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Qualitative Research Paper

Using Community-Based Research to Explore Common Language and Shared Identity in the Therapeutic Recreation Profession in British Columbia, Canada

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Abstract

To date, very little peer-reviewed research on the therapeutic recreation (TR) profession has emerged from British Columbia (BC), Canada. The TR Research Network, a group of researchers and recreation therapists (RTs), adopted a community-based research approach to investigate the current state of TR in BC and to better understand common language and shared identity of diverse RTs in BC. Eighty-four (84) on-line surveys were gathered using Survey Monkey. Closed- and open-ended responses were coded numerically and thematically with the development of descriptive code books. Findings suggest that the profession in BC describes TR as "therapy," uses clinical language to describe their work, and identifies with both humanistic and individualistic values. Research recommendations include bringing greater consistency to the language of TR, viewing research as the collaborative generation of practice-based evidence, and applying a strengths-based perspective to the ongoing professionalization of the field.

Keywords: *Therapeutic recreation, professional identity, language and values, community-based*

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Purpose of Study

In Canada therapeutic recreation, (TR) is a rapidly growing and evolving allied health profession. Recreation therapists (RTs) use recreation experiences to assist people with disabilities and illnesses to overcome barriers that prevent them from achieving a fulfilling quality of life. They also provide services to people who have any barrier that prevents them from achieving optimal health (Therapeutic Recreation, 2012). RTs work in a variety of community and institutional contexts with diverse individuals and groups. As a result it can be difficult to generalize about the nature of TR work.

TR in Canada has grown exponentially in the last 30 years. Provincial and national professional associations have been formed (e.g., Canadian Therapeutic Recreation Association, British Columbia Therapeutic Recreation Association), degree programs have been established (e.g., at Douglas College in British Columbia, 2006), and national certification is soon to be launched. Despite growing professionalization in the field, RTs struggle to be recognized as legitimate equals among interdisciplinary groupings of allied health professions. Indeed, TR in Canada and in the province of British Columbia (BC) more specifically, reflects the typical challenges of a new emerging profession.

The BC Therapeutic Recreation Association (BCTRA) and the TR Department at Douglas College concomitantly identified research as a means to establish greater legitimacy for the profession. Not only do TR interventions need evaluation and documentation but the growth of the field requires a broad research focus to identify future opportunities and directions towards a shared vision for the field. In 2010 a group of RTs and a TR faculty from Douglas College in Metro Vancouver formed the TR Research Network. The Network determined that the most fundamental issues facing TR in BC were the broad diversity of practitioners in the profession and a lack of common language and shared identity among RTs. Our research questions were: (1) What is the current state of TR practice in British Columbia? and (2) What are the common language and shared identity of diverse recreation therapists in British Columbia? Ultimately, our intention was to identify the strengths, limitations and needs of the profession in BC, and to possibly contribute to the growth and advancement of TR in Canada.

Review of Literature

It is beyond the scope of this paper to provide a detailed historical overview of the evolution of TR in BC and other Canadian provinces. For the purposes of this analysis some major developments in the TR profession in BC are discussed as well as its most salient and current debates.

Increasing Professionalization: Therapeutic Recreation (TR) in British Columbia

The TR profession in BC has been long challenged with defining itself because of its diverse job titles, job descriptions, client groups, and work contexts. In BC, the debate around these challenges and TR's professionalization has been largely shaped by the BCTRA and Douglas College.

In 1987 the first TR diploma was offered at Douglas College. Douglas College remains the only educational institution in BC that offers post-secondary training in TR.[1] In 1990 the BCTRA developed its philosophy, mission and by-laws. After other provincial TR organizations formed across Canada, the Canadian Therapeutic Recreation Association (CTRA) was established in 1996. The CTRA adopted a code of ethics and standards of practice, as

[1]Prior to 1987 Douglas College offered a TR certificate.

well as ongoing advocacy of TR practice.[2] In the late 1990s and early 2000s, TR degree programs were established at various Canadian academic institutions.[3] In BC, Douglas College admitted its first cohort of TR degree students in 2006. Currently the TR Department at Douglas College supports the BCTRA vision for professionalization by offering internship opportunities and supporting students in completing CTRS certification.

Despite this increased professionalization, there remain significant discrepancies across Canada and within the provinces around the educational level required to be a RT (Adams, Arnott & Boothman, 2008). In BC the various recreation practitioners are set apart by many distinctions in responsibilities, skills, and educational requirements. Responsibilities "differ from site to site and city to city, and depend on site, facility and agency policies and procedures, job descriptions and duties identified according to union classifications" (Adams et al., 2008, p. 6). The TR profession in BC is concerned about its perceived legitimacy and acceptance among other health professionals and believes that standardizing the profession and reducing its many discrepancies is the solution. Indeed, it is a commonly held belief that professionalization can increase the credibility and legitimacy of clinical and community work (Alsbury, 2010). However, Sylvester (2002) argues that efforts towards professionalization, such as those in BC, may not have the desired effect. "Marketing, credentialing, and even science cannot fix the problem. It will take the right method for the task, which means TR must dramatically improve its moral theory and practice" (Sylvester, 2002, p. 328). Although values may be obscured by the daily routine of practice or be taken for granted, they cannot be ignored if TR wishes to achieve the status of a learned-service profession (Sylvester, 2002). It is therefore essential to examine the values and philosophies of the TR profession.

Persisting Debates: The Values and Philosophies of Therapeutic Recreation

The professionalization of TR in BC has been largely navigated by the BCTRA and Douglas College. Yet discussions of professionalization are incomplete without examining the underlying values of the TR profession. Debates of TR's values are not unique to BC, in fact they reflect the broader and more persistent deliberations that, for several decades, have waged across Canada and the United States.

The goals and processes of TR, as well as the relationship between RTs and their clients, are steeped in values (Sylvester, 2002). TR values are explicitly humanistic including person-centred, holistic and strengths-based approaches (Carruthers & Hood, 2007; Iwasaki, Coyle & Shank, 2010). One of TR's philosophies is to create meaningful connections through caring, trusting, respectful and non-judgmental interventions (Lansfield, 2010). TR has long articulated the importance of working with the "whole person" (Carruthers & Hood, 2007).

In the United States, debates around the values and philosophies of TR have historically focused on the recreation therapy versus therapeutic recreation distinction. TR corresponds to leisure/recreation, community work, and is non-clinical, whereas clinical

[2]In the next decade, major restructuring of CTRA included increased regulation and a review and update of a set of standards that reflected current practice (Canadian Therapeutic Recreation Association, 2012). In 2007 the CTRA endorsed official negotiations with the National Council for Therapeutic Recreation Certification (NCTRC) with the intent of developing a cooperative arrangement to establish certification for Canadian Therapeutic Recreation Specialists.

[3]Universities and Colleges in Canada that offer a bachelor degree in therapeutic recreation include Douglas College (British Columbia), University of Regina (Saskatchewan); Brock University (Ontario); University of Waterloo (Ontario); Seneca College (Ontario); Concordia University (Quebec); Dalhousie University (Nova Scotia); and Memorial University (Newfoundland).

work, or therapy, refers to RT (Wozencroft, Kennedy & Pihera, 2009; Skalko, 2009). Skalko (2009) goes further in arguing RT and TR are two sub-specialties with different training, experience, and qualifications, and that these two distinct functions of the field are not united by a primary philosophical position. In Wozencroft et al.'s (2009) analysis, some practitioners felt that the use of two terms is confusing and prevents the field from moving forward and gaining recognition. Historic disagreements over the definition and philosophy of RT/TR have perpetuated the current-day debate over the clinical versus non-clinical nature of the profession (Wozencroft et al., 2009).

In 1994, Velde and Murphy wrote an analysis of TR in Canada. They documented the fear that TR in Canada will adopt the values and philosophies from the United States without creating ones unique to Canada. TR debates in Canada are slightly different than those from the U.S. In Canada, the terms "therapeutic recreation" and "recreation therapy" have been used synonymously for many years without controversy (Adams et al., 2008). Yet, similar to the U.S., in Canada disagreement remains around the purpose of TR. Adams et al. (2008) differentiate TR's purpose as "therapy versus activity" (p. 6). Although all RTs use the "modality" of the recreation and leisure interests of the clients to improve their quality of life, therapy-based recreation programs involve setting goals and objectives to find meaning through leisure by promoting independence, healthy lifestyles, leisure-related skills, and optimism whereas activity-based recreation programs do not involve active treatment or therapy (Adams et al., 2008).

According to Sylvester (2002) "values must be openly and fully confronted, for they are the essence of a professional calling, giving meaning and purpose to services conducted in the public interest" (p. 328). A current struggle for the TR profession in BC and across Canada and the U.S. is the need to survive in health and human service systems with their focus on deficit reduction (Carruthers & Hood, 2007). A problem- or needs-based approach has permeated many allied health care professions as they have aligned themselves with the pervasive medical model (Carruthers & Hood, 2007). A deficit-reduction approach is antithetical to the strengths-based, person-first values espoused in many TR texts. Although the emphasis on problem resolution is not limited to TR, it is deeply problematic for a profession that is navigating professionalization.

It is from this perspective that we sought to better understand where and to what extent the identity and values of TR professionals in BC were coherent and divergent. Schwartz's (2005, 2010) framework of basic human values contends that it is possible to classify virtually all values across cultures into one of ten core values. He argues that the dynamic relationship among core values can be explicated on two dimensions: (1) self-enhancement (values of achievement, power) versus self-transcendence (values of universalism, benevolence) and (2) openness to change (values of hedonism, stimulation, self-direction) versus conservation (values of security, conformity and tradition). Actions in pursuit of any value have psychological, practical, and social consequences that may conflict or be congruent with the pursuit of other values (Schwartz, 2005). For example, "the pursuit of achievement values may conflict with the pursuit of benevolence values—seeking success for self is likely to obstruct actions aimed at enhancing the welfare of others who need one's help" (Schwartz, 2005, p. 2).

Schwartz's framework can enable a fuller examination of the TR profession's values in BC. Although values may be obscured or taken for granted, they cannot be ignored if TR wishes to gain legitimacy as an allied health profession (Sylvester, 2002). A better understanding of TR's values can also help advance

the profession across Canada and in the United States.

Aligning Values and Approaches: Therapeutic Recreation and Community-Based Research (CBR)

There have been numerous calls for Canadian research in TR (Velde & Murphy, 1994; Stumbo, 2009). When we envision a view of research in BC there is room for both evidence-based practice and practice-based evidence. Similar to other allied health professions, there are mounting expectations for the profession in Canada to establish its unique body of knowledge and for TR practices to be evidence-based. Evidence-based medicine is the "integration of best research evidence with clinical expertise and patient values" (Sackett, Straus, Richardson, Rosenberg & Haynes, 2000, p. 1). It is imperative that TR interventions and assessments be based on sound evidence (Stumbo, 2009; Carruthers & Hood, 2007). However, there are tensions in expecting community and clinical work—across fields and disciplines—to be evidence-based. Evidence-based practice, which is derived from evidence-based medicine, disregards many kinds of research that have different criteria for trustworthiness (such as qualitative research) and imposes on quantitative studies a narrow set of criteria of what counts as evidence. Practitioners are criticized for failing to base actions on research evidence, while academic research is sometimes condemned as irrelevant to practice (Fox, 2003). Oftentimes, there is a mismatch between the day-to-day experiences of practitioners in their work and the evidence that is generated in an effort to inform that work. Green and Glasgow (2006) contend that "if we want more evidence-based practice, we need more practice-based evidence" (p. 126). Practice-based evidence uses the clinicians' real-time feedback to develop, guide, and evaluate behavioural health services. This involves finding what works for a particular individual and requires ongoing monitoring and feedback (Miller, Duncan, & Hubble, 2004).

Community-based research (CBR) is:

> ... a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities (W.K. Kellogg Foundation's Community Health Scholar's program, 2001; cited in Minkler & Wallerstein, 2008, p. 6).

Traditionally the world of academia was considered the only legitimate place for building theory, conducting research, and generating valid knowledge (Reid, Brief, & LeDrew, 2009). We now live in a knowledge-based society where researchers are increasingly diverse, research teams often include people with a range of experiences and expertise, research questions arise from practice and experience, research methods can be participatory and collaborative, and research findings are used to improve practice and policy. The recent popularization of CBR has resulted in the inclusion and valuing of diverse approaches to research, researchers themselves, and research outcomes (Reid, et al., 2009).

Method

A community-based research (CBR) project was initiated in 2010 by a group of RTs from the Metro Vancouver area. The group met regularly to discuss all stages of the research and agreed that our first project together needed to be manageable and realistic in scope and timeframe. An inherent challenge in addressing our research questions was the dearth of documentation regarding TR in BC. Very little has been published in unpublished

reports from health agencies or peer reviewed literature. Consequently our collaborative research project was explicitly exploratory and descriptive in nature.

Participants

Currently, there is no formal mechanism for tracking the TR profession in Canada or provincially—a formal accreditation process does not exist and there is no requirement to belong to any professional association. In addition there is a wide range of job titles, client groups, and work contexts (i.e., clinical, community, private). As such recruiting a probability sample of a representative group of RTs in BC was unfeasible.

To best address our research questions we purposively selected a diversity sample with the aim to cover as many existing relevant varieties of the phenomenon as possible (Jansen, 2010). We discussed at length sampling strategies for the qualitative survey. Research participants were recruited through the BCTRA listserve,[4] Douglas College distribution lists of current and past TR students, recruitment emails sent by Network members to their colleagues and practice groups, and recruitment notices distributed at the annual CTRA conference in May 2011. The recruitment e-mails included a brief description of the project and its goals. Following the initial e-mails, reminders were sent to encourage participation in the study. In order to distribute the surveys as widely as possible, the researchers asked those contacted to forward the link to their TR colleagues. Given our knowledge of the diverse job titles in the TR profession, we were careful to solicit the participation of practitioners who identified with the TR profession regardless of their job title.

Data Collection

Once we gained ethical approval from the Douglas College Research and Ethics Board, a four-page survey was developed.

> The qualitative survey does not aim at establishing frequencies, means or other parameters but at determining the diversity of some topic of interest within a given population. This type of survey does not count the number of people with the same characteristic but establishes the meaningful variation within that population (Jansen, 2010, para. 6).

A qualitative survey was the most appropriate method given our exploratory and descriptive research questions and the challenges of sampling and recruitment. Rather than relying solely on face-to-face methods that would favor RT perspectives from the Metro Vancouver area, an on-line non-interactive method of data collection was chosen in order to reach as many practitioners in the province as possible.

The qualitative survey questions were then posted on Survey Monkey (http://www.surveymonkey.com). The first page of the survey comprised the informed consent form that described the study purpose and methods and provided contact details for further information. Of the 24 questions posed, nine were close-ended and 15 were open-ended. The close-ended questions were drop-down or click-boxes that provided a range of pre-set answers. In order to answer the first research question—What is the current state of TR practice in British Columbia?—demographic data were collected from respondents, including close-ended questions on job title, education, certification, years of work experience, and affiliation with professional organizations. Open-ended questions were used to enable the full diversity of respondents to emerge so that they could describe where they worked, the client group with whom they worked, and context in which they worked. These data allowed the researchers to gain a better sense of the state of TR practice in BC.

[4]BCTRA has over 300 members.

Our second research question, "What are the common language and shared identity of diverse recreation therapists in British Columbia?", was addressed primarily through open-ended questions. Examples of these questions included:

In your own words, how do you describe TR to someone who has never heard of it before?

- List 2 or more work tasks that fall within your description of TR.
- List 2 or more work tasks that you are required to do that fall outside your description of TR.
- What is it that you identify in yourself that makes you a recreation therapist?
- What values do you hold that help you in your work in the field of TR?

We included 2 close-ended questions to further explore questions of identity:

- Regardless of your work title, do you consider yourself to be a TRP, RT, or TRS?
- Do the work titles mentioned in the question above mean different things to you? (yes/no)

The intention was to gain an overall sense of RT job titles, understandings of their work and role, and to explore issues regarding professional identity and values. Due to the quantity of data collected, the survey questions that focused on certification, professional associations, and professional development, were not included in this analysis.

Data Analysis

Two therapeutic recreation degree students were hired as research assistants to manage, sort, and code the data. In total we had over 100 responses that resulted in 84 usable surveys. Frequencies were tallied for the close-ended responses to gain a sense of British Columbian RT demographics. Given how little is known about the profession in Canada and the sampling challenges we faced, we were unable to draw any meaningful comparisons to the TR profession in other Canadian provinces.

We applied a content-analysis approach to analyze the text data (Hsieh & Shannon, 2005). Open-ended text responses were coded descriptively with the iterative development of code books for each question. We drew on various analytic frameworks to develop the codebooks. The question "How do you describe TR to someone who has never heard of it before?" was broadly divided into three codes: population served; process (APIE, holistic approach, purposeful intervention, choice, and adaptation); and purpose (recreation as a means to an end, recreation as an end in itself) (Adams et al., 2008). The question that focused on identity was descriptively and inductively coded. Finally, we used Schwartz's (2005, 2010) basic human values theory to guide our coding of the question on values. Refer to Table 1 for an overview of Schwartz's theory. In all cases the text data drove the analysis, meaning that we began with a descriptive coding process and adopted and adapted the frameworks that were the best fit.

Responses that were ambiguous or unclear were brought to the Research Network for further examination and definition. As a community-based researcher with training in health promotion, the lead author relied on members of the Network to check the accuracy of the analysis and the portrayal of the TR profession in BC. Members of the Network were also instrumental in uncovering unpublished reports from health agencies as well as peer-reviewed articles for the literature review.

Table 1

Schwartz's (2005, 2010) Basic Human Values Theory

Basic human value	Definition	Dimension	Description
Self-direction	Independent thought and action; choosing, creating, exploring.	Openness to change	"values that emphasize independence of thought, action, and feelings and readiness for change"
Benevolence	Preserving and enhancing the welfare of those with whom one is in frequent personal contact (the "in-group").	Self-transcendence	"values that emphasize concern for the welfare and interests of others"
Universalism	Understanding, appreciation, tolerance, and protection for the welfare of all people and nature.	Self-transcendence	"values that emphasize concern for the welfare and interests of others
Achievement	Personal success through demonstrating competence according to social standards.	Self-enhancement	"values that emphasize pursuit of one's own interests and relative success and dominance over others"
Hedonism	Pleasure and sensuous gratification for oneself.	Openness to change and self-enhancement	"values that emphasize independence of thought, action, and feelings and readiness for change"
Security	Safety, harmony, and stability of society, of relationships, and of self.	Conservation	"values that emphasize that emphasize order, self-restriction, preservation of the past, resistance to change"

Findings

The State of TR Practice in BC

The demographic data that were collected through close and open-ended questions addressed the first research question of providing an overview of the state of TR practice in BC. In response to the survey question regarding job title, 64 respondents clicked one of the job titles in the drop-down menu provided. Table 2 captures the range of responses to the job titles provided. Twenty (20) respondents filled in the 'other' box, citing job titles such as recreation practitioner, practice leader, community services coordinator, leisure access counselor, aquatic therapist, volunteer services manager and discipline leader. Nineteen percent (n=16) of respondents had supervisor, manager, or leader as part of their job title, the majority of whom had more than 14 years work experience. Twenty percent (n=17) of respondents indicated that they were NCTRC certified and almost 80% (n=66) were not.

Fifty-seven percent (n=47) of respondents worked with older adults, 32% (n=27) in mental health, 8% (n=7) in physical rehabilitation and disabilities, 2% (n=2) with children and their families and 1% (n=1) in forensics. There was a broad but expected range of responses regarding work context and setting, including long-term residential care and assisted living, community mental health, inpatient psychiatric care, and day programs. Sixty-eight percent of the respondents resided in the Metro Vancouver area.

Table 2

Recreation Therapists' Job Titles

	Response Count	Response Percent
Recreation therapist	42	65.6
Recreation worker	6	9.4
Program coordinator	3	4.7
Recreation programmer	3	4.7
Activity worker	2	3.1
Recreation coordinator	2	3.1
TR practitioner	2	3.1
Activity aid	2	3.1
Recreation assistant	1	1.6
Activity coordinator	1	1.6

Note. n=64

Other relevant research participant demographics that were gathered focused on education and years of experience. Tables 3 and 4 capture the recreation therapists' highest level of education and years of work experience in TR.

Eighty-three (83%) percent of respondents had more than 4 years work experience in TR. This survey question allowed for two responses in order to capture the number of RTs upgrading their credentials. RTs who also indicated that they were currently a student were enrolled at Douglas College to earn an undergraduate degree in Therapeutic Recreation. Seven of the 8 students were part-time.

When analyzing job title by years of experience, there was a greater mix of titles for RTs with fewer years of experience, followed by coordinators and supervisors with a higher concentration of leaders and managers as years of experience increased. There were two significant trends regarding educational background, with the majority of participants with bachelor degrees having fewer than 11 years of experience while the majority of participants with diplomas had more than 14 years of experience (see Figure 1).

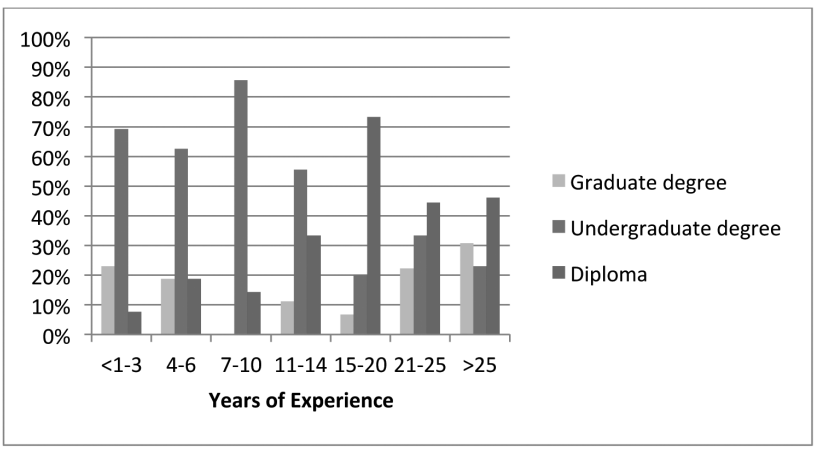

Figure 1. Years of Experience and Highest Educational Attainment

Table 3

Recreation Therapists' Highest Level of Education

	Response Count	Response Percent
Certificate	2	2.4
Diploma	29	34.9
Undergraduate Degree	38	45.8
Graduate Degree	14	16.9

Note. n=83. In the survey we did not ask respondents to specify the highest level of education in TR or a closely related discipline.

Table 4

Years of Work Experience in TR

	Response count	Response percent	Student Status
Less than 1 year	3	3.6	
1-3 years	11	13.1	1
4-6 years	17	20.2	1
7-10 years	7	8.3	2
11-14 years	9	10.7	
15-20 years	16	19	2
21-25 years	9	10.7	1
More than 25 years	13	15.5	1
Currently a Student	8	9.5	

Note. n=84

In reflecting on these data, members of the Research Network agreed that they were broadly representative of what they knew of the TR profession in BC. There is a wide range of job titles, the majority of jobs exist with older adults, an increasing number of younger and/or less experienced RTs have bachelors' degrees, and positions with manager, supervisor or leader in the title are held by RTs with more years of work experience.

The Language of TR

Survey questions focused on language and identity of TR professionals in BC attempted to address our second research question. Members of the Research Network discussed at length how the diverse settings in which RTs work created inconsistent language and descriptions of TR which in turn stymied the growth and acceptance of TR by other health practitioners. As a result, a central question posed in the survey was, "In your own words, how do you describe TR to someone who has never heard of it before?" Responses to this question were coded into three broad themes: (1) purpose of TR, including recreation or leisure as a means to an end and recreation or leisure as an end in itself; (2) TR process, including references to APIE (assessment, design, implementation, evaluation), a holistic approach, purposeful intervention, choice, and adaptation; and (3) population served, including references to people with disabilities, older adults, children and youth. Table 5 represents the major themes and their descriptions, frequencies and percentages.

Most responses to this question were double- or triple-coded, meaning that the majority of research participants described TR by connecting the themes identified. TR purpose was the most dominant theme with 34 responses single-coded and another 41 responses double- or triple-coded. Recreation and leisure as a means to an end, as "therapy" (Adams et al., 2009), was raised almost 4 times more often than leisure as "activity" (Adams

Table 5

Description of TR

Code	Description	Frequency	Percentage
PURPOSE		75	89.3
Recreation/Leisure as Means to an End	Any reference to: - Meeting needs - Increasing/enhancing health - Improving lifestyle - Maintaining/increasing quality of life - Increasing health/wellness - Increasing functional abilities - Increasing independence	63	75
Recreation/Leisure as an End in Itself or as an Activity	Any reference to: - Increasing leisure involvement - Enhancing leisure - Satisfying leisure lifestyle - Discovering leisure - Being in the moment - Pleasure in relation to leisure involvement	19	22.6
PROCESS		42	50
Holistic Approach	Any reference to: - Social, physical, cognitive, spiritual and emotional elements of individual's life	14	16.6
Purposeful Intervention	Any reference to: - Desired outcomes - Purposeful activities/interventions - Achieving goals through activities	12	14.3
Choice	Any reference to: - Leisure choice - Meaningful activity/leisure - Leisure Interests/Preferences/Desires	12	14.3
APIE	Any reference to: - All aspects of APIE process (assessment, design, implementation, evaluation)	3	3.6
Adaptation	Any references to: - Adapting activities	1	1.2
POPULATION SERVED	Any reference to: - Population served (people with disabilities, elders, special needs population, children, youth, families)	23	27.4

et al., 2009) or as an end in itself. Seventy-five percent of the respondents mentioned recreation and leisure as "therapy." Examples of participant responses included: "TR uses recreation as a treatment modality to help a person improve aspects of his/her health," "use of leisure and recreation to improve quality of life" and "purposeful planned recreation interventions chosen to bring about a specific health or wellness outcome." Recreation and leisure as "activity" was mentioned only 19 times: "I assist people in finding their comfort and enjoyment during their leisure time, and pursuing any recreational interests or goals." In only 7 instances did respondents refer to leisure and recreation in both ways, for example: "Assisting people to become engaged again in activities they are passionate about. Or the use of recreation to build connections, friendships, and belonging to one's community." The data seems to indicate that RTs in BC are moving toward using more therapeutic and clinical language to describe their work.

Population served was mentioned the least frequently, with only 1 response single-coded and 22 double- or triple-coded. One respondent wrote "design and delivery of programs and services to meet the needs of clients with disabilities." Similarly, TR process was only mentioned 3 times on its own, for example when a respondent wrote: "[TR is] holistic-based treatment that focuses on the whole person. I don't focus on what's wrong or the illness but what can be added to have a fulfilled life." Another participant linked population served and TR process when she/he wrote: "TR is the provision of client-centred (personally meaningful) activities for persons' with physical and/or cognitive disabilities and/or mental health issues, in order to achieve a therapeutic measure or outcome."

In sum, what the data revealed is that the language of TR, through asking for plain-language open-ended descriptions, was more consistent than expected. All responses could be thematically coded under population, process, and/or purpose. Although participant responses varied in terms of aspects that were emphasized and included, almost two-thirds of respondents described their work in language that can be characterized as clinical and technical.

Recreation Therapists' Identity

To deepen our understandings of the language of TR in BC we also asked research participants about preferred job title and distinctions made between the titles recreation therapist (RT), therapeutic recreation practitioner (TRP), and therapeutic recreation specialist (TRS). Across all years of experience (ranging from less than one year in the field to more than 25) over 72.6% of practitioners indicated that regardless of their current title they preferred RT whereas only 26.2% preferred TRP and 14.3% TRS. The research participants suggested that TRP was a job title for practitioners with a diploma and that their work was more "hands on" involving "no assessment." RT was "more clinical," involved "assessment" and likely required a degree. TRS connoted CTRS certification and was considered to be a newer and less familiar job title. In addition, when asked to list job tasks that they are currently required to do that fell both within and beyond their descriptions of TR, the three tasks listed most often that fell within their description of TR were program delivery, assessments, and individual program planning. Job tasks that were beyond their description of TR included personal care, housekeeping, and budgeting and fundraising. Interestingly an almost equal number of participants listed staff and volunteer management as within and beyond descriptions of TR. Altogether, these findings confirm that RTs in BC identify with being clinicians or therapists through using clinical language, performing assessments and delivering programs. Although the research participants had relatively clear and consistent understandings of the distinctions between RT, TRP and TRS, only half of them indicated that these terms actually meant different things to them.

When asked about how they identify with being an RT/TRP/TRS there was striking uniformity that can be broadly grouped into four themes: knowledge, desire to help others, passion for leisure and the profession, and a holistic, person-centred strengths-based approach. Knowledge was the most dominant theme and was mentioned by almost half of all participants. Desire to help others and passion for leisure and the profession were raised just over 30 times each, while the holistic, strengths-based, person-centred approach was raised 16 times. Notably the predominance of the "knowledge" theme is consistent with RTs reliance on technical and clinical language used to describe TR. Refer to Table 6 for representative quotations from these four thematic areas.

Recreation Therapists' Values

We felt it was also important to ask the research participants about their values. Spe-

Table 6

Recreation Therapists' Identity

Theme	Frequency	Percentage	Definition	Representative Quotations
Knowledge	41	35	References to formal education; knowledge; experience; professional skills and training	"getting my degree in TR" "very resourceful, good communication skills" "using therapeutic programs to create change within the individual" "vast knowledge of benefits of leisure and recreation participation" "my specialized training"
Desire to Help Others	30	25.5	References to personality traits such as caring, loving, compassionate, empathic; desire to empower, help, motivate or support others; advocacy	"the love of making people happy" "commitment to support and advocate for my clients" "be helpful, love working with seniors, being supportive" "love of people, compassion, and ability to engage"
Passion for Leisure and the TR Profession	30	25.5	References to leisure lifestyle; leisure and recreation as a component of health and wellness; right to leisure; TR profession and philosophy; professionalism	"healthy living and the idea that you have a choice in your leisure" "passion for the field of RT" "belief in the value of leisure" "passion for leisure and [I am] someone who walks the talk in participating in all domains of leisure and people know that about me"
Holistic, Person-centred and Strengths-based Approach	16	14	References to the "whole" person and domains of wellness; person-centred / individualized care; clients' strengths and abilities; seeing people beyond their disability	"seeing the person as a whole and not what's wrong with them but what's positive" "looks at big picture, identifies individual's strengths and abilities" "[helping] others maintain their quality of life in all domains of their wellbeing" "I maintain their [clients'] dignity by setting them up for success. I give choices with boundaries to enable positive results"

cifically we asked "what values do you hold that help you in your work in the field of TR?" Respondents used diverse terms to describe their values. We grouped these terms according to the underlying meaning and chose a value word that represented each theme. Table 7 reports the coded responses to the open-ended responses to the question focused on values in TR.

Self-determination and benevolence were the most dominant values raised by respondents. The value of achievement and professionalism was raised less often. Conversely, in response to the survey question focused on identity, knowledge and experience was the strongest finding.

Discussion

One of the TR Research Network's primary motivations for engaging in collaborative research was to better understand the state of TR practice in BC. Findings suggest that the majority of respondents lived in the Metro Vancouver area and over half of them worked with older adults. There were wide discrepancies in educational level and job title among RTs in BC. The range of job titles reported was consistent with findings from a project conducted in the Fraser Health Authority[5] that found a total of 20 different job titles (Adams et al., 2008). The younger and/or more inexperienced RTs had, in general, higher credentials since the only TR degree program in BC has existed for just over seven years. What these data suggest is that despite BCTRA and Douglas College driving the ongoing professionalization of TR in BC, it is still a relatively young profession that is experiencing ongoing growth, development and change (David, 2010).

Interesting research findings arose when examining the language used by RTs to describe their work and the profession. Regardless of educational background, years of professional experience or job title there was significant consistency in language and identity among RTs in BC. The majority of respondents used clinical and technical language to describe TR as a modality that uses leisure and recreation as a "means to an end." Additionally, although respondents had relatively clear and consistent understandings of the distinctions between RT, TRP and TRS, only half of them indicated that these terms actually meant different things to them in the first place. Respondents distinguished the titles

Table 7
Language and Identity in British Columbia

Theme	Frequency	Keywords From Research Participants
Self-determination	57	choice, autonomy, freedom, respect for diversity, individuality, uniqueness, intuition, human potential, strengths-based, self-determination, hope, optimism
Benevolence	53	relationships, empathy, kindness, care, compassion, helpfulness, attentiveness, love, understanding, support
Inclusion and rights	43	fairness, equality, inclusion, open-mindedness, empowerment, right to quality of life and leisure, advocacy
Achievement and professionalism	31	discipline, knowledge, skills, education, professionalism, ethics, quality, commitment, motivation, organization, efficiency, leadership, assertiveness, critical thinking, accountability
Leisure and pleasure	20	humour, fun, leisure, recreation, benefits, balance, wellness
Integrity	19	honesty, integrity, trust

[5]The Fraser Health Authority is one of 5 geographic health regions in British Columbia.

with differences in educational background rather than with philosophical debate (Skalko, 2009) or the therapy setting (Wozencroft, 2009). It appears that, as Adams et al. (2008) argued, the philosophical discussions in the US mired in debating "therapeutic recreation" and "recreation therapy" language (Wozencroft et al., 2009; Skalko, 2009) are less salient to RTs in BC.

When asked about identity, RTs emphasized knowledge and professionalism but when asked about values the notion of self-determination was more dominant. When drafting the survey questions, members of the Network discussed at length whether RTs would respond to the question of identity by reflecting on their values. What is evident here is that in responding to the notion of identity RTs emphasized their knowledge and expertise, but when reflecting on values the notion of self-determination (i.e., strengths-based, choice, and autonomy) was more dominant.

In mapping these findings on Schwartz's (2005, 2010) framework, new ways of thinking about TR identity and values are revealed. TR values of benevolence, inclusion, and rights, consistent with Schwartz's self-transcendence dimension, directly oppose the self-enhancement dimension where TR identity and values of achievement and professionalism fall. Although data frequencies from this question suggest the predominance of the self-transcendence dimension, when considered with findings from other questions a more startling conflict emerges. Data from questions on language and identity created a clear picture of RTs using clinical and technical language, preferring a title that connoted higher credentials and identifying strongly with their expertise, skills and knowledge base—all of which align with the self-enhancement dimension (Schwartz, 2005). Fundamentally, the motivational goals of these conflicting dimensions —self-enhancement emphasizing pursuit of self-interests and self-transcendence involving concern for the welfare and interests of others—can lead to conflicting standards, criteria, and actions (Schwartz, 2005) within the TR profession.

Importantly, this conflict in values is only tenable if one accepts Schwartz's (2005) model; indeed it is possible that humanistic and individualistic values are not oppositional for professionals who want to be well compensated and respected for their work in helping others achieve their wellbeing. Yet Schwartz's model reminds us that there is a strong tendency for these values to conflict, a tendency that is also noted in detail in Carruthers and Hood's description of the challenges of upholding TR's strengths-based values and approach (Carruthers & Hood, 2007). Given the predominance of more medical and clinical approaches to service provision and positivist research, it is understandable that a profession with strong humanistic values can compromise them in order to be more highly respected (Carruthers & Hood, 2007). The authors postulate that the ongoing desire for greater legitimacy despite increased professionalism (Alsbury, 2010) and the continual struggle to articulate a philosophical vision (Skalko, 2009; Wozencroft et al., 2009) may stem from the tension between the profession's humanistic and individualistic values.

Many TR scholars in Canada and the U.S. argue that TR's professionalization and legitimacy rely on settling its philosophical debates (Skalko, 2009; Wozencroft et al., 2009; Sylvester, 2002). As illustrated in this study and elsewhere, TR is a highly diverse profession with a wide range of community and institutional contexts and client groups. TR is "characterized by eclecticism, or the utilization of approaches from various theories depending on the needs of particular clients" (Strassle, Witman, Kinney & Kinney, 2011, p. 116). The process of professionalization itself involves excluding those who do not fit pre-determined criteria while imposing strict philosophical and practical guidelines (Welsh, Kelner, Wellman & Boon, 2004). Alsbury (2010)

proposes "generative professionalism" as a radically new way of thinking about emerging professions (p. 35). She argues that in diverse, practice-based fields such as child and youth care, professional identity is not fixed, rather it is "constituted and reconstituted through the various discursive practices in which they participate" (Alsbury, 2010, p. 32). Perhaps a stable, internally coherent professional identity is not the goal for the TR profession. In embracing the fullness and complexity of the field it is possible that alternate ways of professionalization, and the legitimacy of the profession, may emerge.

Although the professional identities of RTs in BC are cohesive, they are not static; as the field continues to emerge and evolve through its life cycle (David, 2010), in its diverse contexts, and with influence from external contextual factors, so too must the field remain flexible about how it envisions its professionalization. This involves remembering where the field has been, where it is currently, and then clearly envisioning a path to the future. Everyone—including new graduates with degrees and CTRS certification as well as those working in the field for 25 years with a diploma—has a role to play in shaping the future of the profession.

Almost 20 years ago Velde and Murphy (1994) called for TR in Canada to adopt its own TR philosophies rather than adopting those from the US. This research project is the first in BC to begin to articulate some key issues for the profession as well as to document its language and identity. More of this kind of work needs to be completed to bolster and advance the profession. The broad implication for RTs from this research, to other Canadian provinces and to the US, is that a crucial part of their role on health care teams is to advocate for the profession and to find new ways to bring the work into clinical and community settings. With the increasing number of highly credentialed RTs there is the opportunity to move into nontraditional work settings, to take on evaluation and research roles, and to help other health professionals better understand the value of TR.

Implications and Recommendations

There are four major implications and recommendations from this research project: (1) bring consistency to the language of TR, (2) adopt CBR approaches to generate practice-based evidence, (3) apply a strengths-based perspective to build the profession, and (4) pursue research opportunities in BC.

Bring Consistency to the Language of TR

Although philosophical debates in the U.S. are mired in opposing characterizations of recreation therapy versus therapeutic recreation (Wozencroft et al., 2009; Skalko, 2009) these debates have not been taken up to the same degree in Canada. Our findings suggest that almost two-thirds of RTs in BC prefer the title "recreation therapist" and that they are increasingly using more clinical and technical language to describe their work. Seventy-five percent of the respondents described TR as "therapy"—using recreation and leisure as a means to an end—rather than TR as "activity," recreation or leisure in and of itself. In BC inconsistency in professional language adds to the perceived sense of insecurity within the field and to the confusion and lack of clarity in terms of roles and responsibilities of RTs that exists among professionals, employers and clients.

Language consistency might be achieved by (1) regulating the profession in BC; (2) increasing evidence-based practice within the profession; (3) keeping practitioners up to date by creating more opportunities for professional development; and (4) bringing more language consistency to educational institutions, professional associations, and work places (e.g., in 2003, the BCTRA and Douglas College adopted the title Therapeutic Recreation Practitioner (TRP), however the major-

ity of job descriptions in BC have RT in the title and most professionals prefer the RT title.

How the RTs describe TR may represent their ideal, or "hoped for" future and not necessarily what they currently experience at work. Although RTs have a fairly unified description of TR, ongoing political and economic factors such as budgetary constraints broaden their work roles, resulting in many RTs performing tasks that do not fall within their descriptions of TR. Bringing greater language consistency to the profession and clarity around its philosophical position can only help advance how it is understood by others in the allied health professions as well as the general public. Developing standard descriptions of the profession and bringing these into job descriptions and union classifications will build the profession from the bottom-up.

Adopt Community-Based Research Approaches to Generate Practice-Based Evidence

This study reveals a TR profession in BC that identifies with clinical language, a strong knowledge base and credentials, and honouring values of self-determination, benevolence, inclusion and rights, achievement and professionalism, leisure and play, and integrity. The application of Schwartz's (2005, 2010) framework of basic human values revealed a potential conflict in the field. As stated by respondents in this project, TR self-determination values of being strengths-based, holistic, and person-centred are unequivocally fundamental to the field. What was also revealed was the importance of knowledge, achievement and professionalism.

TR assessments and interventions must be evidence-based. However, testing the validity of TR work does not singularly define the research that should be done within the profession. CBR is not a particular research method, rather it is an "orientation to research" with a heavy emphasis on "issues of trust, power, dialogue, community capacity building and collaborative inquiry" (Minkler & Wallerstein, 2008, p. 6-7). Despite its ongoing philosophical debates, the field of TR in Canada strongly embraces its values of self-determination. Iwasaki et al. (2010) argue for a more balanced, holistic/ecological and humanistic orientation for research and practice "to bring attention to the wholeness of the individual in his/her life" (p. 10). CBR, which brings together diverse partners and actively involves them in all phases of the research, is an ideal research approach for honouring these deeply held TR values. To generate evidence to support the important TR work being conducted day-to-day in the field we argue that the field needs to engage in practice-based evidence through aligning with a CBR orientation. The field requires a range of high-quality research evidence generated through diverse research designs and approaches—from clinical research to highly qualitative research. Not only will this engage RTs meaningfully in producing knowledge to support their practice, but the inherent values of the TR profession will be honoured and upheld.

As a profession we must find ways to move forward that are consistent with the values of the profession so that internal conflicts no longer hamper the growth of the field. This means embracing and centering the growth of the TR profession from its strong humanistic values and finding the most appropriate, internally consistent methods for doing so, such as more collaborative and participatory approaches to research that generate practice-based evidence.

Apply a Strengths-Based Perspective to Build the TR Profession

Study findings provide a portrait of a more unified than stratified profession, built on a solid base of values and coherent sense of identity, supported by a strong knowledge base and sense of professionalism. These findings reveal the field's strengths and capacities rather than its limitations and needs. What was originally framed as "the problem"—the diverse educational backgrounds, work set-

tings, populations and geographic locations of RTs—can instead be viewed as indicators of the profession's relevance, adaptability, and impact. We live in a time of rapid change and growth. Political, economic, and social contexts are shifting at unprecedented rates, often beyond our control. As we consider how TR grows as a profession, we need to acknowledge the profession's assets and strengths as well as its stage of development, while remaining mindful of external factors that will inevitably influence how the profession develops. If the language used with clients and others consistently reflects a strengths-based perspective of TR practice, it can transform the profession. A strengths-based profession and the associated language cultivates the full potential of the clients it services, the practitioner, and the profession itself (Baker, Greenberg, & Hemingway, 2006; cited in Carruthers & Hood, 2007, p. 278).

Pursue Research Opportunities in British Columbia, Canada

From this research study future research questions have emerged, including:

- Explore the role of educational institutions (Douglas College) and professional associations (BCTRA, CTRA) in shaping culture of TR in BC.
- Examine how current paradigm shifts toward evidence-based practice in the health care system affect client-centered care.
- Use qualitative research to explore unique and innovative ways of bringing consistency to professional language of TR with a range of stakeholders including Douglas College, BCTRA, unions, other allied health professionals and RT practitioners.
- Examine if professional language and identity are more consistent among RTs working within a similar setting and with a similar client group.

Study Limitations

One of the limitations of this study was the participant recruitment strategy. The Network was cognizant of the fact that not all RTs in BC are members of BCTRA. We therefore relied on the BCTRA listserve as well as snowball sampling through informal networks, which means that we don't know how many RTs across the province were contacted. It is possible that some respondents, who align themselves with TR values and practices, may not have had any formal education in TR. It is also possible that the ones who responded to our survey are the ones who are the most professionally active. Additionally, it was impossible to sample representatively across health regions of BC. As a result, we had a larger number of respondents from the Metro Vancouver area. In part this speaks to the "state" of TR in BC; although the BCTRA has been in existence for almost 20 years, membership is not mandatory. Currently there is no mechanism that reaches all RTs in the province. With the demographic information gathered from participants we felt the sample was representative of RTs in the province, although not absolutely certain. Our data collection method also presented some limitations. Since we used a qualitative online survey to collect data, there was no trained interviewer available to clarify questions when needed. It is also possible that some people decided against participating in the study or providing honest opinions due to confidentiality concerns related to an online data collection. Also, filling out an online survey might have allowed individuals to search for "the right" answer rather than an honest one. The design of the survey did not allow respondents to save their answers and return to them at a later time, which might have negatively impacted the number of submitted surveys. Another study limitation was the quantity of data collected. Given the number of survey questions and respondents, we had to make strategic decisions regarding our data analysis.

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