is socially created). By combining the two models, the ICF provides a holistic understanding of health in the lives of persons with disabilities, making possible more coherent, relevant, and effective care (WHO, 2002).

The first systematic effort to incorporate a holistic or bio-psycho-social approach in therapeutic recreation was Howe-Murphy and Charboneau's (1987) *Therapeutic Recreation Intervention: An Ecological Perspective*. Endeavoring to integrate the medical and social models through an "ecological perspective" (xxi), they skeptically questioned the degree to which therapeutic recreation belonged to "the holistic health movement" (p. 225). They cited acceptance of the medical model "to the near exclusion of other models" (p. 225) as a possible reason why therapeutic recreation had failed to develop bio-psycho-social approaches. More recently, Ross and Ashton-Shaeffer (2009) reported in their analysis of eight

therapeutic recreation models of practice that only three models mentioned the environment and none addressed it substantially. More than 20 years after Howe-Murphy and Charboneau criticized therapeutic recreation's neglect of bio-psycho-social perspectives, Ross and Ashton-Shaeffer recommended that "the ecological approach should be revisited and incorporated directly into models as appropriate" (pp. 241-242).

Their advice, however, has been only partially heeded. Systems models and ecological approaches have appeared in the literature on recreation inclusion, such as the Supportive Recreation Inclusion Model and the Community Inclusion Target Indices (Long & Robertson, 2010). However, virtually no analyses of the social component of the bio-psycho-social paradigm are evident in the mainstream of therapeutic recreation. For example, the program of the 2010 American Therapeutic Recreation Association Conference listed no presentations that explicitly dealt with ecological approaches in general or the social model in particular. Although the second edition of *Issues in Therapeutic Recreation: On Competence and Outcomes* (Stumbo, 2009) includes a chapter on the ICF, it does not contain any substantial material on social or ecological models. Furthermore, discussion on evidence-based practice that produces medically necessary outcomes far outweighs discourse on social change that enables people with health conditions to participate in society. Moreover, the demise of the National Therapeutic Recreation Society and efforts to marginalize recreation in the field of therapeutic recreation[1] (see Sylvester, 1994/95, 2006) further raises the risk of inflating the medical model, despite the ICF.

Therefore, as efforts continue to understand and optimize therapeutic recreation's association with the ICF, the social element of the bio-psycho-social ensemble must be rigorously developed if therapeutic recreation intends to holistically embrace the ICF. As such, the purpose of this discussion is to enhance therapeutic recreation's relationship with the ICF by strengthening the social component of the paradigm. In particular, the *capability approach*, a social model that has been favorably associated with the ICF (e.g., Baylies, 2002; Welch-Saleeby, 2007), will be introduced. Initially, the social model will be briefly described, including its main shortcoming. The capability approach will then be generally explained, followed by a more detailed presentation of Nussbaum's (2000, 2006) capability approach. Subsequently, the intersection among the ICF, the capability approach, and therapeutic recreation will be explored from the level of society. Discussion will conclude with implications and recommendations.

An Overview of the Social Model

One basic premise differentiates the medical and social models. The medical model conceptualizes disability as an abnormality within the individual. Medicine's goal is to treat and ideally eliminate the abnormality, permitting the individual to function as normally as possible. In contrast, the social model views disability as a social construction that results in discrimination against individuals who are different than what society considers normal. Individual differences are transformed into disabilities by an unaccommodating society, putting individuals at a disadvantage compared to people who are perceived as "normal" or "non-disabled." Rather than use medicine to make people with disabilities more like individuals without disabilities, the social model treats the inequities that discriminate

against people with impairments, such as physical barriers and job discrimination. The following personal example attempts to illustrate the basic difference between the two models.

Nearly 40 years ago, I participated in a recreation class that included a person who used a wheelchair. One day the class involved folk dance. Everyone danced, except the person in a wheelchair. Her role was to play the record player, starting and stopping the music as everyone else learned the dance. According to the medical model, she did not participate because, being "disabled," she was not well or healthy enough to dance and would not be until her medical condition was treated, enabling her to dance like her non-disabled classmates. According to the social model, her participation was not a result of being unable to stand and move her legs. Rather, she was disabled because of the attitudes of her teacher and classmates, who presumed that people who used wheelchairs were unable to dance until they could stand and move their bodies like people who did not use wheelchairs. Until medicine made that possible, people with spinal cord impairments were not healthy enough to dance, though they were well enough to play records. (One day medicine may make it possible for people with spinal cord impairments to walk again. In the meantime, many people who use wheelchairs today are dancing to their hearts' delight, thanks mainly to transformed social attitudes rather than to changes in their physical condition.)

While the medical model has been criticized for sustaining socially constructed disability, some disability theorists acknowledge a role for it. Oliver (1990) observed that the problem is not the medical model, per se, which has an appropriate function. The problem is medicine's proclivity to situate all problems in the individual, failing to take into account environments that disable people with impairments. Oliver exposed the heart of the issue, stating:

> There have, of course, been substantial gains from this medicalisation of disability, which has increased survival rates and prolonged life expectancies for many disabled people as well as eradicating some disabling conditions. But the issue for the late twentieth century is not one of life-expectancy but expectation of life and it is here that the negative and partial view prompted by medicalisation is most open to criticism. (p. 48)

On the other hand, Terzi (2005) found both models lacking. She concluded that the medical model fails to account sufficiently for the social character of disability and the complexity of human diversity, whereas the social model puts too much emphasis on social causes while neglecting the reality of individual impairment. In other words, the impact of the social environment should not obscure the effects of impairment on the lives of individuals nor should impairments that limit functionality be isolated from the social context in which they inextricably occur.

Intending to dissolve the medical versus social dichotomy by synthesizing what is true in each model, the ICF combines the two perspectives into a holistic framework (WHO, 2002). Accordingly, the ICF consists of three main components: (a) body functions and structures, (b) activities and participation, and (c) contextual factors. Body functions pertain to physiology of the body (e.g., diges-

tion, brain functioning) and body structures involve the body's anatomy (e.g., limbs). Activities relate to the execution of a task or action by an individual (e.g., opening a door) and participation refers to involvement in a life situation (e.g., play, work, worship). Contextual factors include personal factors (e.g., age, gender) and environmental factors or the external influences that interact with the other components (e.g., physical barriers, support groups); (National Center on Physical Activity and Disability, 2006). Where health care would have previously ended with the medical treatment of bodily structures and functions, along with rehabilitation (e.g., activities of daily living), the ICF's holistic approach goes beyond medical outcomes by addressing participation in the environment. Participation amounts to what individuals with health conditions want to do with their lives and the environmental factors that interfere with or facilitate the lives they wish to lead. Moreover, participation in life becomes the ultimate outcome by which all other health care outcomes are evaluated.

The importance of environmental factors has been acknowledged in the therapeutic recreation literature (Porter & Van Puymbroeck, 2007). Porter and burlingame (2006) discuss environmental factors at length in their extensive analysis of recreational therapy and the ICF. Nonetheless, while moving in the right direction, their analysis is substantially limited by not having stronger theoretical footing in the social model. For instance, they quote the ICF as defining recreation and leisure as:

> Engaging in any form of play, recreational, or leisure activity, such as informal or organized play and sports, programmes of physical fitness, relaxation, amusement, or diversion, going to art galleries, museums, cinemas, or theatres; engaging in crafts or hobbies, reading for enjoyment, playing musical instruments; sightseeing, tourism, and traveling for pleasure. (p. 330)

As examples, the ICF lists "play, sports, arts and culture, crafts, hobbies, and socializing" (p. 331). Yet, to the likely surprise of leisure theorists, it excludes religion, spirituality, political life, and citizenship, areas that would be evident from the frame of reference of the social model. And, while Porter and burlingame are at their best explaining the technical complexities of the ICF, their treatment of leisure theory is weak, amounting to three sentences in a 770-page book:

> The terms recreation and leisure are often used synonymously. The field of recreational therapy, however, often divides the terms. Recreation is commonly defined as activity, compared to leisure that is defined as a state of mind. (p. 331)

Reducing leisure to a "state of mind" significantly underemphasizes the economic, political, geographic, sociological, philosophical, and social psychological dimensions critical to any discussion that wishes to offer a holistic theory of leisure. The perspective afforded by the social model, which stresses the social world that individuals inhabit, offers a more theoretically complete and robust account of people's lives.

Criticism of Porter and burlingame (2006) is not meant to slight their contribution. Mainly responsible for launching the ICF in therapeutic recreation, they are

not expected to have completed such a difficult journey on their own that only recently started and has far to go before its success can be judged. Rather, the intention is to build on their and others' work, making one of many contributions needed to reach a mature relationship with the ICF that optimally serves people with health conditions. Having neglected the social model, therapeutic recreation is not prepared to capitalize on what it can receive from and contribute to the ICF. Therefore, discussion turns to the capability approach, a social paradigm that has been regarded as consonant with the ICF, followed by Nussbaum's capability approach and its implications for therapeutic recreation.

An Overview of the Capability Approach

Pioneered by Nobel Prize winning economist Amaryta Sen (1990, 1993) and well-regarded philosopher Martha Nussbaum (2000, 2006), the capability approach has been applied across a variety of disciplines, including health (Ruger, 2006), education (Terzi, 2005), economics (Robeyns, 2003a), social work (Welch-Saleeby, 2007) and occupational therapy (Stamm et al., 2006). Like the ICF, it offers a broad framework for discourse on and evaluation of individual well-being in terms of social arrangements and social change, accounting for all facets of well-being, including health, social, cultural, economic, and political dimensions (Robeyns, 2003b).

Similar to the ICF, the capability approach uses specialized terminology. *Functionings* refer to what individuals desire to be and to do with their lives (Robeyns, 2003b). For instance, people generally desire *to be* healthy, sexual, and appreciated and *to do* such things as ride a bike, enjoy sex, work at a job, and perform community service. Functionings encompass everything an individual values for well-being, from the basic (e.g., health, nourishment, safety, security, literacy) to the more typical (e.g., being employed, visiting friends, going to parks, taking vacations) to the extraordinary (e.g., volunteering for disaster relief, biking cross-country, starting a dance company of youth with developmental disabilities).

The broad, inclusive connotation of functionings used by the capability approach is important to grasp. Similar to other health-related fields more focused on medicine and rehabilitation, therapeutic recreation often uses *functioning* to connote individual mental, emotional, and physical capacities, such as memory, affect, and mobility. Consequently, client outcomes tend to be limited to more basic social, physical, and psychological operations, such as social skills and activities of daily living. These fundamental functionings are part—but only part—of the expansive conception of functioning used by the capability approach, which intends to reflect the diverse scope of human development and well-being. This distinction is crucial because therapeutic recreation is especially conducive to the breadth and variety of human functionings.

Another key term is *capabilities*, meaning the actual freedoms or possibilities available to an individual (Robeyns, 2003b). Capabilities are real opportunities for people to do and to be what they value. For example, people need opportunities *to do* exercise, volunteer work, and dance and *to be* fit, esteemed, and expressive. The relationship between capabilities and functionings is equivalent to possibilities and achievements. Capabilities represent the actual possibilities for individuals to achieve their desired

functionings, whether the functioning is nourishment, mobility, feeling respected, doing a job, or enjoying recreation. Capabilities are potential functionings, the set of freedoms or opportunities available for individuals to actualize what they desire in their lives. For example, imagine a person who is a double amputee and uses a wheelchair. Among her achieved functionings, she rides the bus, is employed, and feels respected as a contributing member of society. Besides these functionings, she also desires to hike in the country on the weekend. Yet is she *capable of* or free to achieve the desired functioning of a weekend hike in the country? Accessible trails are available. However, due to budget cuts, public transportation no longer travels outside of city limits on weekends, eliminating the freedom or opportunity to hike. So, even though she has the *capacity* to hike on an accessible trail, she is *not capable* of achieving the functioning she desires. Once bus service is restored or another means of transportation is provided, she would be free or capable of going on a hike, at which point hiking would become an achieved functioning. After enjoying a hike, she might then want to camp overnight, only to discover that there are no accessible campsites, making her incapable of achieving the next functioning in a desired set of functionings that constitute her well-being.

According to Robeyns (2003b), "What is ultimately important is that people have the freedoms or valuable opportunities (capabilities) to lead the kind of lives they want to lead, to do what they want to do and be the person they want to be" (p. 95). The capability approach, then, is inherently a theory of human development, well-being, and justice. Similarly, "the ICF is fully in line with the human rights approach to disability" (Bickenbach, 2010, p. 54). Welch-Saleeby (2007), for example, found the ICF and the capability approach well-suited to social work, a profession recognized for its commitment to social justice. Therefore, the ICF and the capability approach are partners in justice, assessing social arrangements and change for what impedes and facilities opportunities for all individuals with health conditions to satisfy their needs for health and well-being.

Tracings of social justice can also be detected in discussions of the ICF and therapeutic recreation. Writing about recreational therapy and the ICF from a global perspective, Genoe and Singleton (2009) observed that "the indicators used within the ICF have implications for healthcare providers and policy makers in relation to the rights of individuals and groups" (p. 37). Referring to section d940, Human Rights, of the ICF, Porter and burlingame (2006) explained that recreational therapists must be knowledgeable of disability laws and rights, enabling them to educate clients on how to achieve their rights. In particular, they urge therapists "to be very familiar with the [Americans with Disabilities Act] to . . . empower and educate clients about their civil rights" (p. 487).

Yet disability experts have cautioned that the ADA alone is not enough for ending discrimination (Potier, 2004). Furthermore, The ADA, 20 Years Later, a survey commissioned by the Kessler Foundation and the National Organization on Disability (2010), concluded that "while there has been modest improvement in a few areas, the general implication of the indicators is that now twenty years after the passage of the Americans with Disabilities Act (ADA), there has yet to be significant progress in most areas" (p. 8). The survey further found:

- "Large gaps still exist between people with and without disabilities with regard to: employment, household income, access to transportation, health care, socializing, going to restaurants, and satisfaction with life" (p. 8).
- "People with disabilities are less likely than those without disabilities to socialize with friends, relatives or neighbors, once again suggesting that there are significant barriers to participation in leisure activities for this population" (p. 15).

Therefore, despite some improvements brought on by the ADA, social justice is still elusive rather than inclusive for many persons with disabilities.

Unfortunately, with the exception of Hemingway's (1987) trenchant argument for distributive justice and Sylvester's (1992) defense of the right to leisure, discourse on social justice and therapeutic recreation has risen to no more than a whisper. As a partial theory of justice, Nussbaum's capability approach raises the volume, revealing a prominent place for leisure and recreation in the development and well-being of persons with health conditions and inviting a major role for therapeutic recreation that is compatible with the ICF.

Nussbaum's Capability Approach

Nussbaum (2006) situates her capability approach in the history of justice, most notably John Rawls' (1971) highly regarded social contract theory. Social contract theories of justice start from the premise that individuals form society for their mutual benefit by reaching a contract or agreement on their shared rights and responsibilities. While expressing her debt to Rawls, Nussbaum criticizes him for excluding persons with disabilities from the aggregate of individuals in hypothetical society who initially come together to reach agreement on the conditions of justice. Rawls does address the matter of disability, but only after the fundamental conditions of justice have been reached among those individuals with the minimum "*moral*, *intellectual, and physical capacities* that enable them to be *fully cooperating* members of society over a complete life" (italics added) (Rawls, 1971, p. 183). Attributing dignity to all human beings, Nussbaum argues that "the failure to deal adequately with the needs of citizens with impairments and disabilities is a serious flaw in modern theories [of justice]" (p. 98). Consistent with the ICF's bio-psycho-social perspective, Nussbaum emphasizes going beyond basic functional needs to self-determined well-being, explaining that:

> People with physical disabilities want medical care for their needs, the way we all do. But they also want to be respected as equal citizens with options for diverse forms of choice and functioning in life, comparable to those of other citizens. (p. 189)

Therefore, in both the ICF and Nussbaum's theory, holistic care, while including medicine, also applies to the social environment and matters of justice so people with disabilities are equally capable of enjoying lives of worth and dignity comparable to non-disabled citizens.

Nussbaum's (2006) capability approach is a theory of human development and well-being grounded in Aristotle's conception of flourishing. According to this notion, human beings require a set

of conditions and opportunities in order to grow and to reach their potential (see Hemingway, 1987; Wise, 2010). Nussbaum identifies 10 human capabilities "that can be convincingly argued to be of central importance in any human life" (Nussbaum, 2000, p.74). They include:

- Life
- Bodily Health
- Bodily Integrity
- Senses, Imagination, and Thought
- Emotions
- Practical Reason
- Affiliation
- Other Species
- Play
- Control over One's Environment

(See Nussbaum, 2006, pp. 76-78, for a more extensive description of the capabilities)

Being central to human development and well-being, the 10 capabilities also constitute a defensible set of human rights. The choice of exercising the capabilities rests with the individual, preserving personal autonomy. For instance, while all human beings are entitled to play and nourishment, an individual may choose not to play and instead go on a hunger strike in order to express a political view. Nonetheless, "a society that does not guarantee [the capabilities] to all its citizens, at some appropriate threshold level, falls short of being a fully just society" (Nussbaum, p. 75).

Nussbaum (2006) presents the 10 capabilities as a starting point, expecting modifications as others join in the dialogue on the capability approach and its applications. Accordingly, discussion next turns to the capabilities in relation to therapeutic recreation.

The relevance of the capabilities of *Bodily Health* and *Play* particularly stands out, reflecting two fundamental responsibilities therapeutic recreation has historically adopted: (a) to help restore and maintain the health of persons with illnesses and disabilities and (b) to provide opportunities of leisure and recreation for their health and well-being. Falling within the broad capability of *Bodily Health,* contributions to health restoration, protection, and promotion have been documented in therapeutic recreation (Coyle, Kinney, Riley, & Shank, 1998; Shank & Coyle, 2002). Recreation benefits (Driver, Brown, & Peterson, 1991), including fitness, enjoyment, autonomy, citizenship, spirituality, positive relationships, psychological well-being, and a sense of community, are well suited for the diverse and wide-ranging capability of *Play*. In this regard, play, leisure, and recreation are essential and arguably unrivaled for helping people with health conditions to continue growing, developing, and enjoying their lives during and after treatment. Hence, therapeutic recreation's historically fundamental goals of treatment and recreation satisfy Nussbaum's (2006) condition of self-determined well-being, providing "medical care for their needs" as well as "options for diverse forms of choice and functioning in life, comparable to those of other citizens" (p. 189). Indeed, most models of therapeutic recreation practice include the dual roles of treatment for the purpose of functional improvement and recreation for the sake of overall health and well-being. Yet, by systematically applying the concept of leisure, the relevance of Nussbaum's theory extends well beyond the capabilities of *Play* and *Bodily Health*.

The capability of Bodily Integrity contains two relevant facets. The first one, "being able to move freely from place to place" (Nussbaum, 2006, p. 76), may not initially appear germane. However, using a more holistically robust theory of leisure than is typical in therapeutic recreation reveals a pertinent parallel. In his analysis of therapeutic recreation and the right to leisure, Sylvester (1992) wrote:

> Article IX of the United States Constitution holds that rights enumerated in the Constitution "shall not be construed to deny or disparage others retained by the people." Former Supreme Court Justice William O. Douglas (1977) opined that "a catalogue of these rights . . . come within the sweep of 'the Blessings of Liberty' mentioned in the preamble to the Constitution." Douglas further argued that except for areas of harmful behavior, every American has the right "to shape his own life as he thinks best, do what he pleases, go where he pleases . . . .," including the 'freedom to walk, stroll, or loaf.' (p. 15)

Without free time, open space, and public places to enjoy parks, playgrounds, theatres, restaurants, or simply stroll along an avenue or bike down a country lane, freedom of movement would be fettered. Leisure time, leisure spaces, and leisure places are thus essential resources for "being able to move freely from place to place" (Nussbaum, p. 76), enabling citizens with disabilities to do what they want with their lives when and where they wish.

Second, *Bodily Integrity* also includes "having opportunities for sexual satisfaction" (Nussbaum, 2006, p. 76). Discussing leisure, sexuality, and disability, Howard and Young (2002) observed that "leisure and recreation activities also serve as the primary means by which people come into contact with one another and form relationships and eventually opportunities for sexual expression" (p. 101). Despite occasional nods to sexuality (e.g., Howard & Young, 2002; Misselhorn, 2010; Richter & Kaschalk, 1996), the sexual lives of persons with disabilities have been neglected in the therapeutic recreation literature. In conjunction with other fields, such as nursing and rehabilitation counseling, therapeutic recreation should be taking a lead in supporting the right of persons with disabilities to experience themselves as sexual beings.

Fostered particularly well by the diversity of therapeutic recreation, the capability of *Senses, Imagination, and Thought* warrants a complete description:

> Being able to use the senses, to imagine, think, and reason—and to do these things in a "truly human" way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid non-beneficial pain. (Nussbaum, 2006, p. 76)

Art, music, dance, and other activity-based therapies and services certainly contribute to this capability. Nonetheless, with its traditional ties to leisure and recreation, it is hard to imagine a profession more conducive than therapeutic recreation for helping persons with health conditions to live in "truly human ways" through the countless ways humans are capable of living.

The capability of *Emotions* also accords well with therapeutic recreation. Empirical studies associate emotional expression with physical and psychological benefits (Nyklicek & Temoshok, 2004; Pennebaker, 1995). Moreover, emotions are one of the primary ways that people experience and express themselves in the world, illustrated poignantly in a brief anecdote shared by Nussbaum (2006). Describing Sesha, the young adult daughter of philosopher Eva Kittay, Nussbaum wrote:

> She responds with joy to the affection and admiration of others. Sesha sways to music and hugs her parents. But she will never walk, talk, or read. Because of congenital cerebral palsy and severe mental retardation, she will always be profoundly dependent on others. She needs to be dressed, washed, fed. … Beyond such minimal custodial care, if she is to flourish in her own way she needs companionship and love, a visible return of the capacities for affection and delight that are her strongest ways of connecting with others. (p. 96)

Without the opportunity to share her emotions, Sesha would be as alienated as a writer unable to express her thoughts, both being incapable of living in ways that are "truly human" for each of them. A moment's reflection brings to mind the plentiful range of emotional opportunities possible in leisure and recreation, including, as a small sample, failure, success, disappointment, joy, suffering, elation, anger, happiness, displeasure, appreciation, heartbreak, and triumph.

Representing the opportunity to reflect on and plan for a life seen as desirable by the individual, including the liberties of conscience and religion, *Practical Reason* may at first appear more remote to therapeutic recreation compared to other capabilities. Yet Sylvester (1992) included practical reason in his analysis of therapeutic recreation and the right to leisure, explaining:

> Two salient premises converge to justify leisure as a necessary condition of human well being. *First, leisure provides the opportunity to consider the kind of life a person wishes to live, permitting reflection on the personal meaning of well being and how it might be achieved* (italics added). Second, leisure provides the opportunity to do those things people consider meaningful and worthwhile beyond what they may or may not find fulfilling in their occupations, if in fact they are employed. In sum, leisure allows people to reflect on and to realize many of the personal values that constitute their well being. (p. 15)

The capability of *Practical Reason* also resonates with autonomy and self-determination, a pair of related principles historically prized in therapeutic recreation (Sylvester, 2005). Drawing from leisure theory, therapeutic recreation is thus ger-

mane to the freedom to reflect on and plan the particular kind of life one desires to live, perhaps incorporated as part of leisure education.

The relevance of therapeutic recreation to the capability of *Affiliation* cannot be addressed sufficiently in the limits of this discussion. As Robinson, West, and Woodworth (1995) explained with respect to disability:

> Our relationships with others are the keystones of society. In some instances, our lives depend on them. Our encounters with others run the gamut from casual acquaintances to the intimacy of conjugal unions. These encounters affirm our existence, foster growth, help ensure stability, and give us a sense of place and purpose. (p. 99)

Rokach, Lechcier-Kimel, and Safarov (2006) noted that relatedness and loneliness are persistent human concerns, with loneliness having debilitating effects, including depression, alcoholism, poor self-concept, and unhappiness. Constanca, Salma, and Ebrahim (2006) concluded that loneliness was the most important predictor of psychological distress among elderly persons with disabilities. And, according to *The ADA, 20 Years Later* (Kessler Foundation/National Organization on Disability, 2010) "People with disabilities are less likely than those without disabilities to socialize with friends, relatives or neighbors" (p. 20).

Relationships, therefore, are indeed one of the keystones of society, and recreation is a key builder and supplier of relationships. The research on therapeutic recreation's contribution to the development of relationships, particularly friendship, is well established (Schelein, Green, & Stone, 2003). Furthermore, studies suggest that leisure and recreation are important sources of social bridging and bonding (Devine & Parr, 2008; Glover & Hemingway, 2005). More generally, the principle of *recreation inclusion* implies not only equal opportunity for people with disabilities to participate in recreation-related experiences, but participation and affiliation with non-disabled people.

The capability of *Other Species*—caring for and relating to animals, plants, and nature—is fostered by leisure and facilitated through myriad forms of recreation, such as pets, gardens, parks, and ecotourism. Although Richard Louv's (2008) heralded *Last Child in the Woods* draws attention to the plight of children spending less time in direct contact with nature, his thesis can be confidently extended to all people, young and old. The applications of horticulture and animals in therapeutic recreation attest to the influence of flora and fauna, as does the power of outdoor experiences in helping human beings to sustain their own nature through connections to the natural world.

The relevance of the final capability, *Control over One's Environment*, occurs in "being able to participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association" (Nussbaum, 2006 p. 77). Leisure-time is one of several resources needed for participation in social and political movements (McCarthy & Zald, 1977).[2] Goodwin, Rice, Parpo, and Ericksson (2008) contend that control over time is as important as money and other resources for control over one's life, amounting to a "currency of egalitarian justice" (p. 3). More comfortable with the medical model, the field of therapeutic recreation is likely uncertain about how to inter-

vene in something as nebulous as leisure and political autonomy. Consequently, therapeutic recreation will need to conceptualize its work more broadly than individual interventions alone, including sociopolitical functions, such as advocacy and activism. Collaborating with organizations devoted to social justice, such as *Take Back Your Time* (www.timeday.org), is one way that therapeutic recreation can help people with health conditions gain greater control over their lives.

In sum, from a strengths-based perspective that centrally includes leisure theory (see Anderson & Heyne, in press), the capability approach forms a promising synergy with therapeutic recreation. Further, bridging the capability approach and the ICF so both frameworks can be used by professionals from a variety of disciplines is an important step in the development of their alliance (Welch-Saleeby, 2007). Due to their complexity and diversity, as well as the existence of multiple models of therapeutic recreation, synthesizing the ICF and the capability approach with therapeutic recreation is a challenge that lies beyond the scope of this introductory discussion. Nonetheless, suggesting ways the ICF and the capability approach can complement each other in therapeutic recreation may help break ground in bridging the frameworks. Since the ICF is "a tool for measuring functioning" (WHO, 2002, p. 2), including participation in life, and the capability approach is a social model that addresses how people actually live in society, the following suggestions focus on their intersection with the social environment.

In the ICF, *functioning* refers to all body functions, activities (execution of tasks or actions), and participation (involvement in life situations). *Activity limitations* refer to problems with activities and *participation restrictions* pertain to difficulties with participation in life. In the capability approach, *functioning*, the doings and beings of individuals, is synonymous with *participation* in the ICF. Equivalent to freedom or opportunity, the concept of *capability* asks the following question: Is a person actually capable of participating in life situations for the purpose of achieving what he or she would like to do and be? For example, imagine a 12-year-old boy with severe autism. He desires to participate in a summer day camp program offered by his community's recreation department. Is he capable of achieving his desired functioning of *being* a camper and *doing* the many interesting things campers do? In terms of environmental factors, the recreation department's inclusion policy reinforced with well-trained staff and barrier-free design facilitate the boy's participation. Accordingly, while he is diagnosed with autism, the boy is not disabled with respect to involvement in summer camp. Therefore, he is capable of achieving many of the desired functionings contained in Nussbaum's capability approach, such as *Play, Emotions, Affiliation*, and *Other Species*. At least from the perspective of recreation, the ICF would assess the boy as reasonably healthy and well, an active participant in his community despite his condition of autism.

Imagine now a similar scenario. This time, however, the recreation department has had to eliminate one of two inclusion specialists due to budget cuts, making it impossible to sufficiently train staff needed to successfully accommodate persons with health conditions, including the boy with autism. On his first day at camp, the boy has an outburst because one of the staff innocently placed her hand on the boy's shoulder for encouragement, not realizing that the boy needed social space until he became comfortable in a

new setting with people he did not know. Although the recreation staff wishes to include the boy, it believes the lack of a full-time inclusion specialist and adequately trained staff jeopardizes the safety of the boy, the staff, and other campers. Consequently, he is not permitted to return to camp without someone to assist him throughout the day. His family, however, cannot afford to pay for an aide. Despite his health condition being unchanged, the boy, no longer capable of participating in his desired functioning, is now disabled from the perspective of the ICF. In this situation, disability does not occur at the level of impairment or activity limitation. Rather, it is socially created, requiring a social intervention. The immediate environmental barrier—insufficiently trained staff—is manifest. In this case, however, the problem is exacerbated by inadequate funding in an economy where public services have been severely slashed. Now the nature of intervention shifts from the familiar therapeutic recreation process used for individual care to the necessity of a broader focus on society, disability, and justice. As such, intervention will require a different approach than is typical of therapeutic recreation practice, one that is grounded in the social model and competencies appropriate to it.

Devoid of the ICF's intricate coding system, this example was simply intended to show how the ICF extends health care from the medical model to how people are capable of functioning in their communities. It also demonstrates how the capability approach can complement the ICF, increasing its analytic power and potential to plan and implement effective interventions in the social dimension of the ICF's bio-psycho-social fusion. Whether therapeutic recreation is as prepared to work as effectively in the social dimension as it is with individuals, however, is an issue that will be revisited in the conclusion of this discussion.

The ICF also operates as a needs assessment at the social level, inquiring as to "the needs of persons with various levels of disability—impairments, activity limitations and participation restrictions" (WHO, 2002, p. 6). Because the ICF is holistic, assessment needs to account for the wide and diverse range of functionings that constitute the well-being of individuals in their cultures, societies, and communities. Nussbaum's capability approach would be especially useful for that purpose. Returning to the example of the 12-year-old boy with autism, a therapeutic recreation practitioner would ask, "Which of the capabilities are essential to his well-being and is he capable of achieving his desired functionings?" In conjunction with the boy and his parents, and perhaps other key persons and professionals, such as his siblings, his teacher, and his music therapist, Nussbaum's capability approach would be administered, identifying how the environment facilitates or interferes with his participation in situations that enable him to grow, develop, and flourish.

Conclusion

The capability approach is a promising social model that has already made inroads in a variety of disciplines. Because of its compatibility with therapeutic recreation and the ICF, it is an excellent place to begin the work of improving the social model in therapeutic recreation, leading to a stronger bio-psycho-social foundation. Other ways of developing the social model that promote the goal of holistic theory and practice should also be explored. Otherwise, the next obvious step is to submit this conceptual analysis to

scientific investigations. In particular, the effectiveness of Nussbaum's capability approach as an assessment and evaluation tool should be tested using quantitative and qualitative methods.

Many of the key theoretical and programmatic implications have already surfaced in the course of discussing Nussbaum's capability approach and its relation to therapeutic recreation, particularly the importance of restoring leisure theory to a position of greater prominence. By way of recommendations, therapeutic recreation should assess, plan, deliver, and evaluate services using the capability approach both within and outside the context of the ICF. Experiences with the capability approach should then be shared through different forums, such as publications, presentations, and the internet. Since this discussion was mainly intended to introduce the capability approach to therapeutic recreation, further speculation should be properly tentative until other analyses and studies have been conducted. Nonetheless, what the author considers the most important implication arising from this analysis warrants attention, followed by not just a recommendation, but an imperative.

If therapeutic recreation intends to effectively incorporate the social dimension as theorized by the ICF, it must become serious about social justice. Of course, who in therapeutic recreation would disagree with seriously aspiring to justice? Yet therapeutic recreation must move from aspiration to action. Unfortunately, it is not prepared. Certainly, the issue of health, disability, and social justice is complex and controversial in the U.S., as debate continues to swirl. And while therapeutic recreation should be more involved in discourse and action on disability rights, the end of this paper is not sufficient for extensively airing the issue of health care. Nonetheless, a critical factor that is preventing therapeutic recreation from living up to the expectations of social justice inherent in the ICF and the capability approach demands acknowledgement.

At their core, all fields oriented to the medical model, including therapeutic recreation, primarily emphasize *individual* care. The clinical act occurs between a clinician and a client. That approach is appropriate where individual care is needed, which is why the medical model has a time and a place. However, while individual treatment is effective for individual illnesses and impairments, it is ineffective for dealing with the persistent injustices faced everyday by citizens with disabilities. Exploring why the ethical responsibility of justice has not been emphasized in medicine, Earnest, Wong, and Federico (2009) wrote:

> Attending to justice requires a much broader focus. To even consider justice requires accounting not just for an individual, but for the relationship of that person to the community and to society as a whole. To seek justice a physician must act not in a clinical capacity, but as a citizen, an advocate, and an activist. Physicians are not prepared for these roles. (p. 1269).

Consisting of individual assessment, planning, intervention or implementation, and evaluation, the *therapeutic recreation process* defines the crux of therapeutic recreation practice and the quintessential act of therapeutic recreation practitioners. The primary object of professional skill and knowledge is overwhelmingly on individuals. As a result, the community, society, and social jus-

tice are significantly underemphasized. Therefore, substantive attention to social justice in medically dominated therapeutic recreation is negligible. This state of affairs is all the more ironic, because the ultimate purpose of the ICF is how people with health conditions are actually able to participate in their neighborhoods, communities, and society. How they participate is profoundly affected by access to health, economic, political, educational, housing, transportation, recreational and other resources, all of which amounts to social justice.

According to the principles of the ICF, therapeutic recreation, no matter how clinically efficacious, cannot succeed unless the people it serves are able to participate in society. Surrounded on all corners by the medical model, therapeutic recreation cannot be a change agent for social justice without a social process to complement the clinical process. So how do therapeutic recreation practitioners become better prepared for social justice? For starters, just as the ICF combines the medial model and the social model, therapeutic recreation must complement individual methods of care with social approaches. Therapeutic recreation services, organizations, and education must provide leadership that equips students and practitioners with suitable knowledge, skills, and qualities. For example, social justice requires competencies in law, activism, diversity, advocacy, languages, negotiation, communication, human relations, group process, systems thinking, critical thinking, and community development. Therefore, recognizing that therapeutic recreation practitioners need to work within the social and medical models, a blend of knowledge and competencies from medicine and social work seems appropriate. Irrespective of the specific combination of knowledge, skills, and qualities, therapeutic recreation must reorient itself from treating individuals in a clinical vacuum to serving people in the social world they depend on for their well-being.

The ICF is designed to assess functioning at three levels: individual, institutional, and social (WHO, 2002). At the social level, it pointedly asks, "Will guaranteeing rights improve functioning at the societal level?" (p. 6). While the ADA has resulted in some improvements, significantly more progress is necessary for citizens with disabilities to substantially achieve rights comparable to citizens who, at least at the time, do not have disabilities. Consequently, professions must do more than offer counsel on laws and rights. They must assess, plan, and intervene to effect change at the social level. Grounded in the social model and social justice, the capability approach is a framework compatible with the ICF that promises to move rights from aspiration to achievement, enabling therapeutic recreation to become genuinely holistic in the process.

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Endnotes

[1]Reference to recreation was removed for ATRA's revised definition. The original definition stated, "Therapeutic recreation is the provision of treatment services and the provision of recreation services to persons with illnesses or disabling conditions. The primary purpose of treatment services, which is often referred to as recreation therapy, is to restore, remediate or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purpose of recreation services is to provide recreation resources and opportunities in order to improve health and well being" (ATRA, 1998). The revised definition now states: "'Recreational Therapy' means a treatment service designed to restore, remediate and rehabilitate a person's level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition" (ATRA, 2009).

[2]The ancient Athenians considered leisure essential for citizenship (see Hemingway, 1988). Further, one of the reasons for the Shorter Hour Movement in U.S. labor history was workers' desire for civic participation (Hunnicutt, 1988).