The Health Protection/Health Promotion Model

David R. Austin

This article describes the Health Protection/Health Promotion Model of therapeutic recreation. Following a brief introduction and an overview of the model, concepts that underlie the model are presented. Concepts included are the humanistic perspective, high-level wellness, the stabilization and actualization tendencies, and health. Next presented is a description of the various components of the model and information on utilization of the model in practice. The final sections of the article are concerned with the model's strengths and limitations and the continuing development of the model. Health, nursing, psychology, therapeutic recreation, and recreation and leisure studies literature are drawn upon for support of the model.

KEY WORDS: *Therapeutic Recreation, Model of Practice, Health Protection, Health Promotion*

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Conceptual models of therapeutic recreation provide explicit frames of reference to describe and direct professional practice. They are means for us to articulate what is distinctive about our profession. In this day of health care reform, it is especially critical that we are clear about our mission and are able to communicate our mission to clients and policy makers. Equally important is the role conceptual models play in directing practice. Therapeutic recreation practice

David R. Austin, Ph.D., CTRS, FALS, is Professor of Recreation at Indiana University Bloomington.

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models guide decision making for therapeutic recreation professionals and allow them to practice in a reasoned manner. I developed the Health Protection/Health Promotion Model to provide a comprehensive model for therapeutic recreation practice.

The Premise and Focus of the Model

The Health Protection/Health Promotion Model (Austin, 1996, 1997) stipulates that the purpose of therapeutic recreation is to assist persons to recover following threats to health (health protection) and to achieve as high a level of health as possible (health promotion). Under this model, "The mission of therapeutic recreation is to use activity, recreation, and leisure to help people to deal with problems that serve as barriers to health and to assist them to grow toward their highest levels of health and wellness" (Austin, 1997, p. 144).

Underlying Concepts

There are four major concepts that underlie the model. These are the humanistic perspective, high-level wellness, the stabilization and actualization tendencies, and health.

Humanistic Perspective

The Health Protection/Health Promotion Model rests on a humanistic perspective. Those who embrace the humanistic perspective believe that each of us has the responsibility for his or her own health and the capacity for making self-directed and wise choices regarding our health. Because individuals are responsible for their own health, it is critical to empower individuals to become involved in decision-making to the fullest extent possible. Further, under the humanistic approach, people are seen as being in a dynamic interaction with their environment in which they are both affecting their environment and being affected by it. They are active participants in the world, rather than passive puppets controlled by the environment. Finally, the humanistic perspective recognizes that people have the capacity for self-development throughout their lives. A key assumption is that each of us has a need to grow and to realize our full potential (Austin, 1997). As Murphy (1975) has stated, those possessing the humanistic perspective "seek to promote the capacity and ability of groups and individuals to make self-determined and responsible choices—in light of their needs to grow, to explore new possibilities, and to realize their full potentials" (p. 2).

Murphy (1975) went on to discuss how those who hold a humanistic perspective are accepting of their clients. He emphasized that those with a humanistic perspective are not judgmental but, instead, accept their clients as fellow human beings, with frailties and potentialities. Thus a caring, understanding attitude is displayed toward each individual client.

Further, the humanistic perspective holds that human beings are holistic. We are bio-psycho-social-spiritual beings whose parts may only be viewed in the context of the whole. Powell and Sable (1990), in an article on holistic health, have explained it is imperative to attend to all aspects of an individual when providing care. They particularly emphasize the importance of recognizing that each person has a unique make-up and each should be treated accordingly.

High-Level Wellness

The humanistic perspective also has provided a foundation for the high-level wellness movement. In 1961, Dunn defined high-level wellness as ". . . an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable" (p. 4). Dunn's concept of high-level wellness is a holistic approach that goes beyond the absence of physical illness to include both psychological and environmental wellness. The highest-level wellness is gained when we exist in a "very favorable environment" and enjoy "peak wellness"

(where illness and wellness are conceived along a continuum, with death on one end and peak wellness at the other). According to Ardell (1986), the aim of "well medicine" is to help clients move toward self-actualization. High-level wellness deals with health enhancement in contrast to the traditional medical model that concerns itself with treating disease. Thus the concept of high-level wellness goes beyond traditional medicine toward helping persons to achieve as high a level of wellness as they are capable of achieving (Austin, 1997).

There is a great amount of similarity between high-level wellness and therapeutic recreation (TR). Both have been heavily influenced by the humanistic perspective and both have striven to foster health enhancement and self-actualization. Although TR has long been concerned with illness, it has not restricted itself to disease. Instead, TR has historically attempted to promote the growth and development of clients.

Therapeutic recreation has been an ally of traditional medicine in attempting to alleviate illness. But TR has gone beyond this. Therapeutic recreation professionals have been similar to both leisure service professionals and physicians who practice "well medicine" in that they attempt to assist clients toward self-actualization. Therefore, TR professionals have concern for the full range of the illness-wellness continuum (Austin, 1997).

Stabilization and Actualization Tendencies

Underlying the Health Protection/Health Promotion Model are two motivational forces: the stabilizing tendency and the actualizing tendency. The stabilizing tendency is concerned with maintaining the "steady state" of the individual. It is an adaptation mechanism that helps us keep stress in a manageable range. It protects us from biophysical and psychosocial harm. The stabilizing tendency is the motivational force behind health protection that "focuses on efforts to move away from or avoid negatively valence states of illness and injury" (Pender, 1996, p. 34). The actualization tendency drives us toward health promotion that "focuses on efforts to approach or move toward a positively valence state of high-level health and well-being" (Pender, 1996, p. 34).

Health

King (1971) and Pender (1996) both reflect the stabilization and actualization tendencies in their definitions of health. King (1971), a nursing theorist, has written:

> [Health is] a dynamic state in the life cycle of an organism which implies continuous adaptation to stress in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living (p. 24).

Pender's (1996) definition of health also reflects the stabilizing and actualizing tendencies. Her definition of health follows:

> Health is the actualization of inherent and acquired human potential through goal directed behavior, competent self-care, and satisfying relationships with others, while adjustments are being made as needed to maintain structural integrity and harmony with relevant environments. (p. 22)

Health encompasses both coping adaptively and growing and becoming. Healthy people can cope with life's stressors. Those who enjoy optimal health have the opportunity to pursue the highest levels of personal growth and development.

Summary

The Health Protection/Health Promotion Model is then based on a humanistic perspective from which flows the assumption

that all human beings have an inherent drive for health and wellness that can be nurtured by nonjudgmental, caring professionals. The model takes a holistic approach consistent with the concept of high-level wellness and embraces the notion that we should strive not only to alleviate illness but to enhance health. In short, we should have concern for the full range of the illness-wellness continuum ranging from severe illness at one end to peak health at the other. More specifically, the model builds on the assumption that people have a stabilizing tendency that comes into effect when there is a threat to health (e.g., illness or disorder) and an actualization tendency that motivates growth enhancing behaviors leading to health promotion.

Under the Health Protection/Health Promotion Model, therapists* recognize that to help clients strive toward health promotion is the ultimate goal of therapeutic recreation. Further, therapists prize the right of each individual to pursue his or her highest state of well-being, or optimal health. TR practice is therefore based on a philosophy that encourages clients to attempt to achieve maximum health, rather than just recover from illness (Austin, 1997).

Description of Components

Under the Health Protection/Health Promotion Model, therapeutic recreation is a modality to help people to, first, restore themselves or regain stability following a threat to health (health protection), and, second, optimize their potentials in order that they may enjoy as high a quality of health as possible (health promotion). As illustrated in Figure 1, the Health Protection/Health Promotion Model has three major components that range along an illness-wellness continuum (with poor health on one end and optimal health on the other) that clients may enter at any point. The three components of prescriptive activities, recreation, and leisure are means through which therapeutic recreation clients strive to achieve health and wellness. Throughout the process, clients are encouraged to assume responsibility for themselves and to exercise as much personal choice as possible. As clients move toward optimal health, clients' choices increase while the control of the TR professional continually decreases until the point that clients assume primary responsibility for their own health, at which time the services of the therapist are no longer needed.

The Component of Prescriptive Activities

When clients initially encounter illnesses or disorders, often they become self-absorbed. They have a tendency to withdraw from their usual life activities and to experience a loss of control over their lives (Flynn, 1980). Research (e.g., Langer & Rodin, 1976; Seligman & Maier, 1967) has shown that feelings of lack of control may bring about a sense of helplessness that can ultimately produce severe depression. At times such as this clients are encountering a significant threat to their health and are not prepared to enjoy and benefit from recreation or leisure. For these individuals, activity is a necessary prerequisite to health restoration. Activity is a means for them to begin to gain control over their situation and to overcome feelings of helplessness and depression that regularly accompany loss of control.

At this point on the continuum, TR professionals provide direction and structure for prescribed activities. Once engaged in activity, clients can begin to perceive themselves as being able to successfully interact with their environments, to start to experience feelings of success and mastery, and to take steps toward regaining a sense of control. Such outcomes are energizing. Clients come to realize that they are not passive victims but can take action to restore their health. They are then ready to partake in the recreation component of treatment.

* The terms therapists and therapeutic recreation professionals are used interchangeably.

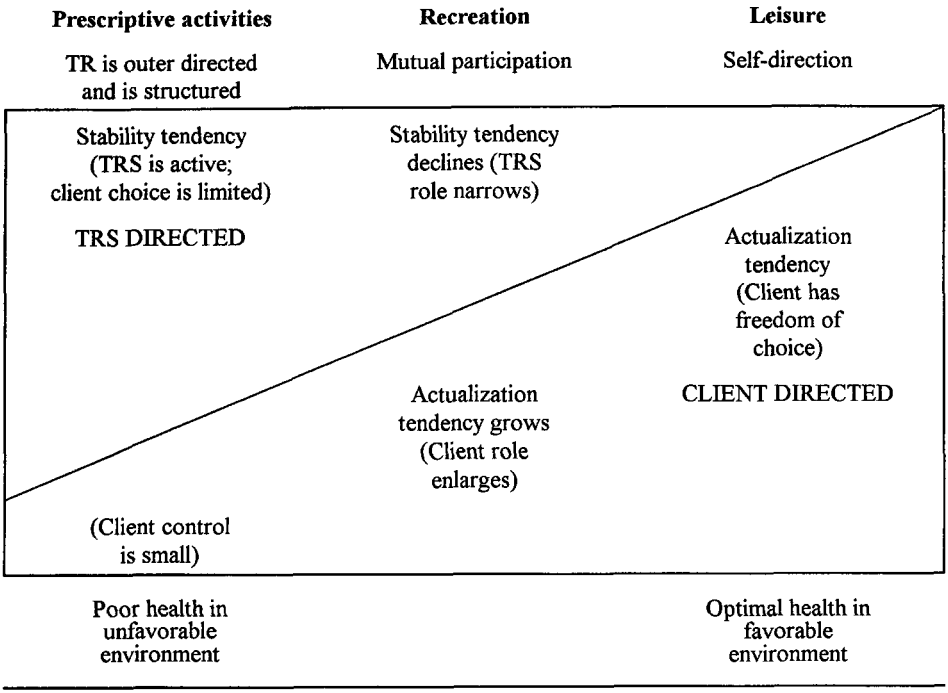

FIGURE 1. TR CONTINUUM. FROM: AUSTIN, D. R. & CRAWFORD, M. E. THERAPEUTIC RECREATION: AN INTRODUCTION (2ND EDITION). NEEDHAM HEIGHTS, MA: ALLYN & BACON, REPRINTED WITH PERMISSION.

The Recreation Component

There are several ways to define recreation. One is seeing recreation as activities that take place during leisure time (Kraus, 1971). Another is that recreation is constructive, meeting socially accepted goals of those taking part in it (Neulinger, 1980). Recreation has also been associated with restorative properties, offering an opportunity for the participant to re-create himself or herself (Kelly, 1996). It is this ability for recreation to restore or refresh physically, mentally and spiritually that perhaps most of us associate with recreation and it is in this context that I employ the term within my model. Through recreation, clients begin to regain their equilibrium disrupted by stressors so that they may once again resume their quest for actualization. They take part in intrinsically motivated recreation experiences that produce a sense of mastery and accomplishment within a supportive and nonthreatening atmosphere. Clients have fun as they learn new skills, new behaviors, new ways to interact with others, new philosophies and values, and new cognition about themselves. In short, they learn that they can be successful in their interactions with the world. Through recreation they are able to re-create themselves, thus combating threats to health and restoring stability.

The Leisure Component

Whereas recreation allows people to restore themselves, leisure is growth promoting. Leisure is a means to self-actualization

because it allows people to have self-determined opportunities to expand themselves by successfully using their abilities to meet challenges. Feelings of accomplishment, confidence and pleasure result from such growth producing experiences. Thus leisure assumes an important role in assisting people to reach their potentials (Iso-Ahola, 1989). Core elements in leisure seem to be that it is freely chosen and intrinsically motivated. Mannell and Kleiber (1997) have written that "Perceived freedom and intrinsic motivation seem to be extremely important to human mental and physical health, and they also just happen to be at the core of what people see as leisure" (p. 117). Elsewhere I have written (Austin, 1997):

> Leisure experiences contain the elements of intrinsic motivation, self-determination, mastery, and competence, which, in turn, lead individuals toward feelings of self-efficacy, empowerment, excitement, and enjoyment. Leisure experiences provide opportunities for the expression of the actualizing tendency and enable individuals to develop themselves. Leisure can play a critical part in helping clients to actualize and move toward optimal health. (p. 149)

I went on to state the following about the relationship between health and actualization:

> Health and actualization are intimately intertwined. The attainment of high-level wellness permits actualization. Those who enjoy peak health are free of barriers to actualization so that they may actively pursue personal growth and development. (p. 149)

The Recreation and Leisure Components

Although recreation and leisure differ in that recreation is an adaptive device that allows us to restore ourselves and leisure is a phenomenon that allows growth, they share commonalities. Both recreation and leisure are free from constraint. Both involve intrinsic motivation and both provide an opportunity for people to experience a tremendous amount of control in their lives. Both permit us to suspend everyday rules and conventions in order to "be ourselves" and "let our hair down." Both allow us to be human with all of our imperfections and frailties. It is the task of the therapeutic recreation professional to maintain an open, supportive, and nonthreatening atmosphere that encourages these positive attributes of recreation and leisure and which help to bring about therapeutic benefit (Austin, 1996).

The Continuum

As clients move across the continuum toward higher levels of health their feelings of self-efficacy are enhanced. They feel better about their abilities. According to Bandura (1986), bolstered efficacy expectations allow clients to have confidence in themselves and in their abilities to succeed in the face of frustration. Thus, clients feel more and more able to be in control of their lives and to meet adversity as they move along the continuum toward higher levels of health. It is the role of the TR professional to help each client assume increasing levels of independence as he or she moves along the illness-wellness continuum. Of course, the client with the greatest dependence on the therapist will be the individual who is in the poorest health. At this point the stabilizing tendency is paramount while the client attempts to ward off the threat to health and to return to his or her usual stable state. At this time the therapist engages the client in prescriptive activities or recreation experiences in order to assist the client with health protection. During prescriptive activities the client's control is the smallest and the therapist's is the largest. During recreation there is more of a mutual participation by the client and therapist. With the help of the therapist, the client learns to

select, and participate in, recreation experiences that promote health improvement. Approximately midway across the continuum, the stabilizing tendency reduces and the actualizing tendency begins to arise. Leisure begins to emerge as the paramount paradigm. As the actualization tendency increases, the client becomes less and less dependent on the therapist and more and more responsible for self-determination. The role of the therapist continues to diminish until the client is able to function without the helper. At this point the client can function relatively independently of the TR professional and there is no need for TR service delivery (Austin, 1997).

It is important to note that for the sake of clarity, no mention has been made that interventions may occur concomitantly. For example, as the client moves across the continuum, he or she may take part in both recreation and leisure experiences. Even the client who is sickest may have "good moments." Another may have an illness that does not impair the performance of some growth enhancing activities. Thus, although the majority of interventions for these clients would be directed toward health restoration, some may be aimed at the provision of growth experiences during the first client's "good moments," or in the case of the second client, to allow the intact parts of the individual to develop. It is thus critical that a holistic assessment be completed so that all aspects of each client may be considered and appropriate interventions implemented to meet the comprehensive needs of each client.

Summary

The Health Protection/Health Promotion Model contains three major components (i.e., prescribed activities, recreation, and leisure) that range along an illness-wellness continuum. According to their needs, clients may enter anywhere along the continuum. The model emphasizes the active role of the client who becomes less and less reliant on the TR professional as he or she moves toward higher levels of health. Initially, direction and structure are provided through prescriptive activities to help activate the client. During recreation, the client and therapist join together in a mutual effort to restore normal functioning. During leisure, the client assumes primary responsibility for his or her own health and well-being.

The Model in Practice

The Health Protection/Health Promotion Model may be applied in any setting (i.e., clinical or community) in which the goal of therapeutic recreation is holistic health and well-being. Thus, anyone who wishes to improve his or her level of health can become a TR client. TR professionals view all clients as having abilities and intact strengths, as well as possessing intrinsic worth and the potential for change. Through purposeful intervention using the TR process (i.e., assessment, planning, implementation, evaluation), therapeutic outcomes emphasize enhanced client functioning. Typical therapeutic outcomes include increasing personal awareness, improving social skills, enhancing leisure abilities, decreasing stress, improving physical functioning, and developing feelings of positive self-regard, self-efficacy and perceived control (Austin, 1996).

A Case Study

An example of the application of the model would be with an older man suffering from severe depression in retirement. Initially, due to his depressive state, the client was self-absorbed and lacked the readiness to participate in recreation or leisure pursuits. At this point, he needed to become activated through participation in an energizing activity in order to begin to regain control and to overcome feelings of helplessness and depression. It was not the role of the therapist to manipulate the client but to offer the structure and support necessary to encourage the man to become active. Once successfully engaged in a relaxation class, the

client began to experience feelings of mastery and to start to regain a sense of control.

Perceptions of increased confidence and self-efficacy naturally motivated the client toward greater readiness to pursue therapeutic outcomes. He was now ready to move into an action stage in which he entered into a partnership with the therapist to select healthy recreational pursuits that had the potential to help him overcome his feelings of depression. It was important at this phase of treatment that the recreation activity provided the proper level of challenge and that it produced self-determined outcomes to offer the client positive feedback and locus of causality. In this case, with the help of the therapist, the man decided to take part in an exercise program that involved walking and working out on weight machines. His depression seemed to lift as his strength and fitness level increased. Finally, during leisure counseling, the client decided that he had been too sedentary in his retirement and that he would alter his leisure pursuits to include a variety of physical activities. Among these were walking, bicycling, swimming and gardening. At this point, he joined the local YMCA and ceased to require the services of his therapist. Thus the client was able to progress from a prescriptive activity to recreation activities and, ultimately, to self-directed leisure pursuits.

Strengths and Limitations of the Model

As previously emphasized (Austin, 1996a), it is important for our development that we establish clear boundaries for our profession. An obvious strength of the Health Protection/Health Promotion Model is then that it sets boundaries for the therapeutic recreation profession by conceptualizing TR as involving purposeful intervention to improve health and well-being by both protecting and promoting health. Another strength of the Model is that it has a sound theoretical foundation. It has strong theoretical underpinnings. Finally, well constructed conceptual models both describe and direct. The Model not only describes therapeutic recreation but it also has the potential to guide therapeutic recreation practice, research and curriculum. An obvious limitation of the Model is that it does not apply in agencies that do not have health as a major goal.

Continuing Development of the Model

In the past we in therapeutic recreation have largely been concerned about threat to our clients' health or those times when clients have been in disequilibrium. Our efforts have focused on helping clients to overcome states of illness and injury. This concern for health protection is an important element in our practice that should remain. At the same time, however, we need to pay more attention to clients who are well but who wish to seek higher levels of health, or to become "weller" if you will. It is within this area of health promotion that I would like to further describe and define therapeutic recreation practice. For instance, I can envision identifying specific illness prevention strategies as a part of health promotion. Additionally, I believe that leisure counseling can become a major element in health promotion but we need clearly articulated leisure counseling models that will allow us to assist clients toward optimal health. On a theoretical level, I would like to refine further the definition of leisure employed in my model because this is a critical component within it. Most of all, I would like for the Health Protection/Health Promotion Model to be a constantly evolving conceptual tool that practitioners and educators will adopt or adapt in order to continually improve therapeutic recreation practice, research and curricula.

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