Therapeutic Recreation Models of Practice

A Synthesis of Key Elements and Examination of Children’s Narratives of a Camp Experience for Evidence of These Elements

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Abstract: Therapeutic recreation (TR) has emerged as a popular form of psychosocial intervention for individuals affected by chronic illness. The present study aimed to develop a synthesized representation of the key conceptual elements espoused within TR models of practice and to explore the narratives of children, who have attended a TR-based camping program for children with chronic illness and their siblings, for evidence of these elements. A review of three prominent models—the Leisure Ability Model, the Health Protection/Health Promotion Model, and the TR Service Delivery and TR Outcome Models—highlighted 20 key elements, which were delineated into the categories of Targets, Processes, and Outcomes. Semi-structured qualitative interviews were conducted with nine children (age range: 7–14 years, $M=10.11$, $SD=2.15$), who had participated in a TR-based camping program at Barretstown in Ireland. The findings of a deductive analysis showed a high level of corroboration for the key elements within the synthesized model, and provide some preliminary empirical support for the presence of these elements in TR-based practice. Future research directions included further exploration of the theoretical and empirical contexts which underlie TR, and investigation of potential differences in the TR experience of children who are ill, and physically healthy siblings.

Keywords: therapeutic recreation, chronic illness, models of practice, children’s experiences

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Medical advances over the past few decades have greatly diminished the risk of fatality associated with life-threatening conditions such as cancer, AIDS/HIV, renal disease, and diabetes, and consequently, such illnesses are now generally considered more chronic in nature (Kiernan, Gormley, & MacLachlan, 2004). It is well established within the literature that childhood chronic illnesses have the potential to significantly impact the psychosocial well-being of children who are ill and their families (e.g., Barlow & Ellard, 2005; Pinquart & Teubert, 2012). In response to the diverse range of challenges in coping with the effects of chronic illness, which include physical, psychological, social, and academic sequelae, intervention programs have steadily evolved to address both medical and psychosocial elements (Hunter, Rosnov, Koontz, & Roberts, 2006). Given the chronic nature of illnesses, psychosocial interventions commonly focus on facilitating long-term adjustment (Kiernan et al., 2004).

In this vein, therapeutic recreation (TR) camping programs have emerged as a prominent form of intervention for addressing the psychosocial impact associated with childhood chronic illness (Hancock, 2011). A recent paper by Allsop, Negley, and Sibthorpe (2013) considers the literature on summer camps and TR programs to build a rationale for expecting programs combining these elements to have a positive impact on the social functioning of children affected by serious illness. At the same time, studies such as those by Kiernan and colleagues (2005) have provided evidence for an impact at the psychological level. In addition, the empirical literature has also considered the benefits of these types of programs for siblings and parents (Hancock, 2011). It is not surprising then that such specialized camping programs have become particularly prolific. For example in the United States, there are over 280 accredited camps for children with a variety of chronic illnesses and over 100 camps for children with cancer (Wu, Prout, Roberts, Parikhshak, & Amylon, 2011). In addition, based on the models of their American counterparts, such camps have also become more prevalent in Europe (Kiernan & MacLachlan, 2002).

The empirical context surrounding the efficacy of TR and TR-based programs continues to develop a burgeoning body of support (Kiernan et al., 2004), with the general summation emanating from review studies suggesting that camping programs show positive therapeutic effects (e.g., Epstein, Stinson, & Stevens, 2005; Martiniuk, 2003). However, within the theoretical background of the field, there is enduring debate surrounding conceptualizations of TR, and conflicting viewpoints around the nature and orientation of TR services (Kunstler & Daly, 2010).

Historically, the field of TR has been characterized by a struggle for a consistent and distinctive identity, and a division between clinical and non-clinical philosophies (Austin, 2002). In the attempt to harmonize and progress the conceptual foundation of TR, a number of practice models have been proposed. Significantly, the practice of TR predates the theory of TR, with models of practice being applied reactively to a field that existed in various forms long before it was subjected to empirical justification (Mobily, 1999). As such, the development of TR practice models represents a bridging between philosophy, theory, and professional practice, and reflects the endeavor to define what TR is, and what it could be (Kunstler & Daly, 2010; Mobily, 1999). Accordingly, TR practice models aim to describe and direct the practice of TR.
and play a significant role in advancing the theory and practice of TR by providing an explicit conceptual framework for the delivery of TR services (Austin, 1998, 2002).

The Present Study

Although practice models have been influential in shaping the architecture of TR, they are largely based on theoretical and practical knowledge, rather than empirical appraisal (Mobily, 1999). The present study aimed to develop a synthesized representation of the key conceptual elements espoused within TR practice models, and to examine whether these elements are evident in the perspectives of children with a chronic illness and their siblings (given the evidence for the potential for both groups to benefit from these types of programs), who had attended a self-identified TR-based camp. The process of examining children's narratives deductively for evidence of conceptually-derived elements of TR models allows for an initial enquiry as to the presence of these elements in practice.

Synthesis of Practice Models

Within the initial phase of the present study, the aim was to identify key elements contained in prominent TR practice models, and to develop a synthesized representation, which could be suitably operationalized to facilitate empirical exploration of these elements in children's narratives of a TR-based camp experience.

Method

A review of the literature was undertaken to identify practice models of TR. Within the scope of the present study, critical focus was applied to three of the most prominent models: the Leisure Ability Model (LAM; Stumbo & Peterson, 1998), the Health Protection/Health Promotion Model (HP/HPM; Austin, 1998), and the TR Service Delivery and TR Outcome Models, which are considered as a unitary model within the present study (TRSD/TSOM; Van Andel, 1998). The content of these models was critically reviewed by the first author to facilitate identification of key elements, and integrated into a synthesized representation, which was reviewed by both researchers.

Synthesized Representation of the TR Practice Models

In the endeavor to juxtapose the three models identified above, key elements were delineated into a number of categories: targets, processes, and outcomes. These key elements were incorporated into a synthesized representation of the TR practice models, as illustrated in Figure 1.

![Figure 1. Synthesized representation of the key elements in the TR practice models.](image-url)
The elements on the left of Figure 1 represent the category of Targets, in that the models suggest that TR acts upon these constructs. The LAM suggests that the psychological basis underlying the behaviors of individuals with disability and/or illness is affected by the process of learned helplessness, that is, the perception that environmental events are outside of personal control, which leads to passivity or avoidance in attempting to effect changes or outcomes. This construct is particularly pertinent for individuals with disability and/or illness as their developmental context is often characterized by others effecting outcomes on their behalf and structured around routines (Stumbo & Peterson, 1998). The HP/HPM maintains that individuals who have encountered threats to their health experience a loss of control which in turn leads to helplessness. Therefore TR services should initially target these elements as precursors to health restoration (Austin, 1998). While the TRSD/TSOM does not set out explicit targets, the model advocates diagnosis and assessment of client needs in order to consider what areas should be targeted.

In the center of Figure 1, the elements that make up the Processes espoused within TR practice models are demarcated into three constituents: Concepts, Operations, and Effects. These constituents illustrate the systematic framework of TR processes outlined by the models, and present TR processes as cyclical in nature. Concepts emerge as a central feature across all three TR models and represent the theoretical foundations that underlie the processes described by models. The concepts included in the LAM are expressed in overt terms, while the HP/HPM details them in a less explicit manner. However, both models incorporate five interrelated concepts; intrinsic motivation, control, personal causation, choice/perceived freedom and flow. The TRSD/TSOM also includes the elements of intrinsic motivation, control, and choice/freedom, and organizes these concepts not just in terms of TR processes, but as the pivotal characteristics which differentiate leisure and non-leisure experiences. Within a TR service delivery context, the TRSD/TSOM proposes that the concepts of perceived freedom and perceived constraint may converge during the TR experience, and the clients’ motivation may vary between intrinsic and extrinsic at any given time. Thus, the experience of clients may also oscillate depending on the dynamic interaction of these variables.

As illustrated in Figure 1, a further constituent within the category of processes is that of Operations. Here, operations represent the functional basis of processes, through which, the conceptual elements become manifest. Relative uniformity among the models is evident in terms of the continuum-based, linear structure of services (Mobily, 1999); the LAM proposes three service categories (treatment, leisure education, and recreation participation); the HP/HPM is also comprised of three components (prescriptive activities, recreation, and leisure); and the TRSD/TSOM includes four areas within the scope of services (diagnosis/needs assessment, treatment/rehabilitation, education, and prevention/health promotion).

While the HP/HPM arranges the component of prescriptive activities in the aim of energizing clients by increasing their sense of control, both the LAM and the TRSD/TSOM initially prescribe a treatment component that aims to address functional limitations which may hinder involvement in other processes. Both of these models also set out an edu-
cation component which is tasked with the development of skills, knowledge, and attitudes. A point of departure within this common educational component is that while the TRSD/TSOM emphasizes educational strategies centered on improving health and quality of life, the same component within the LAM focuses on education relevant to leisure participation, particularly in relation to control, causality, and choice.

A service component common to both the LAM and the HP/HPM is recreation. Within both models, this component involves structured activities set in a context of fun, which affords clients the opportunity to participate in intrinsically motivated recreation experiences, and thereby practice newly acquired skills and develop competence and mastery. The HP/HPM also includes the further component of leisure which gives clients self-determined opportunities to use their abilities to overcome challenge. Challenge also represents a significant operational element espoused within the LAM, as it is proposed that for individuals to achieve optimal experience (flow), while simultaneously promoting intrinsic motivation, the level of challenge presented by activities should be set slightly above the client's perceived skill level.

In line with the continuum-based conceptualization of the nature of services, the models also share a continuum-based viewpoint around the degree of control exerted by the TR specialist (Mobily, 1999). The LAM describes the progression of the TR specialist’s role as transitioning from providing professional judgment and guidance with little client input (therapist), to teaching new knowledge and skills (instructor/advisor), to a position where they are no longer in charge per se (facilitator/supervisor). A comparable progression is evident in the HP/HPM, which describes that as clients move towards higher levels of health; they become less dependent on the TR professional, and ultimately, can function relatively independently. Similarly, the TRSD/TSOM acknowledges degree of control as a necessary variable in the continuum of services, as a high level of control is required during the diagnosis/assessment component, with clients’ level of control gradually increasing during subsequent components. In the models, the TR specialist is not only an active agent in TR processes, but in effect; degree of control becomes a means in and of itself in operationalizing theoretical elements such as choice, freedom, and perceived constraint, and in contributing to the achievement of outcomes.

The final constituent within the category of TR processes, Effects, is produced through the accumulation of conceptual and operational elements. The effects of processes indicated within the models stem from a number of sources. The TRSD/TSOM suggests that leisure experiences produce feelings of enjoyment and states clients become empowered through the dynamic relationship of service components and the progressive degree of client control. Similarly, the HP/HPM attributes the development of empowerment and the outcome of enjoyment to leisure experiences. Also within the HP/HPM, it is purported that leisure experiences lead individuals towards feelings of bolstered self-efficacy. Feelings of accomplishment are referenced within both the HP/HPM and the LAM, and are attributed to overcoming challenges by the former and to a sense of personal causation in contributing to outcomes by the latter. Finally, self-determination is a construct which is interwoven into the conceptual basis and operational constructs in both the HP/HPM and the LAM. These models
advise that clients are afforded the freedom, choice, and education to be self-determining, which transitions to being an effect of TR processes as clients begin to assume the responsibility associated with making independent, self-determined choices.

As depicted on the right-hand side of Figure 1, Outcomes represent the final category identified within the TR models. The framework of the LAM proposes that the overarching outcome of TR is a leisure lifestyle, which is described as the “day-to-day behavioral expression of one’s leisure-related attitudes, awareness and activities revealed within the context and composite of the total life experience” (Stumbo & Peterson, 1998, p. 83). In contrast, the HP/HPM proposes that “the mission of therapeutic recreation is to use activity, recreation and leisure to help people deal with problems that serve as barriers to health and to assist them to grow toward their highest level of health and wellness” (Austin, 1998, p. 144). The TRSD/TSOM positions a sense of well-being as the primary outcome of TR, with well-being referring to the satisfaction of health needs, and social, spiritual, aesthetic, and intellectual experiences and expressions (Van Andel, 1998, p. 185).

Therefore, although the orientations of TR services espoused by the models are philosophically divergent, the desired outcomes promoted within each of the models reflect movement towards an optimal state of being (Mobily, 1999). Within the LAM this state is a leisure lifestyle, within the HP/HPM it is high-level wellness, and within the TRSD/TSOM it is a sense of well-being.

Summary

No single therapeutic recreation model has been described that satisfies the needs of all TR service providers (Williams, 2008). Despite concerns that existing models of practice are founded on ill-defined concepts, indistinct theoretical frameworks, unclear process components, ambiguous terminology, and lack operational definitions (Lee, 1998; Parker & Carmack, 1998; Ross, 1998), there is general consensus regarding the fundamental constructs which structure the practice of TR (Mobily, 1999). Considering the lack of evaluation of TR models of practice, a synthesized model provides a useful platform for integrating the key elements of TR practice models and empirically examining these elements.

Analysis of Children’s Narratives

The empirical literature has highlighted the potential for negative sequelae associated with the impact of chronic illness among children and siblings, as well as the contribution that TR-based camping programs can make in alleviating this impact. This phase of the study aims to examine children’s narratives following participation in a TR-based program for the key elements of TR models that emerged in the initial phase of the study.

Method

Research design. The present study employed a qualitative research design, which aims to understand and represent the experiences and actions of people as they encounter, engage, and live through situations (Elliot, Fischer & Rennie, 1999). In spite of the assertion that the optimum method of eliciting and understanding a child’s perspective is to ask the child themselves (Alderson, 2000), few studies have adopted a qualitative approach when exploring the camp experience of children.

Research context. The present study was conducted in conjunction with Bar-
Barretstown (www.barretstown.org), an Irish charity, which has developed a suite of TR-based camping programs for children and families coping with serious illnesses. Barretstown's programs operationalize elements of TR within a model of ‘Serious Fun’, whereby in a context of fun, clients participate in entertaining, exciting challenges; they experience success in overcoming these challenges; they reflect on their experiences and make discoveries about their true potential for confidence, self-esteem, independence and friendship (Kiernan & MacLachlan, 2002). While this program does not formally employ recreation therapists or implement individual plans based on an APIE process (e.g., see Carter & Van Andel, 2011), the organization has formally drawn on key principles of TR to inform the development of its programs. As such, it is reasonable to examine whether this form of TR-based programming shows evidence of the elements identified in the synthesis of existing models.

**Participants and sampling.** Purposive sampling (e.g., see Coyne, 1997) was used to identify a sample. The sample was recruited from children who had attended the most recent session of the Barretstown’s Brothers and Sisters Camp, where children who have chronic illnesses and their siblings attended the same camp together. While children from 26 families attended the camp, 14 families were contacted based on their geographical location. Of these four families agreed to take part. Nine participants took part in the study, five males and four females. The age of participants ranged from 7-14 years old (M=10.11, SD=2.15). The sample consisted of children from four families, with each family comprising of one child who had a chronic illness (with diagnoses consisting of oncological, immunological, and hematological conditions) and one or more children who were siblings of the child with a chronic illness. Within the total sample, six participants had previously attended a TR-based camping program on at least one occasion prior to attending the target program.

**Materials.** A qualitative semi-structured interview was utilized for the purposes of data collection. Semi-structured interviews offer a method of attending to lived experiences in a manner which simultaneously facilitates consistency and flexibility (Galetta, 2013). The interview schedule was composed in line with the age range of participants, and formulated to explore children’s lived experiences of the target program. The interview posed questions around the general camp experience, prominent aspects of the camp experience, and the areas of impact associated with the program. Specifically, participants were asked about their most salient memories, most enjoyable experiences, whether they would make any changes if they were the boss, if they had learned anything at camp, and how they would describe the camp to other people.

**Procedure.** Information sheets were provided to all potential participants. For families who agreed to participate, parents were invited to complete signed consent forms, and children were invited to complete signed assent forms. Data collection was conducted on a one-to-one basis in the participants’ homes. The length of interviews ranged from 17–52 minutes (M=32, SD=12.29). All interviews were conducted within three months of the participants attending camp. The timeframe for the completion of the interviews was influenced by the process involved in securing permission and ethical approval to conduct the study, and the practical issues involved in organizing data collection.
Data analysis. Data were analyzed using qualitative content analysis, which is a systematic, rule-based approach of analyzing qualitative data (Schilling, 2006; Shaw 1999). Given that the analysis was driven by concepts within existing models of TR, whereby a priori knowledge was applied to the data, a deductive content analysis approach was employed. Analysis was conducted in line with the procedure outlined by Mayring (2000): key elements were identified from the synthesis of models (see Figure 1); explicit definitions for each element were derived from the relevant source material; a coding agenda was developed; interviews were transcribed verbatim; a formative inter-rater reliability check was conducted with an external researcher, which highlighted that a number of areas did not meet the required level of 70% (Guerin & Hennessy, 2002); areas of agreement and disagreement were discussed with the external researcher in terms of definitional issues, epistemological positions, and individual interpretations, after which the coding framework was revised; and then a summative reliability was conducted, wherein the overall consensus-percent reached was approximately 76%. All data analysis was completed manually.

Findings

Within this section, findings are presented and interpreted within the context of the synthesized representation of TR practice models (as portrayed in Figure 1). The synthesized representation of the models identified two key Target elements, both of which were evident in the children’s interviews. Learned helplessness was present in four of the participants’ narratives. All instances of this category were apparent in reference to experiences outside of camp but extended into the camp experience in different ways. For example, a 14-year-old boy stated that being away from home was a difficult aspect of camp as his caregiver did “everything” for him at home. This participant articulated that during camp he felt slightly uncomfortable when attending camp as he felt that he couldn’t ask for things. However, for another 12-year-old boy, attending camp represented the opportunity to overcome learned helplessness. He stated “I used to thought that I can’t do anything cause the thing I have. Cause I wasn’t allowed do anything cause all the contact sports and all” but elaborated “I knew that I can do all that stuff and all” and “I thought that camp was going to be great fun.” Evidence of loss of control was present in three interviews, and is particularly reflected in the use of the word ‘had’ in the following quote discussing the impact of chronic illness, “I had to sleep over at my cousin’s cause my mam and dad were, my dad was at work and my mam was with my sister” (8-year-old girl). This category was also evident for another participant with a chronic illness, whose functional limitations meant that she sometimes had to call her parents for assistance when she needed to go to the bathroom. Interestingly, with the exception of one participant, evidence of learned helplessness and loss of control were exclusive to children with an illness. This would appear consistent with the context of the source material for these target-based elements as both the LAM and the HP/HPM orient TR practices towards individuals with disability and/or illness.

Moving on to the category of Processes within the synthesized representation of the models, the data were examined for the elements which encompassed Concepts, Operations, and Effects. To begin five key elements were identified as underlying Concepts. As presented in
Table 1, the findings presented evidence for all of these elements.

The participants’ narratives reflected a high level of intrinsic motivation during their camp experience. As illustrated in the sample quotes, intrinsic motivation was primarily deduced through inference regarding why the participant enjoyed engaging in activities. Choice/Freedom was evident in terms of the range of activities from which to choose (“There’s loads of games that you can do”), children being afforded the opportunity to choose between activities (“You got like to choose what activity you can do”), children actively making a choice of what to do (“Me and the boys picked the spy section”), and freedom within activities (“Yeah, but you don’t have to. You can just sit down at your table if you like”).

As illustrated in Table 1, the element of perceived constraint was also prevalent within the participants’ narratives. One 7-year-old boy encapsulated the nature of perceived constraint stating “It’s like if someone is forcing you to do that game. And if you have already done that game then you don’t really like it, and you have to go to that game, it’s not so good.” The participant elaborated, “But if you choose, its better,” highlighting his preference for choice/freedom over perceived

### Table 1

Overview of Findings Related to Elements within the Concepts of TR Processes

<table>
<thead>
<tr>
<th>Element</th>
<th>Sample Quote</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic Motivation</td>
<td>“The most I liked to do is bow and arrow” [And why was that so good?] “Because I like bow and arrow”</td>
<td>8</td>
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<tr>
<td></td>
<td>“It is good place because it had a lot of things to do and you are never sitting around, like you’re always bored at home”</td>
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<tr>
<td>Choice/Freedom</td>
<td>“You got to like choose what activity you could do. Everybody got to choose”</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>“You can leave whenever you like and just go to a different one”</td>
<td></td>
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<tr>
<td>Perceived Constraint</td>
<td>“We went around the whole village on the horse with a leader and she holds you on the horse, cause you’re not allowed to go on the horse on your own”</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>“But you have to bring a Cara (leader) with you cause you can’t just roam around on your own”</td>
<td></td>
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<tr>
<td>Flow</td>
<td>“There was a machine that you only put your finger in and it did, and you know, it did everything”</td>
<td>7</td>
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<td></td>
<td>“I like the canoeing the way you play that ‘ping pong’ game … it was kind of hard and easy”</td>
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<tr>
<td>Internal Locus of Control</td>
<td>“You had to keep your balance like, so you have to keep your balance and not fall, and try not to fall off”</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>“There was fake ducks in the water and you had to try and get them when they were in the water. And you had to throw them in the basket.”</td>
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<tr>
<td>Personal Causation</td>
<td>“There’s things on trees and if you jump, you get some”</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>“I could get them when I kept on trying”</td>
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</table>
constraint. Significantly, the simultaneous presence of both the aforementioned elements within the children's narratives provides support for the notion espoused with the TRSD/TSOM, which proposes that perceived freedom/perceived constraint may both be present at any given time during the TR experience.

Evidence of the conceptual elements of flow, internal locus of control, and personal causation were also interspersed throughout the children's narratives, particularly in instances related to engagement in activities. In the case of the first sample quote displayed in Table 1 for flow, the participant (9-year-old girl), was referring to making necklaces and bracelets, and stated although she had functional impairments, she was able to undertake the task as the machine made the process easier. As described within the LAM, flow was predominantly present in cases where the design of the activity specifically influenced the level of challenge, which corresponded to the individual's skill level. A number of children described cases where they felt responsible for their behavior when participating in activities and the outcomes of these behaviors were dependent on their own personal effort or decision-making, which displayed evidence of an internal locus of control. There was considerable conceptual overlap found between the categories of internal locus of control and personal causation. For example, the first sample quote outlined in Table 1 for internal locus of control was also interpreted as indicative of personal causation as it was viewed that the child (8-year-old girl) believed that she could personally influence the outcome of “not falling off” by keeping her balance.

Table 2 presents an overview of the Operations evident within TR processes across the TR models.

<table>
<thead>
<tr>
<th>Table 2</th>
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<tbody>
<tr>
<td>Overview of Findings Related to Elements within the Operations of TR Processes</td>
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</table>

<table>
<thead>
<tr>
<th>Element</th>
<th>Sample Quote</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing Competence/ Mastery</td>
<td>“Well when you start to get like a little bit better every time I went up like. I got closer shots then”</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>“I used to be afraid of heights, but when I started doing New Heights (an activity) I thought it was great fun now”</td>
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<td>Challenge</td>
<td>“It was just hard to get the target. It looked easy but it wasn’t that easy”</td>
<td>9</td>
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<td></td>
<td>[why was that so good?] “Cause it was like a challenge”</td>
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<tr>
<td>Degree of Control</td>
<td>“The Caras (leaders) were there and they said ‘It’s rest time at 2’, and we wouldn’t go asleep so we started jumping on the beds”</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>“I thought all the Caras (leaders) were nice to me. Let me do all the fun things and all”</td>
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</tr>
<tr>
<td>Development of Skills/Knowledge/ Attitudes</td>
<td>“You get three arrows and three goes to hit it and then you go back to the end of line and you just queue”</td>
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<tr>
<td></td>
<td>“We found it a bit easy cause we all worked together”</td>
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</table>
As depicted in Table 2, developing competence/mastery was reflected within all the children's narratives and was primarily present when participants were referencing their engagement in activities. The majority of participants' interviews also described the development of skills, knowledge, and attitudes. Participants described development of attitudes related to participation and decision making, and the development of a range of activity-related skills such as organization, cooperation and teamwork (as illustrated in the sample quotes in Table 2). Such areas of development correspond with the development of skills, knowledge, and attitudes contained within the education component outlined within both the LAM and the TRSD/TSOM.

Individuality was apparent in relation to challenge, as participants found different activities challenging. One participant expressed that he found archery difficult but that he got better at it. When asked how he got better, he stated, “You just start to get used to it” and suggested the analogy “It's like when I was learning how to drive a bike. I learnt how to drive a bike when I was four. Like it was sort of difficult, then you start to get used to it.” The level of challenge also appeared to be a significant factor; when participants perceived tasks to be too difficult, they were inclined to stop the activities.

There were examples in the narratives of children having a higher degree of control than staff and also staff having a higher degree of control than the children (see quotes in Table 2). The roles played by staff were closely aligned with the conceptualization outlined within the LAM, in that, camp leaders were described as instructors, who taught the children new knowledge and skills, and as facilitators, who assisted and supervised.

Table 3 displays an overview of the five Effects of TR processes identified in the synthesized representation of the models.

### Table 3
Overview of Findings Related to Elements within the Effects of TR Processes

<table>
<thead>
<tr>
<th>Element</th>
<th>Sample Quote</th>
<th>n</th>
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<tbody>
<tr>
<td>Enjoyment</td>
<td>“Oh it was deadly. Anytime we were doing the Guinness Record it was awesome”</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>“I enjoyed it because we were all sharing having fun”</td>
<td></td>
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<tr>
<td>Self-Determination</td>
<td>“You go out and do something, it can be anything. There’s a list though, and at lunch or dinner the day before, you get a stick and you have to stick it on this sheet and there’s a maximum number in each activity. It’s really good”</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>“If I was bored like I’d say ‘yeah,’ but if I was already playing a game, I’d just say no”</td>
<td></td>
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<tr>
<td>Accomplishment</td>
<td>“The record was 100 and we did 101”</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>“You had to make them that size and we got it that size”</td>
<td></td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>“I put up my hand more in school which I didn’t really do before”</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>“I knew that I can do all that stuff and all”</td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>“I don’t have to do something that I don’t want to do”</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>“Getting my say in the matter”</td>
<td></td>
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</tbody>
</table>
**Enjoyment** was evident in all interviews, and was the most prevalently coded element within the data. A large majority of examples of enjoyment were associated with engagement in activities, as evidenced in the sample quotes in Table 3. Significantly, all nine participants cited enjoyment in their concluding summary of the camp experience.

As reflected in the sample quote in Table 3, examples of **self-determination** were particularly palpable when participants described actively making a choice in what they did at the camp. However, the second sample quote for self-determination in Table 3 illustrates that it was also evident in experiences outside the camp as the participant described that he did not particularly like playing football and his quote indicated that if his brother asked him to play football his actions would be self-determined. A sense of **accomplishment** was also reflected within the children’s narratives, particularly in reference to successful performance in activities.

**Self-efficacy** and **empowerment** were present in examples both inside and outside of the camp experience. In reference to inside the camp experience, participants described developing bolstered self-efficacy in performing difficult tasks and overcoming fear, shyness and nervousness. This enhanced self-efficacy was also evident in subsequent experiences outside of the camp. Though examples of developing empowerment were not particularly widespread, two participants did describe that being away from home (10-year-old girl) and having the opportunity to try new things (12-year-old boy) led to developing a sense of empowerment. Inspection of the data highlighted that the outcomes of self-efficacy and empowerment were almost exclusive to the narratives of children with an illness. As with the case of target-based elements, such findings may point to differences in the TR experience for children who are ill and their healthy siblings, which are not reflected in the TR practice models.

In relation to the final category of the synthesized representation of the TR practice models, the spectrum of outcomes espoused within the models was reflected in the areas of impact which the participants associated with the camp experience. The contribution of the TR camp experience towards achieving a **leisure lifestyle** was the most frequently reflected outcome in the participants’ narratives (n = 7). Evidence of this element was typified by a 12-year-old boy who articulated, “Well, I’d never usually play football, but I usually go out the back garden now. And I play with my brother there.” Another participant stated that after enjoying arts and crafts at camp, he had started going to art club. While indications of further outcomes being met were less evident, **sense of well-being** (n = 4) and **high-level wellness** (n = 3) were also present in the children’s interviews. In examining the range of outcomes, there was considerable overlap between sense of well-being and high-level wellness, with both elements being reflected by children developing confidence, overcoming shyness, and gaining personal freedom during the camp experience, which extended into their family, academic and social lives in a variety of positive ways. Enhanced leisure lifestyles also contributed a sense of well-being and high-level wellness in the form of spending quality leisure time with family members and friends. In combination, the findings concerning outcomes indicate the potential of TR camping programs to have a positive impact on children affected by chronic childhood illness, and imply that such interventions may be
flexible enough to simultaneously incorporate the range of outcomes around leisure, well-being and wellness espoused within the three TR practice models.

**Discussion**

The objective of the present study was to develop a synthesized representation of the key conceptual elements proposed within prominent TR practice models and to explore the narratives of children, who had attended a TR-based camping program, for evidence of the elements.

In aggregate, the key elements comprised within the synthesized representation of the TR practice models (see Figure 1) were largely corroborated by the children's narratives. Although there was evidence of the Targets elements, they did not feature as prominently as most other elements. While their presence does provide some support for the inclusion of these constructs in TR practice models, it has been previously argued that focusing on such specific concepts may ignore the complexity of the impact of illness (Bullock, 1998). Furthermore, there does not appear to be an explicit link between these areas that the TR models aim to target and the psychosocial sequelae of chronic illness indicated within the empirical literature. In addition, the findings of the present study tentatively suggest that these elements may principally affect children who are ill. Given the empirical findings, which indicate that chronic illness has the potential to impact members of the family who are not ill (e.g., see Barlow & Ellard, 2005), and the expanding progression towards family-based psychosocial interventions (Meyler, Guerin, Kiernan, & Breatnach, 2010), priming TR services to target such constructs may also undermine the suitability of TR as a method of intervention for individuals who do not have an illness.

The concepts underlying the Processes of TR were well represented in children's descriptions of their camp experience. The presence of locus of control, personal causation, and intrinsic motivation, particularly in relation to engagement in activities, suggests that TR-based services could be in a position to utilize, and incorporate, these concepts.

The strong presence of TR processes' operations such as the development of competency, skills, knowledge, and attitudes within the children's narratives reflect both the theory outlined in the TR models (e.g. Stumbo & Peterson, 1998), and mirror the findings of previous research which has indicated that TR-based camps facilitate the learning of activity-related skills (e.g., Wu et al., 2011). Given this convergence between the theoretical and empirical contexts of TR, these elements would appear to represent fundamental components of TR-based camping programs. The findings also indicated that degree of control plays a key operational role in TR processes. Although this element is a common feature across TR practice models, little attention has been paid to the continuum of control within the empirical literature relating to TR services.

There was considerable inconsistency in terms of the effects of TR processes; while effects such as enjoyment, self-determination, and accomplishment presented with high incidence, elements such as self-efficacy and empowerment were less prevalent. The suggestion that self-efficacy and empowerment were effects predominantly experienced by children with an illness provides support for these elements within the models, but again, poses questions around the applicability of these elements in TR services.
which cater for individuals who do not have an illness.

Consideration of the Outcomes of TR also showed significant variability. The realization of a leisure lifestyle was described by a number of children but there was less evidence to support the notion of moving towards a sense of well-being or high level wellness. In combination, the findings of the present study and the findings of previous research (e.g., Epstein et al., 2005) support the potential of TR camping programs to have a positive impact on children affected by chronic childhood illness. Accumulatively, these areas appear diverse enough to manifest in physical, emotional, social and cognitive domains, which significantly, also represent prominent domains in which children affected by chronic illness experience adjustment difficulties (e.g., see Barlow & Ellard, 2005).

Critical Appraisal of Methodology

A key strength of the present study was the development of a synthesized representation of the TR practice models, which provided a platform to identify key elements in the practice-based theory of TR, and to examine children's narratives for evidence of these elements. That being said, the methodology employed to synthesize the practice models also presented a number of limitations. Although the synthesized model was reviewed by multiple researchers, it remains an interpretation of the models rather than a pure representation. Furthermore, it represents only three of the many TR practice models which have been proposed and is therefore not a comprehensive representation. Moreover, as the program at the center of the study does not include a formal TR assessment or an explicit ‘treatment’ component (as would be expected within the context of the APIE process), the children’s narratives cannot be expected to wholly embody the key elements in the models, for example those that relate to addressing functional limitations (e.g., see Van Andel, 1998).

In exploring children’s narratives around their TR-based camp experience, the use of a qualitative research design in conjunction with a child-centered approach afforded depth of perspective. Furthermore, the process of analysis was strengthened considerably by the inclusion of three researchers, which can serve to enhance clarity and accuracy (Guerin & Hennessy, 2002). However, considering that purposive sampling was used to recruit participants who had attended a recent camp for children and siblings, and camps structured in such a manner are significantly limited, the pool of potential participants to draw from was relatively small. Nevertheless, there was variation in the sample in terms of age, gender, children with different types of illness, and children without an illness, and therefore the insights gained from this group may possess a sufficient level of provisional theoretical generalizability (as per Sim, 1998).

Implications

Given the divide in perspectives surrounding the orientation of TR services is reflected in the TR practice models, and the areas of concern outlined by previous critiques of the models, a synthesized representation offers practitioners and researchers a useful framework of the key conceptual elements which underlie the theory-based practice of TR. Considering the paucity of empirical examination of TR practice models, the findings of the present study, which provide some initial support for the presence of the elements contained within TR practice models, point to a number of significant con-
 structs that may inform future theoretical considerations in this area. However, the implications considered here must be tempered by the fact that the program considered in the present study is TR-based rather than a formal TR program. That being said, the presence of these elements in the perspectives of children who attended the target program, may speak to the potential applicability of these TR concepts across different levels of TR interventions.

In terms of the practice-based models of TR, the present study, particularly given the methodological issues noted above, represents an exploratory starting point from which to base further study. In this respect, research which incorporates and empirically examines the elements in the wider range of TR practice models would provide a clearer and more comprehensive portrait of the key elements of existing models of practice. Such theory-driven research would contribute to further understanding of what it is that TR does, and what it can do, and ultimately augment the evidence base of theory-based practice. As the empirical findings within the present study may be representative of TR-based programs rather than formal TR programs, future research which aims to identify the presence of key TR elements in a formal TR program would provide more unequivocal support for these elements in TR practice.

Finally, previous research has emphasized the need for investigation of the TR experience from the perspective of siblings (Wellisch, Crater, Wiley, Belin, & Weinstein, 2006). Given the findings in the present study indicated that there may be differences between children who are ill and their siblings in terms of the key elements of TR practice models, future research which examines potential contrasts between these groups may lend further insight in the development of more inclusive models of TR practice.

**Conclusion**

The present study represents the attempt to synthesize, and empirically examine, the key elements which comprise prominent models of TR practice. Based on children’s narratives of a TR-based camp experience, the findings provide some initial support for the presence of the elements contained within the synthesized model. In discussing the findings within the wider context of TR, significant similarities and divergences are apparent between the theory-based and empirical landscapes. Therefore, the present research points to a number of areas where this gap may be narrowed in future reflection around the theory underlying the practice of TR.

**References**


