

**Exploring Therapeutic Relationships in Recreation Therapy  
at Sunnybrook Health Sciences Centre**

by

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## **Author's Declaration**

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

## **Abstract**

Therapeutic relationships were explored using participatory action research in recreation therapy at Sunnybrook Health Sciences Centre (SHSC). The 22 recreation therapists at SHSC comprised the research team and were actively involved throughout the research process; they determined the research questions, the research process, and engaged in data collection and data analysis. This study explored how recreation therapists understood their therapeutic relationships, how different waves of influences were negotiated and philosophies of care that emerged in their therapeutic relationships. At first glance, therapeutic relationships were understood as meaningful connections and shared experiences that developed over time between a recreation therapist and individual receiving care. Later on, therapeutic relationships emerged as a complex process with welcoming, continuing and closing phases. Positive therapeutic relationships were defined by qualities such as caring, trust, respect, and non-judgment for everyone involved. Therapeutic relationships were also influenced by the organizational context, unit specific cultures, family, and staff members and recreation therapists continually negotiated the expectations, power and boundaries of these influences within their therapeutic relationships. The recreation therapists also discussed the different roles, they and the individuals receiving care could engage in during their therapeutic relationships ranging from the traditional, contemporary or controversial. Findings revealed that recreation therapists' practices were predominantly influenced by person-centered care philosophies, although the biomedical model and relationship-centred care philosophies were also apparent. The practice of being in the moment emerged as a means of enhancing therapeutic relationships, whereas self-reflective practice assisted the recreation therapists to negotiate different waves of influence on their therapeutic relationships.

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## Chapter One: Introduction

In recreation therapy literature, therapeutic relationships are often described as complex entities but are rarely discussed in detail. Whereas, disciplines such as nursing, social work, psychology, and psychotherapy have more thoroughly documented the nuances of their therapeutic relationships (Clark & Gioro, 1998; Glasson, Change, & Bidewell, 2008; Kadambi & Truscott, 2004; Pearlman & Saakvitne, 1995). Although philosophical differences were apparent throughout the literature from these disciplines, several qualities were identified as essential to therapeutic relationships including: communication (Gostecnik, Repic & Cvetek, 2008; Shank, 2002), connection (Cassidy & Shaver, 1999), trust (Nathanson-Elkind, 1994; Pelham, 2008), empathy, positive regard and genuineness (Rogers, 1957). Interestingly, Samstag, Batchedler, Muran, Safran and Winston (1998) indicated that differences in understandings may influence intended outcomes of therapeutic relationships. Yalom and Leszcz (2005) suggested that the context of the therapeutic relationship impact its ability to foster outcomes and relationships with therapists played greater roles in individual therapy sessions than in group settings. Although literature on therapeutic relationships was available from other disciplines, it was unclear at the onset of this research journey, whether or not it applied to the leisure-based context of recreation therapy.

Despite the small amount of literature on therapeutic relationships in recreation therapy, this study drew on the understanding that therapeutic relationships were central to recreation therapists' practices (Arai, 2009; Austin, Dattilo & McCormick, 1999; Shank, 2002). Recreation therapy was described by the Canadian Therapeutic Recreation Association (2008) as a profession that "recognizes leisure, recreation and play as integral components of quality of life. Service is provided to individuals who have physical, mental, social or emotional limitations which impact their ability to engage in meaningful leisure experiences" (no page). Recreation therapists at Sunnybrook Health Sciences Centre (SHSC) suggest that "recreation therapy provides meaningful support to individuals as they strive to improve their lives through leisure" (Recreation Therapy Vision Statement, 2010 no page). Participation in leisure promotes life satisfaction, positive health outcomes, healthy communities and

well-being (Coyle, Kinney, Riley and Shank, 1991). Austin et al. (1999) suggested that recreation therapists focus on creating enjoyable situations and experiences to enhance the quality of life and well-being of individuals using their services. Similarly, Wiersma (2003) emphasised the important role relationships play in the enhancement of quality of life and meaning-making for residents involved in recreation therapy. Overall, the aim of this study was to add to the recreation therapy literature by exploring recreation therapists' understandings of their therapeutic relationships with individuals receiving care at Sunnybrook Health Sciences Centre.

Recreation therapy has traditionally been influenced by a biomedical model approach to care focused on mind body separation, scientific rationality, the body as a machine, and goals and outcomes of treatment (Crabtree & Miller, 2005). When aligned with the biomedical model, recreation therapists often provided services that involved “functional interventions, leisure education and participation opportunities. These processes support[ed] the goal of assisting the individual to maximize... independence in leisure, optimal health and the highest possible quality of life” (Canadian Therapeutic Recreation Association, 2008, no page). Despite its longstanding tradition, the biomedical model approach to care has been challenged by the recreation therapists at SHSC when they shifted towards person-centered care (Cantwell, 2000). Person-centered care shifted focus towards the person and their abilities and care partnerships (Caitlin, 2006). Their person-centered care philosophy incorporated Parse's (1995, 1999) *Human Becoming Theory* which emphasized respect for the individual's right to be involved in decisions regarding their care. The recreation therapists at SHSC value “individuality and the freedom to choose leisure experiences according to personal interests” (Recreation Therapy, 2008, no page). Austin et al. (1999) supported the shift towards person-centered care philosophies when they stated the recreation therapists' role was to provide individuals with opportunities to maximize their control and capabilities.

The research team for this study was comprised of 22 recreation therapists<sup>1</sup> dedicated to developing their professional practice, increasing their research capacities, and implementing research findings into meaningful practice. The Recreation Therapy department at SHSC was the ideal context for this study—for it was supported by a culture that encouraged practice-based research and had a long standing history of collaborative research with the University of Waterloo’s Recreation and Leisure Studies Department. Previous collaborations focused on patient-centered care (Cantwell, 2000); meaningful experiences and the importance of place (Wiersma, 2003), and the development of quality indicators for use in recreation therapy programming (Rotteau, 2008).

The purpose for this study with recreation therapists at SHSC emerged from a strategic planning session that took place during their annual retreat in the Fall of 2007. At the retreat it was determined that all members of the Recreation Therapy department at SHSC would participate in a memory work study supported by Dr. Susan Arai from the University of Waterloo. The resulting memory work study took place in the Fall of 2008. Findings from the memory work study suggested in addition to person-centered care there was also evidence of relationship-centered care philosophies underlying practices and beliefs at SHSC (Arai, 2009). Therefore, Arai (2009) recommended further exploration of the recreation therapists’ understandings and philosophies surrounding their therapeutic relationships. At a subsequent strategic planning session, the recreation therapists at SHSC unanimously supported ongoing exploration of therapeutic relationships and their increased involvement in the research processes.

To increase their involvement in research, the recreation therapists chose to use a Participatory Action Research (PAR) approach. Glasson et al. (2008) defined PAR as “a cyclical, participatory process of gaining evidence used to bring change to the workplace” (p. 34). PAR positions the power of the research into the hands of a collective of main stakeholders and encourages self-reflective practice (Kemmis & McTaggart, 1990). Consistent with PAR, the recreation therapists helped to

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<sup>1</sup> In this study the phrase *recreation therapist* includes both recreation therapy assistants and recreation therapists.

determine the purpose of this study. The purpose of this PAR initiative with recreation therapists at Sunnybrook Health Sciences Centre was to explore practices of engaging in therapeutic relationships with individuals receiving care at Sunnybrook Health Sciences Centre. The original research questions guiding this study were:

1. How do recreation therapists at Sunnybrook Health Sciences Centre understand their therapeutic relationships?
2. How do those understandings of the therapeutic relationship influence care provision at Sunnybrook Health Sciences Centre?

However, as the research progressed the research questions were modified. The modified research questions included:

1. What is the philosophy of practice that defines therapeutic relationships at Sunnybrook Health Sciences Centre?
2. How do recreation therapists at Sunnybrook Health Science Centre understand their therapeutic relationships?
  - a. What is a therapeutic relationship in recreation therapy?
  - b. What are the qualities of therapeutic relationships?
  - c. What is the process surrounding a therapeutic relationship?
  - d. What are the roles within therapeutic relationships?
3. How are different influences negotiated within therapeutic relationships?

In the literature on recreation therapy and healthcare, voices of recreation therapists have been relatively absent. Therefore, in this study the voices of recreation therapists from all areas of SHSC were intentionally included. This PAR study hoped to increase knowledge about therapeutic relationships in the context of recreation therapy, encourage recreation therapists at SHSC to revisit understandings and philosophies surrounding their therapeutic relationships, and enhance the recreation therapists' research capacities.

### *Summary*

Therapeutic relationships are important to the practice of recreation therapy. This study endeavoured to gain a deeper understanding of the meaning of therapeutic relationships from the perspectives of recreation therapists at SHSC. Through this study the recreation therapists' articulated differences in their understandings regarding therapeutic relationships to one another. As the recreation therapists engaged in the PAR process, they drew on their previously established research skills and

self-reflective practice. As a collective, the recreation therapists at SHSC identified the therapeutic relationship as a process, several qualities that define therapeutic relationships, numerous waves of influence, and the negotiation of expectations, boundaries, and power throughout their therapeutic relationships. Their findings also emphasized several philosophies of care that influence their practices. During focus group discussions, it was clear, person-centered care dominated, although relationship-centered care and the biomedical model were also present. Being in the moment also arose as a means to enhance their therapeutic relationships and self-reflective practice became a means negotiate different waves of influence.

The remainder of this thesis is divided into six chapters. Chapter Two describes more fully the PAR framework for the study, self-reflective practice, and the research team. Chapter Three contains a review of relevant literature, providing a history of research conducted within recreation therapy at SHSC and describes how therapeutic relationships were understood by a variety of disciplines including nursing, social work, psychology and recreation therapy. Chapter Four further describes how the PAR unfolded in this study including the research plans, focus group methods used and ethical considerations. Chapter Five explores the research findings which include: reasons supporting recreation therapists' engagement in therapeutic relationships (e.g. building a sense of community and belonging); the positive qualities (e.g. care, trust) fostered throughout a therapeutic relationship; roles of recreation therapists and individuals receiving care within their therapeutic relationships ranging from traditional to contemporary to controversial; the therapeutic relationship process (e.g. welcoming, continuing and closing phases); how the recreation therapists' negotiated the different influences (e.g. institution, family) on their therapeutic relationships. Chapter Six provides a discussion of the research findings. Included is a discussion of the philosophies of care that emerged and the issue of power. Chapter Six also suggests possible implications of this study and provides recommendations for future research. Chapter Six concludes that traditional understandings of recreation therapy may no longer be consistent with the recreation therapists' practices at SHSC and further examination of these topics is recommended.

### *A Reflection on My Involvement in a PAR Study*

In the spring of 2008, I was graduating from the University of Waterloo with a degree in therapeutic recreation and contemplating the next step in my life. At that critical time I was approached by Dr. Susan Arai, a professor in the Recreation and Leisure department at the University of Waterloo, to work on an innovative research study with the Recreation Therapy department at SHSC. This research study interested me greatly, for it bridged my two passions, enhancing recreation therapy research and working in the field. At that point, I knew that the proposed study would follow a PAR methodology and might involve studying how recreation therapists experienced their therapeutic relationships. Yet, what exactly PAR meant, how the research would unfold, and the power this type of research had was still unknown to me.

In the beginning, I was extremely excited; the study was groundbreaking and built on past research studies conducted collaboratively between the Recreation Therapy department at SHSC and the University of Waterloo. From a large binder that contained all of the information on the Recreation Therapy department's past research collaborations I read that their studies had focused on a variety of topics including patient centered care (Cantwell, 2000), quality indicators (Rotteau, 2008), sense of community (Cantwell & Pedlar, 2002) and the importance of place (Weirsmas, 2005). As much as I could read about the recreation therapists' research, I did not have hands on experience working with this research team. All I knew was that this collaborative partnership was beginning a new phase of their research and it needed a new master's student (me) to be involved. I saw the opportunity to work with the Recreation Therapy department at SHSC, as a means of increasing the prevalence of recreation therapy research within academic literature and creating meaningful and practical changes within the field. Early on, I thought that participating in this research study would also help to increase widespread knowledge of recreation therapy and its unique role in healthcare settings. After all, if I could assist in furthering the understanding the recreation therapists' perspectives of their therapeutic relationships, the research and my efforts could also have the potential to impact the way recreation

therapists practice. At that time, I was not aware of how influential this study would be on me as a person, I was solely focusing on how I would be influential.

As a co-researcher in this study, I experienced firsthand how recreation therapists working in the field conducted meaningful and innovative research that influenced both their personal and collective practices. I also witnessed the progress made by the research team throughout this PAR journey. The research team began with an initial desire to collectively explore therapeutic relationships in recreation therapy in greater depth. Then as the PAR process and focus group method transpired, a supportive context for open and analytical group dialogue formed. While engaging in the PAR cycles of planning, reflection, action and observation, the recreation therapists were able to discuss their understandings of their therapeutic relationships with one another and created numerous opportunities for shared learning amongst all members of the research team. As a research team, therapeutic relationships were understood as processes engaged in for several reasons including that they supported a new beginning for the individuals receiving care at SHSC. Throughout the welcoming, continuing and closing phases of their therapeutic relationship process, the research team found that positive qualities (e.g. trust and respect) were fostered; a variety of roles (e.g. traditional, contemporary and controversial) were possible; and different waves of influence (e.g. institution and family) were continually negotiated. Negotiating of expectations, power and boundaries occurred both within the recreation therapists' therapeutic relationships and throughout this PAR process.

In summary, I found that participation in this study empowered the research team it increased research capabilities while simultaneously drawing upon previously-established knowledge, skills and abilities. Findings from this study also provided a wealth of knowledge (e.g. on PAR, therapeutic relationships and self-reflective practice in recreation therapy) that the research team at SHSC and other practitioners and researchers can expand upon in the future. I was honoured to be a co-researcher on this research team and I look forward the upcoming research that stems from this innovative exploration of therapeutic relationships in recreation therapy at SHSC.



## **Chapter Two: Framing the Study in PAR and Self-Reflective Practice**

This chapter describes the framework for the study including Participatory Action Research (PAR), self-reflective practice and the research team. PAR is described as a research approach focused on enhancing the power and abilities of research participants and stakeholders (Kemmis & McTaggart, 1990), and is useful within healthcare practice settings and compatible with self-reflective practice. PAR was compatible with the recreation therapists' self-reflective practice as it required the practitioners to reflect in and on their practices. Recreation therapists at Sunnybrook Health Sciences Centre (SHSC) were dedicated to engaging in innovative research to improve their practice and PAR encourages social action and change (McTaggart, 1989). Harmony between these three components of the research framework—PAR, self reflective practice, and the research team's commitment to improvement and change—was essential to the success of the study. This chapter ends with a brief description of the research team.

### ***Participatory Action Research***

PAR is a complex form of inquiry involving cycles of planning, action and reflection and places the power of research in the hands of its stakeholders. When researchers embark on a PAR process, they often refer to McTaggart's (1989) 16 tenets of PAR to deepen their understanding of the approach. McTaggart (1989) states PAR:

1. is an approach to improving social practice by changing it
2. is contingent on authentic participation
3. is collaborative
4. establishes self-critical communities
5. is a systematic learning process
6. involves people in theorising about their practices
7. requires that people put their practices, ideas and assumptions about institutions to the test
8. involves keeping records
9. requires participants to objectify their own experiences
10. is a political process
11. involves making critical analyses
12. starts small
13. starts with small cycles
14. starts with small groups
15. allows and requires participants to build records

16. allows and requires participants to give a reasoned justification of their social (educational) work to others  
(p. 79)

In essence, PAR engages the maximum participation of stakeholders in the research process (Wadsworth, 1997), “for the purpose of taking action and making change” (Nelson, Ochocka, Griffin, & Lord, 1998, p. 885). Traditionally, PAR stemmed from action research described by Lewin (1946) and critical epistemologies (Kemmis & McTaggart, 2008). The action research approach focuses on social action to create change. However, in action research, researchers choose research topics and make decisions for participants, “stakeholders are not seen as active participants in the design of the study” (Koch, Kralik, Loon, & Mann, 2006, p. 12). PAR developed as participants in action research wanted more involvement in the entire research process and play a more direct role in personal and political change. Although, both action research and PAR attempt to create changes within situations of power imbalances through cycles of planning, taking action, observing and reflecting on the research (Lewin, 1946), in PAR, participants’ involvement in the research moved beyond *tokenism* towards *citizen control*. Arnstein (1969) indicated tokenism occurs when citizens have little power to make decisions leading to meaningful change, whereas citizen control emerges when citizens have power to create change. In PAR, the participants determine the research issue and are in control of the research design, implementation, analysis and dissemination of the findings (Koch et al., 2006).

PAR was also influenced by feminist considerations. It aims at raising consciousness and empowerment of its participants (Koch et al., 2006). In PAR, participants are no longer seen as apprentices of academic researchers; they become the educators and researchers (Grant, Nelson, & Mitchell, 2008). PAR processes target unequal power relations occurring in other forms of research by focusing on equal partnerships to create knowledge and change (Koch et al., 2006). PAR also supports Freire’s (1970) wishes to empower disenfranchised groups. As McTaggart (1997) emphasized, PAR can be an empowering process. At the same time, McTaggart (1997) warned that for the research to be truly participatory and empowering, authentic participation between parties were essential. McTaggart (1997) claimed “authentic participation in research means sharing in the way research is

conceptualized, practiced and brought to bear on the life-world” (p. 6). In essence, PAR is as empowering as it is political. PAR “aspires to communitarian and egalitarian politics: people working together towards rationality, justice, coherence, and satisfactoriness in workplaces and in other areas of people’s lives” (McTaggart, p. 6). Therefore, collaborative action and equality within a PAR study are only as strong as the participants’ dedication to embody these philosophies.

The value of PAR has been increasingly recognized over the last four decades. McTaggart (1997) described PAR as “a movement...it expresses a recognition that all research methodologies are implicitly political in character, defining a relationship of advantage and power between the researcher and the researched” (p. 1). PAR is viewed as an approach providing individuals who are relatively absent from traditional research communities with opportunities to contribute to the literature in a practical and meaningful way. PAR is a “vital, dynamic and relevant approach that can be engaged by practitioners and health service providers” (Koch et al., 2006, p. 1).

The philosophical underpinnings of PAR include: democracy, equality and learning through hands on involvement (Wadsworth, 1997). During PAR, all members of the research team are considered equals and all opinions are encouraged to be freely expressed. During PAR studies, researchers often vote on complex issues to maintain equality and democracy throughout the process. By expressing opinions openly and making collaborative decisions regarding the future of the research, participants learn about their individual differences and negotiate what it means to act as a collective. In healthcare settings, practitioners are often one of the main stakeholders of research. The next section discusses how PAR is compatible with practice in a healthcare setting.

### ***PAR and the Power of Change for Recreation Therapists.***

PAR is commonly used by practitioners attempting to change their practices through collaborative and active participation in research. PAR positions the power into the hands of practitioners for designing, implementing, and facilitating research, analyzing data and distributing findings (to peers, academics and other health professionals) (Glasson et al., 2008), and encourages practitioners to engage as researchers. Using PAR, practitioners develop knowledge and enhance their

research capabilities to become less reliant on academic resources and able to facilitate their own rigorous and meaningful studies. As an approach to empowerment, PAR assists practitioners to become leaders of personal and social change. Glasson et al. (2008) provided support for using PAR in healthcare settings and the nursing profession, citing “PAR empowers people to bring change by generating knowledge through reflection on their personal experiences and situations” (p. 34). PAR appreciates practitioners’ knowledge and lived experiences. Through PAR, practitioners are encouraged to take a systematic and critical look at their practices (McTaggart, 1997). Through PAR, practitioners are encouraged to theorize and reflect on their understandings while simultaneously recording and analysing their data. Flicker and colleagues (2008) stated “[p]articipatory approaches acknowledge that communities often already have local knowledge that is crucial to understanding and addressing their own social problems” (p. 288). Flicker et al. (2008) also highlighted the powerful ability of practitioners as researchers to use PAR to promote healthy changes in their communities. According to Kemmis and McTaggart (1990), the process of PAR is a powerful,

collective, self-reflective inquiry undertaken by participants...to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out (p. 5).

Further, Miller and Pedlar (2006) emphasized self-reflective practice is necessary to create positive changes in recreation therapy. The next section introduces self-reflective practice and how it is supported in PAR studies.

### ***Self-Reflective Practice and Insight through PAR***

When this study began, self-reflective practice was central to the culture of recreation therapy at SHSC. With recreation therapists at SHSC, Pedlar, Hornibrook and Haasen (1998) used reflective practices to challenge traditional approaches to assessment and help the practitioners develop their *Personal Leisure Profile*. Wilson (1996) described self-reflective practice as a “practice [that] encourages the development of critical thinking [and] articulation of ... practice” (p. 138) and Marshall (2006) emphasized the importance of self-reflective practice in research. Marshall (2006) indicated “self-reflective practice [is] a necessary core for all inquiry. For example, anyone engaging in

collaborative research needs robust, self-questioning discipline as their base” (p. 335). However, self-reflective practice is not as simple as it sounds, it requires dedication and practice. To assist practitioners to be more self-reflective, Schon (1983) stated self-reflective practice begins:

with the assumption that competent practitioners usually know more than they can say. They exhibit a kind of knowing in practice, most of which is tacit...Indeed practitioners themselves often reveal a capacity for reflection on their intuitive knowing in the midst of action and sometimes use this capacity to cope with the unique, uncertain, and conflicted situations of practice (p. 8-9).

Atkins and Murphy (1993) added to the term’s complexity when they suggested there were two types of self-reflective practice: reflection *in* action and reflection *on* action. Atkins and Murphy developed a model to guide practitioners through their self-reflective practices. The model followed a three stage process which began with becoming aware of a situation and the thoughts and feelings involved in that situation. The awareness stage was followed by a self-analysis stage. Then self-analysis flowed into the development of a new perspective (See Figure 1).

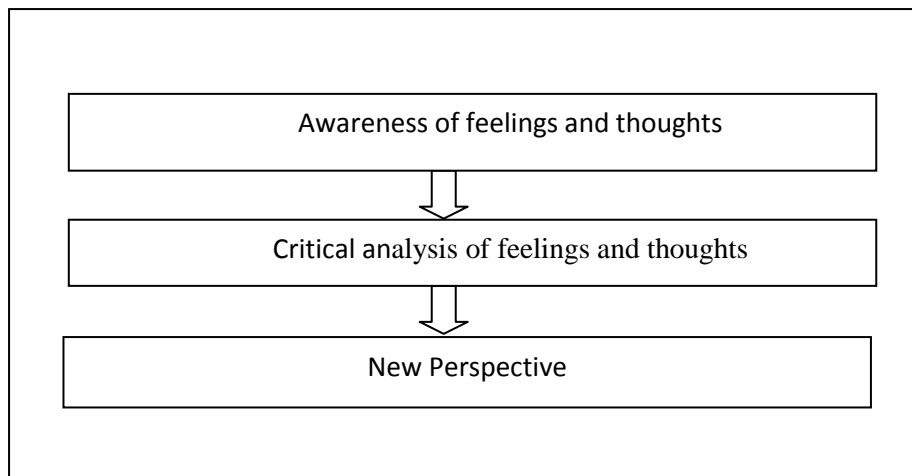


Figure 1. A reflective process model. (Modified from Atkins and Murphy, 1993)

Atkins and Murphy (1993) also warned practitioners could blindly follow steps of self-reflective practice without first developing several essential skills. The required skills included self-awareness, the ability to be descriptive (recall events as they actually unfolded), the ability to critically analyze (realizing the difference between knowledge and assumptions), and the ability to synthesize knowledge (novel and past) to make an evaluation (Atkins & Murphy, 1993). They emphasized if practitioners

conducted self-reflective practice on a regular basis; then PAR could assist the practitioners to draw on their reflection skills, deepen their understandings of the research and enable them to convey those understanding to others.

Reflection is also a key component of the cyclical PAR approach and draws on the same skills required for self-reflective practice. Reflection in PAR helps research teams become aware of their own knowledge, challenges them to voice their knowledge, and use their knowledge to work through challenging situations arising during the research process and within their practice. Reason and Bradbury (2008) supported the use of reflection in action research stating:

within an action research project, communities of inquiry and action evolve and address questions and issues that are significant for those who participate as co-researchers. Typically such communities engage in more or less systematic cycles of action and reflection: in action phases co-researchers...gather evidence; in reflection stages they make sense together and plan further actions. And since these cycles of action and reflection integrate knowing and acting, action research does not have to address the “gap” between knowing and doing that befuddles so many change efforts and “applied” research (p. 1).

Reason and Bradbury argued reflection assisted research teams to grow and evolve by integrating their practical and research skills. Hughes and Seymour-Rolls (2000) cautioned self-reflection during PAR can be challenging at times, for it is an ever-evolving process. Despite its challenging nature, Reason and Bradbury (2008) were certain reflection assists with positive changes in both practical and research settings.

The research team at SHSC used their self-reflective practice skills regularly during this PAR study. The research team was supported by the strong research culture at SHSC. This culture of research began with a strategic plan introduced by Heather Pherson in 1998. Heather Pherson was a Chief of Health Disciplines at SHSC who set the stage for the development of practice-based research. Practice-based research is often conducted by practitioners and reflects a need for practical knowledge and useful research findings within the workplace. Pherson’s strategic plan was to enhance research at SHSC and involved creating a professional advisory committee to oversee all practice based research. In her strategic plan, she outlined the importance of integrating research and practice. Through her practice-based research mandate, Pherson encouraged all departments at SHSC to conduct relevant critical inquiries of their practices in a systematic and ethical manner. According to Pherson, practice-based research had the potential to increase quality of service and practice, positively impact

employment and enhance the knowledge and research skills of SHSC employees. Pherson's practice-based research mandate helped to create the positive research culture found within the Recreation Therapy department at SHSC. Since the introduction of practice-based research at SHSC, a collaborative research partnership has existed between researchers in the Department of Recreation and Leisure Studies at the University of Waterloo and members of the Recreation Therapy department at SHSC.

### ***Description of the Research Team***

The research team for this study emerged from the positive research culture at SHSC and the collaborative research partnership between the Recreation Therapy department at SHSC and the Department of Recreation and Leisure Studies at the University of Waterloo. The research team for this study included all 22 members of the Recreation Therapy department at SHSC and me, a MA candidate from the University of Waterloo. Dr. Susan Arai from the University of Waterloo and Nancy Bowers-Ivanski, Manager of Recreation Therapy and Creative Arts at SHSC, also provided support for the study. The research team chose to use PAR for this study as it was compatible with their self-reflective practices and research goals. Since 2007, the research team has increased the participatory nature of their research involvement (Arai, 2009) and members of the research team were dedicated to using the PAR approach. The research team members represented a number of different practice areas within SHSC including: cognitive support resident care units, community support, geriatric day hospital, and mental health and physical support units. Table 1 includes descriptions of each area of practice provided by recreation therapists at SHSC. In these descriptions, written by the recreation therapists in different areas of SHSC the terms patients, adolescents, adults, residents, and veterans were commonly used. For the purposes of this study, the research team decided to use the inclusive term of *individuals receiving care at SHSC* when referring to the people with whom they engaged in therapeutic relationships. At the time of this study, the entire research team (except for Jessica Lansfield, the University of Waterloo co-researcher) was employed by SHSC within the Recreation Therapy department and worked on-site. The research team also regularly attended Recreation Therapy

department meetings and were accessible by either phone or email. All research processes took place at SHSC.

Table 1  
*Descriptions of Areas of Recreation Therapy at Sunnybrook Health Sciences Centre Provided by Recreation Therapists*

AREA	DESCRIPTION
Cognitive Support Units	Provides services to veterans with a primary diagnosis of dementia who have medical and/or behavioural needs that can no longer be met in their communities. Each cognitive support unit consists of 34 beds and many residents are diagnosed with complex illnesses, challenging behaviours and/or physical impairments. The goal and focus of recreation therapy is to optimize and support residents' quality of life through meaningful activities, programs, and a holistic approach to care. Programs and activities focus on enabling residents to reach their full potential and achieve a higher quality of life. Activities are offered both on and off unit and are planned to meet residents' needs and interests. Programs include a weekly quiz group, breakfast and lunch groups, bus outings, and special events (Remembrance Day, Warrior's Day Parade) within Sunnybrook and the external community. We also facilitate one on one time with our veterans who do not enjoy group activities.
Community Support	Provides leisure opportunities for residents of K and L wings of the Veterans' home at SHSC. Individual, small group, and large group programs are offered in combination with special events throughout the year. Similar to any community this service strives to bring residents together through a social venue to meet others, learn and be challenged.
Geriatric Day Hospital	Provides services to seniors primarily living at home in community and have been referred to the Geriatric Day Hospital by their family physician. They are often frail seniors who have multiple diagnoses. Recreation therapy programs focus mainly on developing leisure skills and providing leisure education. Seniors learn new, or rediscover, leisure activities they can carry on in their home or at a local community centre. Some of the programs we currently provide are painting (e.g., acrylic, watercolour), silk screening, crafts, computers, Mental Aerobics, mini putting, jewellery making, gardening, etcetera. Our day is mainly spent in patient programming (4 hours); however, there is a significant amount of setup and cleanup time required. We supervise volunteers, conduct assessments, plan discharges, document our patients' progress, record program statistics and planning time as well as participate in interdisciplinary rounds and/or scheduled meetings each day.
Mental Health Unit	In the acute care inpatient unit in the Department of Psychiatry, the recreation therapist provides services to three age groups, including adolescences, adults and older adults. Although group therapy dominates on the Mental Health Unit, the recreation therapist also provides a variety of individual recreation therapy services to adult/older adult patients to help meet individualized needs (identified by the patients or members of the interdisciplinary team). The inpatient unit has 35 beds, with 5 beds in the Psychiatric Intensive Care Unit that provides care for patients requiring greater support given the severity of illness and safety concerns. The recreation therapist also works as the Group Program Coordinator for the Inpatient Unit. Within the isolated 8 bed adolescent unit (ages 14+), recreation therapy facilitates two group programs per week, an arts-based group (with creative expression focus using multiple art modalities) and a group that incorporates approaches and themes based on group membership, need, and interest (the session may be recreational, educational, or more therapeutic in its orientation or it may incorporate health living themes with experiential exercises). An interdisciplinary approach is vital on the Mental Health unit, therefore, the recreation therapist continually communicates with teachers, youth workers, nurses, etcetera. The adult group program is open to all adults on the unit (ages 19 and up). Adults may be in hospital for a short time (few days, several weeks, and few months). There are various factors that may influence the interpersonal dynamics on the unit which affect the interplay in a group session. The recreation therapist uses experiential approaches and patient involvement to meet the challenges of great diversity on the unit and create meaningful programs to assist in the patients' recovery. Examples of our adult programs are creative expression, healthy living (focuses on humour, self-confidence, assertiveness training, mindfulness, yoga & relaxation, pet therapy, relaxation training/ support (individually), and outdoor wellness walk. The focus of recreation therapy is on skill development, building self-awareness, (re)discovering sense of self, values and



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	goals along with skill enhancement. As part of the discovery process, the recreation therapist assists in the identification of resources and supports that will be helpful for the patients and enable them to make connections. The recreation therapist aims to be flexible, inclusive, foster patient choice, optimize resources, and a consistent presence for the patients while providing a variety of programs and regular exercise (both indoor and outdoor) while using an interdisciplinary facilitation approach (which offers patients the opportunity to access expertise of different staff but also benefit from exploring issues from multiple perspectives).
Physical Support Units	The nine physical support units cater to resident veterans diagnosed with chronic medical conditions and physical disabilities (e.g., cancer, Parkinson's disease, amputations, Traumatic Brain Injury). L-Wing residents (e.g., LFSE/W and LTSE/W) are considered to be Nursing Home level II. These Veterans are either partially or fully independent in their mobility and require minimal to moderate nursing assistance with Activities of Daily Living. Individuals residing on K-Wing units other than K1E (which provides palliative care) are classified as level III Complex Continuing Care and require more nursing assistance than their L-Wing counterparts (please refer to the Sunnybrook website - the Physical Support unit profiles for further explanation of the differences in services offered). There are four recreation therapists and two recreation therapy assistants who work on the Physical Support units. The recreation therapists meet with new arrivals to complete a <i>Personal Leisure Profile</i> . Based on their responses to these five open ended questions, we encourage residents to get involved in groups of interest to them. Programs are facilitated by recreation therapists and recreation therapy assistants; together or independent of one another. It is hoped that the relationship between recreation therapists and recreation therapy assistants is a collaborative partnership, characterized by a mutual respect for each other's specific knowledge and skill-set. Recreation therapists complete Personal Leisure Profiles, quarterly documentation, and attend Rounds/Family Case Conferences, while the recreation therapy assistants facilitate more programs per day on units where both a recreation therapist and recreation therapy assistant are assigned. Due to the difference in the roles, sharing of information is vital. Recreation therapists offer similar programs on all units, which are adapted and modified to help our residents achieve their maximum potential given their current level of functioning and abilities. Examples of programs include: Tai Chi classes, exercise groups, meal preparation programs, mental aerobics, bingo, card groups, intergenerational visits, pet therapy visits, community bus outings, reminiscence, travel programs, and unit special events. Recreation therapists also conduct collaborative programming with members of the multi-disciplinary team (e.g., exercise group with a physiotherapist, programs with Creative Arts Therapists). Finally, one Physical Support practitioner organizes some of the Life Long Journey initiatives, such as the Air Force Crew meetings and other outings, as well as the Taste of Toronto monthly event; all of which are open to residents from both Physical and Cognitive Support units.

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Although the research team worked in a wide range of settings at SHSC, the focus of the Recreation Therapy department was to provide programs to enhance program participants' freedom of choice, independence, leisure lifestyles and overall well-being. The vision statement of the Recreation Therapy department at SHSC indicated the recreation therapists at SHSC aimed to provide,

meaningful support to individuals as they strive to improve their lives through leisure. [They] value individuality and the freedom to choose leisure experiences according to personal interests. Together, [they] explore opportunities for personal growth and development, meeting and helping others, building self-confidence and a sense of belonging (Recreation Therapy, 2008).

As a group, the research team wanted to ensure that the highest quality of care possible was being provided. For the benefit of the research team, Leanne Hughes acted as a co-investigator in accordance with the SHSC ethics application. Dr. Susan Arai from the University of Waterloo also provided

assistance as an academic consultant and Nancy Bowers-Ivanski, Manager of Recreational Therapy and Creative Arts at SHSC, ensured practical and administrative support for this study.

### *Reflections on My Role as a Co-Researcher*

As a graduate student from the University of Waterloo my role was that of a research team member and author of this thesis. As a member of the research team, my responsibilities included: writing a research proposal including a review of relevant literature, researching and presenting viable research method options; facilitating dialogue between other members of the research team and supporting the research committee; and conducting a verbal defence of my master's thesis proposal. In addition, I completed two ethics applications (one for the University of Waterloo and one for the ethics review board at SWHSC); supported the PAR process and focus group discussions; managed, transcribed, analyzed, summarized and presented data; facilitated subsequent data analysis meetings; encouraged the research team to create a self-reflective guide for practice; and disseminated the research findings. Despite the tasks I undertook during this PAR study, the one task which rose above the rest was my own reflexivity. The practice of reflexivity is discussed in greater detail in Chapter Four. During my periods of reflexivity, I considered how the research impacted me and vice versa through periods of reflexivity. At the same time, I encouraged my co-researchers, the recreation therapists at SHSC, to conduct their own self-reflective practice.

### *Summary*

Chapter Two described the framework for this study with recreation therapists at SHSC. The research team who engaged in this PAR study were a group of dedicated individuals, interested in recreation therapy, self-reflective practice, and PAR research. By embracing a practice-based research approach and being committed to self reflective practice, the recreation therapists at SHSC created a wonderful context to conduct research. Their self-reflective practice supported analysis of themselves, and their beliefs, attitudes, and practices. PAR was also compatible with the research team at SHSC because it drew on and appreciated the skills and knowledge of the recreation therapists. Chapter

Three provides a review the literature the research team drew on throughout this study. Chapter Four will provide more details about the research team's approach to PAR.

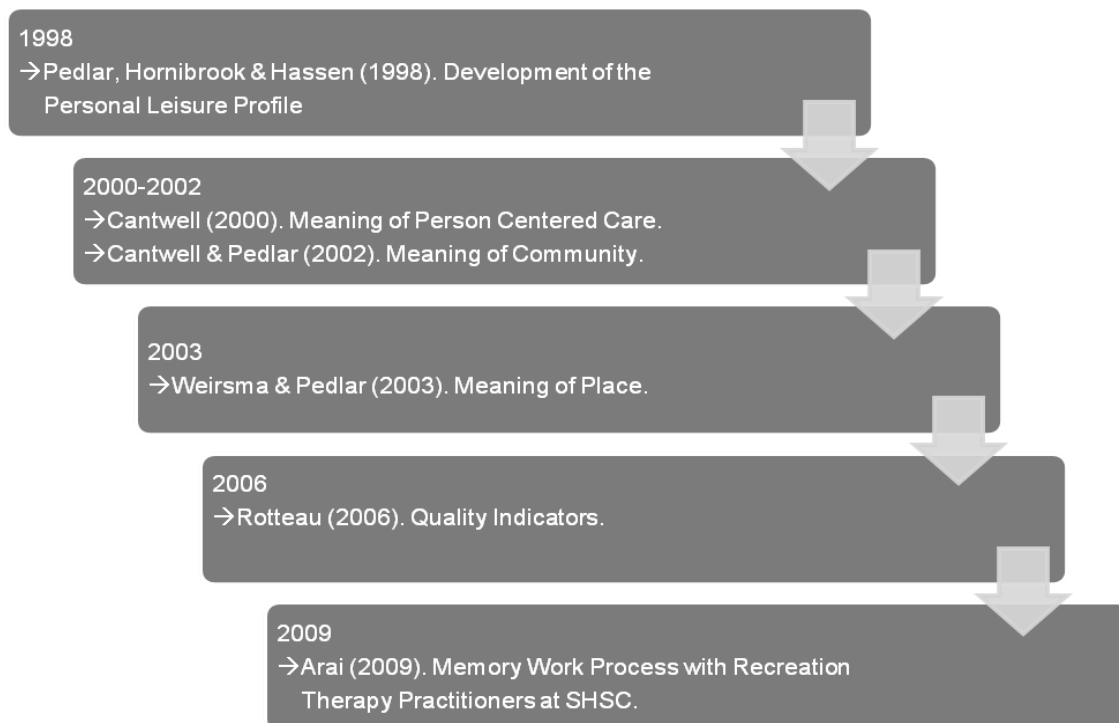
### **Chapter Three: Review of Literature**

This review of literature is separated into four main sections. The first section provides a chronological history of research endeavours involving the Recreation Therapy department at Sunnybrook Health Sciences Centre (SHSC) and researchers from the University of Waterloo, which led the research team towards the study of therapeutic relationships. The second section of the literature review describes how other disciplines, such as psychology and social work, have understood, developed, overcome challenges and placed boundaries around their therapeutic relationships. The third section reviews the literature on mindfulness. This section was added to the review based on input from members of the small research committee as the PAR process unfolded. The fourth section discusses therapeutic relationships in the recreation therapy literature and the remaining gaps. Although in this research study, the preferred language to identify a person with whom a recreation therapist was engaging in a therapeutic relationship was an *individual receiving care at SHSC*; the original language used by the authors in this review of literature to describe this group (e.g., client, residents) is maintained. Individual receiving care at SHSC was chosen so that it could represent all of the people with whom recreation therapists engaged in therapeutic relationships and provide consistency throughout the research document, instead of switching from patient, to resident, to veteran, etcetera.

#### ***Recreation Therapy Research at SHSC***

Through their research, recreation therapists at SHSC hoped to improve their practices and in turn, the lives of the individuals receiving care at SHSC. Figure 2 provides a chronological flowchart of research conducted by the Recreation Therapy department at SHSC and the University of Waterloo. The Recreation Therapy department at SHSC was dedicated to conducting research to improve their practices. For example, findings from previous research on quality indicators were used to shape the vision statement of the Recreation Therapy department, and ideas such as *personal growth and development, meeting and helping others, building self-confidence and a sense of belonging* have been incorporated into their daily practice. Other research conducted within the Recreation Therapy

department at SHSC focused on: assessments (Pedlar, Hornibrook & Haasen, 1998), meaningful patient-focused care (Cantwell, 2000), meaning and the experience of place (Wiersma, 2003), and a therapeutic relationships with individuals receiving care at SHSC (Arai, 2009). The following section illustrates how the past research has supported the development of this current study on therapeutic relationships.



*Figure 2.* Chronological flowchart of research conducted with the Recreation Therapy department at SHSC, 1998-2009.

### ***Research on Assessments***

In 1998, to ensure quality care was being provided to the residents of SHSC, the recreation therapists at SHSC explored their traditional method of assessment. All of recreation therapy interventions at SHSC began with an assessment, which followed a biomedical model philosophy (Pedlar et al., 1998). The traditional biomedical model focused on eliminating or minimizing disease (Caitlin, 2006). Miller and Crabtree (2005) emphasize 10 premises of the biomedical model, including:

a) scientific rationality, b) an emphasis on individual autonomy rather than on family or community, c) the body as machine with an emphasis on the physiochemical data and on objective numerical measurement, d) mind body separation and dualism, e) diseases as entities, f) the patient as object and the resultant alienation of physician from patient, g) an emphasis on the visual, h) diagnosis and treatment from the outside, i) reductionism and the seeking of universals, and j) separation from nature (p. 610).

Assessments based on the biomedical model reinforced the idea of recreation therapists as experts with the power to make decisions on behalf of the individuals receiving care at SHSC. The biomedical model has been associated with male-centeredness, expertise, valuing only science and technology, focusing on short term outcomes, hierarchy and intolerance (Miller & Crabtree, 2005). Pedlar et al. (2001) analysed the recreation therapists' practice of conducting assessments based on the medical model of care and found the process to be incongruent with their evolving philosophy of care. At that time, the practitioners were beginning to embrace person-centered care philosophies (Pedlar et al., 2001). In their groundbreaking research, Pedlar et al. (1998) followed an action-based research approach involving recreation therapists at SHSC in research proposal development, data collection and interpretation. Through the assessment research project, the recreation therapists critiqued current assessment practices and reflected on the implications of those practices. This level of involvement fostered positive changes in recreation therapy practices at SHSC as the recreation therapists played a large role in developing the *Personal Leisure Profile*. The *Personal Leisure Profile* was adopted as the approach to assessment at SHSC. The *Personal Leisure Profile* attempted to: increase trusting relationships with residents, gain an understanding of the individuals in their care and their leisure interests, and provide the recreation therapist with direction for future leisure engagement with the residents (Pedlar et al., 1998). The *Personal Leisure Profile* asked individuals receiving care at SHSC questions about who they were. These questions helped to guide the practitioners to provide care that was desirable to the individuals receiving care. Therefore, the new *Personal Leisure Profile* was congruent with the recreation therapists' philosophies of patient-centered care as it involved care recipients in their care decision-making. As an outcome of the assessment project, Pedlar et al. (1998)

created six recommendations for the recreation therapists to assist the practitioners in maintaining a person-centered approach to care. Pedlar and her colleagues (1998) recommended:

- the importance of being present by actively listening to residents
- using language that was easily understood by residents
- ensuring transparency of actions/questions
- fostering positive exchanges of information
- focusing on current leisure interests of residents rather than assessments
- providing real and meaningful choices.

Research that followed the *Personal Leisure Profile* explored changes the recreation therapists and individuals receiving care at SHSC underwent during transition from a medical model to a person-centered care model (Cantwell, 2000).

#### *Research on Shifting Philosophies of Care*

As research on assessments came to a close, the Recreation Therapy department at SHSC became aware their care philosophy was transitioning. They were formally shifting from an approach entrenched in the biomedical model to a person-centered care approach. A person-centered care model follows a philosophy that:

focuses on the value of each individual. It involves respecting and honouring the uniqueness of each person and allowing him or her to be involved in decisions that impact his or her life. Traditional care and person-centered care differ in the following ways: disease focused versus person focused; managing behaviours versus heavier acceptance; caregiving versus care partnering; control and losses versus empowerment and abilities programming; activities versus meaningful occupation (Caitlin, 2006, p. 45).

Embracing person-centered care shifted attention from loss, loneliness, sadness, worry, anxiety, frustration, fear, paranoia, anger and embarrassment to fulfillment, connectedness, cheerfulness, orientation, contentment, peacefulness, security, trust, calm and confidence (Bell & Troxel, 1999). At SHSC, Cantwell's (2000) study explored the meaning of patient-centered care in recreation therapy and found three major themes including issues of practice, enlivening relationships, and being with the person. Cantwell's (2000) findings suggested:

1. Residents value the time they spend with [recreation therapists] regardless of the activity.
  2. Residents enjoy socializing, contributing to the group and being involved in meaningful activities.
  3. *Being with* the resident involves humour, a unique approach with each resident and communication that indicate that you are friends.
- (p. 7).

Cantwell's (2000) study highlighted the importance of truly *being with* the resident during shared moments and how recreation therapists benefit residents by engaging them and enhancing their enjoyment while they lived at SHSC. After Cantwell's (2000) findings were presented to the Recreation Therapy department at SHSC, a person-centered care philosophy was formally accepted. At that point in the Recreation Therapy department's research journey, the importance of relationships and community began to emerge.

### ***Research on Building Community***

After Cantwell (2000) analyzed the meaning of patient-centered care in recreation therapy at SHSC, she and Alison Pedlar, from the University of Waterloo, began to focus their research on the meaning of community established in the cognitive support unit (Cantwell & Pedlar, 2002). Cantwell and Pedlar (2002) built on previous recreation therapy research findings to create an '*aspects of care-in-community*' report. Cantwell and Pedlar (2002) found to build a sense of community, staff (including recreation therapists) successfully moved to the unique rhythms of each individual. By focusing on the rhythms of each resident within the cognitive support unit, capacity building, enlivening relationships, affirmation of the residents' selves and sense of place also occurred (Cantwell & Pedlar, 2002). Overall, moving to the rhythms of the residents built a sense of community, enhanced social support, contributed to the person's overall well-being and unconditional acceptance, and residents were recognized as unique persons (Cantwell & Pedlar, 2002).

Cantwell and Pedlar's (2002) study was significant for our research team's work on therapeutic relationships because it highlighted the concept of enlivening relationships. An enlivening relationship occurs "between the practitioner and the resident [and] was a crucial aspect of providing leisure



opportunities within a [patient-centered care] framework” (Cantwell & Pedlar, 2002, p. 3). Enlivening relationships support opportunities for meaningful and enjoyable leisure, socialization and contribution to a group (Cantwell & Pedlar, 2002). However, these enlivening relationships were not discussed in greater depth, thus leaving room for further study.

### ***Research on the Resident Experiences in Different Settings***

In 2003, the impact of two different contexts (an institutional and a camp setting) on interactions between staff and campers was explored and reflected upon by researchers from the Recreation Therapy department at SHSC (Wiersma, 2003). Wiersma (2003) focused primarily on the experiences of residents with dementia in different contexts, meanings they associated with those places and analyzed the impact contexts (pre-camp, during camp, and after camp) had on interactions between residents and staff. Wiersma (2003) found life within the facility was highlighted by confinement, lack of freedom, and choice. During institutionalization, residents with dementia were more likely to disengage and conceal their true selves from staff (Wiersma, 2003). The residents would only reveal their identities to supportive individuals who fostered humour-filled, helping environments or reminiscence (Wiersma, 2003). In contrast, the camp setting was associated with residents increased engagement and revelation of themselves (Wiersma, 2003). The essences of a relationship enhanced revelation in the different contexts were: equality, sharing, reciprocity and trust (Wiersma, 2003). These essences were investigated further in this research study.

### ***Research on Relationships***

Although relationships were discussed briefly in past research projects at SHSC, in depth exploration of therapeutic relationships had not occurred until recently. Last year, the recreation therapists used a memory work research method to discuss positive and challenging relationships they experienced with individuals receiving care at SHSC (Arai, 2009). According to Cadmen et al. (2007) during the writing, sharing and analysing of memory work experiences, “memory-work researchers...seek to derive common meaning from...shared experiences, yet [researchers] cannot necessarily assume this commonality” (p. 3). To encourage the recreation therapists shared experience

and meaning-making process, Arai followed the traditional memory work pattern of writing, sharing and analyzing outlined by Haug (1999). The recreation therapists wrote two memories, one about a positive experience and another regarding a challenging experience that had occurred with an individual receiving care at SHSC. During their Annual Retreat in 2008, the recreation therapists separated into five small groups and read one another's positive memories. Each small group then discussed and analyzed the themes present in the writings. After a short break, the small groups were rearranged and the recreation therapists, read, discussed and analyzed themes expressed in their memories of their challenging experiences. Afterwards, the group members amalgamated and discussed their preliminary findings together. Susan Arai, from the University of Waterloo was asked to summarize the research findings and report back to the Recreation Therapy department. The preliminary themes that emerged during the memory work study included: the flow of the therapeutic relationships, developing the therapeutic relationship, recreation and the therapeutic relationship, what emerges from the therapeutic relationship, and endings in the therapeutic relationship (Arai, 2009). Arai (2009) recommended all of the themes from the memory work study required further investigation.

As the memory work study concluded, the research team eagerly continued to discuss their experiences and discovered they held many different understandings of their therapeutic relationships with individuals receiving care at SHSC (Arai, 2009). For example, some recreation therapists implied a therapeutic relationship could be described as a friendship with a resident, and other recreation therapists implied a therapeutic relationship was different from a friendship (Arai, 2009). Other issues surrounding the closing of a therapeutic relationship arose, for example: Was a challenging relationship (in which the individual's needs were not being met or the individual did not want to be engaged in recreation therapy) still considered a therapeutic relationship? Some recreation therapists stated a therapeutic relationship had to be beneficial and others stated any relationship (positive or challenging) could be therapeutic. Another interesting finding of the memory work study was relationship-centered care practices and philosophies were beginning to emerge in recreation therapy at

SHSC. After the memory-work study it was determined further investigation of therapeutic relationships and relationship-centered care was required.

Relationship-centered care was described by Tresolini and the Pew-Fetzer Task Force (1994) as a care philosophy that believes biomedical and psychosocial components of life cannot be compartmentalized and emphasizes the “importance of the relationships among people as the foundation of any therapeutic or healing activity” (p. 11). According to Dossey and Keegan (2008) practitioners engage in three different types of relationships during relationship-centered care giving: 1) relationships with individuals receiving care, 2) the community and 3) other practitioners or staff members. Dossey and Keegan (2008) claimed “relationship-based care is ...valued as it provides ... the most direct routes to achieve the highest level of care and service to patients and families” (p. 13). Nolan, Davies and Grant (2001) used the *Senses Framework*, which contains six different ‘senses’, to how relationship-centered care was developed and sustained within different care settings. The six senses outlined by Nolan et al. (2001) for quality caring relationships included the senses of security, continuity, belonging, purpose, achievement and significance (refer to Table 2). According to Nolan et al. (2001) in strong relationships all *senses* should be experienced by all individuals involved. The *Senses Framework* also provided guidelines for older adults receiving care, family carers and practitioners to enhance relationship-centered care.

Table 2  
*The Six Senses Framework for Caring Relationships*

<b>1. A Sense of Security</b>	Feeling safe and receiving/delivering competent and sensitive care.
<b>2. A Sense of Continuity</b>	Recognizing one’s biography- using the past to contextualize the present, and recognizing that trust and security can only be built over time
<b>3. A Sense of Belonging</b>	Having opportunities to form meaningful relationships or feel part of a team
<b>4. A Sense of Purpose</b>	Having opportunities to form meaningful relationships or feel part of a team
<b>5. A Sense of Fulfillment</b>	Achieving meaningful or valued goals and feeling satisfied with one’s efforts
<b>6. A Sense of Significance</b>	Feeling that you matter, and that you are valued as a person

(Modified from: Dupuis, Gillies, Mantle, Loiselle, & Sadler, 2008; Nolan et al., 2001)

The Six Senses Framework has been used in a variety of different settings such as healthcare, research, and education, to challenge traditional ways of establishing, maintaining and perceiving relationships. The Murray Alzheimer’s Research and Education program also embraced concepts from

relationship-centered care and the senses framework to assist them in creating their own partnership approach used to work with persons with dementia (Dupuis et al., 2008). Their partnership approach was drastically different from the traditional biomedical model approach as its guidelines included: valuing all parties equally, establishing community, commitment and connection; encouraging critical reflection, and creating and maintaining safe, shared spaces for open communication and dialogue (Dupuis et al., 2008). Adams and Clarke (1999) described building partnerships in healthcare settings as an interactive process where individuals are respected, treated as equals and knowledge is exchanged to create meaningful care. Adams and Clarke (1999) suggested a continuum of control and power exists within healthcare settings. At one end of the continuum, partnerships in care were capable of forming and professionals accepted they were only one knowledge base among many (Adams & Clark, 1999). At the other end of the continuum, professionals were viewed as knowledgeable experts who sought compliance and engaged in a hierarchical biomedical model approach to care. There were numerous points along the continuum where individuals and professionals engaged in relationships with others; some had the goals of compliance and others focused on reaching consensus (Adams & Clarke, 1999). Before this research study, it was unclear where the recreation therapists positioned themselves along this continuum, and they hoped exploration of their therapeutic relationships would provide greater insight.

### *Summary*

At SHSC, research within the Recreation Therapy department gradually evolved from a focus on the biomedical towards person-centred care practices (cf. Cantwell, 2000; Pedlar et al., 1998; Pedlar and Cantwell, 2002) and the presence of relationship-centered care begun to emerge (Arai, 2009). Although relationship-centered care incorporated several types of relationships within a care setting, discussions during the memory work study focused mainly on therapeutic relationships between recreation therapists and individuals receiving care at SHSC (Arai, 2009). At the onset of this study, it was uncertain where the recreation therapists aligned themselves on the continuum of care and control outlined by Adams and Clarke (1999). To deepen their understandings of their therapeutic relationships

and philosophies of care, the research team drew on literature written on therapeutic relationships from other disciplines' such as sociology, psychology, nursing and counselling to further their understanding. This information was shared with the research team by me through our discussions as the research process unfolded. The following sections of this chapter explore understandings of therapeutic relationships arising in the literature from other disciplines.

### ***Understanding Relationships in the Contexts of Other Disciplines***

Therapeutic relationships are frequently discussed within sociology, psychotherapy, psychology, social work, nursing and other health-related literature. Terms found in the review of literature similar to therapeutic relationship were: therapeutic alliance, working alliance; and client-practitioner relationship, patient-practitioner relationship, or resident-practitioner relationship. The terms professional relationship and working relationship were also used. For the purposes of this section, the term *therapeutic relationship* was used as the amalgamated term for all relationships between a professional providing a service such as therapy to another person requiring that service. In this portion of the literature review, definitions of therapeutic relationships from other professions are discussed. In the literature, definitions of the therapeutic relationship varied greatly from the belief the relationship contained god-like qualities (Gostecnik et al., 2008) to simple interactions between two different people (Mandell, 2007). Several qualities of therapeutic relationships were highlighted in the literature from other disciplines including communication (Gostecnik et al., 2008), trust (Pelham, 2008; Watson & Greenberg, 2000) and empathy (Sevenhuijsen, 1998) and will be discussed in greater detail.

### ***Communicating and Feeling Connected***

Across a number of disciplines (e.g., Christian theology, nursing, and social work) communication and connection were identified as two essential qualities of therapeutic relationships. Carl Rogers (1957), the influential humanistic psychologist, highlighted the importance of communicating with congruence or authenticity, warmth and empathy in therapeutic relationships. According to psychoanalytic and Christian theology literature, the relationship between a therapist and client was incredibly important to therapy outcomes. The therapeutic relationship was described by

Christian theologians as an intense form of communication that held a powerful spiritual meaning (Gostecnik et al., 2008). Gostecnik et al. (2008) discussed therapeutic relationships in family and faith counselling:

we all long for relationships with others, because only in connecting with others can we develop our intrapsychic structure and become functional adults. We are psychologically predisposed to have a constant connection with others and are driven toward relationships with others. Our deepest yearnings are therefore devoted to building solid dialogue as the means of becoming fully human. We, therefore, consciously or unconsciously, long for a relationship where we can experience happiness, satisfaction and, above all, redemption or salvation from our dreads, miseries and unhappiness. In this article we presuppose that a therapeutic relationship, demonstrated in a psychoanalytic setting, namely in relational family therapy, can contain redemptive dimensions in which the inextinguishable longing for salvation is always present (p. 386).

The argument Gostecnik and his colleagues put forward was that individuals innately look to build relationships with others to become fully human. Abraham Maslow (1943) referred to the process of becoming fully human as *self-actualization* and used a hierarchy to outline several different categories of human needs, including social and self-actualization needs. According to Gostecnik et al. (2008), the innate desire for connection helped to strengthen relationships between clients and professionals during therapy and it was through communication with therapists, goals were achieved and patients reached their full potential or salvation. The communication quality of the therapeutic relationship was emphasized by Gostecnik et al. (2008):

communication has a sacred dimension. The dialogical relationship between us and our fellow beings is thus also marked by sacrality, since this dialogical relationship at the human level is a reflection of the basic relationship between Creator and creature. The relationship among our fellow human beings, the I-You relationship, reflects our likeness to God and, in the most profound sense, brings salvation. It is this potential for redemption to be found in human communication, in its sacred dimension that relational family theory advocates (p. 387).

Although the focus of this theological argument was on relational family theory, the important theme of communication also emerged in literature from other disciplines. Communication was documented as essential in the development of nurse-client relationships. The Registered Nurses Association of Ontario (2002) suggested nurses engage in “active listening, trust, respect, genuineness, empathy and responding to client concerns” to create positive relationships (p. 17).

A shared connection between two people was an important theme throughout the literature on therapeutic relationships. Having a sense of belonging and a shared connection were particularly important for the development of relationships and progress (or salvation in Christian family therapy). Gostecnik et al. (2008) stated all individuals desire “a promise of contact, relationship and thus a sense of belonging without which an individual would not be able to survive. All these contents also carry the fundamental longing for resolution and redemption” (p. 390). Although other disciplines did not focus their therapeutic relationship on salvation, they did describe the significance of open communication in a comfortable environment to promote a sense of belonging (Mandell, 2007).

### ***Creating Positive Change***

Linking therapeutic relationships to positive change was another common theme in the literature. Mandell (2007) discussed how social workers view their therapeutic relationships with clients. From the social work perspective, therapeutic relationships focused on creating a different outcome for the client and had “a formal purpose of offering support, solidarity, and collaborative efforts toward desired change” (Mandell, 2007, p. x). Mandell explained relationships between social workers and their clients consisted of a series of therapeutic interactions operating “in a two-person rather than one-person field, so that two subjectivities, each with its own set of internal relations, begin to create something new between them” (p. 3). The social work literature implied that positive change occurred due to the interactions of two people (the therapist and the client) working toward a common goal. The two people worked together and brought different resources and perspectives into the shared situation to create change. Flaskas and Perlesz (1996) stated the “therapeutic relationship is not only the unit of change but it is the context of change” (p 85). Many researchers discussed therapeutic relationships as the context for positive changes when qualities of the relationship such as attachment, empathy and autonomy are constructed by the professional.

### ***As a Context: Attachment, Empathy and Autonomy***

Sometimes within the literature, the definition of the therapeutic relationship was vague and referred simply to the relationship between the client and the therapist (Crowe & Grenyer, 2008).

Other authors suggested therapeutic relationships created environments in which therapy occurs, “therapy work takes place within a therapeutic relationship” (Cassidy & Shaver, 1999, p. 586). To create a positive context for therapy, attachment and empathy appeared to be necessary in the relationship. Attachment has been described as “a process through which people develop specific, positive emotional bonds with others” (Newman & Newman, p. 149). Cassidy and Shaver (1999) stated attachment or the sense of connection and concern for another person significantly impacted therapeutic relationships in psychotherapy. Other researchers suggested establishing trust (Pelham, 2008), empathy (Rogers, 1957; Watt-Watson, Garfinkel, Gallop, Stevens, & Streiner, 2000) and responding in a sensitive manner were important in therapeutic relationships (Cassidy & Shaver, 1999; Rogers, 1957). Cassidy and Shaver (1999) indicated empathy helped to create a positive context for psychotherapy,

[e]mpathy is in many ways the complement or counterpoint to aggression. Whereas aggression often reflects an alienation from others, empathy reflects an amplified connectedness, and whereas aggression reflects a breakdown or warping of dyadic regulation, empathy reflects heightened affective coordination (p. 78).

During therapy, Rogers (1957) encouraged therapists to show positive regard towards the client and respond to comments in a calm and sensitive manner. Through empathy, psychotherapists attempt to create understanding and a collaborative space to work on goals with their clients. Yet the concept of empathy was not unique to the field of psychotherapy; nursing also highlighted the importance of empathy in therapeutic relationship (Gallop, Taerk, Lancee, Coates, Fanning & Keatings, 1991; Olson, 1995; Watt-Watson, Garfinkel, Gallop & Stevens, 2000). None the less, the literature also reveals critics of empathy, particularly in healthcare settings. White (2000) suggested professionals attempt to understand another person’s perspective through empathy; however, “this move often works to perpetuate the power of professionals” (p. 121) and ignores voices of others. Empathy was perceived by some researchers as an impossible feat and paternalistic (Sevenhuijsen, 1998; White, 2000). Sevenhuijsen (1998) stated even though a person attempts to be empathetic they cannot truly eliminate their own prejudices. As the author states:



“Empathy” in itself forms no guarantee that someone’s moral considerations are free of projection or misconception. The promotion of empathy is in itself insufficient to break the dominance of cognitive processes, in which “others” are objectified, and long with this the sexism, classism, and ethnocentrism in dominant currents in Western philosophy (p. 156).

Sevenhuijsen suggested when trying to understand another’s perspective in a caring relationship, engaging others in communication and actively listening to them was more important than empathy.

Aside from empathy, therapeutic relationships were described as contexts supporting autonomy; that is, the ability to be self-determining, to govern one’s actions independently (Merriam-Webster Dictionary, Autonomy, 2009). In the literature, autonomy meant independence of thought and actions within one’s life. There was also support for the development of client autonomy through therapy so the client resists becoming dependent on a therapist. Empathy, attachment and autonomy were not the only qualities discussed in the literature as being essential in a therapeutic relationship. Support, solidarity and collaboration also emerged in definitions of therapeutic relationships (Mandell, 2007).

### ***Support, Solidarity and Collaboration***

Support, solidarity and collaboration were mentioned in social work literature as qualities the professional needed to develop and foster for a positive therapeutic relationship to occur. In this section the three themes of support, solidarity and collaboration arose in Mandell’s (2007) description of a therapeutic relationship. Support was the first theme mentioned by Mandell, yet the type of support required was not clearly outlined. There are many forms of support. Support, documented by Schumaker and Brownell (1984) included “an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient” (p. 13). In this example, support included provision of resources (e.g., financial or educational resources) between two people. In nursing literature on adjusting to transitions, meanings of support included practical help, companionship, and providing opportunities for confidential expression of emotions or opinions (Peterson & Bredow, 2008). Pearson (1990) stated support occurs in a variety of forms including acceptance, self-esteem, love and intimacy, personal or work relationships, peer groups, stimulation and challenges, role models, guidance and comfort and assistance. Support can occur when

individuals accept one another unconditionally. In turn, unconditional acceptance enhances one's self esteem (Pearson, 1990). When someone feels loved and shares intimacy with another person, they feel emotionally supported. Different relationships provide support in a variety of ways. For example, parents may provide a teenager with financial support, a partner may provide emotional support or a friend may provide guidance and practical support. In addition, the type and intensity of support has the potential to change over time (Pearson, 1990). Simply stating support existed in therapeutic relationships was insufficient to describe the complexity of the term.

Solidarity and collaboration were two additional qualities of therapeutic relationships Mandell (2007) highlighted. Sweet (2003) described solidarity as a complex term involving:

- 1) the recognition of one another as beings who have common interests and who can engage in common action; 2) the existence of practices that enable the participants to begin to realize these common interests; 3) a decision to engage in these practices and to carry out certain actions that achieve these interests; 4) the actual engaging in these practices; and 5) the development of a disposition, or *habitus*, or virtue as a result of engaging in these practices - namely, that of being "in solidarity." And so, those who are "in solidarity" with others have a sense of commitment or *engagement* for the realization of a common interest, care for these others, and may be conscious of moral obligation to continue in such activities (p. 226).

In essence, solidarity occurred when two or more individuals connected over commonalities and actively engaged with one another, towards a shared goal or purpose. Collaboration was another quality Mandell (2007) included in her definitions of therapeutic relationships. Risko and Bromley (2001) stated "there is no universally accepted definition for collaboration...but most view collaboration as a shared partnership among all parties" (p. 22). Watson and Greenberg (2000) discussed if therapists failed to construct feelings of trust and a collaborative agreement in the beginning of their relationships then '*ruptures*' were more likely to occur. It was unclear whether a collaborative therapeutic relationship or partnership was based on equality or if one party had more responsibility or power than the other. Regardless, support, solidarity and collaboration were identified as essential qualities for the development of positive therapeutic relationships.

So far in the review of literature from other disciplines, qualities of therapeutic relationships such as communication, feeling connected, attachment, empathy, autonomy, support, solidarity and

collaboration were emphasized. In this chapter, the therapeutic relationship was also described as a context in which positive changes and therapy took place. Up to this point, the review of research literature focused on the positive qualities and outcomes of the therapeutic relationship. The following sections of this chapter highlight research on the challenges of therapeutic relationships. In addition, group versus individual contexts of relationship, measurement of the therapeutic relationships, and the boundaries around therapeutic relationships are discussed.

### ***Challenges in Therapeutic Relationships***

Some researchers stated therapeutic relationships were not always positive or capable of achieving beneficial outcomes (Hilton, 1997; Rand, 2002; Yalom & Leszcz, 2005). Psychotherapists, Yalom and Leszcz (2005) wrote a “strong therapeutic relationship may not guarantee a positive outcome, [and] a poor therapeutic relationship will certainly not result in effective treatment” (p. 61). Many challenging outcomes of therapeutic relationships appeared in the literature and included negative impacts on therapists, such as secondary trauma (Hesse, 2002; Rand, 2002). Hesse (2002) focused on the secondary trauma social workers were exposed to within their therapeutic relationships and the harmful impacts those relationships had on the personal and professional lives of practitioners. Figley (1993) described secondary trauma as “behaviours and emotions resulting from knowing about a traumatizing event experienced by ...[another]—the stress resulting from helping or wanting to help the traumatized or suffering person”(p. 7). Literature for nurses, therapists and counsellors also stated therapeutic relationships were not entirely beneficial to the two-parties involved, particularly for the professional (Clark & Gioro, 1998; Kadambi & Truscott, 2004; Pearlman & Saakvitne, 1995). Pearlman and Saakvitne, (1995) suggested negative implications often transpired for the therapist when they heard about trauma while being engaged in therapeutic relationships. Rand (2002) emphasized therapists need to maintain healthy and explicit boundaries to prevent trauma from occurring within their therapeutic relationship, for both themselves and their clients.

Also described in the literature was the “rupture” in the therapeutic relationships and how to prevent or overcome weak therapeutic relationships (Nathanson-Elkind, 1994). Nathanson-Elkind

(1994) discussed *impasses*, *wounding* and *ruptures* that occurred in therapeutic relationships. Impasses in therapy were referred to as stalemates or deadlocks, where no progress was made and no new information was shared (Nathanson-Elkind, 1994). Wounding was described as an emotional harm suffered by the client by an external event or an action of their therapist (Nathanson-Elkind, 1994). Whereas, ruptures occurred when therapist and client no longer related to one another and the two parties felt distressed or isolated (Nathanson-Elkind, 1994). Nathanson-Elkind (1994) stated if therapeutic relationships were not well established by the therapist, their clients could be left feeling insecure and distrusting. Watson and Greenberg (2000) warned in weak relationships, therapy goals are often not achievable. In therapeutic relationships both positive and therapeutic and undesirable outcomes occur.

### ***Comparing Group and Individual Contexts***

In the psychotherapy literature, the importance of the therapeutic relationship depended on the context in which the therapy occurred (e.g., individual, group) (Crowe & Grenyer, 2008). For Yalom and Leszcz (2005) the role of the therapist was different within group and individual contexts. In individual counselling sessions, the therapeutic relationship was predominant and impacted therapy outcomes (Yalom & Leszcz, 2005). Roth and Batson (1993) suggested in psychotherapeutic treatment “the therapeutic relationship critically contributes to the resolution of thematic issues” (p. 159) and the role of the therapist was to maintain “a creative balance between autonomy and connection in the therapeutic alliance” (p. 159). In this case, the outcomes of therapy were directly affected by the therapist’s ability to create a connection with the client and their promotion of independent decision making by the client. Yalom and Leszcz (2005) determined cohesiveness between group psychotherapy members fostered positive outcomes more than the therapeutic relationship. In fact, Crowe and Grenyer (2008) concluded that in group-based treatment, relationships between group members are more influential on therapy outcomes than the individual-therapist relationship.

### ***Measuring the Therapeutic Relationship***

Researchers used quantitative scales to measure the strength of therapeutic relationships. Scales referred to in the literature included the Collaborative Alliance Short Form in both patient and therapist versions (Clemence, Hilsenroth, Ackerman, Strassle and Handler, 2005); the Patient Help-Received Scale and Therapist Help Received Scale (Clemence et al., 2005), the Working Alliance Inventory (Horvath & Greenberg, 1989), Patient's Estimate of Improvement to Date (Hatcher & Barends, 1996) and the California Psychotherapy Alliance Scale (Gaston, 1990).

The California Psychotherapy Alliance Scale was the most commonly used scale and was created by Gaston and Marmar (1994, 1993). The California Psychotherapy Alliance Scale was a 12-item scale used to study group psychotherapy from therapists' perspectives and consisted of four smaller scales (Crowe & Greyner, 2007). The four subscales included: the Patient Working Capacity Scale examining a patient's active engagement and focus; the Patient Commitment Scale measuring a patient's attitude, trust and commitment towards therapy; the Working Strategy Consensus considering the ability of the group therapy members to agree on therapy goals; and the Member Understanding and Involvement Scale determining level of empathy and encouragement for others in group therapy (Gaston & Marmar, 1993). One version of the California Psychotherapy Alliance Scale, or the CALPAS-P, was used to study one-to-one psychotherapy counselling from the patient perspective. The Collaborative Alliance Short Form examined individual counselling from the therapist perspective. Clemence, et al. (2005) compared the alliance scale scores of patients and therapists and stated across all scales patients' consistently scored their therapeutic alliances to be stronger than therapists indicated. These findings suggested patients and therapists perceived therapeutic relationships differently (Clemence et al., 2005). In the future it will be important to compare and contrast qualities, outcomes and challenges of therapeutic relationships from a variety of perspectives.

Several researchers also used quantitative research methods and standardized scales to test factors (Clemence et al., 2005) and perceptions of therapeutic relationships (Samstag, Batchelder, Muran, Safran & Winston, 1998). Factors commonly measured within therapeutic relationship-related

standardized scales included: *bond, idealized relationship, goals and tasks* (Hatcher & Barends, 1996) and *confidence collaboration* (Clemence et al., 2005). The idealized relationship factor measured the extent to which two parties disagree on important treatment issues and ability of the client or therapist to acknowledge those disagreements (Hatcher & Barends, 1996). The goals and tasks factor opposed the idealized relationship factor and examined agreement between patient and therapist on goals (Hatcher & Barends, 1996). Bond was a term used to measure the level of mutual trust within the relationship (Hatcher & Barends, 1996), and confident collaboration factors examined the patient and therapist's confidence levels, commitment to therapy, and worth associated with therapy sessions (Clemence et al., 2005).

Researchers often measured and compared several factors or subscales when determining the success of a therapeutic relationship. Clemence et al. (2005) tested 125 therapeutic relationships with the Collaborative Alliance Short Form, and found:

[b]oth the patient and therapist Confident Collaboration factors were found to be primary predictors of perceived improvement in psychotherapy. Number of psychotherapy sessions was related to patient estimates of improvement and therapist ratings of the amount of help received by their patients as well (p. 443).

Clemence et al.'s (2005) research concluded the client's perception that therapy was beneficial, the number of sessions, and time spent with the therapist were important to therapy progress. Therefore, dedication to therapy and the client's belief towards sessions were critical to the success of the therapeutic relationship. Samstag et al. (1998) used the Working Alliance Scale-12 to determine therapist and patient perceptions of the quality of the therapeutic alliance. Samstag et al.'s (1998) findings implied patients who perceived their therapeutic relationships were weak were more likely to drop out of treatment than a patient who described a strong therapeutic relationship. Perceptions of therapeutic relationships appeared to influence outcomes of the therapy. Developing a strong therapeutic relationship was also linked to enhanced participation in treatment and better outcomes (Samstag et al., 1998). In contrast, if the therapeutic relationship was weak it often resulted in poorer outcomes for the client and was labelled as a therapeutic misalliance (Samstag et al., 1998).

Some researchers critiqued the evaluation of therapeutic relationships using standardized scales. Burton (1963) stated standardized scale evaluations “lacked precision and that the outcome of any treatment lends itself to a multi-fold interpretation” (p. 593). Regardless of the criticism, some researchers use standardized scales to examine the strength of therapeutic relationships. The next section provides insights from the literature regarding the development of positive therapeutic relationships and strategies for overcoming challenges.

### ***Developing Therapeutic Relationships and Overcoming Challenges***

Throughout the literature researchers highlighted the development of positive therapeutic relationships and provided several suggestions to therapists to achieve this aim. The Registered Nurses Association of Ontario (2002) suggested to be successful in developing therapeutic relationships nurses needed to be knowledgeable about the clients they work with:

the therapeutic relationship is called many things: a helping relationship, a purposeful relationship, and the nurse-client relationship. All rest in the notion that effective nursing care is dependent on the nurse coming to know his/her client and engaging in a relationship with that client (no page)

Watson and Greenberg (2000) also stated successful therapists fostered a strong therapeutic relationship by ensuring clients acquired knowledge and acceptance of themselves:

Concentrate on facilitating client’s awareness and understanding of their internal experience and the specific processes involved in their generation in order to help them become more self-accepting, resolve interpersonal problems, become aware of characteristic styles of functioning, and formulate alternative courses of action (p. 176).

Watson and Greenberg (2000) encouraged therapists to increase clients’ awareness of their experiences and help them to find effective coping strategies so fewer impasses in the therapeutic relationship would transpire. Watson and Greenberg also suggested when forming a positive therapeutic relationship, a therapist needs to establish connections that foster an “*emphatically attuned bond*” and engage the client in therapy. At the same time, therapists were encouraged by Watson and Greenberg to provide ground rules and goals for therapy. To maintain a positive therapeutic relationship throughout therapy, Watson and Greenberg supported therapists to develop “a sense of

trust and collaboration about the tasks of therapy that will help clients resolve their problems” (p. 176).

In comparison, Gaston and Marmar, (1994) emphasized for:

a good working alliance to be achieved, meaning had to emerge from the material provided by the patient, and emotions need to be sufficiently contained and congruent with the material. Otherwise, such a display can be more reflective of a defensive disorganization rather than of therapeutic work (p. 5).

Gaston and Marmar commented therapists should avoid emotional outbursts while conducting one on one therapy and maintain their focus on creating meaningful experiences for clients.

Several authors had opposing views on disclosing emotions in individual therapy. Rosen (1999) and Gabriel and Monaco (1995) stated disclosure was actually beneficial in therapy whereas Reamer (2001) suggested disclosure was often detrimental to clients and should be used cautiously by therapists. Reamer leans towards a biomedical model approach that places control for developing successful relationship in the hands of therapists. Watson and Greenberg (2000) suggested when developing therapeutic relationships, therapists need to identify tones in their clients’ voices and the messages those tones are delivering. Tone and message identification,

facilitates the development of good working alliance insofar as it allows therapists to be more sensitive to clients’ moment-by-moment, cognitive-affective processing in therapy, and serves as a means of detecting alliance ruptures and periods when clients are not engaged in the therapeutic task (Watson & Greenberg, p. 177).

Watson and Greenberg (2000) also recommended in the early stages of the relationship, therapists should foster feelings of security, trust and agreement of therapy goals:

[t]he primary goals during the early stages are for clients and therapists to form an empathetic attuned bond, to formulate clearly the specific cognitive-affective problems that have brought the clients into treatment and to develop agreement as to the tasks and responsibilities of each of the participants in order to facilitate clients’ resolutions of their problems (p. 176).

In contrast, some authors indicated efforts of both therapist and client are required to achieve a positive and engaging relationship. Rogers (1957) described clients as active players in developing successful therapeutic relationships and noted power was not solely in the hands of therapists. Watson and Greenberg echoed Carl Rogers when they stated clients were actively involved in developing a successful relationship; “clients are active agents in the exploration process [for it] is fundamental to



the establishment of the collaborative working alliance” (p. 175). Pelham (2008) suggested that although therapists were often viewed as powerful healers, clients were not passive in the therapeutic relationship but as “proactive co-creators” (p.111). Walford and Walford (2008), advocates of the co-creative transactional approach to therapy, indicated both parties take various degrees of responsibility to maintain the strength of their therapeutic relationship:

[t]he principle of shared responsibility: co-creative transactional analysis emphasizes the shared client-therapist responsibility for the therapeutic process, in contrast to traditional transactional approach which emphasizes the personal responsibility of the client and integrative transactional approaches which tend to emphasize the responsibility of the therapists. The healing aspects of relationship...are co-created and co-maintained by active contributions from both therapist and client. Summers and Tudor point out that shared responsibility is not the same as equal responsibility and that the therapist’s particular contribution is his or her skill in facilitating and using this shared responsibility to promote awareness and development (p.88-89).

Despite the shared responsibilities of clients and therapists mentioned by Watson and Greenberg (2000), Pelham (2008), Rogers (1965, 1967), and Walford and Walford (2008), many researchers focused on the role therapists played in maintaining boundaries around therapeutic relationships.

### ***Establishing Boundaries***

In counselling and nursing literature, boundaries around therapeutic relationships were often discussed and strictly enforced by management. Boundaries were described as the limits or parameters allowing a professional and client to create a safe space and establish a therapeutic relationship (Peternelj-Taylor & Yonge, 2003). Boundaries defined acceptable and unacceptable conduct in a therapeutic relationship. Nathanson-Elkind (1994), suggested boundaries helped to prevent and overcome impasses in therapy. Roth and Batson (1993) found professionals established boundaries to safeguard both their patients and themselves from harmful implications (e.g., physical, emotional, ethical, legal) while engaging in therapeutic relationships. According to Videbeck (2008) the professional within a therapeutic relationship is responsible for establishing and maintaining appropriate boundaries:

[t]he nurse has the power over the client by virtue of his or her professional role. That power can be abused if excessive familiarity or an intimate relationship occurs or if confidentiality is breached...All staff members, both new and veteran, are at risk for allowing a therapeutic

relationship to expand into an inappropriate relationship. Self-awareness is extremely important: the nurse who is in touch with his or her feelings and aware of his or her influence can help maintain the boundaries of the professional relationship. The nurse must maintain professional boundaries to ensure the best therapeutic outcomes. It is the nurse's responsibility to define the boundaries of the relationship clearly in the orientation phase and to ensure those boundaries are maintained throughout the relationship (pp. 94-95).

Nursing guidelines indicated personal issues and interests of nurses should not be considered and clients' goals should remain the main priority within a therapeutic relationship at all times. The nursing profession traditionally followed a biomedical model approach which encourages separation of professionals from their patients. In contrast, Pelham (2008) suggested the identity of the professional could not be removed from the therapeutic relationship:

[t]he primary task of the therapist is to meet the client in a way that is, as much as possible, trustworthy, accepting and so forth. The capacity to meet the client in this way depends to a large extent on the therapist's self-awareness of her own issues, anxieties and prejudices (p.108).

In essence, before the therapists can assist another individual within their therapeutic relationship they need to be aware of their own issues, limitations and boundaries. Shiers and Paul (2008) suggested challenges arise in a therapeutic relationship if expectations of a therapeutic relationship are not discussed early on. They recommended therapists have discussions involving issues of limitations and privacy, and encourage realistic expectations and boundaries in the therapeutic relationship. Nathanson-Elkind (1994) stated a successful "therapeutic relationship must always be private and exclusive, sealed by confidentiality" (p. 5). In this one sentence, three themes were linked with effective therapeutic relationship development: privacy, exclusivity and confidentiality. These themes provide the context of one-on-one therapy; in psychotherapy, relationships and sessions without privacy, confidentiality and exclusivity were regarded as failures (Nathanson-Elkind, 1994; Samstag et al., 1998). Roth and Batson (1993) warned therapists against overstepping their boundaries and creating dependency in clients, implying boundaries and balance were crucial in a therapeutic relationship. With boundaries in place, positive progress in the therapeutic relationship was achievable, but without boundaries therapy would not progress successfully (Roth & Batson, 1993).

There were also critics of the use of rigid inhumane boundaries in therapeutic relationships (Lazarus, 1994). Lazarus criticized strict and blind application of boundaries for “undermining clinical effectiveness” (p. 256) and dehumanizing the individuals involved in the therapeutic relationship. Wittine (1993) emphasised therapists are human beings who fully participate in their therapeutic relationships and suggested therapists could not ignore their influence and ability to transform along with their clients. Lazarus (1994) also suggested flexibility and *individual nuances* are important to consider in a therapeutic setting, as boundaries that are too rigid may inhibit progress.

### ***Mindfulness***

The practice of mindfulness emerged in the focus group discussions and meetings amongst members of the small research committee. Mindfulness was described as a practice that influenced some of the recreation therapists’ therapeutic relationships and therefore this section of the literature review was added after data analysis had already begun. This section highlights the practice of mindfulness and the role it can play in therapeutic relationships. Hick, Segal and Bien (2008) state relationships between the therapists and individuals are “crucial for effective therapy... [and that] mindfulness has the potential to play a central role in enhancing the therapeutic relationship” (p. 3). Baer (2006) described mindfulness “as the nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise” (p. 125). Siegel and colleagues (2009) drew attention to the traditional understanding of mindfulness which highlighted “*sati*” or the three elements of awareness, attention and remembering. They also highlighted the modern evolution of mindfulness, which also embraces being nonjudgmental, acceptance and compassion to support psychotherapy practice. Woods (2009) described the bridging of traditional and modern understandings of the practice of mindfulness in detail, stating,

[m]indfulness originates from the Buddhist contemplative tradition. It has been described as an, “awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment.” (Kabat-Zinn, 2003; Baer, 2003). Dimidjian and Linehan have posited that key components of mindfulness can be categorized into “(1) observing, noticing, bringing awareness; (2) describing, labeling, noting; and (3) participating.” They also identify three characteristics embedded in the way one engages with these activities, “(1) nonjudgmentally, with acceptance, allowing; (2) in the

present moment, with beginner’s mind; and (3) effectively” (Dimidjian & Linehan, 2003). This constructive description of what constituent components and characteristics might be embedded in mindfulness is helpful in bringing some clarity to the factors we are practicing with and engaging in when teaching mindfulness (p. 464).

Baer (2006) drew attention to the discomfort individuals experience when first being exposed to mindfulness practice. Table 3 illuminates myths surrounding mindfulness and highlights the practical, everyday language and ideas it embodies.

Table 3

*Myths about Mindfulness*

<b>Mindfulness: What It Is Not</b>	<b>Mindfulness: What It Is</b>
<ul style="list-style-type: none"> <li>• A mystical or mysterious state of mind</li> <li>• Blocking or pushing away a thought or feeling</li> <li>• A quick fix, a cure-all</li> <li>• A skill you learn all at once</li> <li>• Something that only Zen Buddhists do or can do</li> <li>• Having perfect focus never getting distracted</li> <li>• A relaxation exercise</li> <li>• An attempt to change yourself or the world</li> </ul>	<ul style="list-style-type: none"> <li>• Awareness: attention: choosing to focus on something without judgment</li> <li>• Noticing thought or feeling (then maybe choosing to focus on something else)</li> <li>• A part of living an effective life, often a first step in using other skills</li> <li>• A skill that requires much practice</li> <li>• A capacity everyone has (whether you know it yet or not)</li> <li>• Choosing to try to keep your focus even though distractions will probably arise again and again. Mindfulness involves noticing the wandering, and gently guiding your attention back to your chosen focus.</li> <li>• An exercise involving full participation and acceptance of “what is” which at any given time could be a state of tension</li> <li>• Nonjudgmental acceptance of reality (even though it may lead you to make changes)</li> </ul>

(Source Baer, 2006, p. 231)

Baer (2006) described mindfulness as skilled and purposeful attention to your surroundings or an object, accepting it for what it is, without judgment or distraction. Siegel et al., (2009) provided two practical ways practitioners can cultivate mindfulness in their daily lives:

*Everyday mindfulness:* This involves reminding ourselves throughout the day to pay attention to what is happening in the moment without radically altering our routines. It means noticing the sensations of walking when we walk, the taste of our food when we eat, and the appearance of our surroundings as we pass through them...

*Formal meditation practice:* This involves setting aside time to go to the mental “gym.” We regularly dedicate a certain period to sit quietly in meditation. There are many types of meditation that can cultivate mindfulness. Most involve initially choosing an object of attention, such as the breath, and returning our attention to that object each time the mind wanders. This develops a degree of calmness which, in turn, enables us to better focus the mind on the chosen object. Once some concentration is established, mindfulness meditation entails directing the mind to whatever begins to predominate in the mind—usually centering on how the event is experienced in the body. These objects of attention can be physical sensations such as an itch, an ache, or a sound, or emotional experiences as they manifest in the body, such as the tightness in the chest associated with anger or the lump in the throat that comes with sadness. Regardless of

the chosen object of attention, we practice being aware of our present experience with acceptance (p. 23).

Other disciplines used mindfulness practice to enhance their therapeutic relationships. Wexler (2006) concluded clients and therapists' positive perceptions of therapeutic relationships strengthened as the therapist displayed more mindfulness in her approach.

### *Summary*

This review on the literature on therapeutic relationships within other disciplines has explored research from psychology, social work, psychiatry and counselling literature. Each profession described qualities of their therapeutic relationships, suggestions for successfully developing or maintaining therapeutic relationships, challenges occurring within therapeutic relationships, and the importance of boundaries around therapeutic relationships. Several qualities of therapeutic relationships were described including: trust, collaboration, connection, attachment, empathy and acceptance. Therapeutic relationships were seen as contexts in which therapy, communication, support, solidarity, and autonomy were possible. Although, some researchers noted the importance placed on therapeutic relationships differed between contexts, the overall aim of professionals appeared to be the creation of positive changes and reduction of harm. Despite positive aims of therapeutic relationships there were also harmful impacts on clients and therapists. Several researchers provided suggestions to therapists to overcome challenges within their therapeutic relationships and establish boundaries for themselves and their clients. Mindfulness was described as a practice used in psychotherapy settings to improve awareness of professionals and aid in welcoming and continuing therapeutic relationships. Despite all of the information on therapeutic relationships within the literature, several gaps remained. For example, there was no literature available on mindfulness in therapeutic relationships of recreation therapists. Additional gaps within the recreation therapy literature are highlighted in the following section.

### ***Gaps in the Recreation Therapy Literature on Therapeutic Relationships***

During the review of recreation therapy textbooks and journals, references were made to therapeutic relationships but detailed descriptions were often not provided. For example, Robertson and Long (2007) stated “facilitation skills are what create and maximize a therapeutic relationship” (p. 93). However, many texts failed to provide a definition or further understandings of the therapeutic relationship. Shank dedicated one chapter to developing therapeutic relationships in recreation therapy. In the chapter, Shank (2002) focused on the personal attributes recreation therapists needed to embody in their therapeutic relationships including: openness, flexibility and genuineness, positive regard and respect for others. Shank (2002) also discussed the competencies recreation therapists should have, “[t]hese include the ability to create partnerships with clients, the ability to practice from a multicultural perspective, and the ability to communicate effectively” (p. 194). Other issues regarding therapeutic relationships present in the recreation therapy literature were the importance of communication (Bedell & Lennox, 1996; Shank, 2002), sense of belonging (Cantwell & Pedlar, 2002) and meaning-making (Wiersma, 2003). The importance of communication training and practice was also highlighted (Austin, 2004). Shank noted effective communication helped to build partnerships in recreation therapy (Shank, 2002), whereas Bedell and Lennox (1996) stated proper communication creates engaging and constructive environments. Bedell and Lennox (1996) emphasized communication skills were important. They stated “recreation and activity therapists provide an interesting and engaging way of facilitating repeated practice of skills... [and] constructive group interactions” (Bedell and Lennox, p. 234). Strong communication skills enabled professionals to learn important information about their clients (Shank, 2002). Recreation therapy researchers also stated obtaining pertinent client knowledge assisted practitioners to be truly present with their participants (Gilbert, Johnston, & Afable, 2008).

A sense of belonging was also deemed to be essential in recreation therapy at SHSC. In environments, such as long-term care (Wiersma, 2003) and cognitive health units (Cantwell & Pedlar, 2002), residents felt a sense of belonging, escaped their problems and increased their well-being in

recreation therapy contexts. Wiersma (2003) also suggested relationships with recreation therapists helped participants create meaning in their lives which increased their quality of life. Robertson and Long (2007) reiterated that positive changes occurred through interactions with recreation therapy professionals stating practitioners built connections that led to positive changes in participants' lives,

[b]ecause therapeutic recreation specialists in long-term care facilities have extensive contact with clients, they have the opportunity to develop deep and meaningful therapeutic relationships. With such extensive contact, these therapeutic recreation specialists are ideally suited to help their clients lead more meaningful and happier lives" (p. 67).

In their code of ethics, the National Therapeutic Recreation Society (2001) also highlighted the importance of therapeutic relationships in treatment and emphasized the power professionals have over individuals receiving care within their therapeutic relationship. It should be noted the term "treatment" used by the National Therapeutic Recreation Society is embedded in a biomedical model approach to care and this language reduces the autonomy and powerful role of the individual receiving care within the therapeutic relationship. McLean and Yoder (2005) reiterated in the therapeutic relationship the therapist holds significant power and this issue should not be ignored. They suggested therapists reflect honestly on their power to prevent it from harming their clients (McLean & Yoder, 2005). To safeguard clients, the National Therapeutic Recreation Society's (2001) established a code of ethics that places boundaries around the therapeutic relationship. They also stated therapists should never bring their personal problems into their therapeutic relationships. Without these boundaries, "the professional runs the risk of using clients to meet personal needs, something which is contrary to the ethical principle of respect for persons" (National Therapeutic Recreation Society, 2001, no page). The importance of the therapeutic relationships, reflection on power imbalances, and boundaries were present within the recreation therapy literature. Yet after reading the literature, a modern and detailed understanding of therapeutic relationships from recreation therapists' perspectives remained elusive.

### *Chapter Summary*

Recreation therapy-based research conducted by members of the Recreation Therapy department at SHSC and academics from the University of Waterloo has evolved over the years. This review of

literature contrasted qualities, processes and boundaries surrounding therapeutic relationships in a variety of disciplines. How the recreation therapists at SHSC perceived their therapeutic relationships will be unveiled in Chapter Five. Before moving on to Chapter Five, Chapter Four describes how the research team used a PAR process to collectively develop, revise, reflect and implement their research plan.



## **Chapter Four: Participatory Action Research Process and Methods**

The purpose of this participatory action research (PAR) was to explore the understandings of therapeutic relationships that form between recreation therapists and individuals receiving care at Sunnybrook Health Sciences Center (SHSC). The research team members wished to participate in innovative research that would change their practices, draw on their self-reflection skills and enhance their care provision. Thus PAR was a natural choice for this study. As mentioned in Chapter One, two research questions originally guided this research study:

1. How do recreation therapists at Sunnybrook Health Science Centre understand "therapeutic relationships"?
2. How do those understandings of the therapeutic relationship influence care provision at Sunnybrook Health Sciences Centre?

As the research study progressed, the research questions were modified:

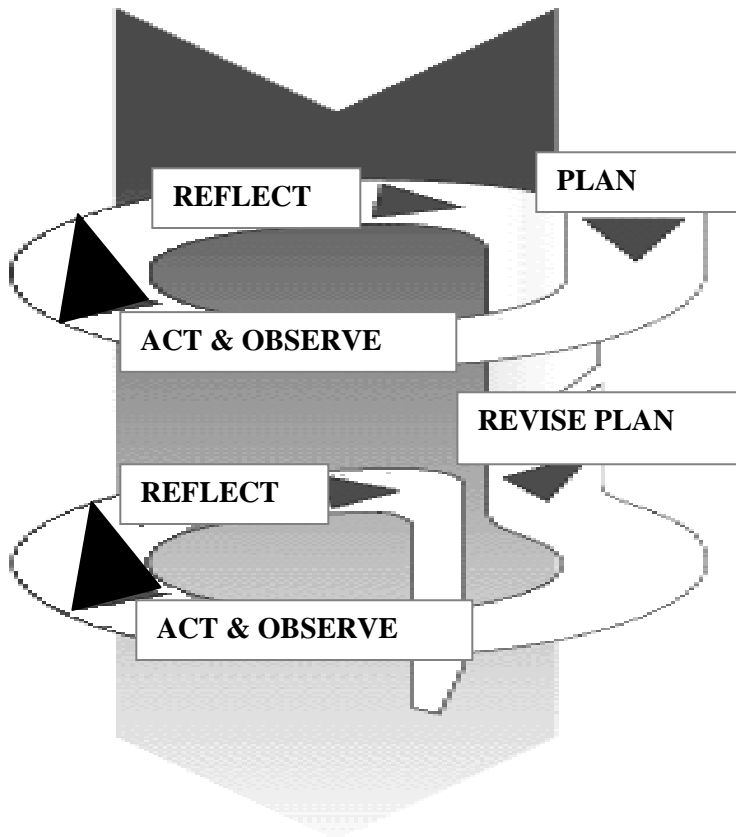
1. What is the philosophy of practice that defines therapeutic relationships at Sunnybrook Health Sciences Centre?
2. How do recreation therapists at Sunnybrook Health Science Centre understand their therapeutic relationships?
  - a. What is a therapeutic relationship in recreation therapy?
  - b. What are the qualities of therapeutic relationships?
  - c. What is the process surrounding a therapeutic relationship?
  - d. What are the roles within therapeutic relationships?
3. How are different influences negotiated within therapeutic relationships?

The research team chose PAR to guide their research endeavours since it enabled their active participation in the research design and implementation process. The team wished to act collectively on knowledge obtained through their past research and PAR processes encouraged this goal. The research team decided all of the recreation therapists at SHSC would be involved in the research process, and the individual level of participation would be determined independently. Eight recreation therapists served on a small research committee. This committee helped to guide and facilitate the research process. During data collection, members of the research committee acted as focus group moderators. The entire research team also engaged in data analysis, yet the level of involvement ranged depending on availability and desire to participate. Members of the research committee volunteered to conduct a preliminary data analysis and summarized the main research themes on

behalf of the research team. Once the preliminary data analysis was completed, members of the research committee presented the research findings to the entire research team for analysis and feedback (steps of the research process will be outlined in further detail later on in this chapter). Chapter Four provides a detailed description of the research plan and concludes with a discussion of ethical considerations.

### *The PAR Process*

The PAR process has several phases which include reflection, planning, action (or implementation of the plan) and observation (McTaggart, 1997). Figure 3 provides a visual representation of these PAR phases which may occur simultaneously or in order. Cycles of the phases may continue to unfold until research findings are agreed upon by the research team (Glasson et al., 2008; Wadsworth, 1997).



*Figure 3.* PAR spiral (McTaggart, 1997)

Reflection helps identify a problem or concern that needs further research to promote change (Wadsworth, 1997). Reflections during PAR may focus on the data, how data is collected, the entire research study or portions of it, involvement of researchers, and changes occurring within or around the research team throughout the process. Reflecting on the positive and challenging elements of the research process is also an important part of PAR. These reflection phases assist researchers to critically analyze their understanding, decision making and practices.

In PAR, the action phase begins when a research plan is established and implemented (Wadsworth, 1997). During the action phase, researchers are actively participating in gathering, analysing and distributing information (Glasson et al., 2008; Wadsworth, 1997). Observation phases can occur throughout the research process. Observation can occur when the researchers are present when data are being collected (i.e., during a focus group) and when they are analyzing data, in this case, the responses to focus group discussions. The PAR process is cyclical and as research progresses, additional periods of reflection, action and observation occur.

After the cycles have waned, the research team may enter an additional planning phase to contemplate how research will be disseminated to create change. In addition, participants are more likely to internalize research findings and create meaningful change as new practices, understanding or philosophies emerge from collective engagement in research (Rotteau & Bowers-Ivanski, 2008). Israel, Schulz, Parker, and Becker (1998) suggested that to sustain changes, researchers need to formally dialogue around and document their changes.

PAR processes have the potential to create personal and social changes (Koch et al., 2006). Personal change often occurs within individuals involved as PAR participants are encouraged to reflect on their situations, develop research skills, and are empowered to express their voices. Personal change also occurs when the research team begins to reflect on and implement their new learning into practice. The desire to grow and develop as individual practitioners and researchers motivated the recreation therapists at SHSC to undertake this research. Koch et al. (2006) stated “what has been noticeable in [the] experience of the participatory action research process has been the growth and development of

all involved” (p. 2). PAR addresses the research team’s needs to be challenged and to evolve. PAR provides the research team with opportunities for reflection on actions and to learn about themselves (Reason, 1998). By reflecting on one’s own and together, assumptions become known and new understanding can develop (Dupuis, 1999). Reason (1998) states:

human persons are centres of consciousness within the cosmos, agents with emerging capacities for self-awareness and self-direction. Human persons are also communal beings, born deeply immersed in community and evolving within community (p. 174).

Reason (1998) noted individuals involved in PAR have the potential to become empowered, for through PAR individuals come together and form a collective of resources. According to Kemmis and McTaggart (2008), powerful outcomes of PAR stem from the creation of open communication between participants and a collective unit through which social change becomes possible. This is what Dupuis et al. (2008) refer to as synergistic relationships.

For personal and social changes to occur through PAR constructive communication (Kemmis & McTaggart, 2008) and reciprocity (Kottak, 2000) are required. Constructive communication is vital to the process, as PAR focuses on “mutual inquiry aimed at reaching intersubjective agreement, mutual understanding of a situation, unforced consensus about what to do, and a sense that what people achieve together will be legitimate” (Kemmis & McTaggart, p. 578). PAR is also based on reciprocity which stems from dialogue and social connectedness. Reciprocity is a form of “exchange between social equals” (Kottak, 2000, p. 325). In this collaborative study, all members of the research team were equals, decisions were made democratically during group meetings throughout the process and each member of the research team determined her own level of involvement in the research process.

### ***Our PAR Process***

This section describes the PAR journey of the research team at SHSC. This PAR study occurred at the request of the recreation therapists; however, their participation throughout the process was voluntary. The research team members were aware they could withdraw from the study at any time. Members of the research team were between the ages of 19 and 60 years of age. They had a wide range of work experiences, ranging from one year on the job to over 15 years in recreation therapy.

The research team followed McTaggart's (1997) tenets of PAR by actively and collaboratively participating in the research agenda and decision making processes. The research team engaged in collaborative dialogue and determined the research topic, research location, various researcher roles and the research method. They were continually involved in every decision throughout the research process and established a small research committee (of volunteer representatives) which enhanced the recreation therapists' participation in data collection and analyses phases of the study. With 22 practitioners in the Recreation Therapy department it was not feasible for everyone to be vigorously involved in data collection and all phases of data analysis. Throughout the PAR journey, the research team critically reflected on their decision-making and realized that challenges and setbacks occurred; however, they encouraged one another to reflect on practices and decisions in a positive, collaborative and constructive manner.

This study began with a desire to continue the research team's exploration of therapeutic relationships which began during the memory work study led by Dr. Susan Arai from the University of Waterloo (Arai, 2009). All members of the research team were involved in the numerous cycles of planning, reflection, action and observation. Table 4 outlines the steps in the PAR process that the research team planned and implemented. This visual representation of the PAR process for this study was created using a table created by Hughes and Seymour-Rolls (2000) as the foundation. The first and second columns in Table 4 display the cycle number and the phase sequence. The third column describes what happened in each phase of the cycle. Column three was modified to reflect this particular research study. Column four, labelled SHSC, was added to the original table format and contains the details of this research study.

### *Cycle One*

As indicated in Table 4, the first cycle of this PAR study began in 2007 during the Recreation Therapy department's Annual Retreat facilitated by Nancy Bowers-Ivanski, Manager of Recreational Therapy and Creative Arts at SHSC, and Dr. Susan Arai from the University of Waterloo. In 2008, the Recreation Therapy department conducted a memory work study facilitated by Dr. Susan Arai during

which the recreation therapists discussed positive and challenging memories of relationships they had with individuals receiving care at SHSC.

Table 4  
*PAR Cycles Used in the Exploration of Therapeutic Relationships at SHSC*

<b>CYCLE</b>	<b>MOMENT</b>	<b>WHAT'S HAPPENING</b>	<b>SHSC</b>
Cycle One	1. Reflection	The group and thematic concern were identified through discourse.	During the Annual Retreat 2007, the Recreation Therapy department discussed a desire to conduct additional PAR.
	2. Plan	Group planned to examine thematic concern and social situation to describe both and gather ALL stakeholders together to decide how much participation constitutes collaboration	A memory work study focused on our experiences of therapeutic relationships was agreed upon on September 9 <sup>th</sup> , 2008 during a meeting with researchers from the University of Waterloo. The research team planned to reconvene on September 29 <sup>th</sup> , 2008 to conduct the memory work research during the 2008 annual retreat.
	3. Action, and	The plan was put into action and the group collected their memories and reconvened.	On September 29 <sup>th</sup> , 2008, the sharing of memories, analysis of memories and dialoguing around research ideas occurred.
	4. Observation		The findings were summarized and presented to the Recreation Therapy department by Dr. Susan Arai (2009).
Cycle Two	1. Reflection	The group reflected on memory work findings to define their thematic concern, included self-reflection by the participants.	Also during the Annual retreat in 2008, the research team reflected that they wanted to conduct research to deepen our understandings of our therapeutic relationships.
	2. Plan and Reflection	The group planned a change in practice to improve the social situation. It included the methods of critical examination. Potential problems were dealt with and approval sought from the Ethics Committee.	This phase was created with assistance from Jessica Lansfield who presented three options and the group initially planned one-on-one interviews would be conducted. Upon reflection, we decided that interviews may not be a viable option. Jessica presented two focus groups options during a professional practice meeting on April 22, 2009. The team voted to change the method to focus groups which the research committee would moderate and support, taking on greater roles in data collection and analysis. At the professional practice meeting, we agreed participation in the study and research committee and moderator roles were voluntary. Focus groups and guiding questions were constructed by members of the smaller research committee.
	3. Action	The research commenced.	Focus groups were conducted during the summer/fall of 2009 with everyone involved in data collection and analysis. Jessica Lansfield transcribed discussions, created a summary of the data analysis, to present to research committee for further dialogue, reflection and refinement.
	4. Observation	The group discussed the implications of the findings, consequences of change in practice and used the research method outlined in the plan to examine results.	Themes confirmed from focus groups and smaller research committee meetings and brought to practitioners during research retreat on November 16 <sup>th</sup> , 2009 for reflection, feedback and/or approval. At the retreat the larger research team reflected on the findings and developed self-reflective questions around each theme to guide their practice.

(Adapted from Hughes & Seymour-Rolls, 2000)

### ***Cycle Two: Reflection***

When the research team reflected and dialogued about their positive and challenging experiences with individuals receiving care at SHSC, they found several complex issues emerged from the memories (Arai, 2009). On that day, the recreation therapists unanimously agreed they needed to explore their perspectives of therapeutic relationships in more depth. During the memory work study, discussions around therapeutic relationships involved issues of friendship, attachment, importance of language, power, boundaries, values embedded in recreation therapy, shared experiences and impacts of therapeutic relationships on recreation therapists and their care practices (Arai, 2009). As the research team identified, the issues around therapeutic relationships required further analysis and at that point the research team began its second cycle of PAR.

### ***Cycle Two: Planning***

For the purposes of this planning section, I switch into a first person narrative since I played a large role in the planning phase. I reviewed the literature and past research methods used by the recreation therapists at SHSC. After this review, I presented three different research methods options to the Recreation Therapy department's Small Professional Practice Committee on February 2<sup>nd</sup>, 2009. During the review, I highlighted the strengths and weaknesses of each method. At that time, a research committee had not been formed and the Small Professional Practice Committee members were acting as the research team's temporary representatives. The three methods I originally presented were:

1. Recreation therapists would conduct in-depth interviews on each other at SHSC, interviews audio taped and analyzed by the group.
2. Face to Face interviews conducted between the recreation therapists and Jessica Lansfield as a co-researcher, data analyzed with an advisory research committee made up of representatives from the Recreation Therapy department
3. Online discussion forums presenting a new theme for discussion every week over six weeks, six themes discussed in total by all recreation therapists in a flexible and confidential online community.

These options were presented to the entire Recreation Therapy department by members of the Small Professional Practice Committee the following week. After reflecting on the methods available, the research team chose the most desirable option. Their original research plan was to have one member of

the research team, me, conduct interviews with the research team. The interviews were meant to explore therapeutic relationships recreation therapists have with individuals receiving care at SHSC and how those relationships are welcomed, continued and closed. The research team also decided I would transcribe the data and a primary data analysis would be conducted by me and the research committee to discuss and clarify research themes and then present these themes to the entire research team for feedback and clarification.

### ***Cycle Two: Reflection and Revised Data Collection Plan***

The research team followed the cyclical process of PAR highlighted by McTaggart (2008) to determine their method of data collection. They questioned a particular issue (What research questions to ask?), reflected upon and investigated the issue (What research method was most appropriate for the study?), developed an action plan (choosing an initial research method of one on one interviews) and then implemented and refined the said plan. At that point, with the team it was decided focus groups were more feasible for the large PAR research team and would be more consistent with the objectives of the study than one on one interviews, as focus groups encourage open discussions and collective learning. It was also determined that research committee members would take on a larger role in data collection process and I would provide support throughout the entire process. The following section discusses why qualitative research methods were chosen for this study and the research team's processes to revise their data collection plan.

### ***Qualitative Methods***

Qualitative research methods have often be used when detailed accounts of human experiences are required to answer the research questions. Malterud (2001) described qualitative research as “the systematic collection, organization and interpretation of textual material derived from talk or observation” (p. 483). Qualitative research was used for this study for its focus on the idiographic experiences of individuals through rich and complex exploration rather than the generalizability of group perspectives (Hoyt & Bhati, 2007). Since the focus of this study was on individual and collective understanding of therapeutic relationships, a qualitative approach was more suitable.



## ***Focus Groups***

The research team chose to use focus groups to collect their data during this research study.

Krueger and Casey (2008) wrote focus groups are:

a carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. Each group is conducted with 5 to 10 people led by a skilled interviewer (p. 2).

Krueger and Casey (2001) indicated focus groups have several important characteristics: they involve people with similar characteristics, these people provide qualitative data, and the qualitative data is obtained through a focused discussion. Generally, the purpose of a focus group is to “collect qualitative data from homogeneous people in a group situation through a focused discussion” (Krueger & Casey, 2008, p. 15). Krueger and Casey (2008) suggested focus groups are successful when,

[p]articipants feel comfortable, respected and free to give their opinions without being judged. The intent of the focus group is to promote self-disclosure among participants. We want to know what people really think and feel (p. 4).

When carefully planned and facilitated focus groups enhance the participatory nature of research, increase dialogue and reflection among the research team and create opportunities for group data analysis to occur simultaneously with data collection. In this study, the homogeneous group of people involved was the recreation therapists at SHSC, and discussion was carefully focused on how the research team understood their therapeutic relationships. To assist with refining their data collection method, I approached the Recreation Therapy department with two focus group options.

1. I would moderate five equal sized focus groups and be supported by members of the smaller research committee.
2. Focus groups would be moderated by members of the smaller research committee who wish to play a larger role in the data collection and supported by other members of the research committee and myself.

Option one enhanced consistency in moderation of focus groups and reduced the time commitment of other members of the research team during data collection, while option two increased participation of research team members in data collection. As a group, the research team chose option two to increase their commitment and participation to the study.

There were several purposes of the focus groups. The focus groups made it possible to gather information about therapeutic relationships from all members of the research team. Focus groups also provided opportunity for the research team to build their research capacities, to critically reflect on the process and emerging findings, and collectively determine their next research steps. In total, five focus groups were conducted in the hopes of incorporating all 22 recreation therapists' insights from different areas of SHSC. (See Figure 4)

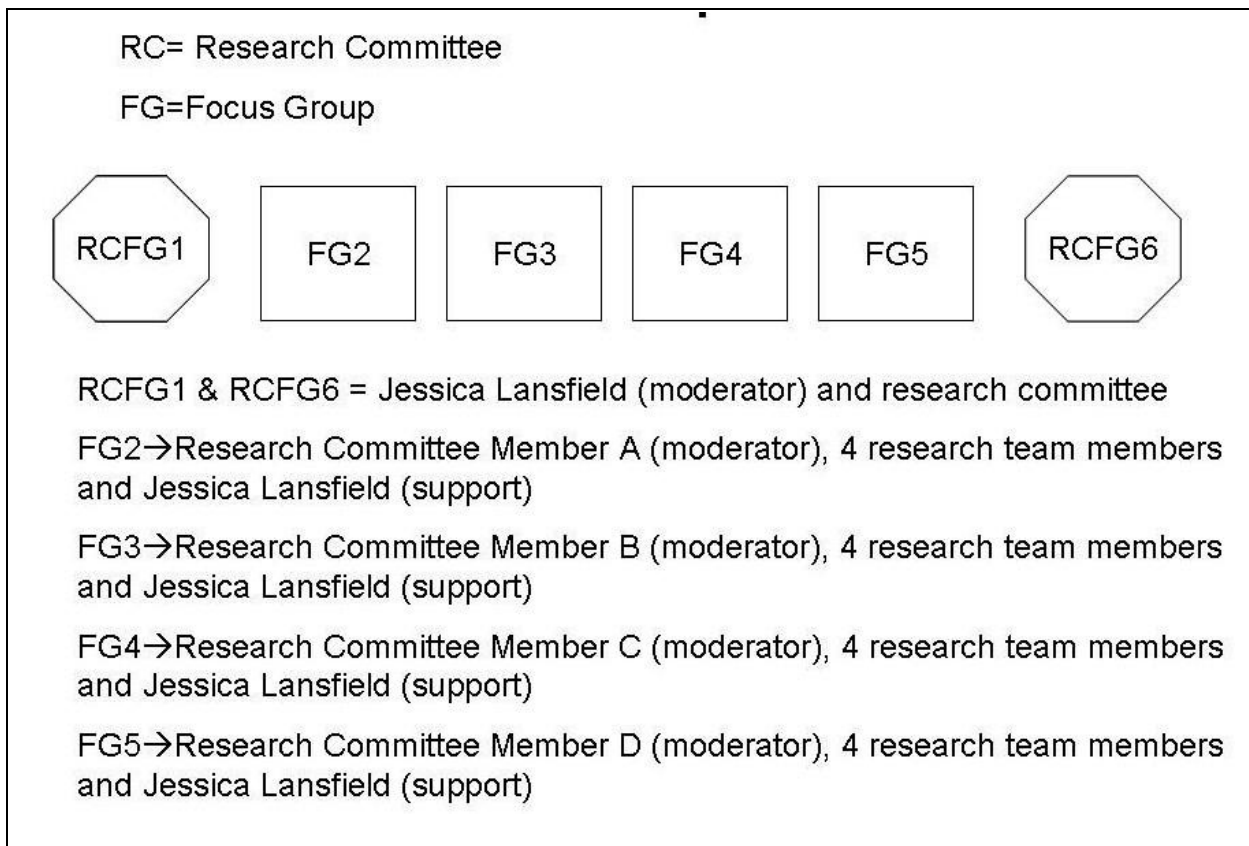


Figure 4. Focus groups with recreation therapists at SHSC.

Details of the focus groups are outlined in the following list:

1. Using the questions outlined in the Guidelines for Focus Group Moderators in the Appendix C, five focus groups occurred.
2. All focus groups were audio recorded and a member of the research committee recorded answers on a flip chart during the sessions.
3. In focus group #1, eight recreation therapists on the research committee and I participated in the first focus group and three practitioners took turns moderating the discussion on therapeutic relationships. Turns were taken to enhance the research capabilities and moderating abilities of the research committee members so that they would feel comfortable leading the rest of the focus groups (#2-4). I was present for all of the focus groups and helped with facilitation and note taking.

4. The remaining 14 recreation therapists were divided into three focus groups (of five, five and four members respectively).
5. A different research committee member moderated each focus group and asked the same questions posed in focus group #1.
6. During the focus groups, the practitioners reflected on their perceptions of their therapeutic relationships and how those perceptions impacted their care provision.
7. In the last focus group (#5), research committee members reconvened to reflect on discussions which took place in focus groups #1-4.
8. Data analysis began simultaneously with the focus groups. All of the recreation therapists were engaging in the data analysis process when they answered questions on the key themes that arose in their focus group discussions (See Data Analysis on p.57).
9. Following the focus group discussions, I summarized the research findings into themes, and circulated those themes to the research committee.
10. The research committee then reviewed the themes and reached consensus on the preliminary themes, I presented preliminary research findings to the rest of the recreation therapists for further reflection and feedback.
11. The research team discussed the themes and created self-reflective questions around each theme to help guide their practice.
12. The small research committee then volunteered to work with the themes to create a tool to be used in practice.
13. After the self-reflective questions were further developed, they were presented to the entire research team, they will then decide upon further dissemination of research findings (e.g., presentations at Therapeutic Recreation Ontario, Canadian Therapeutic Recreation Association annual conferences, or journal articles in Therapeutic Recreation Journal).

This research team was involved in research projects in the past that incorporated collective discussion and self-disclosure, such as the memory work study (Arai, 2009). Collective attempts were made throughout this research process to enhance the open, inclusive and encouraging self-disclosure research environment. For example, group meetings often began with opening statements reiterating that the research was a collective process where all opinions were welcomed and that everyone shared the responsibility of creating a safe space.

Two important issues emerged when determining which data collection method to use, theoretical saturation and power imbalances. The research team was concerned with reaching theoretical saturation during the five focus groups. Theoretical saturation was described by Krueger and Casey (2008) as “the point where you are not gaining any new insights” (p. 25). Although additional focus groups were possible, they were not required for this study. The research team was also concerned with power imbalances that traditionally occurred in action research. Generally, PAR studies help to reduce power imbalances. For this research study, practitioners became moderators

during the data collection stage which helped to equalize power imbalances. The rest of the research team had the opportunity to sign up for the focus group and moderator they wished to participate in.

### ***Moderating Focus Groups***

When the research team considered using focus groups as a research method, they wanted to ensure clarity and appropriate facilitation by the moderators. Researchers have provided instructions, and suggested research questions and probes should be clear to prevent confusion and misunderstanding among research participants (Edwards, 1996; Holstein and Gubrium, 1995). Krueger and Casey (2008) stated to prevent confusion and lack of focus, moderators and focus group participants need to be well-prepared for their roles. Effective moderators needed to be respected by focus groups participants and be respectful of participants in return (Krueger & Casey, 2008). Moderators should show respect through actively listening, showing interest, empathy and positive regard to all focus group participants (Krueger & Casey, 2008). Moderators are required to “believe that the participants have wisdom no matter what their level of education, experience, or background” (Krueger & Casey, 2008, p. 85). The compatibility of PAR and focus groups was evident to the research team, to encourage democracy and equality in research groups. Krueger and Casey described being a moderator as a privilege and the role should be viewed as “a special opportunity to better understand” (p. 86) the views of focus group participants. A strong moderator does not have to be an expert on the topic at hand, but capable of understanding the participants’ language and knowing the important issues needing to be addressed during the discussions (Krueger & Casey, 2008). To be effective moderators, the recreation therapists rehearsed the overview, ground rules, questions and prompts prior to their focus group discussions. The recreation therapy moderators were also accountable for obtaining signed consent forms and confidentiality statements (See Appendices B, E & F) and ensured suitable equipment and meeting facilities, and fostered a welcoming environment as suggested by Krueger and Casey (2008).

The research committee members acted as the focus group moderators, and the focus group participants needed to be informed by the moderator of their responsibilities. During the research

study, the focus group supporters were responsible for: confirming attendance; ensuring chairs, flip charts, writing utensils and note pads were in place; and ensuring audio recording devices were in excellent working condition. The focus group supporters were responsible for handling unexpected challenges occurring during focus group sessions (interruptions, need for additional supplies) so discussions continued smoothly. To ensure all participants, supporters and moderators were clear of their roles and focus group expectations, written and verbal instructions of the focus group process were created and verbally described before and during the focus group by the moderator. Data analysis occurred simultaneously with data collection, as the research team reflected on the main themes, and similarities and differences emerging in group discussions.

### ***Data Analysis***

Members of the research team actively engaged in data analysis. This enhanced the collaborative or participatory nature of the data analysis (Krueger, 1994). Three phases of data analysis occurred.

#### ***Data Analysis Phase 1: Establishing Themes***

All of the recreation therapists at SHSC were involved in this phase of data analysis as a moderator, supporter or participant. There were several focus group questions directly encouraging participation in data analysis. For example, at the end of the focus groups, the moderator asked the recreation therapists to identify similarities and differences they heard during the focus group. The focus group moderator also asked each participant to write down on a note pad the main themes which arose during the focus group (See Appendix C). I, Jessica Lansfield, collected responses to the written questions. The practitioners were free to communicate their written responses with the group, and were encouraged to share by the moderator. In the fifth focus group, when the research committee reconvened, the members of the research committee reflected collectively on the responses from focus groups 1-4. This step in the process encouraged the moderators and focus group supporters to play a larger role in data analysis, since they discussed meaningful points from each group and identified similarities and differences in the discussions as well as the overall themes that appeared

### *Data Analysis Phase 2: Deepening Analysis*

This phase occurred simultaneously with the first phase of data analysis. In this second phase, I transcribed notes taken by the focus group supporters and myself during the focus group sessions. The notes included non-verbal information shared in the focus groups and highlighted important quotes or initial themes discussed. I transcribed the audio-recordings and continued analysis of the data by reading through all of the transcripts and identifying units of important information (Miller & Crabtree, 1999). I deepened the data analysis of the themes created by the research team in the focus groups by assigning codes to the data using the research team's original language. James, Milenkiewicz, and Buckman (2007) describe codes as:

labels put on data that summarize the data's content or highlight a primary idea... one piece of text can be coded in various different ways. Codes serve to separate and sort text into different categories, allowing researchers to look at it with fresh eyes and in new ways (p. 88).

During the second phase of analysis, I looked for meaningful information initially overlooked, assigned relevant codes to data that used the recreation therapists own language as much as possible. After coding the transcripts I reflected on the codes the research team and I created, revised them if necessary and attempted to combine them into categories. These categories were revised, sorted and connected to one another (Crabtree & Miller, 1999) to establish the preliminary themes of the research. I followed Crabtree and Miller's (1999) suggestion and used verbatim quotations to strengthen the meaningfulness of the research themes.

Once I identified several preliminary themes and supported those themes with verbatim quotations, I then attempted to create thick and rich descriptions of each theme (Grant, Nelson, & Mitchell, 2008). Thick description was described by Denzin (1989) as:

more than [a] record [of] what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions and meanings of interacting with individuals are heard (p. 83).

This was done to ensure the research findings in the summary stemmed from the focus groups, and the data analysis was representative. Once the preliminary themes were established, I introduced them in small increments, to the small research committee over the course of several weeks.

### ***Data Analysis Phase 3: Data Analysis Elaboration***

As the themes were presented to the research committee, the research committee became re-engaged in the data analysis process. I staggered the introduction of the themes, to make the analysis more manageable for members of the small research committee. Each week I provided condensed written summaries of the main themes, discussed the themes as a group and encouraged reflection and feedback. Maintaining dialogue with the research committee aimed to add clarity and thick description of each theme and was consistent with the PAR approach. I hoped that by facilitating subsequent data analysis discussion sessions with the research committee, we would reach consensus on the themes meaningful to them. Some of the research committee members reviewed the document, reflected on the themes and provided feedback and insight into several main research themes. However, this process was challenging for the small research committee members to engage in due to other work and personal life responsibilities; their allotted time to engage in thorough data analysis was limited. As a result of these challenges, I engaged in discussions around time commitments and data analysis expectations with the small research committee members, Dr. Susan Arai from the University of Waterloo, and Nancy Bowers-Ivanski, Manager of Recreational Therapy and Creative Arts at SHSC, to address challenges experienced by the research team. These discussions determined for the purposes of this study, the small research committee would participate in a preliminary analysis, I would deepen the analysis of themes for the purposes of my master's thesis and greater time allotments would be given in the future to members of the Recreation Therapy department to participate in collaborative data analysis.

Once the research committee had the opportunity to review the research themes, I presented the preliminary research findings to the entire research team at their research retreat on November 16<sup>th</sup>, 2009. At that point, all 22 recreation therapists had the opportunity to reflect, discuss and provide

feedback on the research findings. It was important to have discussions regarding the themes to ensure the findings were inclusive of all the different areas of recreation therapy at SHSC.

In addition, at this retreat the recreation therapists began to create self-reflective questions around each of the major themes presented. The group collectively decided the questions would be worded in a general way so they would be relevant to the different areas of SHSC. After the questions were developed, the research team determined the small research committee would work with the self-reflective questions to develop a tool for the recreation therapists to use in everyday practice. It was confirmed by the research team that I would conduct a secondary analysis for the purpose of completing my master's thesis and present these findings to the Recreation Therapy department.

The themes presented in Chapter Five arose from the research conducted by the recreation therapists at SHSC during the fall of 2009. The themes evolved from a document provided to SHSC containing a preliminary data analysis of themes from focus groups conducted by the recreation therapists at SHSC between August and September, 2009. Their interpretation and analysis of the focus groups sessions occurred during small research committee meetings following the focus groups discussions. These subsequent meetings took place in October and November of 2009. To view the original themes from which Chapter Five stems please refer to Appendix I. Themes from the focus groups and the preliminary data analysis stage were presented to the entire Recreation Therapy department on November 16<sup>th</sup>, 2009 by me, Jessica Lansfield. The themes were positively received and the recreation therapists indicated they felt the themes were accurate and represented their understandings of therapeutic relationships well

After the secondary analysis of the findings are presented on May 12<sup>th</sup>, 2010 the practitioners will then determine how and where to disseminate the research findings. Possible venues for dissemination of the research findings are presentations at Therapeutic Recreation Ontario conferences, the Canadian Therapeutic Recreation Association annual conferences, or journal articles in Therapeutic Recreation Journal or the TRO Research Annual.



During data analysis it was important to ensure the language used and themes identified accurately represented the recreation therapists at SHSC. Creswell (2009) emphasized the importance of language and clarifying meaning, stating through “the entire qualitative research process, the researcher[s]... focus on learning the meaning that the participants hold about the problem or issue” (p. 175). Therefore, the research team regularly participated in self-reflective practice to express their meanings accurately and to process similarities and differences of opinions that arose during the research study. Attention was drawn to the fact that “interpretations cannot be separated from [individuals’] backgrounds, history, contexts, and prior understandings” (Creswell, 2009, p. 176). Through open and constructive discussions the research team had the opportunity to dialogue around differences within the research team regarding their understandings of therapeutic relationships. While the recreation therapists engaged in self-reflection during this process, I regularly dialogued with them and wrote in my reflective journal to maintain my own reflexivity.

### ***Reflexivity***

Being dedicated to the practice of reflexivity was crucial for me as an academic researcher participating in this PAR study. Alvesson and Skoldberg (2000) stated reflexivity means “interpreting one’s own interpretations, looking at one’s own perspectives from other perspectives and turning a critical eye onto one’s own authority as interpreter and author” (p. vii). I kept a reflective journal of my interpretations throughout this research process. My reflexive journal was “a kind of diary in which the investigator on a daily basis, or as needed, records a variety of information about *self* (hence the term ‘reflexive’) and *method*” (Lincoln & Guba, 1985, p. 327). As my co-researchers engaged in self-reflective practice, I needed to be aware of how I was impacted by the research and members of the research team, as well as how I impacted them in return. Dupuis (1999) indicated researchers are embedded in and affected by the research they conduct. Academic researchers can have powerful impacts on their research, research participants and research outcomes (Alvesson & Skoldberg, 2000; Dupuis, 1999). Alvesson and Skoldberg (2000) described reflexivity as the belief that “there is no one-way street between the researcher and the object of the study; rather, the two affect each other

mutually and continually in the course of the research process” (p. 39). To ignore my own reflexivity would have discredited the PAR process, the collaborative efforts in this research study, and the valuable roles of my co-researchers as teachers and authentic partners.

Reflexivity can be a challenging process, but necessary to balance individual thoughts, feelings and actions with those of the collective (Alvesson & Skoldberg, 2000; Dupuis, 1999; Steedman, 1991). My challenge throughout this PAR process was finding my own voice while ensuring other voices within this collaborative study were being heard and represented. By maintaining my reflexive journal throughout this PAR journey I tried to enhance my own “learning, person reflection and knowledge growth to become integral to the research process” (Koch et al., 2006, p. 17) rather than to become overwhelmed by, or distanced from, the research process. Aside from keeping a reflexive journal, open and transparent dialogue with others fostered my reflexivity. In qualitative research, dialogue has been described as a major component of the research process that must occur between the researched and researchers (Alvesson & Skoldberg). Dupuis (1999) emphasized forms of dialogue, particularly internal dialogue need to be transparent and shared with a broader audience. When researchers share internal dialogue with others it helps to illuminate how they are impacted by the research dialogue (interpersonal or intrapersonal) and the research process (Dupuis, 1999). By sharing the mutual learning I engaged in throughout this research process with my team members and outsiders, it enabled me to be more transparent as an academic researcher and aware of myself as a person impacted by this research study.

My practice of reflexivity also encouraged me to identify and examine the meanings I attach to this research and my co-researchers. According to Steedman (1991) when researchers are reflexive, they interpret the data and create meaning:

Nothing means anything on its own. Meaning comes not from seeing or even observation alone, for there is no ‘alone’ of this sort. Neither is meaning lying around in nature waiting to be scooped up by the senses; rather it is constructed. “Constructed” in this context, means produced in acts of interpretations (Steedman, 1991, p. 54).

Throughout this research process, I became more aware my interpretations of this research needed to be critically analysed. Dupuis (1999) described researchers' interpretations have a powerful impact on how they think, feel and act. Dupuis (1999) also encouraged reflexivity in research and warned past researchers have failed,

to recognize and account for the role that our human "selves" play throughout the research process and how those selves subsequently shape our products; our failure to recognize and account for the role our emotions and personal experiences play in our research endeavours; and our specific data-collection and writing styles, which tend to adhere more to positivist ideals regarding how research should be conducted and reported (p. 43).

My reflexivity in this research study had two parts. One aimed specifically at the data analysis portion of this research to ensure I was representing the recreation therapists accurately and not overpowering their voices with my own. I used a chapter on partnership from the *A Changing Melody Toolkit* (Dupuis et al., 2008) to help guide my reflexive questions. Questions I asked myself around these issues of fairness and accuracy in representation included:

- How were the recreation therapists being represented in the data?
- Do I need to clarify what the recreation therapists meant?
- How were my opinions being presented in the document?
- How were different research team members being represented, are they being represented fairly and equally?
- What processes were in place to balance my data analysis interpretations with those of the collective?

The second aspect of my reflexivity focused on the research process and how research was engaged in by the research team. Questions I asked myself in regards to this part of the research process included:

- How did I include the contributions of the research team and my own contributions?
- How were decision being made, is it truly a democratic process?
- How did I build and maintain the trust of the research team?
- Whose voices dominated and whose voices were being silenced?
- What processes helped to establish equality?
- How did I influence the phases of planning, reflecting, and observing?
- How have Leanne (my co-investigator) and I created a safe space that facilitates the research team's shift from reflection into action?

Throughout the research process, I encouraged my fellow co-researchers to conduct reflections on their progress through self-reflective practice and ensured transparent dialogue with them.

In summary, my role as a research team member was a subjective and interpretive one. I embraced the belief that I am a person who is both influenced and influential throughout this process. I realized I needed to identify and critically analyze those meanings, emotions and interpretations I brought to this research process. I made regular attempts to engage in periods of reflexivity and dialogue with the research team and my academic supervisor around these issues. In my reflexive journal I reflected on how the research process progressed and how it created new knowledge and meanings within my life. Thus far, in my writing and dialogue with others, I am surprised at how many changes in emotions, interpretations and perspectives I had along this journey. One way I have changed is that I no longer view research as a top down approach to improving knowledge in the field. Academic researchers are not the only ones capable of contributing to the current body of literature; practitioners are also capable of conducting meaningful research. I also learned how important consistency and opportunities for dialogue are in PAR processes. It was important to discuss expectations, roles and limitations on a regular basis so participation of all members of the research team was possible and manageable.

### ***Challenges in PAR: Developing Trustworthiness, Credibility and Fairness***

PAR has been described by some researchers as a challenging process. It has also been challenged by others to prove its worth. Some researchers critiqued PAR stating it has difficulty proving its validity; however, Lincoln and Guba (1985) argued PAR does not need to prove its validity. Instead PAR researchers focus on following a rigorous research process, establishing credibility and developing trustworthy findings (Lincoln & Guba, 1985; Wilmsen, Elmendorf, & Fisher, 2008). In this research study the research team collected data from verbal discussions, written responses to self-reflective questions, flip chart summaries, and audio-recordings of focus groups. Following a PAR process enabled the research team to engage in collaborative dialogue and participatory analysis that deepened our understanding of therapeutic relationships. The research team enhanced the credibility of the study through crystallization (Richardson, 1994). Richardson (1994) suggested crystallization moves beyond triangulation for “there are far more than ‘three sides’ from

which to approach the world” (p. 522). Crystallization was described as the means of investigating a topic in a variety of ways. Richardson (1994) suggested researchers look at their research as they would a crystal, since research and findings can change depending on the perspectives of the researchers and the research environment:

[c]rystals are prisms that reflect externalities and refract within themselves, creating different colors, patterns, arrays, casting off in different directions. What we see depends on our angle of repose (p. 522).

Having 22 recreation therapists actively engaged in this research study provided a number of understandings that challenged the research team to grow as a collective. By recording the data and having plenty of opportunities to dialogue, provide clarification and feedback throughout the process the credibility and trustworthiness of the study (Lincoln & Guba, 1985) was enhanced. Grant et al. (2008) also discussed credibility and trustworthiness of data occur by creating open pathways of communication between all researchers. Numerous means of communication were encouraged between members of the research team throughout the research study. An audit trail helped the research team to establish trustworthiness and confirmability of the research (Lincoln & Guba, 1985). I kept an audit trail as part of my reflexive journal. This reflexive journal contained information about the daily details and procedures of the study, personal reflections, and the decision making processes (Lincoln & Guba, 1985). Consistent with PAR, no information regarding the study was disseminated outside of the research team without their approval (Grant et al., 2008; Lincoln & Guba, 1985); however, the team agreed I was able to write my master’s thesis as I wished without any restrictions.

Another quality of research this research team valued was fairness. Fairness meant ensuring a balance between “all stakeholders’ views, perspectives, claims, concerns, and voices” (Guba & Lincoln, 2005, p. 207). As the research team dialogued and gathered information, they regularly reflected on the worth and credibility of their research to promote inclusion and representation of all members (Grant, Nelson, & Mitchell, 2008). Although this PAR study was a challenging process, our aim was to ensure all of the research team’s interpretations were incorporated and negotiated in the findings.

### ***Ethical Considerations***

This study was approved by two ethics boards, one from the University of Waterloo and the other at SHSC. All of the research team members were aware of the research process and the research topic. There were no known risks to the research team while they were engaged in this research study. Following ethical protocol, the recreation therapists were provided with information letters and consent forms to sign before they began their focus group discussions (refer to Appendices A, B & C). The recreation therapists were also aware their participation was voluntary and at any time they could remove themselves from the process without fear this would impact their employment. Nancy Bowers-Ivanski, Manager of Recreational Therapy and Creative Arts at SHSC, remained removed from this research process to reassure the research team their participation would not be influenced by the presence of their professional supervisor.

Since all of the research participants were recreation therapists at SHSC and knew one another personally, anonymity was not feasible in this research study; however, confidentiality was ensured. To ensure confidentiality of the recreation therapists, names of the recreation therapists were not connected to the quotations used in the research finding summaries. The only people with access to the original transcriptions were my academic supervisor, Dr. Susan Arai from the University of Waterloo and myself. All research documentation, transcripts and a list of pseudonyms were kept by Dr. Susan Arai and myself on password protected USB keys. The recreation therapists were encouraged during research discussions not to share any information they did not feel comfortable disclosing and they had numerous opportunities to clarify their understandings and provide feedback on the research findings throughout the process to ensure they were accurately represented.

### ***Reflections on My Challenges While Engaging in a PAR Process***

There were several challenges I faced throughout this research process including: my role as an academic on the team, and time and resource constraints of the research team. Although this was a PAR study, at times it was hard to shed the skin of an academic accustomed to conducting research with a top-down approach. First of all, I had to learn what PAR was and embody it. PAR authors stated that all participants are to be equal and decisions are to be made in a collective and democratic way,

Secondly, I had to accept this approach to research would take longer than originally anticipated. Each step of the way research issues and decisions had to be addressed by the team and it was difficult to have regular meetings with this large research team. Collective decision making was particularly difficult when the research team would ask for my opinion, and accept it without questioning its limitations. To prevent this unconditional acceptance I found that I would have to challenge the other members of the research team to look at the alternatives. This meant prompting them to weigh the pros and cons of the decision and dialogue as a group. At first the research team was uncomfortable with my approach for they were not used to being asked these types of research questions. Slowly the research team adjusted and actually began to expect that the questions they asked me would be turned back to the group. Usually my approach would encourage collective and thoughtful decision making, other times the group would become silent while they contemplated their responses. At those points, I needed to make additional suggestions to get the discussion started again.

Another unavoidable issue I found frustrating along the way was the differences in time and resource availability among the research team. For me, this PAR study was the focus of my master's thesis, meaning that I had all the time and energy available to me to focus on this endeavour. Yet, it took a while to accept that this study may not be as much of a priority to other members of the research team or my supervisors as it was to me. I had to adjust my expectations of what was feasible, how often I should anticipate feedback and how to balance progress with the research team's other responsibilities. For the most part, the research team was very receptive and we worked well together. In truth, the differences in time and energy allotted to the study, did not become an issue until the second stage of the data analysis began. At that point, the members of the small research committee were scheduled to meet weekly and were asked to read the summaries provided to them prior to the meeting. The meetings were meant to be an hour or two in length and focused on discussing the themes and adding thick description to the themes. However, it became apparent that due to busy schedules and other responsibilities, the research summaries were not being read prior to the meetings. Therefore, the meetings were spent reading the summaries and little analysis was actually completed

during the small amount of time allotted. At first, this change in the scheduling was negotiable; however, it became apparent that a deeper analysis may not occur with the small research committee as originally hoped. Therefore, I had the uncomfortable task of bringing this issue up with my supervisors and the small research committee. After several discussions, it was decided that a third phase of data analysis would be required to reach the level of analysis necessary for my master's thesis. These discussions were beneficial for they opened up dialogue around expectations and the time required for the research team to participate in extensive data analysis. Through the ongoing discussions with my supervisors and co-researchers, I realised how important it was to accept your own and others limits when it comes to conducting PAR. The warnings about PAR were true, sometimes goals and timelines had to be altered and one person definitely cannot do everything by themselves; otherwise the research would not be truly PAR. I found (keeping in mind this was accomplished through trial and error) the best way to address my own challenges and frustrations was through independent self-reflection on the issue first followed by a calm and solution-focused dialogue with co-researchers afterwards. Incredibly, although I experienced my challenges throughout my two years as a graduate student, the rewards, both personal and collective, were exponentially greater than the frustration.



## Chapter Five: Findings

This chapter summarizes themes which emerged from subsequent analysis I conducted of the recreation therapists' focus group discussions for the purposes of completing my thesis requirements. Included in this chapter are themes describing the recreation therapists' reasons for engaging in therapeutic relationships, the qualities of a therapeutic relationship, roles within the therapeutic relationship, the therapeutic relationship process and different influences that recreation therapists negotiate within their therapeutic relationships. This chapter highlights how widely therapeutic relationships range in depth from simple acknowledgement between two individuals to mutual connections resembling friendship. Members of Focus Group S suggested that sometimes a therapeutic relationship consisted of simple, regular interactions and some relationships ebbed and flowed with the needs of the individual. A similar thought process was discussed in Focus Group F:

*They might just like a 'hi' and to them that's a relationship because they have never had neighbours. They've never had so many people walking by them everyday. (Recreation therapist, Focus Group F)*

Interactions with individuals receiving care were considered part of a therapeutic relationship when the recreation therapist felt they were helping them in some way.

*Recreation therapist 1: I think that's where we don't see it as a therapeutic relationship, if we are just saying hello but if I was helping [her] on a bus trip and I am developing relationships with some of her guys and I do see them again so we help each other out a lot so it's tricky.*

*Recreation therapist 2: It is tricky and it's hard to.*

*Recreation therapist 3: That's shared programming right?*

### ***Supporting Engagement in Therapeutic Relationships***

Recreation therapists engaged in therapeutic relationships with individuals receiving care to: (1) support a new beginning, (2) shift the focus to the positive and the living, (3) establish a sense of belonging and community within the institutional setting of SHSC, and (4) get to know the whole person. The recreation therapists suggested each therapeutic relationship is uniquely experienced and the purpose of the relationship stems from specific individual needs.

### ***Supporting a New Beginning***

Individuals begin a “new chapter” in their lives when they enter SHSC and have opportunities to try “*things that they haven’t even considered before*” (recreation therapist, Focus Group F). Recreation therapists “*bring them into the community*”, provide information and support through their therapeutic relationships while the individuals receiving care “*adjust to a new life*” (recreation therapist, Focus Group F) they never anticipated having within an institution. When individuals transition into SHSC, they experience many exciting elements and frightening challenges of an institutional setting. The recreation therapists stated involvement in recreation therapy reduced these experiences from overwhelming the individuals receiving care. Recreation therapists engaged individuals receiving care in leisure opportunities as a way to bring purpose and new meaning into their lives. Engagement also helped the individuals to escape from the biomedical focus and demanding routine of SHSC.

*How do all of these things impact on their care? I think that by developing the therapeutic relationship it may help them settle more and even enable other disciplines to approach them to because they are settling and getting happier. It helps the whole team, they can settle and like you said, they will call on you when they need help to help someone settle. (Recreation therapist, Focus Group N)*

According to the recreation therapists, when individuals engaged in recreation therapy, it helped them to adjust to life at the institution. When individuals had easier adjustments, it in turn eased the workload of other staff members at SHSC.

### ***Shifting Focus to the Positive and Living***

The recreation therapists discussed that their therapeutic relationships allowed for a positive focus on “*wellness*” and meaningful engagement for the individual. This shift also brought the individual receiving care more positive attitudes, “*motivation*”, decreased pain, or distraction from illness. One recreation therapist stated engagement in meaningful leisure, helped individuals on mental health units to “*feel better*” (recreation therapist, Focus Group N) and reduce their focus on disabling conditions such as depression.

*We help create a positive attitude and the thing is that we, they sometimes look forward to going to our programs and seeing us and that might be the only positive thing that happens throughout their day. (Recreation therapist, Focus Group F).*

Recreation therapists in Focus Group F and Focus Group N highlighted the differences they witnessed in individuals who were engaged in recreation therapy versus those who withdrew from therapeutic relationships or isolated themselves at SHSC. Individuals who actively engaged in recreation therapy thrived compared to individuals who refused to participate. The recreation therapists' indicated they strive to focus on positive elements within an individual's life despite institutional surroundings.

*I think if there were not these opportunities to get involved, they would withdraw, they would just stay in their rooms, they may just not be social, they may, it gives them a reason, it gives them a purpose... they live fuller and happier lives, they live longer maybe, I think longer potentially longer and happier. (Recreation therapist, Focus Group F).*

In Focus Group N, the recreation therapists stated that involvement in recreation therapy had positive physical outcomes that could be witnessed by nursing staff.

*Recreation therapist 1: I just know the people that are involved with us versus the ones who aren't; the ones that are, thrive.*

*Moderator: So would you say that's a positive.*

*Recreation therapist 2: Yeah.*

*Recreation therapist 1: They do better, and the nursing see it, they see the ones who are isolated and choose not to be involved maybe physically, health-wise don't do as well. (Focus Group N).*

The recreation therapists encouraged individuals receiving care to find meaning in their lives, as described in the following quote, they encouraged living rather than just existing:

*I think it just causes them to thrive and exist. Just the whole thing with recreation therapy being the difference between living and existing, I think with these relationships or opportunities, they are not just existing they are really living. (Recreation therapist, Focus Group N)*

Therapeutic relationships and opportunities provided through recreation therapy enabled individuals receiving care to thrive and live full lives.

### ***Building a Sense of Belonging and Community***

In Focus Group N, therapeutic relationships were said to enhance the sense of belonging and community within SHSC. Recreation therapists welcomed individuals into the community, which enhanced feelings of value and respect. There were several communities individuals could belong to

on the unit, within Sunnybrook, and within the larger community. The recreation therapists in Focus Group N stated belonging to a community was a meaningful part of life.

*A community makes them feel welcomed, you know, makes them feel valued, makes them feel respected... (Recreation therapist, Focus Group N).*

*They have a sense of belonging, a sense of purpose, like things to look forward to. There is meaning in their life, it's not just they come to an institution and that's the end, life can continue, you can discover things; you can still enjoy. (Recreation therapist, Focus Group N).*

Recreation therapists in Focus Group F saw their therapeutic relationships as a way to integrate individuals into external communities. Contact with the outside community through recreation therapy provided social rewarding experiences that were safe and welcoming for individuals receiving care. Leisure experiences also enabled individuals with similar interests or backgrounds to connect to one another and this fostered a sense of community.

*I think they feel part of a community because for a lot of the things we are the ones who introduce them to other people or they really get to know other people through having dinner together... They get to know each other and they build that sense of community, which then it happens outside of us. So we facilitate that part of community, as much and as little as that means. (Recreation therapist, Focus Group F)*

The recreation therapists introduced individuals to one another which facilitated relationship-building and the sense of community within SHSC. They also facilitated relationships and community building with the outside community, by bringing in outside individuals who shared interests with individuals receiving care.

*Recreation therapist 1: Also in the programs that we provide makes them feel part of the community. Some of the courses that we offer from the lifelong series like bringing in chefs from George Brown College and bringing speakers in, that's also part of the community and also the pub. That's stuff that you would do if you were out in the community and we brought it inside.  
Recreation therapist 2: Totally like when [we] had that Paul Easton come in, the guys were just chatting away about baseball from 20 years ago and to the perfect person that was able to respond to them.  
(Focus Group F).*

Through participation in recreation therapy programming, individuals receiving care have opportunities to engage in enjoyable leisure experiences and establish relationships with others who share similar interests. The recreation therapists tried to enhance feelings of belonging and community among individuals receiving care by continually interacting, planning programs, and attending

enjoyable events and excursions with them. When individuals receiving care engaged with members of the outside community during recreation therapy programming, the recreation therapists stated there seemed to be an increase the individuals' feelings of belonging and connection with their external community.

### ***Moving Beyond Needs: Getting to Know the Whole Person Through Leisure Experiences***

Within a therapeutic relationship, a recreation therapist from Focus Group J stated there is a "goal that [the recreation therapists] are working towards and there is an idea of there being a benefit at the end". It was also suggested the purpose or goal of the therapeutic relationship and needs of individuals receiving care are also intertwined.

*The [individual] has some sort of need and that is what has brought the two of you together. So the [individual] has come to receive these sorts of services because of a need, so the need might be that [at] this time they are in a crisis for example, they cannot care for themselves at this time or their safety is at risk. So that need is that at the end of it, they are able to be at home safely again. So at the end of receiving those services [their goal would be that] they would then be able to be living at home again safely. The need that they can care for themselves again, [be] functioning again, feeling safe. Those sorts of things would be needs or goals. (Recreation therapist, Focus Group J)*

In Focus Group J and L, the recreation therapists said for a relationship to be therapeutic there needed to be "a positive outcome" (recreation therapist, Focus Group L) for the individual receiving care. Beneficial outcomes were "individual to each therapeutic relationship" (recreation therapist, Focus Group J) and could include improvements in self-esteem, physical health, etceteras. Recreation therapists used their therapeutic relationships to encourage involvement in leisure opportunities that would lead to beneficial outcomes for individuals. The recreation therapists acknowledged they see themselves as only part of the greater solution. They noted an individual's repertoire of needs often required the effort of an entire interdisciplinary healthcare team. Based on Focus Group S discussions, the goals of recreation therapists' therapeutic relationships were "based on what [was] important to the client" and were "specifically leisure-related" or achievable through leisure-related means. For example, the recreation therapist may assist a woman to participate in a leisure activity, such as gardening, she once enjoyed before she was hospitalized, thereby helping the person feel a sense of

normalcy and recover a lost identity. Recreation therapists also assisted in welcoming friendships between recreation therapy group members who have common leisure interests and lack support networks.

The benefits of engaging in recreation therapy discussed included easing adjustment in an institutional setting, overcoming challenges, fostering meaningful connections and building a sense of community.

*We are trying to let them adjust to life in [a] long term care facility, meeting any needs that they have, and what challenges they may have. (Recreation therapist, Focus Group L)*

Although recreation therapists were aware of how individuals receiving care benefit from recreation therapy programming, they realized these benefits may not be evident to all individuals receiving care at SHSC.

*I was going to say it's outcome oriented, there's something that comes from that relationship and the relationship can be reciprocal or one-way, it could be perceived by you as being therapeutic but you can disguise it in a way that doesn't come across to the client as being therapeutic per say, but just a normal relationship. (Recreation therapist, Focus Group L)*

*I think you are going to have people who are intuitive enough that realize that 'if I do this group or this activity that...I am going to get socialization, develop a new skill, etcetera, etcetera', Whereas you have other people who just will go because there is nothing else to do or they'll go not realizing that you might think I might be socializing and meeting new people but I'm not. (Recreation therapist, Focus Group J)*

*I think often that sometimes the recipient doesn't realize there is actually going to be an outcome, or actually be a benefit, so I think sometimes it's one sided in that sense of what we feel is going to happen with the outcome or need. (Recreation therapist, Focus Group J)*

Some recreation therapists felt unsettled about the one-sided awareness and they tried to enhance others' knowledge of the numerous benefits of recreation therapy. Yet, if the benefits of recreation therapy were not able to be communicated or understood effectively, the recreation therapists accepted sometimes the individual's expectations of their involvement was solely enjoyment-based.

*That idea of there not being anything else to do for that person, the benefit is that there is some sort of enjoyment, that there will be something to do and they are not finding something to do on their own. So they are looking to have some assistance with finding something to do, and there is the benefit. (Recreation therapist, Focus Group J)*

Even if the recreation therapists were only viewed as individuals who provided enjoyable activities, this was still described as an acceptable and beneficial outcome of their therapeutic relationships. For a recreation therapist in Focus Group F, beneficial outcomes were primarily achieved through positive, amicable and social therapeutic relationships, where both parties were continually learning and growing from one another.

*Recreation therapist: Beneficial in the sense that one or both people learn and grow from each other in a positive way, if it wasn't positive I think I would call it something else.*

*Moderator: So it has to be positive, and are there any examples of what they might be learning?*

*Recreation therapist: Because of the word relationship, I think it is the give and take so to me that's from each other, for me, I don't know to me the therapeutic relationship doesn't define what it is that they are learning... it would be the therapist and the patients...we are humans, we are social, we interact, we learn from each other, even when it's...like when we talked before about challenging relationships you still take away learning about yourself with that.*

Therefore, recreation therapists and individuals receiving care create goals for their therapeutic relationship together based on the individual's needs and resources available to them at SHSC.

Although identifying needs was highlighted as one aspect of the recreation therapists' work, throughout their therapeutic relationships they focus on the whole person and aimed to enhance wellness through leisure. The recreation therapists also stated there was a "helpful quality" to their therapeutic relationships, since they assisted individuals when they had "difficulty in being self-sufficient in respect to leisure...in meeting that need on [their] own" (recreation therapist, Focus Group J). Therefore, the concern of the recreation therapists was to provide leisure or leisure-related opportunities that would help individuals become self-sufficient in at least one aspect of their lives.

Recreation therapists stated they were also unique because they focus on process and the therapeutic relationship more than on medical treatments or outcomes. While outcomes were seen as part of recreation therapy, the recreation therapists did not concentrate only on these outcomes during their interactions with individuals receiving care. Focus Group J discussed if an individual was enjoying his/her leisure engagement, truly present in the moment, and unknowingly benefiting from the program, then it was not the intention of the recreation therapist to interrupt enjoyment to highlight the therapeutic aspects of the activity.

*Recreation therapist 1: I think we are unique in the sense that, a few people have said it, is enjoyment because it's not like sitting in the physiotherapy gym you know pedaling away on a bike for ten minutes or lifting weights or something. You are in a food group and maybe some of the goals are not just socializing, but working on fine motor skills and working on choice. So they are picking the menu and stuff, they are enjoying it but there is a therapeutic aspect to that, to what we are doing.*

*Recreation therapist 2: You know like some of our goals are hidden I find. Like we are going to get them involved in something, because we know it'll do this, this and this. But their like you know I just want to do it because of this.*

*Moderator: Right, so they may be attending for the enjoyment and there are other goals happening at the same time.*

*Recreation therapist 1: Absolutely.*

*(Focus Group J)*

The recreation therapists allowed the benefits (e.g., functional improvements, socialization) obtained from engagement in recreation therapy to occur without attention being drawn to those benefits. In essence, a moment of enjoyment was just as essential as the measureable benefit or outcome of recreation therapy programming.

Within the recreation therapists' therapeutic relationships, the whole person is taken into account. The recreation therapists approach individuals receiving care in a holistic and nonthreatening manner to foster feelings of respect:

*I think they feel respected, like they feel that we are respecting their person, their personhood, like we see who they are, because we provide programs and so many choices based on their interests and needs, so they're like, "yeah this person gets me". . . people ask me "so, what's going on?" and I say, "well I've got this, I'm not really sure if it's up your alley but this sounds interesting", and they'll say "ohhh, why isn't this up my alley?" and I'll say, "well you said to me that you don't like heat and you don't like crowds and this is one heck of a crowded event", and they'll say "oh" and they know that I retained what they like and their interests and everything, so when I do recommend something, they'll say "ohh I'll really think about that" or "sure that sounds great." (Recreation therapist, Focus Group F)*

*I think because we are getting to know the person, they are getting the care that they need, we are not guessing, so we are getting to know the person, so we are able to provide the care and the programs that they want and need. (Recreation therapist, Focus Group N)*

The recreation therapists thought individuals receiving care reacted more positively when they were treated as dynamic individuals. In Focus Group N, recreation therapists' described themselves as holistic and focused on the whole person rather than on one or two aspects (e.g., physical or cognitive health).



*Recreation therapist 1: We are separate, we are not so medical so physical. We deal more on a holistic point of view with the client, so they are not or always being treated, or feel that they are being treated. So we kind of give them something separate from that.*

*Moderator: Can you expand on that? Holistic?*

*Recreation therapist 1: I just think the resident having physical therapy, they feel they are getting their exercise, getting their medications in the morning, everything is healthcare, medical focus and then they see us and it's more a friendship and it's completely different and we take them to do fun things like going down for music or discussion groups.*

*Recreation therapist 2: So it's seeing them as a whole person, rather than focusing on one segment, like physio.*

*Recreation therapist 1: Yeah.*

*Recreation therapist 2: Exactly, so there is a benefit of it, they'll come to exercise group with me, but they'll see it as a fun thing but they are really getting the benefits they would*

*Recreation therapist 1: More creative.*

...

*Recreation therapist 2: We tap into all areas, we're not slotting in as the physio is, just working on the physical development, the medical doctor is working on improving health.*

*Recreation therapist 1: Psychological, like working with the guy with paranoia.*

*Recreation therapist 2: Yeah.*

*Recreation therapist 1: So working on their psychological [aspects], but treating them like a whole person, offering them a number of ways to engage in recreation that can deal with cognitive functioning, physical functioning.*

Rather than solely focusing on the individual's physical needs, recreation therapy focuses on enjoyment and the well-being of the whole person including their social, emotional, spiritual, cognitive and physical aspects of their health. In Focus Group J, one recreation therapist stated therapeutic relationships in recreation therapy were “*unique because as therapists we are non-threatening with our relationships*” and no physically painful, invasive or threatening procedures were involved.

*Recreation therapist 1: What we have to offer isn't a painful process. People always say 'oh Mr. Smith really likes you'. Well I'm not changing his dressing. They are going to see it as a positive interaction, especially in dementia. I find we are not trying to invade their personal space, we're more positive.*

*Recreation therapist 2: We're the fun police, but I don't say police, the fun people.*

*Moderator: So not as intrusive maybe?*

*Recreation therapist 2: Yes.*

*(Focus Group J)*

The recreation therapists focused on fun and positive experiences, which set them apart from allied health professionals obligated to fulfill medical procedures or unpleasant tasks.

Recreation therapists get to know individuals through shared engagement across an array of enjoyable leisure experiences. By listening attentively to the individual and sharing experiences with them, the recreation therapists indicated they get to know the person in ways other disciplines may not;

*“I think the big thing is [the individuals receiving care] definitely see us differently than other disciplines like nursing, because we get to know them”* (recreation therapist, Focus Group N). By getting to know one another, the recreation therapist and individual receiving care deepened their mutual understanding. In Focus Group J, one recreation therapist stated a deeper understanding of the individual helped collaboration with that person on her journey towards leisure involvement:

*Recreation therapist: I think collaboration.*

*Moderator: Collaboration?*

*Recreation therapist: Between the resident and the therapist.*

*Moderator: So collaborating on what?*

*Recreation therapist: Collaboration on their journey, journey’s not a great word, but journey towards leisure involvement.*

Although learning about one another and collaboration were viewed positively, the recreation therapists stated what made their therapeutic relationships unique was they engaged in enjoyable and meaningful leisure experiences with individuals receiving care:

*Like you said we are not there to give [care]. Yeah, we are not there providing the care. We are not there giving them needles or medication. We are doing things with them that they enjoy. Even though there is a therapeutic outcome of what we are doing, they are benefitting in some way, they see us as something fun, as comfort and it involves activities that are important to them or they enjoy. (Recreation therapist, Focus Group N).*

Recreation therapy was not based on medical or invasive activities; it supports shared experiences (e.g., scheduled events or impromptu exchanges) that were enjoyable and beneficial. Focus Group N, discussed recreation therapy experiences often unfold with natural ease:

*Recreation therapist: We are just sitting down and I’ll often have a drink or something to eat at the same time.*

*Moderator: So it seems like a natural situation.*

*Recreation therapist: Yeah, a natural occurrence.*

The leisure context created an enjoyable and natural setting for therapeutic relationships to unfold and differentiated recreation therapy from other disciplines.

### ***Qualities of the Therapeutic Relationship***

A therapeutic relationship was described by recreation therapists at SHSC as a meaningful connection that took time, effort and shared experiences to be established. As they described several qualities of their therapeutic relationships, they emphasized care, trust, and respect for everyone

involved. These descriptions implied that a degree of reciprocity existed in the recreation therapists' therapeutic relationships. The recreation therapists also stated nonjudgmental listening was imperative; it helped them to understand the needs of individuals receiving care. They also suggested each therapeutic relationship has its own unique aspects, and some qualities of the therapeutic relationship were distinctly present due to the leisure-based context.

### ***Care, Trust, Non-Judgement and Respect for Everyone Involved***

Care and trust were connected in the recreation therapists' therapeutic relationship, for example a recreation therapist in Focus Group F stated, "*caring...goes hand and hand with the trusting*". Other recreation therapists also stated trust and respect were essential as they created the basis for the therapeutic relationship.

*I think it's more trust, I think it's that a lot of them are paranoid that you are trying to poison them they know that I am not trying to poison them. (Recreation therapist, Focus Group N)*

*I think the relationship is based on trust, mutual respect, comfort, both ways, between us and the person we are working with. (Recreation therapist, Focus Group N)*

Developing respect and trust takes time. A foundation of trust helped the recreation therapists to uncover individuals' needs. Open communication regarding needs and a basic "*level of trust*" were required for an individual's needs and goals to be met. A recreation therapist stated one must be patient in a therapeutic relationship, especially when challenges in the workplace make trust and respect difficult to establish. An individual's depression or behavioural issues were examples of obstacles recreation therapists confronted in their therapeutic relationships:

*Recreation therapist 1: Yeah and there are certain situations where there's depression or they are having an acute illness or something and you know it's not a good time maybe and definitely non-threatening. I know for myself, I work on a mental health unit and we deal with a lot of depression and other things and you have to catch them at a time where you know they will feel comfort and be able to engage....on my unit there are people that suffer from delusions and paranoia and again it's working through that with them and getting them to realize that you are not a threat to them. Just being with them, not challenging what they are saying in that sense. (Recreation therapist, Focus Group N)*

Being non-threatening helped the recreation therapists to establish trust especially with individuals who were wary of other individuals or had behavioural issues. Establishing trust enabled individuals to feel comfortable and engage in therapeutic relationships with the recreation therapists.

*Recreation therapist 1: For sure I think [trust is] essential, if trust isn't there, especially on your unit, you are dealing with underlying behavioural [issues], yeah it's essential, trust is important. They have to feel trust and they are not going to be non-threatening and comfortable.*

*Moderator: When you say nonthreatening, you mean, they feel that?*

*Recreation therapist 1: I guess sometimes it's both ways, you have to feel that you are not in a threatened situation to engage.*

*Recreation therapist 2: True.*

Once trust was established, the recreation therapists' believed that individuals receiving care would feel more comfortable and secure within the therapeutic relationship. The recreation therapists stated if the therapeutic relationship was perceived to be non-threatening, the individuals receiving care were more likely to engage with them or participate in programming. One recreation therapist said "*in a trusting relationship, the resident feels comfortable telling some of the problems that are bothering him.*" In essence, when qualities of trust and respect were fostered it enabled other positive aspects of the therapeutic relationship, such as feelings of comfort and open communication, to occur. It was suggested in Focus Group N, as feelings of comfort increased, the individual receiving care shared more important or personal information:

*I think the comfort level, there are individuals that I work with [when] they are having some sort of crisis in their family or there is something personal they feel that they can share it with me and I'll listen. (Recreation therapist, Focus Group N)*

*So trust, respect, comfort, there's a sense of feeling, a sense that you are able to share information without being judged. (Recreation therapist, Focus Group N)*

*Listening, attentive listening is very important I think. Yeah, listening and non-judgmental listening. (Recreation therapist, Focus Group N)*

As the individual shared personal information, the recreation therapists strongly emphasized the importance of listening attentively and without judgment, otherwise the individual could feel the need to stop openly communicating. Relationships could be threatened by judgment. The qualities of trust, care and paying attention to individuals' changing needs were emphasized throughout focus group

discussions and also appear in the welcoming, continuing and closing of therapeutic relationships sections of this document.

### ***Experiencing Meaningful Connections, Reciprocity and Shared Experiences***

When asked what the therapeutic relationship meant to them, the recreation therapists indicated it was a connection that develops between the practitioner and individual receiving care. According to one recreation therapist it was “a connection [between] two people that has meaning”. In Focus Group J it was acknowledged building a meaningful connection took time and mutual disclosure.

*I think it's the relationship built between the recreation therapist and your client, or resident in this case, over time whether it's built [through] one to one interaction, I mean it takes time to build the trust factor. You're engaging in personal discussions...you might be disclosing a bit in order for them to feel comfortable disclosing a bit of personal information about themselves... and a lot of it's built on trust. So it could be doing groups and you are just generally building that trust over time. (Recreation therapist, Focus Group J)*

The mutual sharing of information enabled the recreation therapists to learn about the person. When the recreation therapists disclosed information about herself, it helped to establish trust in the therapeutic relationship.

Recreation therapists primarily wanted the individual receiving care to benefit from the therapeutic relationship, although several of the focus groups (J, N and S) acknowledged a recreation therapist could also benefit from their therapeutic relationships. Therefore, in some therapeutic relationships, reciprocity existed. As a recreation therapist in Focus Group N described:

*It doesn't have to be, I think for the therapeutic relationship, they may be benefitting and we are not going in there providing the service to gain benefit for ourselves, but it's an outcome because we can take pleasure and joy from the fact that they are, I think that's what it is through their happiness that we benefit, that is true. I just wanted to clarify how we benefit. (Recreation therapist, Focus Group N)*

Recreation therapists stated they were able to benefit from their therapeutic relationships if they enjoyed their engagement with the individuals receiving care, or felt happiness when the individual receiving care benefitted from their involvement in recreation therapy. The recreation therapists indicated they often feel joy when their therapeutic relationships are harmonious and desirable benefits are achieved for the individual receiving care. The recreation therapists stated harmonious therapeutic

relationships were not always feasible; however, the recreation therapists said challenging therapeutic relationships still had the potential for a beneficial outcome.

*By it being challenging though, your hope is that the ultimate outcome is the positive and the growth experience, I mean all along the course it is a learning experience, but it doesn't always end up to be the way you hope it to be, you have to alter your plan of action sometimes with the extremely challenging patients or clients but it doesn't always work out the way you hope but that doesn't mean it's not therapeutic. (Recreation therapist, Focus Group F)*

According to the recreation therapists, something can still be learned from challenging therapeutic relationships. The recreation therapists also suggested making changes to a challenging therapeutic relationship (i.e., altering goals) could enhance the likelihood of beneficial outcomes occurring.

### ***“Being in the Moment”***

The recreation therapists at SHSC described the importance of “being truly present” in their therapeutic relationships. Recreation therapist encouraged “awareness”, “being in the moment”, “openness”, “acceptance”, “compassion”, “understanding”, and being “flexible” in their therapeutic relationships. Actively listening to the person was one way recreation therapists were present with, and showed respect for, individuals receiving care:

*I incorporate listening, so I really hear what the needs are. What they are truly saying so we can eventually respond. I think that it's taking the time, as opposed to being in a rush, listening [as opposed to] half catching and then having them feeling half respected or feeling disrespected, like they are not really heard. (Recreation therapist, Focus Group J)*

Being present everyday “only takes a few minutes” stated one recreation therapist in Focus Group J, but she emphasized it “contributes to the therapeutic relationship in a really meaningful way”. Being in the moment requires “patience, [and] a willingness to be really present” (recreation therapist, Focus Group J). Patience is required as individuals change from day to day, particularly on cognitive support units.

*Where I work, one day I might be trusted and then the next day because of wherever the resident is, they are suspicious of everyone, and I'm going to be lumped in that too, where they think that they are being held against their will because they are on a locked unit or wherever they happen to be that day. (Recreation therapist, Focus Group S)*

The role of the recreation therapist is “*ever changing*” for it is based on meeting and “*respecting where they [the individuals receiving care] are at.*” In addition to having “*patience and understanding*”, recreation therapists need to be flexible and adaptable on a moment by moment basis.

*I think by paying attention you are aware and tuned into [the individual] ...that helps you first of all to notice things that are happening to [the individual], so then that helps you take action in a timely way. It helps you to notice if something is going wrong with them, so you can follow through and provide support, whether that means you are checking in with them or following through with the team. (Recreation therapist, Focus Group J)*

Being present enables recreation therapists to respond quickly to changes in individuals. Even when the recreation therapist is not directly engaging with the individual receiving care, they are being aware of changes in the individual by observing them.

*I think in any area that we work we are always observing, always responding to where [the individuals] are at, always being present with [the individual] and then being flexible, whether its from session to session or within a session. (Recreation therapist, Focus Group J)*

Collectively, recreation therapists at SHSC understood the importance of being present with individuals receiving care.

### ***Providing Opportunities for Choice and Control***

The recreation therapists agreed within an institutional setting, choices were often limited for individuals receiving care and they experienced loss as a result. Recreation therapists stated they offer the individuals opportunities to engage in leisure and make choices, “*ultimately at the end of the day the residents get to choose*” (recreation therapist, Focus Group J). The recreation therapists respect individuals’ choices, but may revisit the issue to give individuals the opportunities to engage at another time if they wish. Opportunities for choice enhance individuals’ feelings of autonomy and “*give them a sense of control or a sense of power back in their lives*” (recreation therapist, Focus Group J).

*Moderator: What choices do they have? Do they always have a choice?*

*Recreation therapist 1: In my sense, when it comes to giving people recreation they have choice... I think they always have a choice. We really hope that we can facilitate that it can lead to something else.*

*Recreation therapist 2: I think so too. When it comes to recreation therapy and I think that’s an important part of our services that they always have that. That they always have a choice and the choice is acknowledged and accepted and respected and it’s an opportunity to exercise choice and to feel respected for sure.*

*(Focus Group J)*

The recreation therapists described individuals receiving care were encouraged to make decisions and the recreation therapists showed respect for choices by truly listening to concerns. In Focus Group N, these actions were seen as enabling the therapeutic relationship to thrive:

*Recreation therapist 1: I just want to add to listen to be a good listener and to hear their concerns and to listen to their choice if they want to be involved or not and I think we do that a lot whereas other disciplines may not have the same choice, in the relationship.*

*Recreation therapist 2: Choice is huge we always stress it's voluntary, whereas other stuff they have to go to the eye doctor, they have to get their ears checked. With us it's what they want to do. So choice, I think that is central to the role. Choice that's the basis that's the big one, it's not what we want.*

*Moderator: So to end with that listening is really important, truly listening to their concerns and choices.*

The issue of power within the recreation therapists' therapeutic relationships differed from other allied health professionals. When individuals receiving care were provided with opportunities for choice and control, the power of the recreation therapist was less evident. As one recreation therapist stated, "I think we have a parallel relationship as opposed to being more of a hierarchy" (Focus Group J). How power is negotiated within the therapeutic relationship is discussed in further detail later in this chapter.

### ***Recreation Therapists' Roles in Therapeutic Relationships: Traditional, Contemporary and Controversial***

This section describes several roles recreation therapists and individuals receiving care at SHSC potentially take on within their therapeutic relationships. The recreation therapists described themselves as adaptable and capable of wearing "many hats" or performing a variety of roles. Their roles constantly morph depending on the needs of individuals receiving care, families and other external influences. Traditional roles of recreation therapists discussed during the focus groups included: leader, facilitator, counsellor, advocate and educator. When recreation therapists took on these traditional roles, individuals receiving care became patients, residents and recipients of their services. In contrast, contemporary roles of the recreation therapists included validating the person's reality, supporting previous roles of the individuals receiving care at SHSC, and providing non-



institutional support. Simultaneously, individuals receiving care took on contemporary roles as active participants and leaders within their therapeutic relationships. Controversial roles also emerged in the focus group discussions. Some recreation therapists mentioned they could be friends with individuals receiving care, whereas others believed this role was not feasible. Even more disparity of opinions arose when individuals receiving care were described as friends and advocates. Therefore, the roles of individuals receiving care ranged from the traditional to contemporary and controversial.

### ***Traditional Roles of Recreation Therapists and Individuals Receiving Care.***

Traditional roles of the recreation therapist included: leader, facilitator, counsellor, educator and advocate. When the recreation therapists took on these traditional roles, individuals receiving care at SHSC became recipients, patients and clients. In the traditional role discussions, the power of the recreation therapists was highlighted and the power of the individuals diminished. At times, the recreation therapists stated they often followed the individual's lead; however, they also described themselves as leaders.

*You said there is no hierarchy but I think... they do see us though as a leader that they can come to us if they want to get involved. And they say, "if you say I can go out" for example on an outing or not, say based on a team decision, you may say, "this is not necessarily the best outing for you", so I think there is that. They may see us as...I know we've talked about the power, I don't know if you like the word power, but I think there is, that we have influence over their involvement, I don't know how you want to define that role but...that's part of our role I think. (Recreation therapist, Focus Group L)*

Recreation therapists in Focus Group L stated as leaders they provided recommendations to individuals and had the ability to influence individual or group leisure involvement. The recreation therapists also used their leadership to determine how extensive leisure involvement, disclosure their therapeutic relationships would be.

As counsellors and educators, recreation therapist's duties were to listen and provide appropriate support. Support involved providing feedback, advice or resources to individuals who require assistance.

*Recreation therapist 1: You are supporting the individual around the concerns they are expressing, feelings that they are expressing, questions they are asking...so it goes along with*

*listening in terms of ensuring that their voice is heard, and then part of counseling is providing feedback.*

*Moderator: So ensuring that voice is being heard and providing feedback.  
(Focus Group S).*

As counsellors, recreation therapists provided individuals receiving care with their perspectives, advice, and feedback based on their skills and expertise. In contrast, recreation therapists became educators when they assisted individuals to develop new skills, knowledge and abilities:

*Moderator: So aside from using our skills and resources what does an educator do?*

*Recreation therapist 1: Teaches.*

*Moderator: the resident? Who else are you teaching?*

*Recreation therapist 2: Family as well as staff too, what it is that we do, and the importance and what can be achieved from that.*

*Moderator: So [the] purpose of recreation therapy?*

*Recreation therapist 1: Benefits...*

*Recreation therapist 2: ...informing the clients/residents of their opportunities of what's available and that goes into resources too.*

*(Focus Group S).*

Often individuals who entered SHSC “*have never had leisure in their life*” (recreation therapist, Focus Group F) and were unfamiliar with recreation therapy. As educators, recreation therapists informed individuals about recreation therapy resources and opportunities. They also educated family and staff members about the purpose, benefits, or opportunities available through recreation therapy.

In contrast, as facilitators, recreation therapists connected individuals to resources, and supported relationship-building and leisure involvement both directly and indirectly.

*Recreation therapist 1: I give him gloves and cutting boards and things but he's not cooking things, it's not like he has a microwave in his room, but he makes things like, he made home-made potato salad, and things like that, and initially it came out of this dinner group, where he realized he has this love for cooking.*

*Moderator: So in that example, do you think your role was to enable him?*

*Recreation therapist 1: I was a facilitator, a facilitator for sure.*

*(Focus Group N).*

As facilitators, recreation therapists led or supported individual or group recreation therapy programming. They also facilitated unexpected day to day issues that arise on the units

*Recreation therapist 1: facilitating is about making things happen, and then you tend to keep in a position to make things happen and it's just things that arise, informally on a day to day basis in between the formal sessions.*

*Moderator: So it's maybe the wearing many hats metaphor, it's being flexible to deal with anything that is thrown at you?*

*Recreation therapist 1: Yeah and it's dealing with things too that may arise in session that may need following up outside of the session.*

*Moderator: So it's about the follow up?*

*Recreation therapist 1: Yeah.*

*(Focus Group S).*

The facilitator role demands flexibility and follow through as recreation therapists often accommodate requests out of the ordinary. Coordinating resources, people and programs was described as a full time responsibility that impacts the therapeutic relationship. When recreation therapists matched the right volunteers and resources to an individual, it enhanced the person's engagement in recreation therapy and the therapeutic relationship.

Another traditional role of the recreation therapists was being an advocate for individuals receiving care who were not able to advocate for themselves:

*We are an advocate for them and sometimes we are willing to look outside the box to make something happen that other people say no to.*

*(Recreation therapist, Focus Group L).*

*I can see myself as being an advocate for the guys on the cognitive unit, for they might share information with me that they wouldn't necessarily share with another staff person and I can advocate on their behalf, you know they're likes and dislikes, comforts, the things they don't enjoy that sort of thing. (Recreation therapist, Focus Group N)*

In Focus Groups S and F, advocacy meant talking to family members, team members, management or the larger community *on behalf of* individuals receiving care to ensure *their needs were being met* and their voices heard:

*I always thought of it as me advocating for them, especially if they can't...like the nurse that always wants to put them in bed early but there's really some good entertainment downstairs that they are going to benefit from and they need to go down...You have to communicate their wishes, what they want to do with the team and sometimes with the families, right? Like, actually this is what they really want to do. (Recreation therapist, Focus Group F).*

When recreation therapists advocated for individuals, they also advocated for recreation therapy. As advocates, recreation therapists tried to ensure leisure remained a part of individuals' healthcare plans as they viewed leisure as a way to enhance the quality of life of individuals receiving care at SHSC.

### ***Contemporary Roles of Recreation Therapists and Individuals Receiving Care***

This section discusses contemporary roles recreation therapists and individuals receiving care take on in their therapeutic relationships including: validating the person's reality, supporting the continuation of past roles and providing non-institutional support. Contemporary roles of individuals receiving care included: a continuation of past roles, and active participants. In contrast to the traditional roles where individuals receiving care were passive recipients, in contemporary roles individuals become active participants.

One contemporary role of recreation therapists was validating an individual's reality. This role was evident primarily on cognitive support units when recreation therapists were perceived as family members or individuals from the person with dementia's past:

*Recreation therapist: They also think we're their family. I'm their daughter or their wife.*

*Moderator: On the cognitive units?*

*Recreation therapist: Yeah definitely...and then you're in their good books.*

*(Focus Group N).*

In Focus Group L, recreation therapists stated that to prevent unnecessary suffering they chose not to contradict persons' with dementia realities. Instead, they validated individuals' realities, meaning they went along with the individual's story to provide comfort as long as their role-playing did not cause any harm.

*Recreation therapist: I also think it depends on your client population, I mean sometimes my role is I'm a daughter, or I'm an employee that they are trying to hire, like my role can change depending on where the resident is at, right?*

*Moderator: You're in cognitive support?*

*Recreation therapist: That's right...I think our role is ever changing. I'm not here just to do one thing with you. I can be your gardener, whoever you need in that moment, I can be stagnant.*

*(Recreation therapist, Focus Group L)*

When the recreation therapists described their work with individuals with dementia, there was a large amount of flexibility that occurred. Many roles used to validate reality were taken; recreation therapists became whoever the individuals with dementia needed in the moment and their *validating* roles changed momentarily or daily. The recreation therapists realized they were fulfilling a need and not

truly members of the individual's family or gardeners, etcetera. It should be acknowledged on other units this type of role-playing does not occur as the need does not exist in the same way.

As for the contemporary roles of individuals receiving care, some returned to previous roles they held prior to institutionalization. Reconnecting to a past role frequently occurred in recreation therapy since the roles were often leisure related and the recreation therapists encouraged dormant parts of the individuals' identities to emerge:

*Recreation therapist 1: I have one gentleman on my floor who has gone beyond his dinner group and has organized meals for his friends. He plans the meals, buys the groceries and they'll go out and have a picnic on their own in the K-wing garden and it's the complete normal thing to do, this is his home and he's entertaining, it's so nice, it's so nice to see that, that they are breaking away from the institution and doing something normal.*

*Moderator: His role has changed?*

*Recreation therapist 1: Yeah his role has changed and his role has continued, he's felt comfort through being involved in recreation therapy he's met other people and that's enabled him to continue roles he would do in the community, as an entertainer, as a cook.*

*Recreation therapist 2: He kind of blossomed here.*

*(Focus Group N).*

The recreation therapists emphasised the continuation of past goals enhanced meaningful experiences, a sense of normalcy, and reaffirmed identities for individuals receiving care.

Within their therapeutic relationships, individuals receiving care were also able to take on contemporary roles as informal helpers. For some individuals, their active participant role was limited to simple acts of chivalry such as opening a door or pulling out a chair. Other individuals extended their helping roles and became leaders in recreation therapy settings.

*Recreation therapist 1: I think both the TR and the resident can have leadership roles.*

*Recreation therapist 2: Leadership in the way the relationship is shaped or in terms of the roles that they take on?...*

*Recreation therapist 1: ... I think leadership in feedback, how far does the resident want to go, how much do they want to share, what their leisure interests are, I mean it can come both ways in the relationship and in terms of TR.*

*(Focus Group L).*

Some individuals were also involved in researching activities, planning outings, and providing constructive feedback. Therefore, as leaders, individuals receiving care had opportunities to become planners, consultants and researchers.

*Recreation therapist 1: When I'm planning bus trips, they feel a part of the process, like they give you suggestions where they would really like to go. So it's not just one-sided. I'm not saying we are going here and here and here. We sort of try to work it out say at a discussion at a dinner group, we talk about, "oh the fall is coming, would you like to go back to this place?" Or, "are there suggestions where you want to go?" So they are actively involved... They feel [that] they get a role. I know there is a gentleman who actually went out and did research on the internet, to find out about a place to go on an outing, so they feel part of the process so.*

*Moderator 1: So how would you describe [their role]?...*

*Moderator 2: An active participant?*

*Recreation therapist 1: Yeah, a very active participant, active participant is good, because we are not just providing something for them, you know, they'll let you know if it's some place that they don't want or they want to see things, particularly on my floor*

*(Focus Group N).*

Recreation therapists also indicated as active participants, individuals receiving care gained a sense of power back into their lives:

*Giving them a sense of control or a sense of power back in their lives, you know, hopefully giving them something, a snap shot of what they used to do or something similar along those lines. If someone was involved in the church and very active, you know giving them something, giving them, they like to be a bit of a leader role. You know, we are giving them something like that to recapture some of their previous involvement. (Recreation therapist, Focus Group J).*

Many individuals receiving care also had volunteer roles within the SHSC community.

*I've had so many guys come forward and I've gone over and I've gotten them an official volunteer badge and it means a lot of them to give back, because they feel like we given them so much. [One] gentleman right now...he helps people who are in wheelchairs, he helps clean up....Part of their role is a volunteer, being someone, it's important, especially for my guys, to feel like they are giving back... There is a sense of ownership to that so they do have set responsibilities. (Recreation therapist, Focus Group N)*

Volunteering enabled individuals to give back to their community and fostered meaningful engagement and ownership. In summary, the active and contemporary roles of individuals receiving care ranged from informally assisting the recreation therapist to prepare for a program to a formal designation as a SHSC volunteer.

### ***Controversial Roles of Recreation Therapists and Individuals Receiving Care***

There were three relatively controversial roles that emerged during the focus group discussions. The first controversial role involved the idea of individuals receiving care as being an advocate for the recreation therapists. The other controversial roles involved the idea of friendship, the recreation therapist being a friend to the individual receiving care and visa versa. These roles were controversial

because there were a variety of opinions and levels of acceptance regarding each role. For example, some recreation therapists described individuals receiving care as influential advocates.

*I had a trip where the bus didn't show up and I [thought], "Oh my gosh, they are going to be really upset", but in the end they were more upset for me...they were sort of protecting me, you know and advocating for me. "Oh no [she] has great trips, I don't know what happened, but it wasn't her fault." So yeah it's kind of cool that they advocated for me as well, because they could have been upset. (Recreation therapist, Focus Group N)*

*Like in a group and there is one person in the group causing problems, or whatever and some of the guys are "hey!" and they put them in their place, and "she's trying to speak or run a group and just be quiet", and that's what I think of when it's the other way around. (Recreation therapist, Focus Group F)*

At times individuals receiving care would take on an advocacy role and confront other individuals who were disrupting recreation therapy groups. As the recreation therapists discussed, this could have signified that individuals receiving care respected, trusted, and valued them as professionals. However, other recreation therapists questioned whether the individual's role as an advocate was consistent with the provision of person-centered care:

*So in that situation, how do you or how do the others of you in this group feel that that reflects on the therapeutic relationship? When the clients are then missing out on their experience but they are then stepping up to advocate or their concern is more for the therapist than themselves and their lost opportunity? So they are taking on the advocate role and their concern is more for the therapist than it is for themselves? (Recreation therapist, Focus Group F).*

Friendship was another controversial topic. Acceptance of roles regarding friendship varied between recreation therapists, and was dependent on how they defined the term. There was a continuum of understandings about the presence of a friendship within the therapeutic relationship. Some recreation therapists indicated individuals receiving care were not their friends, whereas others used the word friendship acceptingly.

*Recreation therapist 1: I think that a lot of the residents see us, rather than a therapist, like a friend. I get called a friend a lot.*

*Recreation therapist 2: You're a friend.*

*Recreation therapist 3: Yeah for sure.*

*(Focus Group N)*

Whether the therapeutic relationship was referred to as a friendship depended on each recreation therapist's interpretation of the term. The notion of friendship appeared when an individual receiving care advocated for a recreation therapist.

*I think when you have a friendship, and I'm thinking of my friends or my relationships outside of here you do advocate for each other. You know someone has hair in their soup, but they are too embarrassed to say something, you are going to speak up or sometimes you know if someone is too embarrassed or too shy, you tend to speak up for somebody. (Recreation therapist, Focus Group G)*

Some drew comparisons between the qualities, (e.g., mutual respect and enjoyment) experienced within their therapeutic relationships and friendships outside of work. Other recreation therapists described their therapeutic relationships as friendships if they felt a strong connection with an individual receiving care:

*I had a resident on Monday who decided to take everyone out for dinner for the group he had every Monday night. It was so wonderful to see that he wanted everyone there as a part of the group because he felt there was a friendship with everyone and that was just wonderful to see the connection with the volunteer, with the therapist, with everyone. I don't know, I think we are all on the same page. (Recreation therapist, Focus Group F).*

Another recreation therapist suggested there is a "wide range in the friendships" individuals' experience, and a professional friendship could be considered a type of unequal friendship. One recreation therapist suggested a professional may feel a bond with an individual that resembles a friendship, but the bond exists within professional boundaries:

*Recreation therapist 1: So what about friend...Friend on a different level, maybe not?  
Recreation therapist 2: Yeah, sometimes it can be, sometimes you have those bonds with people. Right, like sometimes you just sort of develop that bond, whether they remind you of people in your life, or have all the qualities that you look for in a friend in life.  
Recreation therapist 1: Friend, you are all probably putting on your hats like a friend you would have out of work, but a friendship that you would build within your work environment like your clients.  
Recreation therapist 2: Like a professional friendship, if that's possible.  
(Focus Group F)*

In Focus Group L, recreation therapists described their therapeutic relationships as mutually amicable relationships rather than friendships. They stated the term friendship suggested equality, which the recreation therapists in Focus Group L felt did not exist. These recreation therapists indicated perceptions of equal friendship were one-sided, meaning only the individuals receiving care



at SHSC perceived the recreation therapists to be their friends. This one-way perception predominantly occurred on cognitive support units.

*Recreation therapist 1: I know that in cognitive support that there is a perception of [friendship] absolutely, and I know from past research that we had conducted in patient focused care in Therapeutic Recreation that [the perception of friendship] was a key element in cognitive support. That there was an idea of friendship, friendship/I go back to that no hierarchy, that you are on an equal playing field,*

*Recreation therapist 2: A reciprocal relationships right?*

*Recreation therapist 1: But I don't think that is necessarily true, say in [another unit's] case there is probably very clear identity and boundaries and a set 'I'm the therapist', I'm sure.*

*Recreation therapist 2: Right, it depends on the setting.*

*Recreation therapist 1: Yet in cognitive support it's a little different.*

*(Focus Group L).*

A recreation therapist in Focus Group L suggested therapeutic relationships were not reciprocal relationships or true friendships because professionals do not rely on the individuals for personal support.

*Recreation therapist 1: Right, I think you can have a positive relationship without it being a friendship as well, I see a friend as you go to them when you need them, and I'm not going to go to a resident when I need them that's not, I don't see it like that, I see it as very different.*

*Recreation therapist 2: They may see us as friends, so it's not necessarily reciprocal right?*

*Recreation therapist 1: Right and you can be a support to them and you can do what you need but I'm not seeing them as a friend.*

*(Focus Group L).*

In contrast, one recreation therapist stated as long as “*boundaries and power isn't challenged or pushed I think that friendships do happen.*” Another recreation therapist suggested for friendships to build there needs to be a “*lot of disclosure and a lot of communication.*” In the recreation therapists' therapeutic relationships the amount of information disclosed was often unequal. Recreation therapists disclosed less information within their therapeutic relationships than during relationships with colleagues or friends outside of their work. One recreation therapist indicated for a friendship to occur it meant power and disclosure were equal:

*I don't think it would be equal friendship, because you wouldn't divulge your own personal information to the resident when they are sharing their family news with you. You would share some of your family news with them, but you wouldn't tell them what you did on the weekend if you went partying or your own personal life per say. There are just certain things that you would share and certain things that you wouldn't. So it's really up to your discretion to see what would be appropriate, but in terms of whether the friendship would be equal I don't think so.(Recreation therapist, Focus Group F).*

In summary, there was a continuum of beliefs regarding whether the individual receiving care took on the role of a friend. In some situations, based on a vast amount of open communication, disclosure, and mutually enjoyed experiences, the individual was referred to as a friend. In contrast, other recreation therapists who had stricter boundaries regarding the amount of personal disclosure and roles they play stated friendships did not exist within the context of their therapeutic relationships. There were also recreation therapists who fell at various places along this continuum. A recreation therapist's placement on the continuum often depended upon her level of disclosure and strength of the attachment she felt within her therapeutic relationships.

### ***Exploring the Therapeutic Relationship Process***

All therapeutic relationships are not experienced in the same way. How one recreation therapist introduces herself, develops trust, and communicates with individuals receiving care at SHSC may be different from another practitioner. Each recreation therapist and individual receiving care is unique; consequently each therapeutic relationship is also distinct. Despite their differences, each recreation therapist engages in a similar therapeutic relationship process. Each therapeutic relationship is welcomed, continued and closed. Professionals share some commonalities in their approaches and strive for similar qualities within their therapeutic relationships. The following sections describe the therapeutic relationship process in three stages and the actions taken by recreation therapists in each stage.

#### ***Welcoming a Therapeutic Relationship.***

When welcoming a therapeutic relationship, recreation therapists engage in several essential actions including: ensuring a welcoming introduction, engaging in a process of getting to know one another, and following the person's lead. In Focus Group J it was stated a "*relationship built between the recreation therapist and client or resident...takes time to build the trust.*" Recreation therapists disclose a little about themselves during personal discussions with individuals receiving care that occur in the welcoming stage to help them "*feel comfortable disclosing personal information about*

*themselves too.”* The welcoming of a therapeutic relationship is “*built over time, [since] a lot of it’s built on trust.*”

***Ensuring a welcoming introduction.***

One of the first steps in the therapeutic relationship process occurs when the recreation therapist introduces herself to the individual and the family if present. This introduction sets the stage for developing rapport and further interactions:

*I think everyone’s approach is different, I think they are similar but, how...you develop that rapport, I think one of us are going to do that differently based on whoever we are approaching. (Recreation therapist, Focus Group J)*

Each recreation therapist has her own way of approaching individuals and family members, yet her approach can be altered by the direct or indirect feedback she receives. In Focus Groups J, N and S, the recreation therapists discussed that during the introduction the recreation therapist welcomes the individual and learns the preferred name of the individual. This was described in Focus Group J:

*Recreation therapist 1: With a good solid introduction of yourself in the beginning. You make sure that you also really learn a person’s name at the beginning. It sounds so basic but I think making sure you learn what name the person wants to go by in the beginning. Sometimes people just go by the name on the chart or they don’t get the person’s proper pronunciation, it’s things like that.*

...

*Recreation therapist 2: and them telling you what they would like to be called, if you heard their wife calling them something else...asking their permission [about what name they would like to be called]. (Focus Group J)*

As a recreation therapist in Focus Group S described, when a recreation therapist introduces herself and learns the name the individual receiving care wishes to be called, “*it forms a foundation of value and respect.*”

Recreation therapists in Focus Groups N and F emphasized the importance of maintaining a friendly, patient, and non-threatening approach. They also discussed the importance of maintaining a positive attitude with the person and family during the development stage of the therapeutic relationship:

*Recreation therapist 1: It’s established through trust.*

*Recreation therapist 2: We talked about welcoming them.*

*Recreation therapist 3: And nonthreatening.*  
*Recreation therapist 2: Nonthreatening conversation.*  
*Moderator: Trust, patience, welcoming them through conversation.*  
*(Focus Group N).*

A welcoming introduction was described as relaxing the individual, enhancing trust and opening doors of communication within the therapeutic relationship. One recreation therapist stated, “be more relaxed, and more open to sharing” (Focus Group F). The recreation therapists hoped their actions would foster qualities of a positive therapeutic relationship (e.g., nonthreatening, trust, respect) throughout the process.

***Getting to know one another through communication and dialogue.***

When welcoming their therapeutic relationships, recreation therapists focused on getting to know individuals receiving care and their family. They gathered information about the individuals including “*things that provide comfort, what their normal routine was before they came*” (recreation therapist, Focus Group N). Another recreation therapist from Focus Group N stated gathering information essentially builds the relationship. Recreation therapists in Focus Group J suggested this process took patience and involved “*really getting to know what their interests are past, present, future*”, finding “*common ground*”, “*respecting them [as] individuals*” and “*a lot of listening.*” The recreation therapists acquired information by reading the person’s medical chart and by using “*good observation skills.*” Yet, face to face conversations with individuals receiving care and their family members were the primary way recreation therapists gained pertinent information. The recreation therapists noted information on routines, past roles, leisure interests, likes and dislikes, helped to build therapeutic relationships. Recreation therapists in Focus Group S indicated often through direct conversations they listened to concerns, learned about interests, and understood how involved in care a family members wish to be:

*I think it is also a good opportunity to find out any concerns that, if perhaps there are any potential barriers that you can help support them on, whether it is hearing difficulties or physical difficulty or anxiety related or social concerns or if there is anything that they have concerns about or [things] that hold them back from engaging. Maybe there is potential interest [and] that there are some of these concerns that maybe you can address to help support their engagement. (Recreation therapist, Focus Group S).*

One to one conversations enable recreation therapists to understand how to support individuals and families and meet their needs more effectively. During these interactions, recreation therapists observed if there are any conflicts that need to be addressed between family members. They noted it was particularly important to mediate familial conflicts when the voice of the individual was being ignored. The following discussion occurred in Focus Group N:

*Recreation therapist 1: Getting to know the family as well.*

*Recreation therapist 2: Oh yeah, we do, that's a big part, we get to know the families and families do take part in our.*

*Recreation therapist 1: They are very involved.*

*Recreation therapist 2: Oh yeah, they come on outings.*

*Recreation therapist 3: Sometimes you are just as involved with the wife as the husband.*

*Recreation therapist 1: Showing them support.*

*Recreation therapist 2: And if the person isn't able to verbalize what they want then you talk to the family.*

*Recreation therapist 1: Listening to them.*

*Recreation therapist 3: That can be a source of conflict too, what the family wants is different from the individual wants or they may have had a lifelong [struggle].*

To overcome any concerns and conflicts, recreation therapists said they focused on supporting individuals and families without being threatening. They followed through on information they received in a timely manner, to ensure trust in the therapeutic relationship was properly welcomed and continued:

*I think it's also about having a non-threatening approach. It's also about listening to what they are saying and following through...in a positive way and you truly do value what they are saying, and you're not just offering them [lip service]... So if they are interested in cards per say, then actually getting back to them and not just offering them lip service. (Recreation therapist, Focus Group S)*

It was clearly stated that getting to know an individual takes effort and patience, especially if the individual requires a significant amount of support and “time to settle in” (recreation therapist, Focus Group J). It was suggested individuals often need to familiarize themselves with their SHSC surroundings before they can fully engage in recreation therapy programming. The recreation therapists also discussed that families have adjustment periods and require support. Often a recreation therapist will “develop a relationship with the family” (Focus Group J). Recreation therapists in Focus Group S stated some family members are not aware of their needs for adjustment, particularly when

families are “*completely riddled with guilt and don't want them in anything [or] don't completely understand the condition or won't accept the fact that their loved one has dementia.*” The recreation therapists stated relationships with the families also require patience and acceptance:

*Just acknowledging when they are ready, some families will never be ready, and even [with] the whole interdisciplinary team working with them they are never going to accept that Mr. X doesn't recognize them anymore or when he is doing something that they don't like, that it's not something he can necessarily help or stop himself from doing, so slapping him is not going to make the behaviour go away. (Recreation therapist, Focus Group S).*

The recreation therapists noted during adjustment periods they attempt to communicate with family members and individuals regarding realistic expectations and behaviours, in a delicate, casual and supportive manner.

Although it was important for the recreation therapist to get to know the family and individual during the welcoming stage, they stated the process must also occur in reverse. They meant that the recreation therapist should be “*sharing a bit about [herself]*” (recreation therapist, Focus Group N) to allow individuals and families to “*get to know [her]*” (recreation therapist, Focus Group J). What is shared and the extent of communication is based on the professional judgment of each recreation therapist. Typical information a recreation therapist shares includes: the programs are available, how she can be contacted and some general knowledge about herself as a professional or some leisure interests. The following dialogue occurred in Focus Group S:

*Recreation therapist: I think it also gives them an opportunity to inform you of anything that they want you to know from the start. It gives you an opportunity to learn about anything that is important to them right from the get go, whether they want [to] share why they are in hospital or why they moved to [this facility] or anything in terms of goals, if they want to share that from the beginning, or who they are, family.*

*Moderator: So who they are as an individual?*

*Recreation therapist: Yeah, so if there is anything they wish to share with you from the beginning and also for you to share with them what you are here to do, what you are available to them for, the kind of service you provide.*

*Moderator: The sharing of roles, opportunities, expectations?*

*Recreation therapist: Yeah and how they can access you.*

*I think sharing information at that stage is important too, even though you are being patient with them, they have a lot of questions, they want to know how they can get to this, they want to know, so you provide information without forcing involvement you know, do you find that on your floor? (Recreation therapist, Focus Group N)*

Information regarding recreation therapy opportunities is provided in an open, welcoming and non-forceful manner. According to the recreation therapists, this informal exchange of information enables individuals receiving care to absorb the information and participate in programming at their own pace. Focus Group N indicated participation in programming usually occurs after an individual begins to feel comfortable with the recreation therapist and trusts her:

*Recreation therapist 1: Certainly, if they have a dog at home that they absolutely love [named] Trixie, and I sit down and chat that I like dogs, you have topics to discuss. (Agreement throughout)*

*Moderator: So you are basing it on their interest?*

*Recreation therapist 2: Yeah, basing it on their interest.*

*Recreation therapist 1: Yeah, I always share, 'oh my first dog was a poodle named Jingles', and it's not just one sided, it's sharing your information with them as well*

*Moderator: so sharing a bit about yourself?*

*Recreation therapist 2: Yeah...other disciplines may feel that they cannot step out of that, they feel that boundary can't be crossed, where we sort of, we're different.*

*Recreation therapist 3: Almost to earn that trust you have to give a little of yourself, (exactly) you tell them a bit about your life.*

*Recreation therapist 2: Because they want to know, not that you want to cross any boundaries in terms of you know, you know, but you do about mutual things, if they talk about a dog, you talk about a dog and share your experiences with animals and it really does help develop the relationship.*

During focus group discussions, concepts of communication and dialogue were brought forth. It was discussed that communication or one-way flow of information, is not-suitable when welcoming a therapeutic relationship. Instead dialoguing was described as helping the recreation therapists to establish strong therapeutic relationships. Dialogue occurs when both the individual and recreation therapist are active participants in the conversation(s). Focus Group F highlighted the difference between communicating and dialoguing:

*Recreation therapist 1: Well you have to listen to what they say, how they feel, and what they want to tell you.*

*Recreation therapist 2: So it's communicating.*

*Recreation therapist 3: Is communicating the same as dialoguing or?*

*Moderator: How would you define the differences?*

*Recreation therapist 3: I don't know that's what I was asking, is it actually different?*

*Moderator 1: Well to you what does dialoguing mean and then we can see if it's separate.*

*Moderator2: Communicating could be one way?*

*Recreation therapist 3: I was just going to say you could be communicating your wishes or the resident could be doing that...dialoguing is when you are engaged in whatever the issue is and I guess?*

*Moderator 1: Does anyone else want to add in terms of what you would see dialoguing as?*

*Recreation therapist 1: Dialoguing to me is an action word.*

*Recreation therapist 3: Some communication isn't always words, it could be body language or it could be through someone else, but dialoguing it is one on one with that person.*

*Recreation therapist 1: Yeah communication could be responding to emails.*

*Moderator 2: To me, I don't know how much I can respond as a facilitator of this, but to me when I hear dialoguing I think an actual conversation I guess it could be through email, but it could be a two way.*

*Recreation therapist 3: Face-to-face.*

*Moderator: Multiple way conversation, whereas communicating it could be nonverbal, it could just be one way.*

The recreation therapists agreed dialoguing appears to occur when both parties are actively engaged in communication. Open, face-to-face dialoguing was the ideal way for recreation therapists, individuals and families to get to know one another. The recreation therapists recognized dialoguing with individuals receiving care was not always possible; for example, a non-verbal individual maybe unable to verbally participate in a one-to-one conversation. Therefore, recreation therapists must follow the lead of the individual receiving care, and try to work with their abilities.

#### ***Following the person's lead.***

Following a person's lead means the recreation therapist values where the person is at and changes her approach based on feedback from the individual. The professional gives the person plenty of time and space to make decisions and respects the type of relationship the individual wants to have.

This was discussed in Focus Group J:

You build trust between one another and you allow that person to have the space and the time to come to you or give you a sign that he or she is willing to build a relationship with you or someone in the department. (Recreation therapist, Focus Group J)

When individuals move into a new setting, they may experience “*a lot of anxiety and stress*” (recreation therapist, Focus Group N) and often they voice a need for space and time to make arrangements before they engage in recreation therapy:

*They'll say to me "I've just moved here, I need to settle in, I need to take care of my phone". So I respect that, it's more just being there, giving them information, and not forcing them to get involved right away, it's so important to have a few weeks to settle. (Recreation therapist, Focus Group N).*

Sometimes it is the recreation therapist's duty to let families know there is an adjustment process and she will welcome a relationship with the family to assist with this transition:



*Recreation therapist: We definitely let the residents settle in okay, this is a new home. If you were to move into a new community it takes time, to unpack your things.*

*Moderator: Would you say that to them?*

*Recreation therapist: I would not say that to the resident, no, I would explain that to the families, that it takes time to settle in and I will develop a relationship with them, and that might just mean sitting down and having a cup of tea or coffee.*

*(Focus Group N).*

Following the individual's lead is vital in the early stages of the therapeutic relationship. The recreation therapists attempt not to overwhelm individuals with information or expectations of involvement. Recreation therapists in Focus Group N stated life within an institutional setting is full of mandatory tasks and routines. Recreation therapists try to provide relief from demands and obligations by letting the person make the decision whether to engage:

*Recreation therapist 1: You are not trying to do something to them whereas other disciplines may come in and say "we have to do, this, this, this, and this, now", [they are] on a schedule, and they don't wait for you to settle...the wheelchair has to be set up, the Occupational Therapist "the wheelchair has to be put in place."*

*Recreation therapist 2: The [dietitian] comes in to determine the diet.*

*Recreation therapist 1: They are being bombarded by all the other disciplines, that's why I always say to them, take the calendars, I know you are really busy right now, take some time to settle, and when you are ready that's when we'll talk, you know, and I'm always here if you have questions. And they know that.*

Recreation therapists enabled individuals receiving care to choose the direction and intensity of their involvement in therapeutic relationships. It was suggested in Focus Group N that individuals differ in their willingness to engage in a therapeutic relationship depending on the unit (e.g., cognitive support or physical support); some require more motivation than others:

*Recreation therapist: I find that I work on both the mental health unit and physical support and there is a real difference in getting them to engage.*

*Moderator: What do you mean?*

*Recreation therapist: I guess with the physical support they can on the whole they are much more active, much more able to self-engage whereas with the mental health, I can't generalize with everybody, they need more encouragement. They don't do as well in groups, sometimes they need more individual attention, it causes them anxiety. I know one individual ...he really stresses when it comes to being involved with a group. If you come and visit him in his room or he has a few people he meets down in [the program area] every morning, that's comfort, that's familiar, but he can't function in groups. So I think you have to respect where they are, in their illness.*

Within the therapeutic relationship, respecting where the person was at and how she/he wished to engage was important. Acceptance was also essential. One recreation therapist in Focus Group J

emphasized the need for recreation therapists to accept an individual's goals and that not everyone wants help, "*we cannot help everybody, and acceptance that they may not want to have anything to do with us.*"

One of the most challenging things for a recreation therapist to accept is that an individual may not want to engage in recreation therapy. Although recreation therapists want everyone to become involved, they realize it is ultimately the individual's choice whether he wishes to continue a therapeutic relationship or engage in recreation therapy. When a person does engage, the recreation therapist tries to encourage the individual's involvement in decision making. Recreation therapists in Focus Group F indicated they ask the individual questions throughout the process and obtain feedback to ensure the direction of the therapeutic relationship is mutually agreed upon. This strategy also enables the recreation therapist to determine which aspects of recreation therapy programming are enjoyable and which aspects require modification:

*Recreation therapist 1: Giving feedback*

*Moderator: What kind of feedback?*

*Recreation therapist 1: I was thinking along the lines of being in a group or a program and at the end of it saying 'how did it go today? How can we change this? Are there any ideas for the next time we have this group? ...so it could be one on one too, but that was in the context that I was thinking.*

*Recreation therapist 1: So it's more of an inclusion as well, getting them to be a part of the group.*

This feedback occurs during one-on-one conversations or in group settings. This process helps the recreation therapist to follow the individual's lead and show she values his/her choices.

### ***Continuing to Engage in a Therapeutic Relationship.***

Many actions taken by the recreation therapists during the welcoming stage are continued throughout their therapeutic relationship. One way recreation therapists continued their therapeutic relationships was to have an authentic, consistent, and friendly approach. The recreation therapists also stated they put significant effort into ensuring positive qualities of a therapeutic relationship such as trust, respect and honesty are continued. A recreation therapist will share important information with the individual to maintain her trust. Ongoing, open communication helps both parties to continue to get

to know each other and feel comfortable engaging with one another. When a recreation therapist shares information about activities and opportunities with the individual receiving care her ultimate aim is to involve the person in safe and enjoyable leisure experiences. Enjoyable and shared leisure experiences help to continue a therapeutic relationship. Although communication is important, the recreation therapists stated they must consistently listen to and observe the individual so they can appropriately address any changes which occur as their therapeutic relationships progress. Based on the focus group discussions, continuing a therapeutic relationship involved several actions: (1) consistently being there for the individual receiving care; (2) ongoing communication to create safe and enjoyable leisure experiences; (3) paying attention to changing needs or choices and adapting accordingly; and (4) making authentic efforts to nurture qualities of a positive therapeutic relationship.

***Consistency and being there for the individual.***

Trying to establish rapport or build trust with individuals receiving care takes considerable time and demands consistent effort from recreation therapists. The recreation therapists said consistency was imperative during the maintenance stage of the therapeutic relationship. A consistent approach helped recreation therapists to establish rapport and engage individuals receiving care in recreation therapy programming:

*Recreation therapist 1: Rapport.*

*Recreation therapist 2: Yeah having that rapport.*

*Recreation therapist 1: In terms of them having to have trust in me, to be able to dialogue or want to engage with you and what you have to offer and to be able to share, that is not easy. (Focus Group J)*

*I think too, when you are developing a relationship you need to be consistent. They are trying to get to know you and if you are the kind of person that is one way one day and one way another day you are never going to have that relationship because they don't know where you are coming from so that trust can't develop. (Recreation therapist, Focus Group F)*

Recreation therapists in Focus Groups J and L also indicated they must consistently portray a willingness to spend time with the person, so that the individual feels the time spent together is valued. Spending time with the person includes both time engaged in scheduled events or programs and unexpected interactions:

*Recreation therapist: Developing a rapport with them.*

*Moderator: And how would you do that?*

*Recreation therapist: Spending time with them, and letting them know that it's important, that it's important to spend time with them that they are not just a patient in a hospital. (Focus Group L).*

*Willingness to spend time with them too, it's not just time you set aside you know 10 to 11 [that] I am spending time with Mr. X. It's also the times that Mr. X needs you, that you... are not necessarily expecting but you take the time to do the little things that help build a relationship. (Recreation therapist, Focus Group J)*

An actively engaged and interested approach is imperative when continuing a therapeutic relationship. One recreation therapist also suggested that “*establishing rapport [requires] listening.*” Consistently listening to and sharing information with individuals receiving care helps to continue therapeutic relationships. Recreation therapists in Focus Group S indicated they try to focus on the individual and stay present in the moment during every interaction they have; even if it is just for a few minutes at a time. Being present in the moment indicates that a recreation therapist is truly engaged and values their involvement. This approach was also believed to enhance the individual’s willingness to continue to participate in recreation therapy:

*Recreation therapist 1: I think a lot of the things we mentioned in [the theme about developing the therapeutic relationship] can be important for the relationship to be maintained*

*Moderator: So there is consistency... consistency in the following through approach, the communication, the addressing concerns, listening, anything else that helps in keeping the relationship maintained?*

*Recreation therapist 2: I think every little interaction we have, it's not just when you are seeing them in the hallway you say 'hello how are you?' And you acknowledge them, so for us we have an open door policy, so when they all come down for supper...they all stop and say hello.*

*Moderator: So it's through every little interaction?*

*Recreation therapist 1: Definitely, that is a good point.*

*Moderator: So it's being consistent through those interactions?*

*Recreation therapist 1: Yeah.*

*(Focus Group S)*

Being truly present with the individual fosters feelings of respect and connection. However, the recreation therapists in Focus Group J stated being present requires constant effort from the recreation therapist. Focus Group J discussions highlighted the importance of building trust in therapeutic relationships through actively listening and being truly present when engaging with individuals receiving care:

*Recreation therapist 1: Through engaging them.*

*Recreation therapist 2: I think it's being really present for the client...it's through patience...a willingness to be really present...I incorporate that listening, so I really hear, really hear what the needs are, what they are truly saying...we can eventually respond...so I think that's taking the time...as opposed to being in a rush...listening, half catching and then also having them feeling half respected or feeling disrespected like they are not really heard. As a therapist I feel the need to be really present and I think that everyday sometimes it only takes a few minutes to have that client left feeling that you were really there for those few minutes and that contributes to the therapeutic relationship in a really meaningful way. So it can be a few minutes at a time that you are contributing significantly to the relationship, by being truly present, trying and truly connecting. (Focus Group J)*

In essence, to continue a therapeutic relationship and ensure the individual feels valued and respected, it is necessary for the recreation therapist to be consistent in her words and actions. The recreation therapists stated they try to be accountable for their actions. Following through with actions and words in a timely fashion is one way the recreation therapists in Focus Group L communicated their respect for and accountability to individuals receiving care.

*Recreation therapist 1: What about following through what you say you are going to be doing?*

*Recreation therapist 2: That's important as well, the follow through.*

*Recreation therapist 1: Well it's kind of like being accountable, accountable to many things, yeah.*

*Recreation therapist 3: If you listen and things come of it and you want to get, if they have concerns about something, I think it's your role to follow up, to get a resolution or problem solving, they may want to get involved or you may be interested in getting in touch with the other allied health professionals, or maybe it's as simple as getting them involved in recreation therapy, but a part of that, I think ...you are sort of their advocate.*

*(Focus Group L).*

Following through incorporated dealing with unexpected demands (i.e., connecting individuals in need to necessary resources or assistance). The recreation therapists in Focus Groups F and L emphasized that sometimes they needed to enlist the help of other professionals at SHSC to meet these demands:

*Recreation therapist 1: You say you are going to do [something] or someone gives you information that you need to pass on to someone else or that sort of [thing it] goes back to the trust and the respect and all of that. If they respect, they trust you, you are working together to have this relationship and do things together, and if you don't follow through on your end or see to their best interest, then that's all going to fall apart.*

*Recreation therapist 2: Another thing we haven't really touched on is working with the team.*

*Moderator: Do you want to expand on ways that we work with the team?*

*Recreation therapist 1: Oh, ok well conferences, rounds, and sometimes you have meetings outside of that with various team members one on one.*

*(Focus Group F).*

*Recreation therapist 1: Yeah and they may sometimes tell us problems they are having, whether you need to talk to the nurse or patient care manager or family member, sometimes you are the front line, you're the one they will tell you, tell you that and no one else knows about it, or they have been waiting for this, since like weeks and nothing's been followed up.*

*Recreation therapist 2: Like a hearing aid or glasses or something.*

*Recreation therapist 1: Yeah, something like that, they trust you or even if they don't know, you look familiar and they're going to tell, ask you. (Focus Group L).*

When recreation therapists were consistent and followed through, they believed it fostered feelings of trust and respect with individuals receiving care. The recreation therapists in Focus Group L discussed that following through to meet needs of the individuals receiving care involved: orienting the individual to the facility, connecting them with other people, referring the individual to other professionals and fostering friendships with others:

*You're orienting them to life in long term care facility, at Sunnybrook, and then I think you are taking, you're sharing with them, what's involved, you're getting them involved in groups, programs. (Recreation therapist, Focus Group L)*

The recreation therapists recognized if they were not consistent nor followed through then the individuals' needs were usually not met and this had a significant impact on the therapeutic relationship. As one recreation therapist described, *"If you don't meet their needs, there is no maintenance"* (Focus Group L). To meet the individuals' needs, recreation therapists *"make referrals"*, connect them to people and resources and help them welcome *"friendships with others"* (recreation therapist, Focus Group L).

***Ongoing dialogue creates safe and enjoyable leisure experiences.***

Ongoing dialogue also helps a recreation therapist to get to know the individual receiving care in a deeper way. What and how the individual dialogues with the recreation therapist are important focuses for reflection. According to one Focus Group L discussion, ongoing dialogue helps the recreation therapist to gauge the person's mental and physical state and his/her willingness to participate in programs:

*Recreation therapist 1: Ongoing dialogue.*

*Recreation therapist 2: Keeping them informed, of what's going on, maybe they want to be involved, some it might take a little time, maybe they are not feeling well, maybe they are reluctant to participate.*

Regular dialogue with the individual receiving care helps the recreation therapist to stay informed. Providing information regarding upcoming trips or programs gives individuals receiving care events to look forward to. Recreation therapists in Focus Group N indicated when they discussed safety issues or concerns with the individual receiving care, they were communicating to the individual their well-being mattered and this dialogue fostered a sense of security:

*Recreation therapist: I think they are maintained particularly on a physical support unit because they really look forward to getting that calendar every month because it gives them things to look forward to...I have some guys that will highlight things, they know there are some trips coming up, they know things are coming up that they will enjoy. They know they are going to have a try and sneak on that legion trip even if they know their name is not on the list...it's important that we are able to give them information to keep the relationship going.*

*Moderator: So provide information to keep the relationship going?*

*Recreation therapist: Information is so important. We have to share. We have to communicate what's available, that also relates to power, if we don't have the information to share with them, they might not be aware of the opportunities. So [the therapeutic relationship is] maintained through information.*

*(Focus Group N).*

Focus Group F noted open dialogue, “back and forth”, can address concerns, foster safety and increase an individual’s likelihood of engaging in recreation therapy programming in the future.

*Recreation therapist 1: You always have that safe environment.*

*Moderator: So how do you create a safe environment so what does it take to do that?*

*Recreation therapist 1: I think it means developing trust and maintaining it.*

*Recreation therapist 2: Communication and that back and forth.*

*Recreation therapist 3: Open communication.*

*Recreation therapist 1: Communication, is that on there?*

*Moderator: Communication?*

*Recreation therapist 3: Like knowing that they are safe, and the level of dementia you may not be able to go through some of those things, even being a familiar face and being friendly.*

Listening to what individuals receiving care communicate and addressing their ideas and opinions helps recreation therapists to provide meaningful and safe programming. Obtaining feedback on programming assists recreation therapists to increase the flexibility in their programming, enabling them to change along with the needs and desires of individuals receiving care. When recreation therapists in Focus Group N touch base with, or ask for feedback from individuals receiving care, they believe it empowers those individuals and encourages them to “stay involved” in recreation therapy programming:

*Recreation therapist: I think a lot about that feedback, what they think too. People change, things change and as long as you are open to feedback, open to changing with that person, I think it will be maintained. People change. Things change.*

*Moderator: Some flexibility?*

*Recreation therapist: Yeah I'd say flexibility. (Focus Group F).*

*Asking for their opinion, ask them for feedback to make them feel like they are a part of any changes...letting them know... making them feel...like there isn't much of a hierarchy. (Recreation therapist, Focus Group L)*

Dialogue and having individuals receiving care as active participants in decision making processes allows the two parties to create meaningful programs together and reduces differences in power. Creating programs together also enhances enjoyment in the shared experiences of the recreation therapists and individuals receiving care. As one recreation therapist described, *"I think it is maintained because they are doing things that they enjoy and we are providing that opportunity to have them enjoy"* (Focus Group N). In these therapeutic relationships, obtaining input from the individuals receiving care does not occur in a token fashion; rather it is an ongoing aspect of continuing the therapeutic relationship. Involving individuals in the decision making process indicates recreation therapists value their input. Ultimately, when recreation therapists communicate openly and involve individuals receiving care in decision making, the individuals feel informed and help to create leisure opportunities they enjoy participating in.

***Paying attention and adapting to changing needs and choices.***

Being aware of the person, their daily successes, challenges and changes, is vital to the maintenance of the recreation therapists' therapeutic relationship. In Focus Group S, it was discussed that each time a recreation therapist interacts with the individual she tries not to assume it will be exactly the same as the last interaction. The recreation therapists realized individuals' willingness to participate may change over time. They consistently asked individuals to make their own choices whether to participate in recreation therapy programming or not. In this way, one recreation therapist tried to gain informed consent from the individual to engage in programming and avoid making false assumptions:



*Recreation therapist: Yeah and not assuming.*

*Moderator: Not assuming?*

*Recreation therapist: He's always attended a lunch group every week for the last while, but still taking the time to ask if he wants to go.*

*Moderator: So appreciating where they are at, at each point?*

*Recreation therapist: Exactly.*

*(Focus Group S).*

Recreation therapists repeatedly stated that they value where individuals are at. Often they referred to the job of a recreation therapist as a balancing act. They balanced suggestions made to the individual, actions to meet individual needs, and strategies to encourage independent choices:

*I think having patience and understanding. Where I work, one day I might be trusted and then the next day because of wherever the resident is they are suspicious of everyone and I'm going to be lumped in that one too. Where you know they think, you know that they are being held against their will because they are on a locked unit or wherever they happen to be that day. Just the understanding that as a therapist that okay today is not necessarily going to be the best day with Mr. X and this is where he is and I'll be there for him but it's not necessarily going to be the most trust from him, from his side, because he is angry with everyone. (Recreation therapist, Focus Group J)*

The recreation therapists stated this balancing act required patience and understanding. They attempted to pay attention to changes in the person and not have expectations of the individual's state. Although a recreation therapist respects where a person is at, Focus Group S members acknowledged sometimes risk-taking was required to achieve a beneficial outcome or assist the individual further along on his journey:

*Recreation therapist: I think the only thing to add there is the willingness to take risks.*

*Moderator: So the willingness to open yourself up.*

*Recreation therapist: And I guess tied to that is flexibility. So I think in our therapeutic relationships and in our work in general we always have to be flexible and adaptable and always responding and I guess it jumps off that last point, always responding...in our facilitating groups in our individual sessions, you know being present, responding to where our clients are at, I think in any area that we work we are always observing, always responding to where our clients are at. Always being present with our clients and then being flexible, whether it's from session to session, or within a session, and, I think also that willingness to take risks. It is also to keep growing as professionals and keep adapting and in the therapeutic relationship it's also that willingness to take chances to try something new with our client or push them a little further. Sometimes it's that observation and using our skills to you know, when to push and when to pull back, and also to see where things are at and see them through the current stage. I think sometimes it's that willingness to take risks with our clients. Sometimes that is where their growth happens within the therapeutic relationship.*

*Moderator: Ok, knowing when to push and pull back, again that balancing act.*

*Recreation therapist: Right.*

*(Focus Group S).*

Risk-taking required the recreation therapist to be aware and knowledgeable about the individual receiving care so she could accurately gauge when to push the individual, pull back or support a current state. It was suggested by a recreation therapist in Focus Group L that paying attention to the person's changes and "*understanding their health and that it's changing*" was vital to the success of a risk taking initiative. Monitoring and following up on changes in the person outside of her recreation therapy engagement was also deemed to be an essential part of the recreation therapist's duties:

*Recreation therapist: So I think awareness.*

*Moderator: Awareness? Of what?*

*Recreation therapist: Paying attention, I think that by paying attention you are aware and tuned in to your client. I think then that helps you first of all to notice things that are happening with your client. So then I think that helps you take action in a timely way. Like it helps you to notice...if something is going wrong with them, so you can follow through and provide support in a timely way, whether than means you are checking in with them. For example, checking in with a client to make sure you know what's going on...the client may need counselling or follow through with the team. Some sort of follow through and action needs to happen...something has to be done if something is going on. If they are having an off day, then some action needs to be taken, some sort of support needs to occur be provided and it happens in a timely way because you are tuned in, you paid attention, you know the client and I think that enhances and maintains the therapeutic relationship. They know...that you care and that you are present.*

*Moderator: Being present is one of the quality indicators.*

*Recreation therapist: Right.*

*(Focus Group S).*

Observing and paying attention to changes in health enabled the recreation therapists to seek necessary support from other professionals. Monitoring changes was seen as particularly important if individuals could not directly communicate their needs or were not aware they required support. The recreation therapists stated they were responsible for providing support related to leisure services and acting as part of a larger interdisciplinary team. If the recreation therapist observed significant changes in a person's health status, she brought the changes to the attention of an appropriate colleague.

***Authentic efforts to nurture positive qualities of the therapeutic relationship.***

Qualities of a therapeutic relationship including: care, trust, respect, and honesty were said to be just as important in the maintenance stage of the therapeutic relationship as in the welcome stage. One recreation therapist stated "*trust and respect can be carried through.*" (Focus Group S). Another

recreation therapist in Focus Group J suggested trust and respect must be mutual for a therapeutic relationship to be continued.

*Recreation therapist 1: A constant sense of trust, and the ability of the resident to come to you with any kind of information they want to share, I think it comes down to the very beginning question, where we identify trust, honesty, faith, respect.*

*Recreation therapist 2: I agree.*

*Recreation therapist 1: That's how we maintain a relationship.*

When trust and respect were continued, the recreation therapists said individuals receiving care often confided in them. They also described the need for authentic actions to be taken to nurture the qualities of a positive therapeutic relationship:

*I have this quote on my desk, that says professional is about doing the things we love to do on the days when we least feel like doing them...so you just have an off day, you still have to be patience, you still have to display all of these traits and these values, and I think [she] mentioned authenticity or being authentic and I think I would definitely add that. (Recreation therapist, Focus Group J)*

If actions were not authentic, the recreation therapists believed they risked losing trust of the individuals receiving care. Loss of trust or respect would interfere with the maintenance of their therapeutic relationships.

### ***Closing a Therapeutic Relationship.***

The recreation therapists noted therapeutic relationships were closed in different ways: by the individual receiving care, sometimes by natural causes, external influences, and also by the RT. When closed by the individual receiving care, the individual was seen as a self advocate. The individual's decision to close a therapeutic relationship was attributed to: personal preference, lack of interest in recreation, or personality conflict. Before letting go of their therapeutic relationship, the recreation therapists stated they often tried to clarify the reason behind the closure. They respected individuals' decisions to close their therapeutic relationships as long as those decisions were not based on misunderstandings, even if the professionals believed engagement in recreation therapy would benefit the individual. The recreation therapists indicated closing of a therapeutic relationship also occurred naturally, as part of the discharge process or upon the person's death.

At times, therapeutic relationships were closed by external influences. When administration at SHSC transferred individuals or recreation therapists from one unit or facility to another, these transfers ended therapeutic relationships. Decreases in financial resources and time available to recreation therapists placed limits on the quantity and quality of the care they can provide to individuals at SHSC and consequently influenced their therapeutic relationships. Therapeutic relationships were also closed when family members made decisions on behalf of the individual receiving care to not engage in recreation therapy programming.

In other situations, recreation therapists closed their therapeutic relationships. This type of closure usually occurred when the individual receiving care repeatedly crossed professional boundaries and there was no other way to resolve the situation. This type of closing was not always easy and many recreation therapists resisted closing a therapeutic relationship when the individual had some form of cognitive impairment. In those situations, the recreation therapists did not hold individuals responsible for their actions as they were not aware boundaries existed. In these situations, the recreation therapists evolved rather than closed their therapeutic relationships.

***The person advocates his/her own wishes to close a therapeutic relationship.***

The recreation therapists stated individuals receiving care have power to close their therapeutic relationship. At any time, individuals may indicate they do not want to be involved in recreation therapy. Some recreation therapists viewed decisions to close therapeutic relationships made by the individuals receiving care as an act of empowerment:

*Before a request to terminate is formally accepted, a recreation therapist investigates the reason behind the individual's decision to terminate. At times she will attempt to rectify any misunderstandings or personality clashes that occurred. However, if the individual is confident with his/her decision and no misunderstandings caused the termination then the recreation therapist will respect the decision. Even if a recreation therapist accepts the individual's decision to terminate the therapeutic relationship, she may experience feelings of sadness because she is no longer able to provide assistance. Sometimes the individual's decision is perceived in a more positive light, "if it's something they choose...then that could be empowerment". (Recreation therapist, Focus Group N).*

In Focus Group F, recreation therapists stated that the individuals were advocating for themselves and their choices to close their therapeutic relationships should be respected. This was

particularly true when individuals have indicated they did not desire a relationship with the recreation therapist from the beginning:

*Recreation therapist 1: Oh yeah, totally, and for me that's fine, they are advocating for themselves, who know, so it's not necessarily terminated in a bad way.*

*Recreation therapist 2: Usually in that case, it never really started, they've said no from the beginning.*

*Recreation therapist 1: Or sometimes at day hospital they try things and they are like "no I don't [want] this to do, I just want my Occupational Therapist, I don't see the benefit in this, I don't see the benefit in leisure" but you're right it's not necessarily a relationship that's happened, you are just feeling each other out, trying to develop something and usually at that end it gets terminated.*

*(Focus Group F)*

The recreation therapists acknowledged therapeutic relationships were closed because some individuals were not interested in leisure or preferred solitude, "you can't develop a relationship if the other person isn't willing" (Focus Group F). An individual might not have wanted close relationships in his/her life prior to coming to SHSC and therefore a therapeutic relationship with the recreation therapist was unwarranted. In contrast, some people closed their therapeutic relationships because they were self-sufficient and did not require assistance to create a satisfying leisure lifestyle:

*Sometimes the client or resident totally wants to end the relationship. They are making that choice and they are clearly telling you that they want to terminate the relationship for whatever reason. Sometimes it could be natural that they are just not interested or very independent or it could be unfortunately a clash of personalities. (Recreation therapist, Focus Group J)*

Focus Group F discussions highlighted individuals have a choice whether to create a therapeutic relationship with recreation therapists, but they acknowledged when a person rejects a therapeutic relationship with them it can be hard to accept or associated with feelings of sadness:

*I was thinking, for example of someone in particular...he was on my one unit and he's actually pretty young and community patient and lives here since he suffered a stroke and he got severely burned and he made waves but over the last few years he's refused everything...we try to at least have a good rapport [but] it actually causes anxiety [for him] when people acknowledge [him]...The only people that he contacts is his nurse when he needs something. He doesn't want any allied [personnel], nobody so in that case...we are still trying, but pretty much the whole team [is] just saying, "it's not offensive he just medically or behaviourally something is going on, and it has nothing to do with what we were providing, it's something that he has created." So I see him in the hallway and you try to say something and he doesn't look at you, and so it's sad because you cannot even say hi from across the room and I tried and sometimes I still try but there's no way. It's the other allies [too] it's not just me that we all felt that way. We all felt sad because we wanted to provide something...that need of a helping profession that you want to*

*provide, but the nurses said, “just provide what he wants”. (Recreation therapist, Focus Group J)*

***Closing: A natural part of the therapeutic relationship process.***

Natural closings were common for therapeutic relationships at SHSC and there were two ways it occurred. Predominantly, natural closing of a therapeutic relationship transpired when “*the person passes away*” (recreation therapist, Focus Group J). The prevalence of this natural form of closing of a therapeutic relationship was attributed to the large number of older adults receiving care and living at SHSC

*For me where I am, with the exception of some residents that don’t want anything to do with anyone or anything, for most of them its death. (Recreation therapist, Focus Group J)*

A recreation therapist in Focus Group J suggested the second type of natural closing of a therapeutic relationship occurred when individuals receiving care reached the end of their stay at SHSC and were discharged from recreation therapy services:

*Recreation therapist: For me it’s a natural part of the process and it’s positive. So in most cases and hopefully very rarely it’s the first one that was mentioned (mental health unit)... In some cases, we do definitely transfer people to other facilities, but in those cases, it’s also a part of their treatment, you know part of their recovery is to go to another facility. So for us, you know, termination is of the relationship, hopefully done cleanly and you know it’s fairly brief. You know, we do it as part of the natural process, they are moving on.*

This type of natural closing of a therapeutic relationship typically happened within the mental health units or community support areas of SHSC, or with individuals who did not have permanent residence at SHSC. This second form of natural closing was described by recreation therapists as a natural progression in the therapeutic relationship.

***External forces ending the therapeutic relationship.***

Closing of a therapeutic relationship was sometimes influenced by forces external to the therapeutic relationship. Closing of a therapeutic relationship could be brought about by family members, institutional changes, transfers of people (e.g., the individual or professional), and health status changes. The recreation therapists mentioned family members could decide involvement in recreation therapy was not suitable for their loved one:

*Sometimes it's the family that decides that they are no longer allowed to go on trips because it is too far...sometimes the family chooses to speak on behalf of the loved one and they say "Sorry I don't think I can support you" and sometimes the relationship falls. (Recreation therapist, Focus Group F)*

In these situations, recreation therapists believed family members were showing concern for the health of their loved one, but might not have considered the individual's enjoyment of the recreation therapy or the therapeutic relationship. Focus Group F members also suggested institutional changes impacted their ability to engage in therapeutic relationships:

*Recreation therapist: Another way that relationships can get terminated is cut backs and services are not provided and we are not in areas where we are needed, or we are away, or there is less. Termination may happen because of that too, fortunately that hasn't happened here, but it could and if it does staffing could be reduced, so budget cuts.*

*Moderator: So the system influences.*

*Recreation therapist: Yeah, or time may not be cut, but could be stretched, so you are given other units to cover and you don't have the same kind of time to spend with them.*

If administration decreased the Recreation Therapy department's budget, the recreation therapists thought there would be less time and resources available to them. Fewer resources were associated with a limitation on the recreation therapists' abilities to continue their therapeutic relationships. The institution was also seen as a force that could close a therapeutic relationship, particularly "if the staff moves from one unit to a different unit, [or] if the resident or staff is transferred" (recreation therapist, Focus Group F). The recreation therapists stated when people were transferred, often the therapeutic relationship closed quickly without time allotted for goodbyes. As a recreation therapist in Focus Group N described, "[i]f it's not their choice it could be really hard." When transfers resulted in a closing of a therapeutic relationship, it often occurred without warning or input from the individual receiving care and therefore the experiences were very difficult to cope with. These challenges were further discussed in Focus Group N:

*It's hard sometimes when they move to another unit because they miss the friendships they developed with other residents or the groups they were involved in, it is always hard to explain that there will be similar opportunities on the other unit and sometimes I know in other cases, there will be a bit of an overlap for a month and they will continue to be, or if there is a group they really like, they can come back, but we try to encourage them to move on to the other opportunities on the other unit when they are trying to adjust from L-wing to K-wing that a big transition that we experience. (Recreation therapist, Focus Group N)*

Sudden transfers or closings of therapeutic relationships were coupled with feelings of loss (e.g., loss of friendships, functioning or health). The recreation therapists mentioned many individuals receiving care at SHSC were older adults and could be transferred from one unit to another at any time due to a reduction in their health status. The recreation therapists noted individuals, who lacked control over their medical statuses, particularly if they were declining, experienced greater losses and fear as a result of their transfers:

*Recreation therapist 1: I guess if they have been transferred to another floor right, they are off of mine, but I'm still with them.*

*Recreation therapist 2: Yeah it changes, which sometimes can be quite difficult for the resident right.*

*Recreation therapist 1: Well it's different right, a change in health, maybe their diet changed so they have been coming to a lunch group for a couple of years and suddenly they are not appropriate for, it's hard to terminate that, we may try to offer an alternative which is sometimes what you have to do.*

*(Focus Group L).*

Focus Group N discussions highlighted that certain transitions were associated with declines in functioning and health, which enhanced feelings of fear and loss in the individuals being moved:

*Recreation therapist 1: I think it's an adjustment for them, it's an adjustment for them because there is an underlying, an underlying fear with the L-wing veterans, the nursing home level, for physical support, I know you guys have cognitive, the majority of our units are nursing home where they identify that yeah the residents are more independent with their Activities of Daily Living, they need less nursing care, they are more physically well in some points, so often if they move to a unit, they are often moving to a k-wing unit where they require more physical care or they are moving to a cognitive unit a locked unit because dementia has set in, so it's [a] hard transition for them.*

*Recreation therapist 2: So they know they are declining.*

*Recreation therapist 1: They know they are declining, it's a fear, it's a loss, and they are going to miss what they have with you, so it's really hard to let go of that once they've left.*

*(Focus Group N)*

In these instances, when an individual transferred to another unit, there may be attempts to continue some sort of relationship. However, as the recreation therapists described the relationship is often not the same:

*Recreation therapist 1: Moving or transferring to another unit.*

*Recreation therapist 2: But you still see them in the common areas.*

*Recreation therapist 1: But it's not the same kind of relationship.*

*Recreation therapist 2: But sometimes they still need support.*

*Recreation therapist 1: Well yeah that would be, it's still a relationship but it's changed. (Focus Group F).*



Since, transitions moved individuals receiving care away from recreation therapy programs where they felt comfortable, recreation therapists at SHSC often allowed for the continuation of programming until individuals adjusted. Continuation of programming allowed the closing of a therapeutic relationship to be gradual and less traumatic. The recreation therapists justified this strategy because they believed it continued some consistency in programming and enabled individuals to cope better with changes beyond their control.

***Crossed boundaries and the decision to close.***

Recreation therapists considered the safety and quality of life of everyone at SHSC when engaging in their therapeutic relationships. In rare instances, the recreation therapist believed it was necessary to close a therapeutic relationship when there was an “[a]buse of power. . . if they’re like inflicting harm or not respecting another individual (recreation therapist, Focus Group F). At other times relationships are closed if the individual receiving care “crossed a boundary or couldn’t understand it or couldn’t accept that that’s not the way it should be” (Focus Group S). In these situations the relationship was closed when the individual receiving care became a threat to themselves, the recreation therapist, or other people, or repeatedly crosses boundaries without the possibility for redirection as described in the following conversation in Focus Group L:

*Recreation therapist 1: And if it’s going towards not being healthy. All of a sudden the resident is taking things too far and whether they are physical support, cognitive support, whatever. If they cannot be respectful of the boundaries or the relationship sometimes it does have to be terminated because it’s not healthy for the resident.*

*Recreation therapist 2: Or you...if you are feeling that your safety is at risk as well.*

*Recreation therapist 1: And what other residents are seeing too, right? If they are making demands that are not appropriate that aren’t healthy or you know whatever. Not that it would be immediately terminated, but after steps are taken to get them to understand and get them back into a good groove.*

*Recreation therapist 2: And it’s communicating, combination, whether you are sharing that with family, or whether you are charting that, documenting that, what have you.*

*(Focus Group L)*

Recreation therapists in Focus Group N stated therapeutic relationships were closed by them if their safety was a concern when boundaries were crossed. However, they acknowledged closing of a therapeutic relationship for safety reasons was rare:

*Moderator: Do you ever think that it may be the recreation therapist that terminates the therapeutic relationship? ...*

*Recreation therapist: It could be in the situation in the crossing of the boundaries, like I know a recreation therapist who worked here before that had a resident who was kind of obsessed with her and she had to terminate the relationship because even being in contact with him, she was encouraging the behaviour, and you don't want that.*

*Moderator: So the termination was due to boundaries being crossed?*

*Recreation therapist: They had to terminate the relationship due to boundaries being crossed. He was stalking her...she had to, in consultation with everyone else.*

*Moderator: Her safety was.*

*Recreation therapist: For safety, the boundaries were crossed and this was a gentleman from a mental health unit. She had to terminate and I guess sometimes there would be a termination or a put on hold...it doesn't happen often.*

*(Focus Group N)*

One recreation therapist in Focus Group L stated usually before she closes a therapeutic relationship she tries to reconcile the challenging situation (i.e., the crossing of boundaries or abuse of power):

*Moderator: Sorry can I just go back, you mentioned steps that you would take before it's actually terminated what steps would those be?*

*Recreation therapist: A lot around communication, letting them know that whatever is happening that's inappropriate or shouldn't be happening or letting them know that whatever is being done, I don't want to say behaviour that's a terrible word but we can't do that, that's not acceptable, or (these are funny words coming out of my mouth and not the way I want them) but for example, I know guys that want to give you a kiss after dinner group and you have to let them know that you can't do that, that's not within the boundaries of the practice.*

*Recreation therapist 2: It wasn't a date.*

*Recreation therapist 1: Yeah exactly it was not a date and so if you let them know that. So fair is fair, letting them know, I think often because we are friendly, that somebody might actually take it, as we actually like them in a different way. So the communicating with them...something may need to be communicated in writing to them, something might need to be communicated to the family [that] "the resident is doing this within the group and unfortunately it's not a good outcome therefore he will be discharged from this group." [I] might do something else with a different staff, the team needs to know, the patient care manager needs to know.*

The recreation therapist took steps to communicate to the individual, families or staff how boundaries were crossed and to create strategies to prevent reoccurrence of challenging situations. Only if steps were taken to rectify the situation, and no solution other than closing was plausible, then the recreation therapist felt forced to close her therapeutic relationship. Many recreation therapists indicated decisions to close their therapeutic relationships were not made lightly and they often enlisted the help of others (e.g., staff or management) to problem-solve or evaluate the situation prior to solidifying the closing of a therapeutic relationship.

***Changing rather than closing the therapeutic relationship.***

Some recreation therapists indicated there was flexibility in their understandings of how, or whether, the therapeutic relationship was closed. For example, when a recreation therapist attempted to decide whether a therapeutic relationship exists, she based her decisions on the needs of the individual and circumstances:

*Recreation therapist 1: I think sometimes with my guys, it can be put on hold, as opposed to terminated, I think put on hold is the word I would say on a mental health unit, if they are dealing with an acute crisis, or they are having a problem where they have fallen off the wagon, they may choose or we may feel that it is necessary for them to withdraw, they do it themselves often, it's a personal choice, it's put on hold.*

*Moderator: So it could be terminated because the resident chooses?*

*Recreation therapist 1: Exactly, definitely, and at a later date they may come back, but at that point in their life they cannot handle the group. They cannot handle it. It's too stressful for them.*

*Recreation therapist 2: Or they have an acute illness, or anxiety.*

*Recreation therapist 1: Or they don't feel like it. They go through phases too where they are saying "no, no, no", and decline and stuff and they back to saying "yes" and joining in.*

*(Focus Group N).*

Recreation therapists in Focus Group S noted interactions with individuals receiving care could be considered therapeutic relationships. It was a therapeutic relationship as long as the recreation therapist was responsible for the individual and still meeting a need, regardless of where they were located in SHSC or offsite, or if the individual had been transferred off their unit:

*Recreation therapist 1: So how does the hospital see it, in terms of your therapeutic relationship? Like if he is off your unit, does the hospital think that you have a therapeutic relationship still?...*

*Recreation therapist 2: I think when you brought up the needs of the resident to me that defines if it is a therapeutic relationships or not, say after their [goal or program] has happened I'm not going to seek them out but if they come and seek me out and that need that they have.*

*Recreation therapist 3: You're still meeting that need?*

*Recreation therapist 2: Yes.*

*(Focus Group S).*

The recreation therapists stated it was challenging to know when to stop or continue a therapeutic relationship, particularly since the relationship involved leisure, which was described as a consistent part of life; "*leisure is ongoing [and] it's hard to really terminate it*" (recreation therapist, Focus Group N). As long as the recreation therapist was on duty or meeting the individual's needs, the

professionals considered their engagement with the individual to be within the boundaries of a therapeutic relationship:

*I feel sometimes a lot of therapeutic relationships they don't really become terminated within long term care because you always have interactions and you are always that professional. (Recreation therapist, Focus Group J).*

The recreation therapists in Focus Group N described more continuity in their therapeutic relationships, regardless of how many goals were accomplished, compared to other disciplines:

*Recreation therapist 1: And I think one big thing especially in long term care is we continue with that person...it's rare that we discharge them. I mean Physiotherapy as set goals, and Occupational Therapy may see them just to work on their wheelchairs. They have a set task. We stay with them, they come and get involved and they stay with us. I mean unless they choose to no longer to participate, and reasons health-wise they no longer be able, there is not a discharge process.*

*Moderator: Stay with you, you mean continue to be involved with recreation therapy?*

*Recreation therapist 2: Yeah if they want to be involved. We don't say no you've been involved for a year and you've met your goals and you leave, you know? It's a continuation. You're with them it's something that they will continue to do as long as they are here if they still wish too. With other disciplines, I know it's constant. It's a sense of stress for some of my guys that if they have met their goals in physiotherapy they can no longer go to the gym, but that's how it works once you've met your goals you don't go anymore. With us that continue...they know we are not going to be pushing them out the door. They don't quite understand why they can no longer do something.*

*(Focus Group N)*

Pressure to continue a challenging therapeutic relationship often occurred if the recreation therapist appeared to be the only one able to provide the individual with certain services (e.g., taking the resident into the community):

*Recreation therapist 1: It's a balancing, and fortunately I've never had to deal with that I've just sort of had to redirect, but it can be [affected] because they will be angry with you but there has been an instance where they are a threat to themselves or a threat to others and they are falling down and ...it's just not safe for them at that point to stay in the group because they are so intoxicated.*

*Recreation therapist 2: I would say that I have terminated people from activities, but not from the therapeutic relationship*

*Recreation therapist 1: Right, on that day they may not be.*

*Moderator: So their involvement in the activity but not the therapeutic relationship has been terminated.*

*(Focus Group N).*

*Recreation therapist: I think what [name] said and I think when they try to push on the boundaries and break the boundaries... like if you get cussed out by the resident...if someone disrespects you and breaks that respect and breaks that trust you might still deal with that person but that relationship is harmed.*

*Moderator: Can I just ask, do you feel that the therapeutic relationship is terminated at that point or do you feel that you are still in a therapeutic relationship with that person?*

*Recreation therapist: It becomes altered. It doesn't mean that you don't have a relationship at all anymore, [but] it's not likely to be the same, in terms of communication or trust. (Focus Group F).*

Even though communication and trust were diminished in challenging therapeutic relationships, some recreation therapists still engaged the individuals receiving care who crossed boundaries or abused their power. When asked if they felt they had the “*right to terminate certain therapeutic relationships*” the recreation therapists responded “yes” and “no.” Many recreation therapists stated they continued engagement despite challenges and frustration they faced. The relationship was continued because they wanted to benefit the individual (e.g., meet leisure-related goals) or they conceded to outside pressure. The following discussion from Focus Group F describes conflict some recreation therapists experienced when forced to decide whether to continue their therapeutic relationships:

*Recreation therapist 1: Okay, so the thing is, we know that like a professional in your practice, you have to speak up and you have to advocate for your own self and if the abuse is there, and it's coming down from management “don't worry about it” it's that ethics part where you can't just deal with it anymore, if there's that... something is lost, your practice, your own standard and you're getting tied between management and the resident and families and you have to make a decision and you can't ignore it and I was in that situation a couple of years ago for myself I didn't feel comfortable in that situation and I should never have been put into that type of situation despite, and that's my ethic, that's my own, why would you want to be abused?*

*Recreation therapist 2: I think in that situation, if you're being abused and the person is constantly abusing their power, there is only so much as employees that we can do, if it works better for you to end that relationship with them because they have the ability to have a relationship with everybody else, for your piece of mind, your health, you should be able to stop contact with him. Years ago I was pulled into a room and forced to apologize to this resident who was... and I refused and I just chose at that point never to speak to that person again . . . So for myself to keep my job and for my own piece of mind I . . . didn't make any eye contact.*

*Recreation therapist 3: He wasn't removed?*

*Recreation therapist 2: No he wasn't but still that's how therapeutic relationships fall over from unit to unit, because you constantly see the [people on other] units (Focus Group F)*

Recreation therapists in Focus Group G discussed difficulties they experience when respect and trust are broken in a therapeutic relationship. At times, these therapeutic relationships challenge their beliefs and boundaries as professionals and as women:

*Recreation therapist 1: See when I am on a unit, and I am on a dementia unit, and often times they are breaking your respect and breaking your trust, breaking the boundaries, and maybe at some level they know what they are doing but really they are not that responsible for what they are doing, so even though it is hard to provide service , they still want you to take them on trips, they still want you to, unless you trigger something. Everyone seems to support you but especially because they are on a cognitive unit, you're their only way out, off the unit, the only way out, so to take that away, to terminate the relationship, it's hard it's fight it, there is going to be a fight, because managers want you to take them out, families want you to take them out, nurses want you to take them out, the resident wants to go out and there's only you and they want to go out. It has to be you, if you are working with a partner and the partner's okay with that person, then it can work out, but if you are on your own and it is up to you sometimes you have to grin and buck up and do it.*

*Recreation therapist 4: I think that the cognitive support units are different; they have a lot of impairments in judgments.*

*Recreation therapist 2: You can't take it personally.*

*Recreation therapist 4: You don't take it professionally.*

*Recreation therapist 1: But sometimes it's hard to.*

*Recreation therapist 4: Yes.*

*Recreation therapist 1: Sometimes it's hard to, if someone is always sexually inappropriate with you, always sexually inappropriate with you in front of anybody. It upsets the other residents. It's upsetting, you know what I mean they have a relationship with you "what's this guy pushing the boundaries for? No, no, she's mine not yours" (laughter) you know what I mean, that sort of pushes on everybody's boundaries so I think that the relationship is altered for sure, in a big time way but sometimes you can't just terminate it, it's not that simple, because they are always going to see you, you're always on the unit.*

*(Focus Group F)*

When boundaries were crossed or transfers occurred, but care was still required, recreation therapists at SHSC struggled with their decision to close their therapeutic relationships. Choosing to close a therapeutic relationship was described as a difficult process. Often recreation therapists were forced to make changes to their therapeutic relationships rather than close.

### ***Negotiating Expectations, Power and Boundaries throughout the Therapeutic Relationship Process***

During the focus groups, the recreation therapists described that many different people and factors influenced their therapeutic relationships. The therapeutic relationship was influenced by the individual's length of stay and the leisure-based context. In addition, for recreation therapists the negotiation of power and expectations within the therapeutic relationship occurred on three levels:

1. institution  $\leftrightarrow$  recreation therapist
2. recreation therapist  $\leftrightarrow$  individual receiving care
3. recreation therapist  $\leftrightarrow$  family member(s) of individual receiving care

Recreation therapists had the difficult task of negotiating their own power with institutional power, as well as the power of individuals receiving care and their families. Recreation therapists in Focus Group J suggested negotiations can be frustrating for all individuals involved, especially when expectations are not met. According to recreation therapists in Focus Group L, negotiations were also challenging, particularly when individuals or families were unaware of the systemic issues or boundaries that exist and the impact on the therapeutic relationship. They influence the recreation therapists' abilities to negotiate power, expectations and boundaries within their therapeutic relationships.

In focus group discussions, recreation therapists responded to the term "power" with mixed thoughts and feelings. For example, recreation therapists in Focus Group S viewed empowerment of individuals receiving care positively. However, when power was associated with abuse or strong hierarchies it was viewed in a negative way:

*Recreation therapist 1: I don't know that word power to me is so powerful (haha), but no it's such a strong word. You know I think they look to us for guidance, but I would never want to say I have power over them, because to me that's not therapeutic. We're guiding and we have some expertise...but I would never want to say I have power over this person. I don't think that guides the relationship.*

*Moderator: So when you hear 'power', you think 'power over'?*

*Recreation therapist 1: I think power is a negative.*

*Recreation therapist 2: Power is a negative you think?*

*Recreation therapist 3: It can be.*

*Recreation therapist 1: It can be.*

*Recreation therapist 3: I think giving them the power is positive.*

*Recreation Therapist 1: Yeah that's right.*

*Moderator: Giving them power?*

*Recreation therapist 3: Giving them power in a way, our approach in that we allow them to make the decisions, we value, the decisions that they make.*

*Recreation therapist 1: Yeah, maybe we enable them.*

*Recreation therapist 4: Letting them know you have the power to make that choice.*

*Moderator: So we have the potential to give power to our clients?*

*Recreation therapist 1: Yeah.*

*Recreation therapist 3: I think that giving empowerment.*

*Recreation therapist 1: Yeah.*

*Recreation therapist 2: Giving them a sense of empowerment.  
(Focus Group S).*

Recreation therapists in Focus Group L also indicated other people (e.g., family members, staff or other residents) had power over their therapeutic relationships:

*We have to deal with managers, so there's that power relationship that we are dealing with and I think to that, it's educating residents. They may have a perception that we have power, but maybe educating them if you are going on a legion trip [about] how that process works. They may look at you and go "I cannot go because of this?" So it's educating them about how certain systems work. (Recreation therapist, Focus Group L)*

*Recreation therapist 1: There's power of the residents themselves. If you are trying to facilitate the needs of many people, sometimes there are more vocal residents who wish to execute their power that's another way we try to balance it, so that it's not just one person's choice, you kind of meet everyone's needs.*

*Recreation therapist 2: And I guess with the whole resident's council set up, depending on if you are on it or not, you might perceive yourself as having more power or say, than someone who's not.*

*Recreation therapist 1: And they do, they do, they truly do have more power. They meet with, whether they meet with [a supervisor] or whoever, and that gets followed up through [management], and that gets followed up further, so really there's power right?*

*Recreation therapist 3: Yeah, there's a hierarchy within the residents. (Focus Group L).*

According to the recreation therapists, power can be used positively to make choices and maintain balance, but it also has the ability to harm. They suggested if an abuse of power occurred, it hindered the progress of the therapeutic relationship. To prevent abuses of power, the recreation therapists noted the use of several strategies to balance power in their therapeutic relationships. For example, they try to communicate openly and effectively with individuals receiving care and their families regarding systemic limitations that govern life at SHSC.

### ***Leisure as the Context for the Therapeutic Relationship.***

The recreation therapists suggested the leisure-based context of recreation therapy enabled therapeutic relationships to evolve in a natural, informal manner. In Focus Group N, recreation therapists stated they create safe and home-like environments within the institutional setting of SHSC to enhance the quality of their therapeutic relationships:

*Recreation therapist 1: I also think we provide an environment that is not like a hospital.*

*Moderator: Would you like to expand on that?*

*Recreation therapist 2: Just the kind of events we give them, they kind of take them away from an institution and make them more of a home.*

*(Focus Group N)*



*Recreation therapist: Our kitchen it is a home-like environment, it's a home-like environment...it's more of a natural thing to go and have dinner with people in that home-like environment versus eating in a dining room with a hospital tray in your room. It's non-institutional it sort of relates to the other research, where we have the escape from the institution*

*Moderator: So it's escape?*

*Recreation therapist: A form of escape yeah.*

*(Focus Group N)*

The recreation therapists stated they tried to create comfortable situations where individuals receiving care were able to escape the institutional atmosphere of SHSC. It was suggested the informal context creates situations where recreation therapists are trusted and seen as friends or family members rather than as professionals. Focus Group N discussed although this informal atmosphere can be beneficial; it also presents some challenges, particularly to individuals on the cognitive units. It was recognized that at times the setting appears so natural that individuals receiving care do not recognize recreation therapists as employees of SHSC:

*Recreation therapist 1: I think at the same time a lot of the residents don't see us as a therapist, they see us as a friend, I get called a friend a lot, referred to as a friend, so I think that also centers around trust.*

*Recreation therapist 2: For sure*

*Recreation therapist 1: And I also think we are the family, often I am referred to as their daughter or their wife.*

*Recreation therapist 2: I think more on the cognitive units.*

*Recreation therapist 1: Oh definitely.*

*(Focus Group N)*

In these situations, individuals with cognitive impairments receiving care at SHSC are often unaware of professional boundaries or the purpose or direction of their therapeutic relationships. Therefore, the informal setting impacts therapeutic relationships.

### ***Expectations of Therapeutic Services and Negotiating Institutional Power***

In recreation therapy, therapeutic relationships occur under the umbrella, or within the “*context of therapeutic services.*” As recreation therapists described, the institutional setting impacted their therapeutic relationships, “*it's defined and it has certain parameters and certain boundaries.*” Consequently, as one recreation therapist described, the therapeutic relationship, “*happens in a certain context, it involves certain individuals, a certain environment, it's come about to serve a certain*

*purpose, it's usually within a certain timeframe*" (recreation therapist, Focus Group J). Therapeutic relationships begin shortly after an individual requires healthcare from SHSC and ends when healthcare at SHSC is not longer feasible or required. Focus Group J discussions indicated therapeutic relationships occur within a specific therapeutic context, time-frame, and institutional environment (e.g., long term care, acute care):

*Moderator: Are [the boundaries] the same across all of your relationships, are all the parameters the same? Are all those boundaries the same?*

*Recreation therapist: I see long term care being fairly different in that it is their home as opposed to [when] they are going to an acute care setting specifically for the purpose to receive treatment. Although they are here to receive, they are here to receive care, sometimes it is their home, so I think that there is a difference in terms of how we approach the relationship and how they perceive us in a long term care setting as opposed to how they see us in an acute care setting. But there are definitely still parameters in both, there are some boundaries.*

Recreation therapists described that boundaries around therapeutic relationships are influenced by unit-specific contexts and how long individuals reside at SHSC. Therapeutic relationships are approached differently with individuals who live at the facility (i.e., on a long term care unit) versus individuals who stay for shorter periods of time (i.e., mental health unit or community day hospital). In addition, staff members from other disciplines impact therapeutic relationships that occur in recreation therapy. Focus Group N discussed how trust established by one recreation therapist was used so other interdisciplinary team members could achieve their goals:

*A lot of times on my unit I have a very good relationship with the resident so if the nursing staff is trying to get them to take their medication and they don't and they won't take it from a nursing staff, the [nursing staff] will ask me and it's usually in a pudding or whatever, can you sit down with them and often times they will, I have that trusting relationship with them. (Recreation therapist, Focus Group N).*

Recreation therapists at SHSC are responsible for abiding by and enforcing the rules and regulations of the institution to maintain a safe environment. One recreation therapist in Focus Group J suggested when safety becomes an issue or the institution's rules and regulations are challenged, a recreation therapist must assert the power bestowed upon her by the institution:

*Recreation therapist: Sometimes it's taking things away from them too...just say an Occupational Therapist issued a resident with a scooter, but you just so happened to watch them run over someone and you know, hospital wise, you have to report it and fill out all the appropriate paperwork and usually it ends up with something being taken away.*

*Moderator: So it sounds like there are issues of power on a few levels...management, there is power on your level and there is power level of the client.*

*Recreation therapist 2: I think at times it is frustrating for the resident too because they do see us as people that get things done. So when we can't sometimes it's difficult for them to understand that we too have parameters, guidelines that we have to follow.*

When recreation therapists enforce rules and regulations, they shift the power dynamics within their therapeutic relationships. Enforcement highlights the power of organization through the words and actions of the recreation therapist. A recreation therapist in Focus Group L provided an example of this power and stated this occurs when recreation therapists veto the decisions of individuals receiving care, especially when safety becomes an issue:

*Recreation therapist: I don't think it's a real power relationship but I think that there is power within it because I think there are situations where you have to keep people safe or you have to make a decision. So that means if you are the decision maker on certain things then there is a little bit of power there.*

*Moderator: Can you provide an example of where someone would do that?*

*Recreation therapist: If someone wants to on an outing to go off and do whatever they want, well you are going to take the role of saying, "well maybe we can do that another time, but today unfortunately we do have to stay together" as opposed to them being able to have the freedom to do whatever they want. That's not always the case, I mean as much as you would like it to be and I think when we have to, we try to do it, use power in a disguised manner to try to make it in a way that they can turn around and feel like it's their decision in the end. We try to work through it so it doesn't always look like us making that decision. Help them to come to that decision or just come to a decision that is going to be safe, that's...not going to put them in harm's way or have an outcome that is not going to be favourable to them.*

*(Focus Group L).*

Power is an issue that must be handled delicately by recreation therapists and they often take measures to reduce unnecessary power imbalances within their therapeutic relationships. To balance power, recreation therapists attempt to involve individuals receiving care in decision making.

Recreation therapists and individuals receiving care have power, but it is limited by institutional rules or guidelines.

### ***Power Shifts between the Individual and the Recreation Therapist.***

Each person involved in a therapeutic relationship has power. Sometimes the recreation therapist's power is predominant; sometimes the individual's power is central. The recreation therapists also implied their own personal boundaries influence their therapeutic relationships. For example, boundaries impact the amount of personal information a recreation therapist discloses within

her therapeutic relationships. In Focus Group L, boundaries were described as an important part of the therapeutic relationship:

*Moderator: What about issue of boundaries?*

*Recreation therapist: I think they are really important, I think it's easy because you do develop a relationship and because often the resident may confide so much, and they want to talk about you and not have it look like it's just them you know discussing, and I think it's important to keep some sort of boundary.*

*(Focus Group L)*

It was also clearly indicated parameters vary from professional to professional and from relationship to relationship. The recreation therapists in Focus Group J indicated their power is highlighted when they advocate for individuals receiving care or maintain boundaries:

*Recreation therapist 1: I think another comes from our discipline, voicing their opinions and making sure that it's heard.*

*Recreation therapist 2: Advocating for them.*

*Recreation therapist 1: Absolutely.*

*(Focus Group J).*

Individuals receiving care at SHSC also influence, intentionally or not, the direction, goals and outcomes of their therapeutic relationships. The recreation therapists at SHSC suggested when an individual involved in the therapeutic relationship changes or the context changes, the professional's approach alters as well. In Focus Group F, one recreation therapist stated being flexible and working through unexpected challenges were two constant aspects of her therapeutic relationships:

*Moderator: So it's got a plan, it's got a plan to begin with?*

*Recreation therapist: Sometimes yes and sometimes no. Sometimes...in day hospital I have people and I have never assessed them, they just come in and they are like "what do you want me to do?", and I'm like, "oh well, what do you want to do?" Sometimes the plan is developed together if they are able to vocalize that and sometimes when its end stage and you have a plan, they are going to alter it...they are going to voice their opinions or through their actions say what they want to do too.*

*(Focus Group F)*

Some recreation therapists also described moments of sudden change or shifts in their workload. At times, an individual arrives unexpectedly into a recreation therapy setting for care and is without a plan. When this occurs, the recreation therapists mentioned they work quickly as possible to develop new plans for their therapeutic relationship with the new individual.

As recreation therapists advocate for individuals receiving care or assert power to maintain boundaries, they view their power in a positive light. Although the recreation therapists acknowledged they have power, some attempted to reduce the predominance of their power. Sometimes, this power dynamic led to blurry boundaries. In these situations, individuals receiving care may not be clear of the parameters around the therapeutic relationship. The recreation therapists recognized unclear boundaries in their therapeutic relationship may lead to some challenges. As suggested earlier, the flexible, social, and leisure-based nature of therapeutic relationships in recreation therapy also adds to boundary ambiguity.

While recreation therapists negotiate power influences on their therapeutic relationships, individuals receiving care also have power. At times, the individual receiving care has a greater amount of power than the recreation therapist. Individuals receiving care assert their power when they become their own advocates. The recreation therapists stated they are comfortable with this power shift and encourage individuals to assert their own power as long as it is within institutional and professional boundaries. The recreation therapists also acknowledged challenges arise when the individuals advocate for themselves beyond what is possible within the institutional setting of SHSC.

*I don't work on a dementia unit, [but] it's the same frustration for physical support because once they were independent, before they got here, and now they are frustrated. They're like, "I know where to go, I know how to get there and you won't let me" and there's so much red tape. He said "I don't have to get you to sign that because I am capable. If I want to go somewhere I'm going to go". . . I think that sometimes when you are trying to give them that empowerment and then it moves to that next level and you realize that, "ooohhh" (suggesting something is wrong). Maybe you have management saying "why did you help facilitate them", maybe not understanding that we didn't think that it would go that far that they were empowering themselves, their choice. (Recreation therapist, Focus Group J).*

When individuals receiving care try to assert power beyond what is attainable, the recreation therapists stated they need to draw the individual's attention to institutional constraints or unrealistic demands. They emphasized drawing clear boundaries were especially important especially when feelings of entitlement, abuses of power, or the crossing of boundaries begin to emerge. Recreation therapists in Focus Group N mentioned challenges arise when individuals receiving care begin to

display “power over your time” inside and outside of work, particularly when boundaries are not maintained:

*You don't just leave them, and I feel that there is power over my time, and perhaps this is my own fault, I'm thinking of work when I'm not here, I'm shopping on the weekends, I'm planning things, it's just the nature of the job, ah maybe it's just with me, and maybe that's my own fault...it affects my work/home life. (Recreation therapist, Focus Group N).*

The recreation therapists stated their time was more flexible than other disciplines and the demand for their time which went “above and beyond” their requirements was hard to ignore:

*I feel time is also a factor, we end up doing so much, I think other disciplines their day ends at 4 o'clock, it's very set, I guess just our time our boundaries are just all over the place, and you don't just stop because it's this time, because they need you, you know.(Recreation therapist, Focus Group N)*

Demand for extra time was hard for recreation therapists in Focus Group N to ignore for they felt needed; however, they acknowledged not maintaining some boundaries could “be a bad thing too because you can burn out.” One recreation therapist emphasized the continuity of leisure time and how her therapeutic relationships extended beyond set tasks and, therefore, her responsibilities were not transferable to another professional:

*Moderator: You were saying you go with the flow of the resident?*

*Recreation therapist 1: Yeah.*

*Moderator: You mean in terms of leisure?*

*Recreation therapist 1: Leisure exactly, you know leisure can be at any time of the day, you know it doesn't end at 4 o'clock, there's evening opportunities, there's and then again it relates back to the fact that some require a lot...It's just different for other disciplines who have their set tasks, once they are done they are done, they just leave it here*

*Recreation therapist 2: Or pass it on to the next nurse.*

*(Focus Group N).*

One recreation therapist in Focus Group N highlighted a sense of power can lead to entitlement, unrealistic expectations, or demands on recreation therapists:

*Sometimes we give them, especially in long term care, a lot of power, that in turn leads to entitlement and it makes things a little blurry...we can almost give them too much and I think that because our discipline is leisure-related they tend to get involved in things heavily and that can kind of blur some power and then we have to come back and maybe have some power. (Recreation therapist, Focus Group N).*

Power asserted by individuals receiving care can challenge professional boundaries and the recreation therapists stated sometimes they must assert their power in response to these challenges.

Feelings of attachment towards individuals receiving care, also impacts power dynamics within the therapeutic relationship. At times, a greater level of attachment exists within the therapeutic relationship and more leniency around boundaries is shown:

*There is a little more leniency, there is a little more leniency with respect to dealing with us, because of the nature of what we do, it's not a matter of the physiotherapist taking the resident and making them do a workout and him having a heart attack kind of stuff. I think there are such grey areas there, and I think that there's emotions attached to also what we do as well because of what we do in these relationships, there is more grey areas. (Recreation therapist, Focus Group J).*

*Recreation therapist 1: I think the boundaries are hard depending on who you are working with too. Let's say you've got palliative, sometimes you let the boundaries go a little bit and you know you work different hours...because you know they don't have much time, right? I think it's different on cognitive too, right? It's not the same.*

*Recreation therapist 2: You can try to establish boundaries, but the next day the boundaries are forgotten by them, by the residents themselves and because it's such a harsh reminder every time, we do struggle with enforcing boundaries, and sometimes we get into sticky situations because we don't enforce them, but it's your own comfort level and also the resident isn't able to remember and their reality is that they are 20 years old and you are 20 years old and why wouldn't you be getting married? So that can be a challenge. (Focus Group L).*

Leniency around boundaries in therapeutic relationships arose in Focus Group F when the recreation therapists discussed working with individuals with cognitive impairments. Inappropriate sexual behaviour was exhibited predominantly on dementia units and impacted both recreation therapists and other disciplines:

*Recreation therapist 1: When they are too irate or they see you as a wife, where they almost come on to you all the time that could be a boundary.*

*Recreation therapist 2: Like sexually inappropriate or something.*

*Recreation therapist 3: Yeah, you definitely get that... when they want to have [sexual] relations with me... They say they would "like to go to bed."*

*Recreation therapist 1: Or, you know, they stroke your arm...I think that's in dementia care.*

*Recreation therapist 2: Dementia care, but you also see that it happens with other people too, it happens with nurses.*

*(Focus Group F)*

One recreation therapist in Focus Group F stated "*redirection is important*" for individuals with cognitive impairments who overstepped boundaries. Another recreation therapist in Focus Group F said "*leisure is a lifelong thing*"; therefore discharging the individual was not a possibility:

*Recreation therapist 1: You want to be there to support them but at the same time, there is a boundary and you have to say "ok, I have to exit the situation because he is only focused on one thing" which is trying to either kiss you or.*

*Recreation therapist 2: It's a real juggling act, because you don't want to chastise them or treat them like a child but it's not appropriate and in a way that doesn't make them feel bad.*

*Recreation therapist 1: It's hard.*

*Recreation therapist 2: Well it's really hard with you guys.*

*Recreation therapist 3: Well I can't obviously talk to them about it...you just move on.*

*Recreation therapist 1: Yeah because they are so confused.*

*(Focus Group F).*

When individuals with cognitive impairments cross boundaries, the recreation therapists stated they try to redirect them and assert their power in a disguised manner. Sometimes, recreation therapists seek assistance of other interdisciplinary members to negotiate power imbalances and to maintain appropriate boundaries:

*Moderator: So what about the individual's choice? When you look at how the therapeutic relationship is terminated, sometimes it's by the therapist, sometimes its illness, sometimes its death, how does it impact them? ... Does it impact them differently depending on how it is terminated?*

*Recreation therapist 1: I would say positively, it empowers them, they may feel more confident.*

*Moderator: You mean if they choose not to...*

*Recreation therapist 1: Yeah.*

*Recreation therapist 2: ...When you tell a person no sorry I can no longer spend time with you because of these issues, definitely the individual is going to feel a negative impact.*

*Moderator: Unless it's their choice?*

*Recreation therapist 2: Yeah unless it's their choice.*

*Moderator 2: So choice is a contributing factor on impact?*

*Recreation therapist 2: If it's something they choose to terminate then that could be empowerment, but if it's something that's happening because of crossing the boundaries then everything else, obviously it is going to have a negative effect; it's going to effect the behaviour on your unit. It's going to affect all kinds of things.*

*Recreation therapist 3: Oh yeah, depression would probably go up, negative behaviours. (Focus Group N)*

Focus Group N discussion implied power dynamics are impacted by the person who ultimately decides to close the therapeutic relationship. If individuals receiving care choose to close their therapeutic relationships they empower themselves. In contrast, if the recreation therapist closes the therapeutic relationship she openly asserts her power over the individual.



### ***Managing Expectations and Power of the Family.***

Many recreation therapists noted their therapeutic relationships are also influenced by the desires of family members. In Focus Group S, recreation therapists discussed family members often become highly involved in the care planning of their loved one:

*Recreation therapist: It kind of depends when I am meeting the person. If the person is by themselves the first time or if the family is there...you can find out how involved the family is.*

*Moderator: So involving the family would be key in developing the therapeutic relationship or?*

*Recreation therapist: I think so, especially if the resident cannot tell you what they enjoy.*

Recreation therapists obtain information from family members, particularly when individuals receiving care at SHSC are nonverbal. Information provided by family members helps guide welcoming of a therapeutic relationship. A unique aspect of therapeutic relationships in recreation therapy is the cultivation of “relationships with the families.” Engaging family members in opportunities was seen by the recreation therapists in Focus Group J as a way to strengthen experiences and establish family connections:

*Recreation therapist: I would say we are also unique in terms of with the families. We can foster relationships with the families through leisure or also help them especially in dementia care like reconnect with their families in a way earlier they couldn't because of the dementia...or even in physical support I'm sure. There are opportunities for the families to enjoy.*

*Recreation therapist 2: I also think there are opportunities to do so, say an outing and the family joins in or we're at an event and the families there and it's much more a social type of atmosphere. So it leads to that type of relationship developing.*

Involving families in recreation therapy programming, the recreation therapists noted, enhanced the family members' experiences while visiting loved ones at SHSC.

Focus Group J discussions mentioned family members often advocate for their loved ones with the best of intentions, yet their expectations of a recreation therapist and the services she is capable of providing may be unrealistic:

*Recreation therapist 1: Sometimes I think the expectations of the families are, unrealistic and we sort of have to put up a wall or unrealistic in the sense that they don't understand the reality of what we do, and what we can provide to their.*

*Moderator: Can you provide an example of that of those unrealistic expectations??*

*Recreation therapist 1: So unrealistic...we [recreation therapists] always have the philosophy that everyone has a choice, so they [the residents] have a choice to refuse it, a choice to participate, etceteras. So when the resident is constantly refusing and it's something the family has said that he would be interested in and he keeps saying “no” and you keep trying, but it's*

*always been “no” and then the family says “No, you have to force him...you have to force him to go.” Well we all have a choice here. . . “no you just have to push him, well no [you do not have to push him].”*

*Recreation therapist 2: It can go the other way too. I have one resident’s family where I worked that on a different unit that was very involved, and she kept lobbying. It actually went higher up, where our professional practice leader, our manager on the unit was pulled in as well and the president of the hospital... What they wanted us to [do was] take one of the rooms, and take the highest functioning residents and run it like a day program for just those eight or nine residents on that unit and then ignore everyone else, so there’s unrealistic expectations in that sense too. So where you actually have to sit down and say that there are 60 other people on this unit and you know I am one recreation therapist or recreation therapy professional, my job is to see everyone not just your father, husband, uncle, whatever [and] I cannot do what you are asking me to do and ignore all these other people. Sometimes they do take it really high up. (Focus Group J).*

Some family members take their concerns to upper management and as a result management may be required to educate the family regarding institutional limits and professional responsibilities.

*Recreation therapist: Sometimes with the family’s power...what they want to happen is often, can often be different from what the resident wants and then you have a power struggle of who do you listen to, right? Because it’s the family member that’s going to make your life harder to deal with at Sunnybrook than the resident themselves, even though it’s not the resident’s wish.*

*Moderator: What would you do in that case?*

*Recreation therapist: Do what the family wants, grin and bear it.*

*(Focus Group L).*

As indicated in this discussion from Focus Group L, challenges arise in the recreation therapists’ therapeutic relationships when family desires or expectations oppose wishes of the individual receiving care. When family members and individuals receiving care at SHSC are in disagreement regarding care, recreation therapists struggle with whose voice should hold precedent. Some professionals abide by the family’s wishes; others focus on the individual’s choices.

### ***Chapter Summary***

Recreation therapists engage in therapeutic relationships for several reasons including: to support new beginnings and foster senses of belonging and community. Throughout the therapeutic relationship process, the recreation therapists strive to promote qualities of the therapeutic relationship such as trust, care, and reciprocity and to provide opportunities for choice and control. Although recreation therapists attempt to foster positive therapeutic relationships, they acknowledge outside waves of influence which challenge their abilities to negotiate therapeutic relationships. The informal

leisure context alters their boundaries and the length of stay also influences how professionals approach their therapeutic relationships. The institutional setting, individuals receiving care, and family members also influence therapeutic relationships and recreation therapists constantly negotiate these influences and power dynamics within their therapeutic relationships.

### ***Reflections on Data Analysis and Presentation of the Findings***

This chapter summarizes themes which emerged from the data analysis I conducted of the recreation therapists' focus group discussions for the purposes of completing my thesis requirements. The themes that emerged from the first two phases of data analysis can be found in Appendix I and look vastly different from the ones I presented in Chapter Five.

Throughout the data analysis elaboration phase I attempted to stay as true to the words of the recreation therapists as possible, while still looking for overarching and overlapping themes. It was a difficult process because I had to balance staying true to their language while trying to go beyond a superficial understanding of the discussions to uncover the deeper meanings and understandings embedded in the text. This process required me to take a step back and refocus on the material I had been embedded in for so long, so that I could have a fresh perspective to look for new and different connections. I also realized that I needed a lot of feedback and discussing the material with others (my supervisor and committee members) helped me to see the material in a different way and solidify my understanding of past themes. I also realized after presenting my themes that at times I was imposing a structure and language on the themes. For example, themes I developed to describe the processes of the therapeutic relationship incorporated words such as developed, maintained and terminated which aligned with the biomedical model. This did not adequately capture the recreation therapists' experiences of engaging in therapeutic relationships. Therefore, wording regarding the different phases of the therapeutic relationship process were changed (to welcoming, continuing and closing) to reflect the very personal process the recreation therapists engaged in with the individuals receiving care. As this data elaboration process unfolded, I also reduced the presentation of some themes which I had been initially drawn to but did not have enough material to support my initial musings (e.g., the

concept of mindfulness). Although the elaborated data analysis and the writing of this thesis were an important part of my research journey and reflexive practice, they are not the endpoint. Reflective practice continues throughout life. Thus the understandings I obtained from the research findings and from being a part of this PAR process will continue to change and deepen as I continue to engage in reflective practice.

## Chapter Six: Discussion

Based on the findings presented in Chapter Five, a recreation therapist's therapeutic relationship may be described as:

*a shared process between the recreation therapist and individual receiving care defined by qualities of being in the moment, trust, respect, non-judgment, care, reciprocity and opportunities for choice and control. Recreation therapists engage in therapeutic relationships to: support a new beginning, shift focus to the positive and the living, build a sense of belonging and community and get to know the whole person through leisure experiences. The welcoming phase of a therapeutic relationship emphasizes using authentic and open dialogue, getting to know one another, following the person's lead and nurturing positive qualities of a therapeutic relationship. The continuing phase of a therapeutic relationship requires recreation therapists to show consistency and to be there for the individuals receiving care. In this phase, recreation therapists continue to nurture positive qualities of a therapeutic relationship, while paying attention and adapting to changes in the individual and the environment. Continuously throughout the therapeutic relationship process there are negotiations of power, roles and expectations. In essence, no two therapeutic relationships are experienced or unfold in the same way as they are shaped by the people invested in the connection, leisure-based contexts, and external influences. External influences to the therapeutic relationship include: the institutional setting, and wishes and desires of family. When the recreation therapist negotiates different influences it may assist to continue or to close the therapeutic relationship. Overall, the recreation therapists' therapeutic relationships support the aims of the Recreation Therapy department at SHSC, which involve: fostering enjoyment, fulfilling leisure-related needs, and enhancing quality of life for individuals receiving care through leisure.*

This description of the recreation therapists' therapeutic relationships attempts to synthesize the vast amount of rich data that was created in the focus group discussions. Although, the recreation therapists described their therapeutic relationships as a process with phases of welcoming, continuing and closing, the intricate nuances of their engagement were difficult to capture. Although it is clear that each therapeutic relationships of a recreation therapist is experienced differently. Several qualities of their therapeutic relationships such as reciprocity and being in the moment and the acknowledgement of external influences separate the recreation therapists' therapeutic relationships from those of other disciplines. For example, Edelman and Mandle (2005) also defined a nurse's therapeutic relationships as "a process in which one person promotes the development of another by fostering the latter's maturation, adaptation, integration, openness and ability to find meaning in a situation" (p. 1945). However, Edelman and Mandle's definition of the therapeutic relationship implies that therapeutic relationships are quite paternalistic and hierarchical; indicating the professional

possesses all of the skills, tools and knowledge necessary to assist the patient. Edelman and Mandle's definition aligns with a biomedical model philosophy of care and is strikingly different from the way the recreation therapists in this study described their therapeutic relationships, including the degree of reciprocity and power asserted by external influences. Two philosophies of care emerge in the recreation therapist's description of their therapeutic relationships, although person-centered care is largely predominant, relationship-centered care is also highlighted. The recreation therapists' reasons for engagement in therapeutic relationships focused on the benefits experienced by the individuals receiving care. This focus on the individual aligns with a person-centered philosophy of care (Caitlin, 2006). However, when the recreation therapists' acknowledge reciprocity within their therapeutic relationship process they shift into relationship-centered-care philosophy, in which both parties involved are continually learning and growing together (Nolan et al., 2001). Further discussion of these different philosophies will occur later on in this chapter.

In the remainder of this chapter the nuances of recreation therapists' therapeutic relationships are further discussed. The qualities of recreation therapists' therapeutic relationships are compared to qualities present within the literature from other disciplines. The recreation therapists' reasons for engaging in their therapeutic relationships are then discussed. This chapter further discusses the philosophies of care that emerged during the recreation therapists' focus group discussions and how these philosophies influence the recreation therapists' practices. Philosophies of practice including person-centered care, relationship centered care, the biomedical model emerged in the study. Person-care care was predominant, although relationship-centered care and the biomedical model were also present. Person-centered care philosophies emerged in the themes of choice and control, and getting to know the person. The recreation therapists' focus group discussions also predominantly focused on how the individuals receiving care were influenced by the therapeutic relationship rather than how they directly influenced or felt about their therapeutic relationships, which illuminates their person-centered care philosophy. In contrast, relationship-centered care appeared in themes regarding the inclusion of family, contemporary and controversial roles, and negotiation of power or external influences.

Whereas, the biomedical model appeared to influence assessment, planning, implementation and evaluation processes and were reflected in the traditional roles themes describing the power of the institution or recreation therapist. This chapter then explores an essential aspect of the recreation therapists' practice, e.g., their focus on "being in the moment" and using self-reflective practice to negotiate different influences and change. Being in the moment was described as a way to enhance positive qualities of a therapeutic relationship. In addition, recreation therapists' used self-reflective practice as a guide to negotiate different influences on their practices and to implement research findings into practice. Lastly, this chapter touches on the complexity of power within the recreation therapists' practices including those related to their therapeutic relationships and this PAR process. The chapter concludes with a reflexive description of how I have changed as a researcher through this PAR study, a discussion of the implications of this study, and recommendations for future research.

### ***Qualities Comprising Recreation Therapists' Therapeutic Relationships***

Several qualities of therapeutic relationships in recreation therapy such as trust, respect, open communication, feelings of attachment, attempts to create positive change, collaborating, provision of support, emphasis on autonomy, and strategies to overcome challenges were supported in literature from other disciplines. However, the degree of reciprocity, their leisure-based context, flexibility of boundaries, and the practice of "being in the moment" in their therapeutic relationships set recreation therapists apart from other disciplines.

The findings indicated therapeutic relationships in recreation therapy required time, effort and flexibility. Each therapeutic relationship evolved in a unique way. The recreation therapists suggested their relationships required them to have a wide range of skills including: active listening, a nonthreatening approach, effective communication, the ability to develop rapport, attentive observation skills, problem-solving capabilities, patience, and the ability to be truly present in the moment with individuals receiving care. The recreation therapists used these skills to foster several essential qualities within their therapeutic relationships. The recreation therapists suggested the following qualities created the foundation for successful therapeutic relationships: trust, acceptance, respect,

empathy, compassion, understanding and open communication. Support for these qualities was found in several sources within the literature. Researchers suggested care should be taken to continue qualities of a positive therapeutic relationship (Hick, Segal & Bien, 2008), otherwise poorer client outcomes, decreased functioning, and termination of the therapeutic relationship may occur (Gajowy, Marchewka, Sala & Simon, 2004). Lambert and Ogles (2004) analysed 60 years of research on therapeutic outcomes and suggested the strength of the therapeutic relationship was more significant than the school of therapy which guided the therapy sessions.

Hall, Dugan, Zheng and Mishra (2001) conceptualized trust as “the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster’s interests” (p. 615). They indicated trust was central to physicians’ therapeutic relationships giving them meaning and substance as well as enhancing the likelihood of the relationships’ beneficial outcomes. Hall et al. (2001) also provided five dimensions of trust including: fidelity (not taking advantage), competence (belief in abilities), honest (open communication, not withholding information), confidentiality (keeping information private) and global (overall) trust. Whereas, Edelman and Mandle (2005) described trust in nurses’ therapeutic relationships, as individual’s reliance on the professional “to carry out responsibilities and promises, based on a sense of safety, honesty, and reliability” (p. 15). Edelman and Mandle (2005) provided strategies nurses use to foster trust in their therapeutic relationships including:

- Trusting the individual to do as promised.
  - Clearly defining the relationship parameters and expectations, particularly the purpose and specifics of time, place and anticipated behaviour.
  - Being consistent.
  - Examining behaviours that interfere with trust.
- (p. 15)

These strategies were consistent with actions taken by recreation therapists to promote positive qualities of their therapeutic relationships.

Many authors articulated qualities of a therapeutic relationship were interconnected and the strength of the relationship depends on their constructive interplay. The recreation therapists



continually highlighted how the qualities of trust, respect, care and positive communication were interwoven in their therapeutic relationships, including the welcoming, continuing, and closing phases.

According to Welch (1998) in therapy,

things are connected. An attitude of respect leads to empathetic responding; empathetic responding leads to trust. Trust leads to energetic exploration; exploration leads to personal understanding. And understanding leads to person optimal solutions, if they exist (p. 11).

Edelman and Mandle (2005) described several characteristics of nurses' therapeutic relationship that worked in conjunction with one another including: purposeful communication, trust, empathy, rapport, and goal direction. Purposeful communication was referred to as focused conversation on topics that orient the patient or focuses attention on goals. Social topics or small talk was intentionally excluded from this definition. Edelman and Mandle (2005) drew on Rogers understanding of rapport suggesting it was a harmonious amicable relationship where individuals understand their best interests are genuinely important to the professional. Lambert and Ogles (2004 as cited in Hick, Segal & Bien, 2008) identified that therapists were more successful when they portrayed qualities of an "understanding, accepting, empathic, warm and supportive [nature]" (p. 12). Rogers (1957) also advocated therapists use empathic understanding, warmth and positive regard as well as congruence (authenticity) when communicating with their clients. In addition, Strupp, Fox and Lessler (1969) supported therapists' use of a "warm, attentive, interested, understanding and respectful" approach to create beneficial outcomes in the therapeutic relationship (p. 116). Whereas, Larazus (1971) found clients with successful outcomes attributed the positive result to the sensitivity, gentleness and honesty in the therapist's approach rather than type of therapy used. For Shuster (2000) communication held the key success in therapeutic relationships in nursing.

There was also literature which critiqued some of the qualities supported by the recreation therapists. The recreation therapists touched on empathy generally linking it to showing compassion and trying to understand the individual receiving care through active listening and being in the moment. Eisenberg and Strayer (1990) suggested the "notion of empathy is, and always has been, a broad, somewhat slippery concept—one that has provoked considerable speculation, excitement, and

confusion” (p. 3). These authors stated the term lacked uniform comprehension for “there is no correct definition of empathy, just different definitions” (p. 5). Marcia (1990) discussed psychotherapists should use empathy cautiously for he was concerned with its association with countertransference and reduction of objectivity or emotional distance between the therapist and client. Yet, therapists working within person-centered care aligned themselves with Rogers, and thoroughly embraced empathy for its ability to foster beneficial therapeutic outcomes (Marcia, 1990). According to Marcia:

[e]mpathy plays a key role in client-centered therapy... The rationale for this is clear... [i]ndividuals get into emotional trouble because they constrict their experience to conform to internalized conditions of worth. In order to suspend conditions of worth and to restore the organismic devaluing tendency, the therapist must establish an atmosphere of positive regard, free of conditions. Hence, he/she must attend to the client, permit the client’s recognized and unrecognized feelings to enter the therapist’s awareness, gain some sense of the client’s internal world, and then reflect this knowledge back to the client accurately and in an emotionally understandable way. This empathetic process encourages the client to regard previously shunned experiences positively (p. 95).

In the nursing literature, Edelman and Mandle (2005) indicated empathy occurred when the professional used his own “emotions and experiences” to understand their patients’ feelings but at the same time kept her “own identity and perspective” (p. 15).

When the positive qualities were present, recreation therapists indicated they helped to establish common ground, heightened leisure involvement for the individual (whether it was scheduled or spontaneous) and enhanced a shared understanding of boundaries in their therapeutic relationship (including parameters of time, place, purpose, expectations and power). Therefore, as positive qualities, common ground, leisure involvement and shared boundaries were maintained, the recreation therapists indicated benefits associated with engaging in recreation therapy programming were more likely to be obtained. Lambert and Ogles (2004) also identified therapists who successfully developed positive therapeutic relationships engaged in less “blaming, ignoring, neglecting, rejecting, or pushing a technique-based agenda with [resistant] clients” (as cited in Hick, Segal & Bien, 2008, p. 12).

Gajawy, Marchewka, Sala and Simon (2004) suggested positive therapeutic relationships required the respect and effort of both parties, otherwise a “poor alliance may lead to deterioration in terms of symptoms, poorer interpersonal functioning, and, eventually, premature therapy termination (dropout)”

(p. 21). In their focus group discussions, the recreation therapists highlighted in their therapeutic relationships if positive qualities of a therapeutic relationship were not fostered or if boundaries were crossed then closing the therapeutic relationship was most likely to occur. If individuals receiving care do not respect or trust the recreation therapists, they would not engage in or attempt to continue a therapeutic relationship. The recreation therapists put substantial effort into consistently communicating to the individuals receiving care that they were important and so were their therapeutic relationships. Based on Ricks (1974) research, Hick et al. (2008) wrote that “therapist[s] whose patients had the better outcome spent more time with the difficult cases, made use of resources outside the immediate therapy circumstances, w[ere] firm and direct with patients, encouraged autonomy, implemented problem-solving skills and had strong therapeutic relationships.” (p. 22). In addition Lafferty, Beutler and Crago (1991) stated “[c]lients of less effective therapists felt less understood by their therapists than did clients of more effective therapists” (p. 79).

### ***Quality of Life through Therapeutic Relationships and Leisure***

The recreation therapists indicated their therapeutic relationships enhanced the quality of life of individuals receiving care by supporting their adjustment period, shifting their focus to the positive and living, and increasing their leisure involvement and sense of belonging and community. As the recreation therapists described their reasons for engaging in therapeutic relationships a clear connection to the quality indicators previously developed at SHSC arises. Miller and Bowers-Ivanski (2009) described quality indicators (QIs) as “an index of experiences enjoyed by [individuals receiving care] while they are engaged in leisure activities” (p. 36). The quality indicators of—*enjoyment, being yourself, developing yourself, meeting others, feeling like you belong, and helping others*—enable recreation therapists to reflect if desired program outcomes were achieved in their daily practice. Connections to these quality indicators were described when recreation therapists discussed themes related to contemporary roles, getting to know one another, communication and connection, and senses of belonging and community.

Support for the recreation therapists' reasoning was also found in related literature. Santorelli (1999) referred to the hardships individuals face during institutionalization. He stated "the loss of normalcy, the disruption of perceived wholeness, the felt sense of isolation and limitation are at heart the primary predicament of the patient" (p. 21). Through their therapeutic relationships, recreation therapists address a number of these challenges, including isolation and a lack of community. In the theme describing the contemporary roles of recreation therapists, it was noted that the recreation therapists attempt to assist individuals to continue with past roles, in a way supporting a sense of wholeness. The continuation of past roles was also supported by Arai, Griffin, Miatello and Greig (2008) who studied how the use of recreation could be used to enhance the quality of life for individuals coping with trauma. They found people who experienced trauma had greater pleasure and enjoyment when they "reclaimed leisure interests that had been discontinued in the past or even for the first time enabled themselves to play" (Arai et al., 2008, p. 48). Hutchison, Bland and Kleiber (2006) also encouraged use of recreation-based initiatives to improve quality of life. They concluded leisure was able to help a person restore a part of themselves they had previously lost (Hutchison et al., 2006). The restorative aspect of recreation may be linked back to the themes describing contemporary roles of the recreation therapists and the continuation of past roles for the individual receiving care.

As for the recreation therapists' belief that their therapeutic relationships helped to build a sense of community, there was also support for this reasoning found in the literature. Buettner's (2006) research identified that recreation therapy programs could help build community. She discussed that individuals in recreation therapy programs had increased self-esteem and exhibited more pride in themselves when they were included in community or engaged in learning opportunities. Pedlar, Yuen and Fortune (2008) found that incarcerated women benefitted from recreation-based programs with community member involvement that fostered friendships as they increased the women's coping abilities.

### *Focusing On the Individual and Person-Centered Care*

At the time of this study, a person-centered care philosophy was formally held by the Recreation Therapy department at SHSC. The quality indicators created by the Recreation Therapy department were created within a person-centered care philosophy and many of the findings from this study highlight this approach. The findings chapter of this document captures that throughout the focus group discussions the recreation therapists were predominantly focused on how the individuals receiving care experienced and benefited from therapeutic relationships in recreation therapy. The recreation therapists also connected their holistic person-centered care approach to Abraham Maslow's (1943) Hierarchy of Needs. Maslow (1943) originally separated human needs into several categories including: physiological, safety, belonging (social connection) esteem, and self-actualization. However, the theorist acknowledged human needs could be desired and achieved without adherence to a set order. The recreation therapists described that their person-centered care philosophy was holistic, encompassing the wide range of needs that Maslow describes in his hierarchy. Robertson and Long (2007) also described the term holistic as "considering all aspects or properties of a given phenomenon, system, situation, or problem" (p. 286).

Support for holistic approaches to care also appeared in Abraham Maslow's well-known *Theory of Human Motivation* and the Hippocratic Oath, which guides medical ethics. Both texts implied the meaning of human life is much more complex than merely considering its physiological aspects. A *meaningful life* implied by the Declaration of Geneva, Hippocrates, Abraham Maslow and recreation therapists alike, required more than the preservation of physiological functioning (e.g., the rush of blood throughout the body, breathes of air or the reproduction of cells). Maslow (1943) emphasized to be human was to be in a constant state of need and several different needs needed to be considered when living a fulfilled life. Carter, Van Andel, and Robb (2003) encouraged person-centered holistic approaches to care when they stated recreation therapists "have emerged as effective members of the mental health care team. They contribute to the physical, psychosocial, cognitive and spiritual functions as well as to the quality of life and wellness aspects" (p. 415).

In the focus groups, discussions of their holistic approaches often occurred when the recreation therapists described their role in helping individuals receiving care to cope with their institutionalization. Santorelli (1999) also highlighted the important role holistic approaches and socialization had in offsetting losses experienced during institutionalization, stating “the loss of normalcy, the disruption of perceived wholeness, the felt sense of isolation and limitation are at heart the primary predicament of the patient” (p. 21). In this study, the recreation therapists suggested they had a highly unique and complimentary role to play on interdisciplinary teams dominated by a biomedical approach. The recreation therapists stated that they often advocated for, and attempted to ensure that the whole person and his/her needs related to belonging, self-esteem and self-actualization were being considered in care practices.

The presence of person-centered care philosophies was also evident when the recreation therapists described actions they took when welcoming their therapeutic relationships. During the welcoming phase, the recreation therapists attempted to get to know the whole person and follow the person’s lead. Using the *Personal Leisure Profile*, recreation therapists acquired information from individuals receiving care regarding their needs to help guide their therapeutic relationships and programming (Pedlar et al., 2001). In fact, the development and implementation of this profile officially shifted the recreation therapists’ focus away from assessments influenced by the biomedical model towards person-centered care (Cantwell, 2000). The *Personal Leisure Profile* resembled Rogers (1957) person-centered care philosophy and his idea that individuals were active participants in their therapeutic relationships. By using this profile in the welcoming phase of their therapeutic relationships, the recreation therapists stated they worked *with* individuals to create purpose and goal(s) for their therapeutic relationships. Caitlin (2006) supported the involvement of individuals in decision making processes which impact their care to foster empowerment and meaningful occupation.

Person-centered care philosophies were also highlighted when the recreation therapists discussed how they encouraged individuals to have choice and control. A person-centered care philosophy also arose when the recreation therapists stated they adjusted their roles and were flexible

to the individuals' changes. The theme of paying attention and adapting to change in the individual highlighted the recreation therapists' person-centered care philosophy. This theme suggested a one-way flow of influence, placing the individuals receiving care in the centre of the care and positioned the recreation therapists as reacting to the needs of individual. The recreation therapist did not suggest the individuals receiving care needed to modify their roles or approaches within their therapeutic relationships based on the recreation therapists' changes or desires. Cantwell and Pedlar (2002) described the recreation therapists' flexibility as *moving to the rhythms of the person*, and how it assisted with the development of enlivening relationships, affirmation of self and sense of place. In addition, person-centered care arose when closing the therapeutic relationship was discussed, some individuals advocated for their own wishes choosing to continue or close their therapeutic relationships, highlighting the power of the individuals. Some recreation therapists maintained the individual rather than the relationship should be the focus of their work, whereas other recreation therapists on the research team were more comfortable with a therapeutic relationship that had reciprocity. This is further discussed in the following section on relationship-centered care.

***Relationship-Centered Care in Practice: Involving Others, Reciprocity and Power in the Therapeutic Relationship***

In this study, relationship-centered care philosophy also emerged when the recreation therapists discussed the therapeutic relationship that is possible in a leisure-based context, and the reciprocity underlying their therapeutic relationships. The findings also described negotiations of power in recreation therapy leisure experiences and care planning that influenced the therapeutic relationship; including negotiations with individuals receiving care, family, other members of the interdisciplinary team as well as institutional and unit specific influences. Themes associated with relationship-centered care philosophies presented in this study were supported in the literature. Voelkl (2008) supported empowering and relationship-centered approaches in recreation therapy when she stated "perhaps the most important role of the CTRS is partnering with patients and their family and friends to empower them to engage in interactions and activities that transport them from the medical environment to

ordinary pleasures in daily life” (p. 234). Cantwell and Pedlar (2002) emphasized the power of the sense of community within recreation therapy to enhance social support and overall well-being. Dupuis et al. (2008) also supported the use of a partnership approach when working with individuals with dementia. Dupuis et al. (2008) drew on the Six Senses Framework of Nolan et al. (2001) which emphasizes all parties should feel the senses of continuity, security, belonging, purpose, fulfillment and significance when engaging in authentic relationships. What this PAR study brought to light was the issues of power within the therapeutic relationship. At times the research team indicated a discomfort with the term “power” as they saw it as meaning “power over” yet power was also underlying their discussions of advocacy. In Foucault’s (1980) words power is neither good nor bad. Power dynamics shift continually throughout the therapeutic relationship as different influences were negotiated. At times one person asserted more power than another (i.e., when the recreation therapists took on traditional roles or the individuals receiving care advocated for themselves or closed their therapeutic relationships). Sometimes power seemed to be shared, when both the individual receiving care and the recreation therapist worked together to establish goals or plan programming. Foucault (1978) highlighted the complexity of power when he stated “that power is everywhere, not because it embraces everything but because it comes from everything” (p. 43)

The informal leisure-based contexts of recreation therapy made it possible for different relationships of power to exist within therapeutic relationships. In these settings, recreation therapists encouraged all individuals receiving care to actively participate in activities, program planning, and to provide feedback. They also encouraged the involvement of family and other staff members in these informal leisure-based contexts. This intentional inclusion of family and other staff re-emphasized relationship-centered care existed within recreation therapy. Epstein, Alper and Quill (2004) stated that partnership building with family members and understanding the families’ experience helped physicians to communicate clinical outcomes to their patients. Dunbar, Clark, Deaton, Smith, De & O’Brien (2005) also suggested family focused interventions had greater success. Similarly, Beach, Inui and the Relationship-Centered Care Research Network (2006) stated relationship-centered care:



is health enhancing. It is founded upon, proceeds within, and is significantly influenced by the web of relationships that promote the well-being, and full functioning of patients. In RCC, the patient is often our central concern, but is not considered in isolation from all others...we do this work mindful of the contributions of the family, our team, our organizations, and our community...Similarly, we must be mindful of the impact of what we do with patients on the well-being of all others involved, including their integrity, functional capacity, resilience, and financial stability. Finally, we do this work in full knowledge that our own well-being and function need to be sustained if we are to continue to serve others vigorously (p. S8).

The recreation therapists' acceptance of reciprocity within their therapeutic relationships highlighted a relationship-centered approach to care. Their therapeutic relationships were mutual (not to be confused with equal) in the sense that both recreation therapists and individuals receiving care were active participants. Both parties disclosed information about themselves, worked together to establish goals, and often shared leisure experiences. The issue of reciprocity also arose when the recreation therapists acknowledged that although the aim of their therapeutic relationships was to benefit the individual receiving care they could benefit from their therapeutic relationships. At times in the focus group discussions, the recreation therapists described that they were influenced by, or benefited from, their therapeutic; however, they articulated that these benefits emerged after the individuals receiving care had benefited. In relationship-centred care, acceptance of reciprocity within their therapeutic relationships extends far outside the realm of the biomedical model and person-centered care. Relationship-centered care embraces the notion that therapeutic relationships are able to influence and be actively influenced by all parties involved. This reciprocity may also have existed due to the unique leisure-based context in which the recreation therapists' therapeutic relationships unfold. In contrast, supporters of biomedical model discourage reciprocity within therapeutic relationships. Although Edelman and Mandle (2005) agreed nurses' interactions with individuals could benefit both parties, they emphasized that reciprocity was not an intentional outcome. They emphasized nurses' helping relationships were goal-directed and existed only "to meet some need or to promote the growth of the recipient...the relationship is centered on the recipient" (Edelman & Mandle, 2005, p. 16). In this scenario, recipients were central and passive participants in the nurses' therapeutic relationships.

In contrast, Santorelli (1999), a philosopher of mindfulness, supported reciprocity in the therapeutic relationship, stating:

for too long care has been conceived of as either practitioner-centered or patient-centered. In actuality, the healing relationship has always been a crucible for mutual transformation. The bare willingness of human beings to encounter one another in the midst of our weaknesses and strengths is the quintessential transformative agent (p.20).

Recreation therapists also emphasized that boundaries were important in their therapeutic relationships; they indicated their boundaries were not rigid as other professions. Recreation therapists shared information about themselves with individuals and family members. They also shared leisure experiences that established meaning and feelings of connections with the individuals receiving care and their family members. The recreation therapists also acknowledged they were flexible in their boundaries particularly when individuals with cognitive impairments were concerned. All of these statements illustrated relationship-centered care was being practiced within recreation therapy.

Walford and Walford (2008) support co-creative transactional approaches to care, emphasizing that both the individual and therapist collaborate and share responsibility for their therapeutic relationships.

Power also entered into these discussions of boundaries. For example, discussions around controversial roles of recreation therapists and individuals receiving care as friends highlighted different understandings in the boundaries of relationship-centered care within recreation therapy. Although some recreation therapists accepted these controversial roles, others felt uncomfortable with them and the reciprocity they created. Some of the recreation therapists discussed the power that they professionals had within their therapeutic relationships did not enable the relationship to be truly reciprocal or continually follow person-centered care philosophy. For example, during discussions on the closing of the therapeutic relationship, recreation therapists noted they had the ability to end their therapeutic relationship. When the recreation therapists choose to close their therapeutic relationships based on the individuals needs without involving the individual in that decision making, at times this can create situations where the power shifts away from the individual and towards the professional.

Power exerted by family also influenced the recreation therapists' therapeutic relationships. At times, the dynamics of the family played a large role in the strength and duration of the therapeutic relationship. If family members were engaging in recreation therapy and supported the recreation therapists' practices, power appeared to be shared. However, when the desires or wishes of family members contrasted with those of the individuals receiving care or the recreation therapists, struggles over which would take precedent occurred. Sometimes management were brought into these discussions, other times the differences would be negotiated direct amongst the individuals involved.

Staff members also exerted power in the recreation therapists' understandings of their therapeutic relationships. The recreation therapists attempted to highlight the uniqueness of their therapeutic relationships, making them distinct from other disciplines. Other staff members also emerged in the theme regarding the negotiating of different influences. In this theme, other staff members were described as seeing the recreation therapist's therapeutic relationship as a means of helping them achieve some of their goals or tasks (e.g., making sure that an individual receiving care took his medicine).

At other times, rules and regulations of the institution appeared to take precedent in certain situations, such as safety of the individuals receiving care, limitations of resources, and fairness of care. In the recreation therapists' therapeutic relationships, the institution became a distant power, which rarely became apparent until boundaries were crossed or unrealistic expectations, conflicts or safety issues arose. Although the recreation therapists may not agree with the power of the institution, at the end of the day they were still employees of the institution and obligated to follow its code of conduct.

### ***Lingering Influence of the Biomedical Model***

Recreation therapy has traditionally been entrenched in the biomedical model. In the research findings, the biomedical model primarily arose when needs of the individual receiving care and traditional roles of the recreation therapists were discussed. The recreation therapists stated when they begin a therapeutic relationship the individual receiving care often has many *needs*. Focus group

discussions highlighted that through communication (with individuals, family members and other staff members), research and observation, they learned about and identified the individual's need(s). Austin (1999) supported the tradition of needs identification in recreation therapy through assessment. Figure 5 provides a visual representation of assessment, planning, implementation and evaluation (APIE) processes commonly used in recreation therapy. This visual in Figure 5 highlights the ideal progression from need identification to acquisition of beneficial outcomes which aligns with a biomedical model approach to care.

→ **Assessment:** Initial determination of individual's need(s). Needs form purpose/goal(s) of the therapeutic relationship.  
    → **Planning:** Actions taken by recreation therapist and individual towards achievement of goals.  
        → **Implementation:** Ideally actions taken lead to beneficial outcomes which meet individual's need(s).  
            → **Evaluation:** Reanalysis of individual's need(s) and purpose/goal(s) of the therapeutic relationship.

*Figure 5.* Assessment, planning, implementation and evaluation process influenced by biomedical model.

Initially, recreation therapists' assessment strategies appeared to embody the biomedical model approach. The focus on needs and deficits also aligns with the Leisure Ability Model and Stumbo's (2002) client assessment strategies which are embedded in the biomedical model. The recreation therapists also stated their therapeutic relationships needed to have a purpose and goals. This language echoed Peterson, Lee and Stumbo's (2008) recreation therapy program planning strategies, corresponding with a hierarchical practice philosophy entrenched in the biomedical model, where professionals are seen as experts. They also suggested the individuals' goals were primarily obtained through leisure involvement. These comments were consistent with Robertson and Long's (2007) processes of recreation therapy that link an individual's leisure involvement to beneficial outcomes. These beneficial outcomes ideally met need(s) of individuals identified during assessment. A focus on beneficial and measurable outcomes also aligned with the biomedical philosophy of care.

Discussions around roles within the therapeutic relationship highlighted different philosophical stances of recreation therapists within SHSC. The traditional roles of the recreation therapists appeared

to align with the Leisure Ability Model and a biomedical model approach to care. As facilitators, advocates, educators and counsellors the expertise of the recreation therapists was highlighted. In addition, when recreation therapists indicated they had to negotiate and uphold power of the institution, hierarchies within the therapeutic relationship were evident. Discussions around negotiating different influences also highlighted fluidity of therapeutic relationships in recreation therapy. The practice of being in the moment emerged to help the recreation therapists' processes of negotiation within their therapeutic relationships.

***“Being in the Moment”: Enhancing Positive Qualities of a Therapeutic Relationship***

Being in the moment occurs when the recreation therapist is actively engaged with the individual receiving care. Being in the moment enhances the recreation therapists' ability to display compassion, care, authenticity, trust, openness, acceptance, and respect for where the person is at. Through attentively listening, acting in a nonjudgmental way and communicating purposefully with the individual, the recreation therapists uses being truly present in the moment to foster the welcoming and continuation of positive qualities of a therapeutic relationship to occur.

The recreation therapists stated that to welcome and continue their therapeutic relationship, they needed to be aware and adaptable to changes. For recreation therapists to be aware of changes, they highlighted they must be truly present with individuals receiving care. One recreation therapist warned if professionals shifted their focus to outside stimuli or stress caused by life or work challenges it led to distraction and the lack of awareness of change that could damage the therapeutic relationship. The recreation therapists stated being in the moment was associated with fostering positive qualities of the therapeutic relationship and enabled them to follow the individual's lead. Other writers also support the shift of patients into leadership roles (Santorelli, 2000; Suzuki, Dixon & Baker, 2006). Santorelli stated for practitioners to be truly successful they needed to be aware of the individual's experience:

Helping, if it is to be healing, requires practitioners to enter into and begin to understand the disruption, uncertainty, and chaos of identity faced by those seeking their care (p. 20).

The practice of being in the moment encourages practitioners to be truly present with the individuals receiving care and to learn from them. The recreation therapists acknowledged that if positive qualities of a therapeutic relationship were not fostered, then challenges and frustration were experienced by themselves and individuals receiving care. This shared challenge and frustration highlighted the reciprocal nature of the therapeutic relationship.

### *Negotiating Different Influences Using Self-Reflective Practice*

Within their therapeutic relationships, recreation therapists were constantly negotiating different influences (e.g. power, feelings, and expectations of individuals, families, staff members and management). In their focus groups, the recreation therapists suggested they used independent self-reflective practice to negotiate influences in their therapeutic relationships, this could be described as reflection in action. Reflection in action, a component of self-reflective practice, occurs when an individual reflects “in the midst of action without interrupting it. Our thinking serves to reshape what we are doing while we are doing it” (Schon, 1987, p. 26). The reflection on action component of self-reflective practice occurs after the interactions with the individuals receiving care. Reflective on action requires a recreation therapist to purposefully reflect on her therapeutic relationships and her actions, thoughts, and feelings which occurred during moments of interaction with the individuals receiving care.

Throughout this PAR process, the recreation therapists also had to negotiate differences between members of their research team and how to incorporate their latest research findings into their practices. Collectively engaging in self-reflective practice (i.e. reflection on action) helped the recreation therapists to negotiate different issues throughout this PAR process. As a research team, the recreation therapists also created a self-reflective guide to help them integrating their research findings into practice. It appeared that different influences, both within their therapeutic relationships and research processes were negotiated using self-reflective practice. Woods (2009) wrote that if practitioners become more aware of themselves and their surroundings that their relationships will also

strengthen. Self-reflective practice could be seen as a means of enhancing a practitioners' awareness about herself, her surroundings and her relationships.

Self-reflective practice is a means by which recreation therapists negotiate different influences in their therapeutic relationships. In their focus groups, the recreation therapists suggested if influences were too great or if the negotiation of power, expectations and boundaries led to a challenging therapeutic relationship, then the issue of closing the therapeutic relationship would arise. If closing the therapeutic relationship was not an appropriate option, the recreation therapists would continue their efforts to negotiate and continue their challenging therapeutic relationships. When the recreation therapist was self-reflective of the different influences within the situation and her abilities, often the issues of power, boundaries and expectations were successfully negotiated within her therapeutic relationship. Santorelli (2000) supported the practicing mindfulness since it frees people to be truly present in the moment and negotiate different influences as they arise. Although the practice of mindfulness was emerging in recreation therapists' practice at SHSC, there are similarities between it, self-reflective practice and the practice of being in the moment, which may need to be explored in more detail.

### ***The Complexities of Power within this Participatory Action Research***

PAR was a compatible research methodology to use for this study for it drew on the skills, knowledge and abilities of the practitioners. As Koch et al., (2006) describe, PAR enables stakeholders to conduct research on their own terms. The issue of power was also inherent in this PAR approach. .

Power was not only evident in the findings of this study; power was also embedded in the process (Kemmis & McTaggart, 1990). PAR has the power to foster personal and social change (Koch et al., 2006). In the focus groups, as the recreation therapists shared their understandings, they learned from one another. Some of their assumptions were challenged as they collectively tried to describe what therapeutic relationships in recreation therapy were and how they unfolded in practice. With knowledge stems more power as Foucault (1978) suggests, "power is based on knowledge and makes use of knowledge" (p. 93).

It is true that the power of the research was placed in the hands of the recreation therapists to study their therapeutic relationships in a way that was meaningful to them. They were also empowered to make decisions regarding the research process and research methods. The PAR process also encouraged the recreation therapists to take on greater roles in the planning and implementation of their research, as well as the development of a self-reflective guide and dissemination of research findings into the larger communities (both academic and professional). Throughout PAR, collaboration, democracy and equality were focused upon (McTaggart, 1997) as the recreation therapists worked through challenges in their research and daily practices together with openness and acceptance of differences. However, some of the research team members became leaders in the study's data collection (e.g., as moderators of the focus groups). This shifted the power dynamics (perhaps unknowingly at the time) within the research team. The research team might want to reflect as a group, how having some members as moderators influenced the rest of the research team. Now the research team has the responsibility of sharing their knowledge with others. Each person on this research team lived this experience in their own way. In the next section, as I cannot truly know what each person on the research team experienced or how they changed, I will discuss some of the changes I experienced and the influence (or the power) participating in this research project had on me.

### ***Reflections on My Understanding of PAR***

I have been asked by my committee members how this PAR research has influenced me. Briefly I would like to emphasize that it has encouraged me to look at how I interact within my relationships, professional, therapeutic and personal. This study and my life as a masters' student has also demanded that I be more self-reflective, in regards to my thoughts, feelings and actions and more accepting of differences in approaches to life and research issues. For these lessons, I am appreciative.

Looking back, I have learned an incredible amount through my MA program. I have realized the power that PAR research can have and embraced my limitations as an academic researcher within a PAR study of this magnitude. At the end of my time with this research team, while I can say that I was a catalyst for this PAR initiative, it did not begin nor will it end with my involvement. As the research



team continues to engage in cycles of this PAR study, and I believe I have helped them to accept that they have the tools and the abilities to control where their research continues to go in the future. I also saw the benefit of me stepping away from the action piece of this study and leaving the small research committee in charge of its progress. The action piece in this PAR study meant the refinement and the implementation of the self-reflective guide, which was created from the findings from this research, into practice. After my last meeting with Nancy Bowers-Ivanski, the Manager of the Recreation Therapy and Creative Arts department, I can pleasantly announcement the small research committee's progress was going well and future research plans to incorporate the self-reflective guide further into practice were being developed. On the outside I may look relatively similar to when I began this process, but through my lived experiences over the last two year, I have changed on the inside in ways that cannot be truly articulated through words on this page.

### ***Research Implications***

This section discusses implications of this research for the academic literature on therapeutic relationships and recreation therapy. At SHSC, implications also extend to recreation therapists own practices regarding their therapeutic relationships and self-reflective practices. The findings of this research encourage recreation therapists to use self-reflective practice to negotiate different influences on their therapeutic relationships (e.g., their self-reflective guide). The findings also encourage them to reflect on traditional models of practice to determine if they are still compatible with current practice at SHSC. This study also highlighted the need to share their research findings with other disciplines and practitioners. Awareness of recreation therapy at SHSC and a deeper understanding of their therapeutic relationships may be increased with the dissemination of these research findings. Other practitioners may also use this study as a reference when developing their own research studies or self-reflective guides regarding their therapeutic relationships within their own practices.

This study also filled a gap within the recreation therapy literature. In the recreation therapy literature, little has been written on therapeutic relationships, although, facilitation skills were noted to enhance therapeutic relationships (Robertson & Long, 2007). Shank (2002) also mentioned that

openness, flexibility, genuineness, positive regard and respect helped to develop therapeutic relationships. The importance of communication in therapeutic relationships was also apparent in the literature (Bedell & Lennox, 1997; Shank, 2002). However, this study thoroughly explored how therapeutic relationships were understood by recreation therapists at SHSC. The therapeutic relationship process, qualities which comprise a positive therapeutic relationship, waves of influence and potential roles within recreation therapists' therapeutic relationships were explored in detail. It was suggested that therapeutic relationships in recreation therapy may differ from relationships formed in other disciplines; however, further exploration of this issue is recommended. The findings of this study echoed Arai's (2009) research findings that suggested relationship-centered care philosophies were emerging within recreation therapy at SHSC.

When the themes from the second phase of analysis were presented to the research team and to help the recreation therapists further reflect on their therapeutic relationships, a process was designed to engage them in developing a series of self reflective questions. The recreation therapists separated into small groups. Each group was assigned a portion of the themes presented in this document and asked to read the summary and develop a series of self-reflective questions. Each group presented the self-reflective questions they developed to the larger group. (Please see Appendix H to see the list of reflective questions presented and refined on November 16th, 2009.) These reflective questions have the potential to benefit the recreation therapists' daily practice, by encouraging them to discuss the importance of boundaries the importance. They may use the self-reflective questions to negotiate different influences and ethical issues which may arise throughout their therapeutic relationships. The research team may also want to dialogue on their research findings regarding self-reflective practice and the practice of being in the moment and how they can be captured in their philosophy of practice.

After, I presented my findings from the elaborated data analysis to the Recreation Therapy department on May 12<sup>th</sup>, 2010 following my master's thesis defence; the recreation therapy team will determine how to further disseminate the research findings. Their dissemination strategies may include: developing conference presentations, implementing the self-reflective guide they created into

practice, or beginning another research endeavour. The recreation therapists at SHSC may also wish to create a new model of practice regarding therapeutic relationships for the traditional recreation therapy models (Leisure-Ability Model, Parse's Theory of Human Becoming, and person-centered care) may not accurately capture the nuances of their therapeutic relationships or current practices at SHSC.

This study highlighted the role recreation therapists play in interdisciplinary healthcare teams as advocates and in providing a unique aspect of holistic care. Findings from this study could be used to enhance interdisciplinary teams' awareness of recreation therapy and the recreation therapists' therapeutic relationships. Lansfield (2008) also suggested awareness of recreation therapy needed to be enhanced. Presentations or educational materials given to staff members at SHSC may increase their awareness and understanding of the unique aspects of recreation therapy and therapeutic relationships in leisure-based settings. Another way to enhance awareness of practices of the recreation therapists at SHSC would be to approach the website developers of SHSC. Currently there is no information available on recreation therapy at SHSC on the website. Providing information on the SHSC's website would enhance public awareness and perhaps reduce unrealistic expectations or challenging negotiations within therapeutic relationships in recreation therapy.

This study also provided a foundation of knowledge on recreation therapists' therapeutic relationships that other practitioners can draw upon to conduct their own research studies, to create self-reflective guides, or to reflect upon their models of practice regarding their therapeutic relationships. This study also highlighted the challenging nature of PAR within healthcare settings. Individuals planning to conduct a PAR study should have in-depth conversations regarding the limitations of time, resources and energy available for the study. At the start of the process, discussions of ethical considerations and roles within the study should be discussed. These discussions should also occur regularly throughout the process to ensure all members are in agreement and aware of changing circumstances as the process unfolds.

### ***Future Research Considerations***

Throughout the study, there were many opportunities to explore a number of issues regarding recreation therapy practice and therapeutic relationships. Due to time and resource limitations, the participatory nature of the data analysis in this research process had to be modified. The recreation therapists participated thoroughly in a preliminary data analysis of the findings. However, time allotted to this portion of the study was not sufficient to unravel the intricate nuances of the material. The research team has discussed this and in the future more time will be allotted or another form of data analysis will be determined. This study was also the first time the recreation therapists had been leaders of a PAR study. Future endeavours could more widely explore approaches to reviewing literature and collecting and analyzing data.

As this study comes close, gaps in the literature remain. Future research studies could explore therapeutic relationships in recreation therapy from different perspectives. Perspectives which were not taken into consideration in this study but may provide insights into this issue are: interviewing members of interdisciplinary teams, individuals receiving care, or family members. Future research could also attempt to answer the question: Are beneficial outcomes recreation therapists perceive as arising from therapeutic relationships experienced by recreation therapy participants? Future research may also wish to explore or critique models of recreation therapy currently available and determine if these models are suitable within today's practice. Other methodologies such as photovoice or memory work could be used to explore therapeutic relationships in further detail.

### ***Conclusion***

Several qualities of recreation therapy are shared with other disciplines, such as trust, communication and respect. However, the themes of: being in the moment, getting to know the whole person, reciprocity and flexibility in boundaries appear to set them apart. This study highlighted that several philosophies of care were influencing recreation therapy practice, although person-centered care was predominant. In the future the research team may want to discuss how to negotiate these different philosophies in practice. The practice of being in the moment also emerged in focus group

discussions as a means of enhancing their therapeutic relationships, whereas self-reflective practice may assist the research team to negotiate different influences and integrate their research findings into practice. This PAR process also highlighted the complex nature of power within the recreation therapists' therapeutic relationships and research endeavours. Collective reflection on the issues of power may also be required as this cycle of the recreation therapists PAR journey comes to a close.

## References

- Adams, T., & Clarke, C.L. (1999). *Dementia Care: Developing Partnerships in Practice*. London, UK: Elsevier Health Sciences.
- Alvesson, M., & Skoldberg, K. (2000). *Reflexive Methodology, New Vistas for Qualitative Research*, London, UK: Sage.
- Arai, S.M. (2009). Memory work research findings. Waterloo, ON: University of Waterloo.
- Arai, S.M., Griffin, J., Miatello, A., & Greig, C.L. (2008). Leisure and recreation involvement in the context of healing from trauma. *Therapeutic Recreation Journal*, XLII(1), 37- 54.
- Arnstein, S.R. (1969). Ladder of citizen participation. *JAIP*, 35(4), 216-224.
- Atkins, S., & Murphy, K. (1993). Reflection: A review of the literature. *Journal of Advanced Nursing*, 18(8), 1188-1192.
- Austin, D.R. (1999). *Therapeutic recreation: Processes and techniques*. Thousand Oaks, CA: Sagamore Pub.
- Austin, D.R., Dattilo, J., & McCormick, B. (1999). *Conceptual Foundations for Therapeutic Recreation*. (eds.). State College, PA: Venture.
- Autonomy. (2009). In *Merriam-Webster Online Dictionary*. Retrieved July 20, 2009, from <http://www.merriam-webster.com/dictionary/autonomy>.
- Baer, R. A. (Ed.) (2006). *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications*. San Diego, CA: Elsevier.
- Beach, M.C., Inui, T., & the Relationship Centered Care Network. (2006). Relationship-centered care: A constructive reframing. *Journal of General Internal Medicine*, 21(S1), S3-S8.
- Bell, V., & Troxel, D. (1999). *A Dignified Life: The Best Friends Approach to Alzheimer's Care*. Baltimore, Maryland: Health Professions Press Inc.
- Binnie, A., & Tichen, A. (1999). *Freedom to Practice: The Development of Patient-Centred Nursing*. Oxford, UK: Butterworth Heinemann.

- Bishop, S., et al. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and practice*, 11(3), 230–241.
- Boeree, C.G. (2006). Abraham Maslow: Personality Theories. Jan 4<sup>th</sup> 2009 from <http://webspace.ship.edu/cgboer/maslow.html>.
- Bordin, E. (1994). Theory and research on the therapeutic working alliance: new directions. In Greenberg, L.S. (1994). *The Working Alliance: Theory, Research, and Practice*. (pp 13-37) New York: Wiley
- Bordin, E. (1979) The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, 16:252–260.
- Buettner, L.L. (2006). Peace of mind: A pilot community-based program for older adults with memory loss. *American Journal of Recreation Therapy*. 42-48.
- Buettner, L.L., & Fitzsimmons, S. (2003). Activity calendars for older adults with dementia: What you see is not what you get. *American Journal of Alzheimer's Disease*, 18(4), 215-226.
- Burton, A. (1963). The analysis of a therapeutic failure. *Psychoanalytic Review*, 63(4), 587.
- Cadman, K., Friend, L., Gannon, S., Ingleton, C., Koutroulis, G., McCormick, C., et al. (2007). Memory-workers doing memory-work on memory-work: Exploring unresolved power. *Memory-work conference*. Retrieved September 31<sup>st</sup>, 2008 from <http://epress.lib.uts.edu.au/dspace/handle/2100/411>
- Caitlin, P.A. (2006). Activity planning: Developing horticultural therapy sessions. In R.L. Haller and C.L. Kramer. (eds.). *Horticultural Therapy Methods*. Binghamton, NY: The Haworth Press, Inc.
- Canadian Therapeutic Recreation Association, (2008). *Philosophy*. Retrieved October 31<sup>st</sup>, 2008 from <http://www.canadian-tr.org/>
- Cantwell, A.M. (2000). Patient focused care in recreation therapy: Being with the person. *Unpublished master's thesis*. Waterloo, ON: University of Waterloo.

- Cantwell, A.M., & Pedlar, A. (2002). The meaning of community on a cognitive support unit. [Abstract]. *Tenth Canadian Congress on Leisure Research*. Edmonton, AB:Canadian Congress on Leisure Research.
- Carter, M.J., Van Andel, G.E., & Robb, G.M. (1995). *Therapeutic recreation: A practical approach*. Waveland Press.
- Cassidy, J., & Shaver, P.R. (1999). *Handbook of Attachment: Theory Research, and Clinical Applications*. New York, NY: Guilford Press.
- Csikszentmihalyi, M. (1990). *Flow: The Psychology of Optimal Experience*. New York: Harper and Row.
- Clark, M.L., & Gioro, S. (1998). Nurses, indirect trauma and prevention. *Journal of Nursing Scholarship, 30*(1), 85-87.
- Clemence, J., Hilsenroth, M.J., Ackerman, S.J., Strassle, C.G., & Handler, L. (2005). Facets of the therapeutic alliance and perceived progress in psychotherapy: Relationship between patient and therapist perspectives. *Clinical Psychology & Psychotherapy, 12*(6), 443-454.
- Coyle, C.P., Kinney, W.B., Riley, B., & Shank, J.W. (1991). *Benefits of Therapeutic Recreation: A Consensus View*. Philadelphia, PA: Temple University.
- Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed method approaches*. (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications Inc.
- Creswell, J.W. (2007). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches*. (2<sup>nd</sup> ed.). Thousand Oaks, CA: SAGE Publications Inc.
- Creswell, J.W. (2009). *Research design: Qualitative, Quantitative and Mixed Methods Approaches*. (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage Publications Inc.
- Crowe, T. P., & Grenyer, B.F.S. (2008). Is therapist alliance or whole group cohesion more influential in group psychotherapy outcomes? *Clinical Psychology and Psychotherapy, 15*, 239-246.



- CTRA. (2008). *Therapeutic Recreation Definition*. Retrieved September 12, 2008 from <http://www.canadian-tr.org/>
- Declaration of Geneva (1948). Adopted by the General Assembly of World Medical Association at Geneva Switzerland, September 1948.
- Denzin, N. K. (1989). *Interpretive interactionism*. Newbury Park: Sage.
- Denzin, N.K., & Lincoln, Y.S. (2005). *The Sage Handbook of Qualitative Research*. Thousand Oaks: CA: Sage Publications
- Didonna, F. (2009). *Clinical Handbook of Mindfulness*. New York, NY: Springer.
- DiMatteo, M.R., (1998). The role of the physician in the emerging health care environment. *Western Journal of Medicine*, 168, 328-333.
- Dossey, L., & Keegan, L. (2008). *Holistic Nursing*. Sudbury, MA: Jones and Bartlett Publishers.
- Dozier, M., & Tyrrell, C. (1998). The role of attachment in therapeutic relationships. In J.A. Simpson and W.S. Rholes, (eds.). *Attachment Theory and Close Relationships*. New York, NY: Guilford Press.
- Dunbar, S.B., Clark, P.C., Deaton, C., Smith, A., De, A.K., & O'Brien, M.C. (2005). Family education and support interventions in heart failure: A pilot study. *Nursing Research*, 54(3), 158-166.
- Dupuis, S. (1999). Naked truths: Towards a Reflexive Methodology in Leisure Research. *Leisure Sciences*, 21(1), 43-64.
- Dupuis, S., Gillies, J., Mantle, A., Loiselle, L., & Sadler, L. (2008). *A Changing Melody Toolkit*. Waterloo, ON: Murray Alzheimer's Research and Education Program.
- Edelman, C.L., & Mandel, C.L. (2005). *Health Promotion throughout the Lifespan*. (Eds.). St. Louis, Missouri: Elsevier Mosby Inc.
- Edwards, C. (1996). Assessing Attitudes toward the role of recreation therapists amongst members of the Riverdale Hospitals' interdisciplinary teams. *Unpublished masters' thesis*. Waterloo, ON: University of Waterloo.

- Epstein, R.M., Alper, B.S., & Quill, T.E. (2004). Communicating evidence for participatory decision making. *JAMA*, 291, 2359-2366.
- Eisenberg, N., & Strayer, J. (1990). *Empathy and its Development*. New York, NY: Cambridge University Press.
- Elkind, S.N. (1992). *Resolving Impasses in Therapeutic Relationships*. New York: Guilford Press.
- Fewster-Thuente, L. (2008). Interdisciplinary collaboration for healthcare professionals. *Nursing Administration Quarterly*, 32(1), 40-48.
- Figley, C.R. (1993). Compassion stress and the family therapist. *Family Therapy News*, 1-8. In C.R. Figley (Ed.). *Compassion fatigue: Secondary traumatic stress disorder from treating the traumatized*. (p.7). New York, NY: Brunner/Mazel.
- Flaskas, C., & Perlesz, A. (1996). *The Therapeutic Relationship in Systemic Therapy*. London: Karnac Books.
- Flicker, S., Maley, O., Ridgley, A., Biscope, S., Lombardo, C., & Skinner, H.A. (2008). E-PAR: Using technology and participatory action research to engage youth in health promotion. *Action Research*, 6(3), 285-303.
- Forchuk, C., Chan, L., Schofield, R., Martin, M.L., Sircelj, M., Woodcox, V. et al. (1998a). Bridging the discharge process. *The Canadian Nurse*, 94(3), 22-26.
- Forchuk, C., Hartford, K., Blomqvist, A., Martin, M.L., Chan, Y.L., & Donner, A. (2002). Therapeutic relationships from hospital to community. In progress.
- Forchuk, C., Jewell, J., Schofield, R., Sircelj, M., & Valledor, T. (1998b). From hospital to community: Bridging therapeutic relationships. *Journal of Psychiatric and Mental Health Nursing*, 5(3), 197-202.
- Forchuk, C., Schofield, R., Martin, M., Sircelj, M., Woodcox, V., Jewell, J. et al. (1998c). Bridging the discharge process: Staff and consumer experiences over time. *Journal of the American Psychiatric Nurses Association*, 4(4), 128-133.

- Foucault, M. (1978). *The History of Sexuality: An Introduction*. (R. Hurley trans). Harmondsworth: Penguin.
- Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings, 1972-77*, (C. Gordon, Ed.) Brighton: Harvester.
- Freire (1970). *Pedagogy of the Oppressed*. New York, NY: Continuum Publishing Company.
- Gabriel, M.A., & Monaco, G.W. (1995). Re-visiting the question of self-disclosure. The lesbian therapist's dilemma. *In Lesbians and Psychoanalysis. Revolutions in Theory and Practice*, (pp. 161-172). New York, NY: The Free Press.
- Gajawy, M., Marchewka, D., Sala, P., & Simon, W. (2004). Analysis of drop-outs from group psychotherapy in regards to patient's variables. *Psychotherapy*, 2(129), 47-55.
- Gallop, R. (1997). Caring about the client: The role of gender, empathy and power in the therapeutic process. In C.J Titus (Ed.). *The mental health nurse: Views of practice and education* (pp. 28-42). Oxford, UK: Blackwell Science.
- Gallop, R.M., Taerk, G., Lancee, W.J., Coates, R.A., Fanning M., & Keatings, M. (1991). The knowledge, attitudes and concerns of hospital staff about AIDS. *Canadian Journal of Public Health*. 82(6), 409-12.
- Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy*, 27, 143-153.
- Gaston, L., & Marmar, C.R. (1994). The California Psychotherapy Alliance Scales. In A.O. Horvath and L. Greenberg (Eds.), *The Working Alliance: Theory, Research and Practice*. Toronto, ON: John Wiley and Sons.
- Gilbert, A., Johnston, J.E., & Afable, M.A. (2008). The therapeutic recreation (TR) community transition model. *TRO Research Annual*, 6.
- Glasson, J.B., Chang, E., & Bidewell, J.W. (2008). The value of participatory action research in clinical nursing practice. *International Journal of Nursing Practice*, 14(1), 34-39.

- Gostecnik, C., Repic, T., & Cvetek, R. (2008). Redemptive experience in relational family therapy: A Christian perspective. *Journal of Religion and Health, 48*(4), 496-506.
- Grant, J., Nelson, G., & Mitchell, T. (2008). Negotiating the challenges of participatory action research: Relationships, power, participation, change and credibility. In P. Reason & H. Bradbury (Eds) *The SAGE Handbook of Action Research: Participative Inquiry and Practice*. (pp 589-601). London, UK: Sage Publications, Ltd.
- Goffman, E. (1961). *Encounters: Two Studies in the Sociology of Interaction*. Indianapolis, Indiana: Bobbs-Merrill.
- Guba, E.G., & Lincoln, Y.S. (2005). *The SAGE Handbook of Qualitative Research*. (ed.). Thousand Oaks, CA: SAGE Publications Inc.
- Hall, M.A., Dugan, E., Zheng, B., & Mishra, A.K. (2001). Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *The Milbank Quarterly, 79*(4), 613-639.
- Hatcher, R., & Barends, A. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology, 64*, 1326-1336.
- Haug, F. (1999). *Female sexualisation: A collective work of memory* (2nd ed.). (E. Carter, Trans.). London: Verso.
- Hesse, A.M. (2002). Secondary Trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal, 30*(2), 293-309.
- Hick, F.H., Segal, Z.V., & Bien, T. (2008). *Mindfulness and the Therapeutic Relationship*. Guilford Press.
- Hilton, J. (1997). Introduction to the internet for medical practitioners. In: S. McGhee, T. Hannan, & I. Symonds, APAMI - HIC 1997: Managing Information for Better Health Outcomes in Australia and the Asia Pacific Region: 11 to 13 August 1997, Asia Pacific Association of Medical

- Informatics, HISA: Conference Proceedings. Brunswick East, Vic.: Health Informatics Society of Australia, pp. 137-138.
- Holstein, J.A., & Gubrium, J.F. (1995). *The Active Interview. Qualitative Research Methods (Vol. 37)*. Thousand Oaks, California: SAGE Publications Inc.
- Hood, C.D., & Carruthers, C. (2007). Enhancing leisure experience and developing resources: The leisure and well-being model. *Therapeutic Recreation Journal, 41*(4), 298-325.
- Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-232.
- Hoyt, W. T. & Bhati, K. S. (2007). Principles and practices: An empirical examination of qualitative research in the Journal of Counseling Psychology. *Journal of Counseling Psychology, 54*, 201-210.
- Hughes, I., & Seymour-Rolls, K. (2000). Participatory Action Research: Getting the job done. *Action Research e-Reports (4)*, Retrieved October 8<sup>th</sup>, 2008 from <http://www2.fhs.usyd.edu.au/arow/arer/004.htm>.
- Hutchison, S.L., & Kleiber, D.A. (2005). Gifts of the ordinary: Casual leisure's contributions to health and well-being. *World Leisure, 3*, 2-16.
- Hutchison, S.L., Bland, A.D., & Kleiber, D.A. (2008). Leisure and stress-coping: Implications for Therapeutic Recreation Practice. *Therapeutic Recreation Journal, .XLII*(1), 9-23.
- Israel, B.A., Schulz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health, 19*, 173-202.
- James, E.A., Milenkiewicz, M.T., & Bucknam, A. (2007). *Participatory Action Research for Educational Leadership*. Thousand Oaks, CA: Sage.

- Janesick, V.J. (2000). The choreography of qualitative research design: Minuets, improvisations, and crystallization. In N.K. Denzin and Y.S. Lincoln (eds.). *Handbook of Qualitative Research*, Newbury Park, CA: Sage Publications.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future. *Clinical Psychology: Science and Practice*, 10, 144-156
- Kadambi, M.A., & Truscott, D. (2004). Vicarious trauma among therapists working with sexual violence, cancer, and general practice. *Canadian Journal of Counselling*. 38(4), 260-276.
- Kemmis, S., & McTaggart, R. (1988). *The Action Research Planner*, (3<sup>rd</sup> ed.). Geelong, Australia: Deakin University Press.
- Kemmis, S., and McTaggart, R., (1990). *The Action Research Planner*. (4<sup>th</sup> ed.). Geelong, Australia: Deakin University Press
- Kemmis, S., and McTaggart, R., (2008). *The Action Research Planner*. (4<sup>th</sup> ed.). Geelong, Australia: Deakin University Press
- Koch, T., Kralik, D., Loon, A.V., & Mann, S. (2006). *Participatory Action Research in Health Care*. Victoria, Australia: Blackwell Publishing.
- Kottak, C.P. (2000). *Anthropology: The Exploration of Human Diversity*. New York, NY: McGraw-Hill.
- Krueger, R.A. (1994). *Focus Group: A Practical Guide for Applied Research*. (Eds.). Thousand Oaks, CA: Sage.
- Krueger, R.A. & Casey, M.A. (2001). *Focus Groups*. (Eds.). Thousand Oaks, CA: Sage.
- Krueger, R.A., & Casey, M.A. (2008). *Focus Groups*. (Eds.). Thousand Oaks, CA: Sage.
- Lafferty, P., Beutler, L.E., Crago, M. (1991). Differences between more and less effective psychotherapists: A study of select therapist variables. *Journal of Consulting and Clinical Psychology*, 57, 76-80.

- Lambert, M.J., & Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behaviour change*. (5<sup>th</sup> ed. Pp. 139-193). New York: Wiley.
- Larazus, A.A. (1971). *Behaviour therapy and beyond*. New York: McGraw-Hill.
- Lazarus, A.A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics & Behaviours*, 4(3), 255-261.
- Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues*, 2(4), 34-36.
- Lewin, K. (1988). 'Group decision and social change' in S. Kemmis (ed.). *The Action Research Reader*, Victoria, Australia: Deakin University Press, pp. 47-56.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry*, (eds.). Newbury Park, CA: SAGE Publications Inc.
- Malterud, K. (2001). Qualitative research: Standards, challenges and guidelines. *The Lancet*, 358, 483-488.
- Mandell, D. (2007). *Revisiting the Use of Self: Questioning Professional Identities*. Toronto, ON: Canadian Scholars' Press Inc.
- Marcia, J. (1990). Empathy and psychotherapy. In N. Eisenberg & J. Strayer. (Eds.). *Empathy and its Development*. New York, NY: Cambridge University Press.
- Marshall, J. (2006). Self-reflective inquiry practices. In P. Reason & H. Bradbury (eds.). *Handbook of Action Research* (pp. 335-342). London, UK: Sage.
- Maslow, A.H. (1943). The theory of human motivation. *Psychological Review*, 50, 370-396.
- McGill, J. (2000). A retrospective: Twenty-five years of practice in the field of leisure and persons with disabilities. *Journal of Leisurability*, 27(4), 9-31.
- McLean, T., & Yoder, D.G. (2005). *Issues in Recreation and Leisure*, Champlain, IL: Human Kinetics.

- McTaggart, R. (1989). *16 Tenets of Participatory Action Research*. The Third World Encounter on Participatory Research,, Managua, Nicaragua, September 3 – 9<sup>th</sup>, 1989. Retrieved, September 23<sup>rd</sup>, 2008 from <http://www.caledonia.org.uk/par.htm>
- McTaggart, R. (1997). *Participatory action research: International contexts and consequences*. New York, NY: State University of New York Press.
- Merriam-Webster Dictionary (2009). *Autonomy*. New York, NY: Merriam-Webster Inc.
- Miller, B., & Bowers-Ivanski, N. (2009). Looking underneath the activity calendar. *Long Term Care*, 36-?.
- Miller, B. & Pedlar, A. (2006). Self-reflective practice in therapeutic recreation: Celebrating the authenticity and humanism of our practice. *TRO Research Annual*, 4, 34-43.
- Miller, W. L., & Crabtree, B. F. (2005). Clinical research. In N. Denzin & Y. Lincoln (3<sup>rd</sup> eds.). *Handbook of Qualitative Research*, Newbury Park, CA: Sage Publications.
- Nathanson-Elkind, S. (1994). The consultant's role in resolving impasses in therapeutic relationships, *American Journal of Psychoanalysis*, 54, 1, 3-16.
- National Therapeutic Recreation Society (2001). *NTRS Code of Ethics and Interpretive Guidelines*. Retrieved March 31, 2010 from [http://www.nrpa.org/uploadedFiles/Connect\\_and\\_Share/The\\_NRPA\\_Network\\_\(Socnet\\_Function\)/NTRS%20code%20of%20ethics.pdf](http://www.nrpa.org/uploadedFiles/Connect_and_Share/The_NRPA_Network_(Socnet_Function)/NTRS%20code%20of%20ethics.pdf).
- Negley, S. (2007). President's message. *ATRA Newsletter*, 23(2), 2-14.
- Nelson, Ochocka, Griffin & Lord (1998). "Nothing about me, without me": Participatory action research with self-help/mutual aid organization for psychiatric consumer/survivors. *American Journal of Community Psychology*, 26(6), 881-912.
- Newman, B.A., & Newman, P.R. (2009). *Development through life: A psychosocial approach*. Belmont, CA: Wadsworth Cengage Learning.



- Nolan, M.R., Davies, S., & Grant, G. (2001). *Working with Older People and their Families: Key Issues in Policy and Practice*. (ed.). Buckingham: Open University Press.
- Olson, J.K. (1995). Relationships between nurse-expressed empathy, patient-perceived empathy and patient distress. *Journal of Nursing Scholarship*, 27(4), 317-322.
- Orlando, I. J. (1961). *The dynamic nurse-patient relationship: Function, process and principles*. New York: Putnam.
- Parse, R. (1999). *Illuminations: The theory of human becoming in practice and research*. Toronto, ON: Jones and Bartlett Publishers Inc.
- Parse, R. (1995). The Human Becoming Theory: Challenges in Practice and Research. *Nursing Science Quarterly*, 55-60.
- Patton, M.Q., & Patton, M.Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.
- Pearson, R.E. (1990). *Counseling and Social Support: Perspectives and Practice*. Newbury Park, CA: Sage Publications.
- Pedlar, A., Hornibrook, T., & Haasen, B. (1998). Patient focused care: Theory and practice. *Therapeutic Recreation Journal*, 35: 15-30.
- Pedlar, A., Yuen, F., & Fortune, D. (2008). Incarcerated women and leisure: Making good girls out of bad? *Therapeutic Recreation Journal*, XLII(1), 24-36.
- Pelham, G. (2008). The relational approach. In S. Haugh & S. Paul (eds.). *The Therapeutic Relationship: Perspectives and Themes*, Ross-on-Wye, UK: PCCS Books.
- Peternelj-Taylor, C.A., & Yonge, O. (2003). Exploring boundaries in the nurse-client relationship: professional roles and responsibilities. *Perspectives in Psychiatric Care*, 39(2), 55-67.

- Peterson, S.J., & Bredow, T.S. (2008). *Middle Range Theories*. Philadelphia, PA: Lippincott Williams & Williams.
- Peterson, C.A., Lee, S., & Stumbo, N.J. (2008). *Therapeutic recreation program design: Principles and procedures*. Thousand Oaks, CA: Allyn and Bacon.
- Pherson, H. (1998). *Practice-based research*. Toronto, ON: Sunnybrook Health Sciences Centre.
- Rand, M. L. (2002). Boundaries in the therapeutic relationship. *Annals of the American Psychotherapy Association*, 5(5), 32.
- Reamer, F.G. (2001). *Tangled Relationship: Managing Boundary Issues in the Human Services*, Chichester, West Sussex: Columbia University Press.
- Reason, P. (1998). Political, epistemological, ecological and spiritual dimensions of participation. *Studies in Cultures, Organizations and Societies*, 4, 147-167.
- Reason, P., & Bradbury, H. (2008). *The SAGE Handbook of Action Research: Participatory Inquiry and Practice*. (2<sup>nd</sup> ed.). Thousand Oaks, CA: SAGE Publications Inc.
- Recreation Therapy. (2008). *Recreation Therapy Vision Statement*. Toronto, ON: Sunnybrook Health Sciences Centre
- Registered Nurses Association of Ontario (2002). *Establishing Therapeutic Relationships*. Toronto, ON: Registered Nurses Association of Ontario.
- Richardson, L. (1994). *Writing: A method of inquiry*. In N.K. Denzin & Y.S. Lincoln (eds.). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.
- Ricks, D.F. (1974). Supershrink: Methods of a therapist judged successful on the basis of *life history* research in psychopathology (pp. 288-308). Minneapolis: University of Minnesota Press.
- Risko, V. J., & Bromley, K. (2001). *Collaboration for Diverse Learners*. Newark: International Reading Association.
- Robertson, T., & Long, T. (2007). *Foundations of Therapeutic Recreation*. Champlain, IL: Human Kinetics

- Robinson, E.S. (1920). The compensatory function of make-believe play. *Psychology Review*, 27(Nov), 429-439.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95-103.
- Rosen, W.B. (1999). Moments of truth: Notes from a lesbian therapist. *Smith College Studies in Social Work*, 69(2), 293-308.
- Rossmann, G., & Rallis, S.E. (1998). *Learning in the Field: An Introduction to Qualitative Research*. Thousand Oaks, CA: Sage.
- Roth, S., & Baston, R. (1993). The creative balance: The therapeutic relationship and thematic issues in trauma resolution. *Journal of Traumatic Stress*, 6(2), 159-177.
- Rotteau, L. (2008). Documentation of recreation therapy and leisure opportunities in long term care. *Unpublished master's thesis*. University of Waterloo, Waterloo, ON. Retrieved November 30<sup>th</sup>, 2008 from <http://uwspace.uwaterloo.ca/bitstream/10012/2650/1/MA%20Thesis%5b1%5d.pdf>
- Rotteau, L., & Bowers-Ivanski, N. (2008). Enhancement of patient focused care through the incorporation of quality indicators in long term care. *TRO Research Annual*, 6.
- Samstag, L.W., Batchelder, S.T., Muran, J.C., Safran, J.D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behaviour. *Journal of Psychotherapy Practice and Research*, 7(2), 126-143).
- Sapora, A.V., & Mitchell, E.D., (1961). *The Theory of Play and Recreation*. New York, NY: Ronald Press.
- Santorelli (1999). *Heal Thyself: Lessons on Mindfulness in Medicine*. Toronto, ON: Random House of Canada.
- Sevenhuijsen, S. (1989). *Citizenship and the Ethics Of Care*. New York, NY: Routledge.
- Schon, D. (1983). *The Reflective Practitioner: How Professionals Think In Action*, London, UK: Temple Smith.

- Schon, D.A. (1987). *Educating the Reflective Practitioner*. San Francisco, CA: Jossey Bass.
- Shank, J. & Coyle, C. (1995). *Therapeutic Recreation in Health Promotion & Rehabilitation*. State College, PA: Venture Publishing Inc.
- Shank, Gary D. (2002). *Qualitative Research: A Personal Skills Approach*. Columbus, OH: Merrill Prentice Hall.
- Shiers, J., & Paul, S. (2008). Transpersonal dimensions of the therapeutic relationship. In S. Haugh & S. Paul (eds.). *The Therapeutic Relationship: Perspectives and Themes*, Ross-on-Wye, UK: PCCS Books.
- Shum, C., Humphreys, A., Wheeler, D., Cochrane, M., Skoda, S., & Clement, S. (2000). Nurse management of patients with minor illnesses in general practice: Multicentered, randomised controlled trial. *BMJ*, 320, 1038-1043.
- Shumaker, S.A., & Brownell, A. (1984). Toward a theory of social support: Closing conceptual gaps. *Journal of Social Issues*, 40(4), 11-36.
- Shuster, P.M. (2000). *Communication: The key to the therapeutic relationship*. Philadelphia, PA: F.A. Davis.
- Siegel, R.D., Germer, C.K., & Olendzki, A. (2009). Mindfulness: What is it? Where did it come from? In F. Didonna (eds) *Clinical Handbook of Mindfulness*. New York, NY: Springer.
- Solidarity. (2009). In *Merriam-Webster Online Dictionary*. Retrieved July 20, 2009, from <http://www.merriam-webster.com/dictionary/solidarity>
- Steedman, P. (1991). On the relations between seeing, interpreting and knowing. In F. Steier (ed.). *Research and Reflexivity*. London, UK: Sage.
- Steele, P.D., & Zurcher, L.A. (1973). Leisure sports as “ephemeral roles”: An exploratory study. *The Pacific Sociological Review* (16(3), 345-356.
- Strupp, H.H., Fox, R.E., & Lessler, K. (1969). *Patients view their psychotherapy*. Baltimore: John Hopkins Press.

- Stumbo, N.J. (2002). *Client Assessment in Therapeutic Recreation Services*. Venture Publishing Inc.
- Suzuki, S., Dixon, T., & Baker, R. (2006). *Zen Mind, Beginner's Mind*. Singapore: Shambhala Publications.
- Sweet, W. (2003). Philosophical theory and the universal declaration of human rights. Ottawa, ON: University of Ottawa Press.
- Tesch, R. (1990). *Qualitative Research: Analysis Types and Software Tools*. New York: Falmer.
- Tresolini, C.P., and the Pew-Fetzer Task Force. (1994). *Health Professions and Relationship-Centered Care*. San Francisco, CA: Pew Health Professions Commission.
- Videbeck, S.L. (2008). *Psychiatric-Mental Health Nursing*. (Eds.). Philadelphia, PA: Lippincott Williams & Williams.
- Wadsworth, Y. (1997) *Everyday Evaluations on the Run*, (2<sup>nd</sup> ed.). Melbourne, Australia: Allen & Unwin.
- Walford, J., & Walford, R. (2008). Transactional analysis: A diversity of relationships. In S. Haugh & S. Paul (eds.). *The Therapeutic Relationship: Perspectives and Themes*, Ross-on-Wye, UK: PCCS Books.
- Wardlaw, F.B., McGuire, F.A., & Overby, Z. (2000). Therapeutic recreation: Optimal health treatment for orthopaedic disability. *Orthopaedic Nursing*, 19(4)
- Watson, J., & Greenberg, L.S. (2000). Alliance ruptures and repairs in experiential therapy. *Journal of Clinical Psychology*, 56(2), 175-186.
- Watt-Watson, J., Garfinkel, P., Gallop, R., Stevens, B., & Streiner, D. (2000). The impact of nurses' empathic responses on patients' pain management in acute care. *Nursing Research*, 49(4), 191-200.
- Welch, I.D. (1998). *The path of psychotherapy: Matters of the heart*. Pacific Grove, CA: Brooks/Cole.

- Wexler, J. (2006). The relationship between therapist mindfulness and the therapeutic alliance. *Unpublished Doctor of Philosophy thesis*, Massachusetts School Of Professional Psychology, West Roxbury, Massachusetts, USA.
- White, J.A. (2000). *Democracy, Justice and the Welfare State*. New York, NY: The Pennsylvania State University Press.
- Wiersma, E.C (2003). Making meaning: Place and the experiences of individuals living with dementia. *Unpublished master's thesis*. University of Waterloo, Waterloo, ON, Canada.
- Wiersma, E.C. (2008). The experiences of place: Veterans with dementia making meaning of their environments. *Health & Place*, 14(4), 1-16.
- Wilmsen, C., Elmendorf, W., & Fisher, L. (2008). *Partnerships for empowerment: Participatory research for community-based natural resource management*. Sterling, VA: Earthscan.
- Wilson, J. (1996). Reflective practice: A guide. *Accident and Emergency Nursing*, 4, 135-138.
- Wittine, B. (1993). Assumptions of transpersonal psychology. In R. Walsh & F. Vaughan (Eds.), *Paths beyond ego: The transpersonal vision* (pp.165—171). Los Angeles: Tarcher/Perigee.
- Woods, S.L. (2009). Training professionals in mindfulness: The heart of teaching. In F. Didonna (eds) *Clinical Handbook of Mindfulness*. New York, NY: Springer.
- Worster, A., Sardo, A., Thrasher, C., Fernandes, C., & Chemeris, E. (2005). Understanding the role of nurse practitioners in Canada. *CJRM*, 10(2), 89-94.
- Videbeck, S.L. (2008). *Psychiatric Mental Health Nursing*. Philadelphia, PA: Lippincott Williams & Wilkins.
- Voelkl, J.E. (2008). "I love pumpkins": The role of therapeutic recreation in oncology. *Therapeutic Recreation Journal*, XLII, 228-235.
- Yalom, I.D., & Leszcz, M. (2005). *The Theory and Practice of Group Psychotherapy*. New York, NY: Basic Books.

## Appendix A: Letter of Introduction

**Title of Study: *Participatory Action Research Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Science Centre***

July 2009

Hello!

**At last year's Recreation Therapy Annual retreat we collectively identified the need for further research focused on the therapeutic relationship involving all RT practitioners at Sunnybrook Health Sciences Centre.** In keeping with *practice-based research* and *reflective practice* together we will generate insight into our understanding of the therapeutic relationship, and the impact of our understanding on care provision. A *Participatory action research methodology* and *focus group method* will be used in this study. When using focus groups, the discussions are used as the 'raw data' for the study. Our discussions will focus on the therapeutic relationships you have developed with the individuals receiving care at Sunnybrook. From this process, new questions will emerge and we will be able to collectively discuss those questions as they arise. Some additional details about the research process are described below.

### ***Who is conducting the study?***

As you know the study is being conducted through our ongoing partnership between the Recreation Therapy team, Sunnybrook Health Sciences Centre and the Department of Recreation and Leisure Studies, University of Waterloo. Consistent within participatory action research, you and the other members of the Recreation Therapy department at Sunnybrook identified the need for the study. This focus group process represents the next step toward exploring the therapeutic relationship and involves members of the Recreation Therapy team in all phases of data collection and analysis. Leanne Hughes (Sunnybrook) and Jessica Lansfield (Waterloo) are identified as Co-Investigators on the ethics application for the study to oversee the details pertaining to ethics and publications but we invite other members of the team to become involved in providing feedback on summaries, writing journal articles and doing conference presentations. In addition, research assistance will be provided by Dr. Susan Arai, Associate Professor at the University of Waterloo in the Department of Recreation and Leisure Studies and Research Advisor to the Recreation Therapy team at Sunnybrook.

### ***What will my participation involve?***

If you choose to participate in the study you will be asked to:

- **Sign up for a Focus Group.** Before the focus groups occur you will be asked to sign up for one of the focus groups time slots and to attend and participate in that focus group.
- **Sharing in Dialogue within the Focus Group.** During the focus groups, a moderator will welcome the participants, establish the focus and ground rules. Each RT will be asked to share their perspectives and to foster open discussion in a safe environment.
- **Reflecting on your own perceptions openly.** You will be asked to share your understanding of your therapeutic relationships and to reflect on how your understanding influences your care provision. You will also be asked to reflect on the groups responses. This discussion will be audio recorded and the group will use flipchart paper to capture the ideas that arose.
- **Respectfully listening to the perceptions of others.** When it is another person's opportunity to speak, all research participants are encouraged to listen respectfully and to reflect on each other's responses in an open and constructive manner.
- **Large group sharing.** When the focus groups and small research committee data analysis meetings have been completed the entire research group will reassemble at the Annual Retreat so that all the recreation therapists are present. The themes from the focus group discussion will be reported at this time. At this point you will be asked to reflect on the overarching themes and the implications of the findings for practice?

You may ask Jessica or Leanne questions about the research at any point during this process. Sue and Nancy are also available to contact if you have any concerns regarding the study. Your participation in this study is voluntary and you may withdraw from the study at any time and for any reason without penalty. You may choose not to participate in the focus groups and you can still remain in the study. You may also choose not to participate in any aspect of the research discussion and/or dissemination that unfolds. If you choose not to participate in this process you may choose to leave the room during the focus group or research discussion sessions that occur at Sunnybrook or that are scheduled during the Annual Retreat. Please make your wishes clear to Jessica and Leanne on the informed consent form. As we discussed as a group during the meeting on April 22<sup>nd</sup>, 2009 we wish to respect everyone's chosen level of participation or non-participation. During this discussion we came to consensus on the idea that someone's decision to participate or not participate in this study should not have an impact on their involvement in the Recreation Therapy team at Sunnybrook. Should you have any concerns about this issue please feel free to discuss this with Jessica in private so that we may resolve your concerns and make this a safe process for everyone involved. This research is being conducted in keeping with the spirit of exploration and reflective practice that the recreation therapists at Sunnybrook have been engaged in over the last many years. We respect everyone's choices around their participation. There are no known risks to participating in this study.

***Will my information be kept confidential?***

All information you provide will be completely confidential. This means that we will not release or print your name in connection to the study or the focus groups and reflective discussion data you provide. Your name will not appear in any report or publication resulting from this study. In addition, all original research materials will be securely locked in the office of Jessica Lansfield at the University of Waterloo for one year. Jessica has signed a confidentiality statement to ensure the security of the information you provide. During our meeting on April 22<sup>nd</sup>, 2009 we collectively discussed how focus groups will be conducted and the process for managing the data that emerges from focus group discussions. During this process we clearly outlined how the two types of data will be managed and who will have access to the data during that process. As a result it was decided that \_\_\_\_\_. Your name is not going to be connected to any records or reports. Sometimes it is useful to use your words in the report. If we do this, we will not use your real name. Any records that link your words to your actual name will be destroyed (shredded) at the end of the study. All audio recordings will be erased at the end of the study. In addition, no one at Sunnybrook will have access to the digital audiotape files emerging from the focus group discussions at Sunnybrook.

***How will we protect the anonymity and confidentiality of our residents?***

To protect the confidentiality of the people described in your focus groups we ask that you do not identify individuals or other practitioners by name when you discuss your therapeutic relationships. If names are used in your focus groups, the names will be removed and pseudonyms will be inserted into the transcripts of the focus group discussions. While it is important to provide descriptive information in your focus groups to provide a sense of the individuals with whom you have developed therapeutic relationships, try to avoid including specific information that is not necessary (e.g., names of home towns, specific titles and occupations such as CEO of IBM in the 1980s) that may make it possible to identify the people in your focus group discussion. Please be mindful about your comfort level with what you are sharing.



This study, *Participatory Action Research Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Science Centre*, has been reviewed by, and received ethics clearance through, the Office of Research Ethics at the University of Waterloo (file # 15628). If you have any questions about this study, please feel free to contact Jessica Lansfield at 519-888-4567 ext. 33758 or by email at [jlansfie@uwaterloo.ca](mailto:jlansfie@uwaterloo.ca) or Leanne Hughes at 416-480-5490 or via email at [leanne.hughes@sunnybrook.ca](mailto:leanne.hughes@sunnybrook.ca) or Dr. Susan Arai in the Department of Recreation and Leisure Studies at the University of Waterloo at 519-888-4567 ext. 33758 or by email at [sarai@uwaterloo.ca](mailto:sarai@uwaterloo.ca). Concerns may also be directed to Nancy Bowers-Ivanski , the Manager of Recreation Therapy at Sunnybrook, at 416-480-4136 or via email at [nancy.bowers-ivanski@sunnybrook.ca](mailto:nancy.bowers-ivanski@sunnybrook.ca) . Concerns about your involvement in the study may also be forwarded to Dr. Susan Sykes, Director of the Office of Research Ethics at the University of Waterloo at 519-888-4567 ext. 36005. This study has also received ethics clearance through Sunnybrook Health Sciences Centre (file #15628) and any concerns may also be directed to Katherine Perry, Coordinator of Research Ethics at 416-480-6100 ext 4276.

**We look forward to working with you!**

Jessica Lansfield, MA Candidate, Department of Recreation and Leisure Studies
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Leanne Hughes Recreation Therapist Sunnybrook Health Sciences Centre
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Susan Arai Associate Professor Department of Recreation and Leisure Studies
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## Appendix B: Informed Consent Form

**Title of Study:** *Participatory Action Research Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Science Centre*

**Co-Investigators:** Jessica Lansfield, MA Candidate, Department of Recreation and Leisure Studies & Leanne Hughes, Recreation Therapist, Sunnybrook Health Sciences Centre

### Consent of Participant

I have read the information presented in the information letter about this research study emerging from the ongoing partnership between the recreation therapists at Sunnybrook Health Sciences Centre and the Department of Recreation and Leisure Studies, University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted. I am aware that I may withdraw from the study without penalty at any time by advising Jessica Lansfield of this decision.

This study has been reviewed by, and received ethics clearance through, the Office of Research Ethics at the University of Waterloo. If I have any questions about this study, I know I may contact Jessica Lansfield via email at [jlansfie@uwaterloo.ca](mailto:jlansfie@uwaterloo.ca) or Leanne Hughes at 416-480-5490 or via email at [leanne.hughes@sunnybrook.ca](mailto:leanne.hughes@sunnybrook.ca) or Dr. Susan Arai in the Department of Recreation and Leisure Studies at the University of Waterloo at 519-888-4567 ext. 33758 or by email at [sarai@uwaterloo.ca](mailto:sarai@uwaterloo.ca). I may also contact Nancy Bowers-Ivanski, the Manager of Recreation Therapy at Sunnybrook by phone at 416-480-4136 or via email at [nancy.bowers-ivanski@sunnybrook.ca](mailto:nancy.bowers-ivanski@sunnybrook.ca). I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact Dr. Susan Sykes, Director of the Office of Research Ethics at the University of Waterloo at 519-888-4567 ext. 36005. In addition, this study has also received ethics clearance through Sunnybrook Health Sciences Centre (file #15628) and any concerns may also be directed to Katherine Perry, Coordinator of Research Ethics at 416-480-6100 ext 4276. I also understand that this study received ethics approval (file #15628) at the University of Waterloo

**With the information provided to me about the study, I agree, of my own free will, to participate in this study. (Please check all that apply.)**

- I would like to participate in the focus group discussion  
 I would like to participate in the collective discussion of the focus group themes at the Annual Retreat.

**Name of Recreation Therapist:** (please print)

**Signature of Recreation Therapist:** \_\_\_\_\_

Date: \_\_\_\_\_

**In reports and presentations emerging from this study, please use the following pseudonym in place**

**of my real name:** \_\_\_\_\_.

**Please indicate if you would like to receive information coming out of the study.**

- I would like to receive a copy of the summary.  
 I do not wish to receive a copy of the summary.

**Thank you for your participation in this study! Please take one copy of this form with you for further reference.**

**To be completed by researcher:** I have fully explained the procedures of this study to the participant.

Researchers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix C: Guidelines for Focus Group Moderators

### *Participatory Action Research Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Science Centre*

In your small focus group, please work through the following steps.

Step 1. Welcome the participants, provide beverages, and place to sit in a semicircle facing the flipchart.

Step 2. Introduce the purpose of the focus group, review the roles of the participants and your role as moderator and establish the ground rules. We have allotted 10 minutes for this task but if it takes less time then please proceed to Step 3. Below is the script for the Introduction, Overview and Ground Rules (modified from Krueger & Casey, 2008, p. 97).

#### Welcome

Good afternoon and welcome. Thanks for taking the time to join our discussion of therapeutic relationship. My name is \_\_\_\_\_ and I will be moderating the discussion today on behalf of the entire research team. Assisting me today by take notes will be [*insert name of Research committee member*] and Jessica Lansfield.

#### Overview

As discussed at the last Annual Retreat, the purpose of this focus group is to help us get understand how you as recreation therapists understand your therapeutic relationships with individuals receiving care at Sunnybrook Health Sciences Centre and how your understanding influences care provision. This information will help us to understand how therapeutic relationships are understood and help to influence care provision here at Sunnybrook.

#### Ground Rules

There are no right or wrong answers. We expect that you will have differing points of view. Please feel free to share your point of view even if it differs from what others have said. We are recording the session because we don't want to miss any of your comments. No names will be included in any reports, pseudonyms will be given instead. Your comments are confidential. Feel free to have a conversation with one another about these questions. If you want to follow up on something that someone has said, if you want to agree, or disagree, or give an example, feel free to do that. My task is to pose the questions, listen and make sure everyone has a chance to share. If you have not been saying much I may call on you. We just want to make sure all of you have a chance to share your ideas. If you have a cell phone or pager please put in on the quiet mode, and if you need to answer step out to do so. Feel free to get up and get more refreshments if you would like.

This is everyone's research study, this is your opportunity to share your thoughts and opinions while respecting others. Please do not share information that you are uncomfortable disclosing.

Step 3. Now that you have introduced the purpose of the focus group, the discussion can begin. We have allotted 60 minutes for this focus group (plus additional time if you did not use the full 10 minutes for Step 2).

The following questions and probes will help to guide your discussion. Please ask these questions in the order that they appear.

1. Where have you practiced Recreation Therapy and what do you enjoy doing outside of working at Sunnybrook? Thinking back to the memory work study what stood out to you regarding your therapeutic relationships?

2. What does the term therapeutic relationship mean to you?

#### Probes

- What values are highlighted?

- What roles are highlighted?
  - What practices are highlighted?
3. Thinking about other disciplines, how are our therapeutic relationships unique?
- Probes
- How does power differ in our therapeutic relationships?
  - How do our boundaries/friendships differ?
  - Has anyone had a different experience?
4. How does your understanding of the therapeutic relationship influence your care provision?
- Probes
- How does it influence how therapeutic relationships are developed?
  - How does it influence how therapeutic relationships are maintained?
  - How does it influence how therapeutic relationships are terminated?
  - How does your understanding of the therapeutic relationship affect the individuals receiving care at Sunnybrook choices?
  - That is an interesting point, what does everyone else think about that comment?
5. What philosophies or models underlie your understandings of the therapeutic relationships that we have discussed? (biomedical, person-centered care or relationship-centered care)
- Probes
- Could you describe what you mean in more detail?
  - How does the biomedical model influence your understanding?
  - How does the person-centered care model influence your understanding?
  - How does the relationship-centered care model influence your understanding?
  - Are there other points of view?
6. How does the language you use to describe your therapeutic relationship influence your Recreation Therapy practice?
- Probes
- How does your language convey information about the role of the individual receiving care at SHSC?
  - How does our language connection with our values?
  - Does anyone see it differently?
7. What are the similarities in the thoughts expressed today that are appearing within today's discussion?
- Probes
- What are the main themes?
  - What philosophies regarding practices have been discussed?
  - What is the role of the individual receiving care at SHSC with our therapeutic relationships?
  - What values are embedded in our therapeutic relationships based on today's discussion?
8. What sorts of differences that are appearing in today's discussion?
- Probes
- Could you expand on that?
  - Would you provide an example?

9. How should these differences be resolved to ensure that our understanding of the therapeutic relationship is inclusive of all areas of Recreation Therapy at Sunnybrook?

Probes

- Could you expand on that?
- Would you provide an example?

10. During the next 10 minutes please work independently and write down your responses to the following questions on the sheets of paper provided. As you finish please hand in your responses to Jessica Lansfield and feel free to grab additional refreshments or carry on with your day. Thank you for participating in today's discussion.

A) What were the key essences of the therapeutic relationship that arose in today's discussion.

B) Reflecting on your discussion what essences of your therapeutic relationships are unique to Recreation Therapy?

C) What are the key difference in understanding about therapeutic relationships that arose in today's discussion?

**Reference:** Krueger, R.A., & Casey, M.A. (2008). *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks, CA: SAGE Publications

## Appendix D: Letter of Appreciation

**Title of Study:** *Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Sciences Centre*

April 28<sup>th</sup>, 2010

Dear Co-Researchers and Friends,

Thank you for your participation in the research study, “*Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Science Centre*”. Your participation has been essential to deepening our collective understanding of the therapeutic relationship at Sunnybrook Health Sciences Centre.

This knowledge will enable us to develop the next phase of research from a foundation of understanding about therapeutic relationships that emerged from this Recreation Therapy team. Within the next month we will send you a summary of the learning from today’s discussion and we hope to engage the team in further dialogue around these insights. In addition, we will be able to build the next phase of the research from the questions and areas of inquiry that emerged from today’s discussion.

Please remember that any data pertaining to you as an individual participant will be kept confidential. If you have any questions about this study, please feel free to contact Jessica Lansfield at 519-888-4567 ext. 33758 or by email at [jlansfie@uwaterloo.ca](mailto:jlansfie@uwaterloo.ca) or Leanne Hughes at 416-480-5490 or via email at [leanne.hughes@sunnybrook.ca](mailto:leanne.hughes@sunnybrook.ca) or Dr. Susan Arai in the Department of Recreation and Leisure Studies at the University of Waterloo at 519-888-4567 ext. 33758 or by email at [sarai@uwaterloo.ca](mailto:sarai@uwaterloo.ca). Concerns may also be addressed to Nancy Bowers-Ivanski, the Manager of Recreation Therapy at Sunnybrook by phone at 416-480-4136 or via email at [nancy.bowers-ivanski@sunnybrook.ca](mailto:nancy.bowers-ivanski@sunnybrook.ca). Concerns about your involvement in the study may also be forwarded to the Director of the Office of Research Ethics at the University of Waterloo at 519-888-4567, extension 36005. This study, *Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Sciences Centre*, has been reviewed by, and received ethics clearance through, the Office of Research Ethics (file #15628). In addition, this study has also received ethics clearance through Sunnybrook Health Sciences Centre (file #15628) and any concerns may also be directed to Katherine Perry, Coordinator of Research Ethics at 416-480-6100 ext 4276.

**Thank you again for your participation!**

Jessica Lansfield MA Candidate, Department of Recreation and Leisure Studies
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Leanne Hughes Recreation Therapist, Sunnybrook Health Sciences Centre
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Susan Arai Associate Professor Department of Recreation and Leisure Studies	
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## Appendix E: Statement of Confidentiality- Research Committee Members

**Title of Study:** *Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Science Centre*

**Co-Investigators:** Jessica Lansfield, MA Candidate, Department of Recreation and Leisure Studies & Leanne Hughes, Recreation Therapist, Sunnybrook Health Sciences Centre

**Advisors:** Susan Arai, Department of Recreation and Leisure Studies at the University of Waterloo & Nancy Bowers-Ivanski, Manger of Recreation Therapy, Sunnybrook Health Sciences Centre

**Research Committee:** Mary Anderson, Jennifer Ashby, Lesley Breen, Leanne Hughes, Fran Long, Nora Mark, Yvonne Noble, & Nicole Pittman.

*Please read the following:*

*An important part of conducting research is having respect for privacy and confidentiality: Respect for human dignity also implies the principles of respect for privacy and confidentiality. In many cultures, privacy and confidentiality are considered fundamental to human dignity. Thus, standards of privacy and confidentiality protect the access, control and dissemination of personal information. In doing so, such standards help to protect mental or psychological integrity. They are thus consonant with values underlying privacy, confidentiality and anonymity respected. [From the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans, August 1998].*

*Out of respect for human dignity and people's right to privacy we ensure our research participants both anonymity and confidentiality to the greatest extent possible.* Researchers protect privacy by not disclosing a participant's identity after information is gathered (Neuman, 1991). A respondent may be considered *anonymous* when the researcher cannot identify a given response with a given respondent (Babbie, 1992, p. 467). While the identity of the participant will be removed from audio files and transcripts and replaced with a pseudonym, other references that identify other people and organisations have not been removed. In signing below you are agreeing to respect the participant's right to privacy and that of the people and organisations that are referred to during the memory work process.

*In a confidential interview or study, the researcher is able to identify a given person's responses but essentially promises not to do so publicly* (i.e., in reporting the results of the study) (Babbie, 1992). As a research committee member you are asked to respect people's right to confidentiality by not discussing the contents of the focus groups and the research team's discussions in public, with friends or family members. The study and its participants are to be discussed only during research meetings with the Co-Investigators and the participants.

*In signing below you are indicating that you understand the following:*

- I understand the importance of providing anonymity and confidentiality to research participants to the greatest extent possible.
- I understand that the content of the focus groups, meetings and transcripts from the small group discussions may contain references to other individuals or organisations in the community. I understand that this information is to be kept confidential.
- I understand that the contents of the focus groups, meetings and transcripts are not to be discussed outside of research meetings with the Co-Investigators and the Recreation Therapy team.

**In signing my name below, I agree to the above statements and promise to ensure the participants in this study anonymity and confidentiality.**

Signature of the Research Committee Member: \_\_\_\_\_

Date: \_\_\_\_\_

**I have fully explained the issues of anonymity and confidentiality to the above Research Committee Member**

Co-Investigator Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Appendix F: Participant Confidentiality Statement

Engaging in self-reflective practice and focus groups requires that we all feel safe in the process of sharing our perspectives and reflecting on our therapeutic relationships and care practices through discussion. Please keep in mind the comfort level you have when engaging in the focus groups and do not share information that you are uncomfortable disclosing.

This form is intended to further the confidentiality of data obtained during the course of the study entitled “*Exploring Therapeutic Relationships in Recreation Therapy at Sunnybrook Health Science Centre.*”

All of the recreation therapists and the Co-Investigators will be asked to read the following statement and sign their names indicating that they agree to comply.

***I hereby affirm that I will not communicate, or in any manner disclose publicly, information discussed during the course of this focus group session and the group discussion that follows. I agree not to talk about material relating to this study with anyone other than recreation therapists at Sunnybrook and the co-researcher from the University of Waterloo (Jessica) who are facilitating this session.***

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix G: Letter of Support

May 5, 2009

Dear Sir or Madam,

My name is Nancy Bowers-Ivanski and I am the Professional Leader and Manager of Recreation Therapy and Creative Arts at Sunnybrook Health Sciences Centre in Toronto, Ontario. The Recreation Therapy Professional group at Sunnybrook has been most fortunate over the last decade to partner with the Recreation and Leisure Studies program at the University of Waterloo in several practice-based research initiatives. These projects have provided opportunity for our staff and your students to engage in reflective practice and work together to advance the practice of Recreation Therapy, thus benefiting the patients and residents we serve. The outcome of the projects that have been completed to date, have resulted in innovative leading-edge practices in Recreation Therapy.

We are excited to embarking on another study with Jessica Lansfield, a graduate student in the department of Recreation and Leisure Studies at Waterloo. The study will further explore therapeutic relationships in Recreation Therapy. The idea of this study originated from the Recreation Therapists themselves, who believe that there is uniqueness in the relationships that they have with the patients and residents here. The goal is to extend our understanding of those relationships, which we believe will be accomplished through this ground-breaking research.

The study that is being put before you for consideration is wholeheartedly supported by the Recreation Therapy Professional group at Sunnybrook. We look forward to your response and are confident that you will recognize the merit of the study and provide your approval.

Sincerely,

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Nancy Bowers-Ivanski  
Professional Leader/Manager  
Recreation Therapy and Creative Arts  
Sunnybrook Health Sciences Centre  
2075 Bayview Avenue,  
Toronto, Ontario. (416)-480-4136

## Appendix H: List of Reflective Questions

### Group 1 – General Understandings and Qualities of Therapeutic Relationships

- How do I start the foundation (actions, communication) of a relationship?
- How I better relate to this resident?
- How do I know that this is a strong therapeutic relationship?
  - o How do I know/recognize that the individual's needs are being met?
  - o Whose needs are being met in therapeutic relationships?
    - How are these needs being met?
- Why are stronger relationships occur with one resident over another
- Who is the relationship benefitting? And how?
  - o How do I ensure everyone's needs are being met in a group setting?
- How do I recognize who is receiving beneficial outcomes?
  - o RT/resident; resident/resident?
- How do I deal with compassion fatigue?
- How do I deal with counter-transference?
  - o Recognizing values – our values may be different than those of the individual?
  - o How are you able to absorb/deflect issues?
    - How do I cope with challenges in my therapeutic relationship?
    - What do I find challenging in my therapeutic relationships?
  - o How are my values impacting my interactions with individuals receiving care?
- What are the priorities for the individual within this therapeutic relationship?

### Group 2 –Perceptions of Uniqueness

- How do I facilitate or encourage the individual's choice in my practice?
- How do individuals feel like they are in control with their leisure lifestyle?
- What can I do to ensure individuals have an opportunity to exercise control?
- How do I make my practice, approach, demeanor non-threatening?
- Why is using a holistic approach vital to my practice?
  - o How does having a holistic approach impact the individual?
  - o Holistic – looking at many components rather than one issue; we are looking at multidimensional rather than a specific area
  - o How does focusing my approach on the whole person impact the therapeutic relationship?
- What do I need to do to ensure individuals have positive outcomes in programs/in general?
- How do you want my therapeutic relationships to be different and why?
- How can I make my relationship different than other therapies? (or allies)
- Why do we consider family members to be key players?
- How do we involve the families?
- How can be present in the individual's moment?
- What can I do to heighten individuals, family and staff awareness of other benefits in Recreation Therapy involvement?
- How do I feel when our practice is not understood/ recognized as meaningful or unique?

### Group 3 – The Process of Development and Maintaining Therapeutic Relationships

- Being present
  - o How do I make myself available to the individual?
  - o How do I focus in the moment with the individual?
  - o What are the steps I take to be connected with the individual?
- Safe and positive experiences?

- How do I make myself available to the resident?
- How do I involve the individual in making a decision with leisure plan?
- How do I provide a positive experience to the individual?
- Changing needs and choices
  - How does this program maintain the needs of the individual?
  - How do we continue maintaining the needs of the individual?
  - What tools/evaluation methods we are using to ensure the needs of the individual?
  - How do I know that the program is meeting the changing needs of the individual?
  - How do I ensure that the program is still meaningful to the individual?
- Retaining professionalism and boundaries
  - How do I maintain a professional boundary?
- Nurturing a positive environment
  - How do I provide an automatic positive approach?

#### **Group 4 – Terminating Therapeutic Relationships**

- External forces:
  - What are some of the external forces that lead to termination?
  - How do I feel when this occurs?
  - What are strategies do I use to address these external forces?
- Crossing boundaries:
  - How do you know when it's time to terminate?
  - What supports do you have in your decision?
  - How do you ensure that you terminate in a professional way?
    - Naturally occurring
      - How do you deal with the loss of a therapeutic relationship as a result of a death?
    - Choosing to terminate:
      - How does this impact us personally and professionally?
    - Choosing to alter
      - What strategies can we employ to maintain the therapeutic relationship
      - How will it evolve? What will this look like?

#### **Group 5 – Balancing Power, Expectations and Boundaries within Therapeutic Relationships**

- How do I leave work at work?
- What strategies do I use to protect my home life?
- How do I meet a resident's expectations when it conflicts with the institution's rules and/or regulations?
  - When it conflicts with the family's expectations?
  - How do I negotiate and resolve different expectations (individual/family) in my therapeutic relationships
- What are my personal/ professional boundaries? What do I do when they are crossed?
- How do I communicate when there are conflicts? With whom?
  - How do I obtain and/or provide support when dealing with challenges in my practice?
- How do I assert my power without compromising the individual's self-respect?

## Appendix I: Original Themes

1. Understandings of the Therapeutic Relationship
  - 1.1 Meaningful Connections of Trust Takes Time and Mutual Sharing
  - 1.2 Individual Need as the Purpose for the Therapeutic Relationship
  - 1.3 Reciprocity in the Therapeutic Relationship
  - 1.4 Qualities Forming the Basis of the Therapeutic Relationship
    - 1.4.1 Emphasizing Care, Trust and Respect for Everyone Involved
    - 1.4.2 Listening Without Judgment
    - 1.4.3 Helping to Meet the Individual's Needs
  - 1.5 Recreation Therapists Perceptions of their Therapeutic Relationships' Uniqueness
    - 1.5.1 Nonthreatening Focus on the Whole Person and Enjoyment
    - 1.5.2 Providing Opportunities for Choice and Control
    - 1.5.3 Getting to Know the Person Through Leisure Experiences
    - 1.5.4 Enjoyment of the Activity Camouflaging Therapeutic Outcomes
    - 1.5.5 Involving Families in Social Relationship Building Activities
  - 1.6 Waves of Influences on the Therapeutic Relationship
  
2. Exploring the Therapeutic Relationship Process
  - 2.1 How are Therapeutic Relationships Developed?
    - 2.1.1 Ensuring a Welcoming Introduction
    - 2.1.2 Getting to Know One Another
    - 2.1.3 Following the Person's Lead
  - 2.2 How are Therapeutic Relationships Maintained?
    - 2.2.1 Consistency and Being There For the Individual
    - 2.2.2 Ongoing Communication Creates Safe and Enjoyable Leisure Experiences
    - 2.2.3 Paying Attention and Adapting to Changing Needs/Choices
    - 2.2.4 Authentic Efforts to Nurture Positive Qualities of the Therapeutic Relationship
  - 2.3 How are Therapeutic Relationships Terminated?
    - 2.3.1 The Person Advocates His/Her Own Wishes to Terminate
    - 2.3.2 Termination Occur Naturally as part of the Therapeutic Relationship Process
    - 2.3.3 External Forces Ending the Therapeutic Relationship
    - 2.3.4 Crossed Boundaries and the Decision to Terminate
    - 2.3.5 Changing Rather than Terminating the Therapeutic Relationship
  
3. Roles within Recreation Therapists' Therapeutic Relationships
  - 3.1 Roles of the Recreation Therapists
    - 3.1.1 Leaders
    - 3.1.2 Validating an Individual's Reality
    - 3.1.3 Advocate
    - 3.1.4 Counselor
    - 3.1.5 Educator
    - 3.1.6 Providing a Sense of the Normal or Non-Institutional
    - 3.1.7 Facilitator
    - 3.1.8 Friend
  - 3.2 The Roles of the Individual
    - 3.2.1 Whole Person Continuing Past Roles
    - 3.2.2 Volunteer
    - 3.2.3 Active Participant
    - 3.2.4 Advocate
    - 3.2.5 Friend

4. Influence of the Therapeutic Relationship on Individuals Receiving Care at SHSC
  - 4.1 Supporting a New Beginning
  - 4.2 Shifting Focus to the Positive and the Living
  - 4.3 Building a Sense of Belonging and Community
  
5. Negotiating Expectations, Power and Boundaries in the Therapeutic Relationship
  - 5.1 Shifting Power Dynamics and Boundaries
  - 5.2 Involuntarily Enforcing Institutional Power
  - 5.3 Managing Expectations of the Family