

# Grounding the Therapeutic Recreation Process in an Ethic of Care

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In the second volume of *Philosophy of Therapeutic Recreation: Ideas and Issues*, I addressed an article to students, educators, and practitioners on the importance of having a philosophy and how to “grow” that philosophy over time (O'Keefe, 1996). Having received many positive responses to the content and personal style of the article, I wish to continue in a similar vein here with an essay on the therapeutic process of assessment, planning, intervention, and evaluation. First, however, I'd like to reflect on a tension that has emerged in health care.

Over the past ten years I have been searching for a philosophy that might alleviate my distress with the depersonalizing aspects of the medical model. My interest in ethics led me to explore other writers who are also struggling to reconcile the objectified, impersonal approach to treatment with the ethical imperative to understand the personal experience of illness. One philosophy I excitedly discovered was what has become called an *ethic of care*. In particular, it challenges us to approach the therapeutic process within a broader context that always sees the client as a growing person rather than as a diagnostic label hung on a disease. Furthermore, it treats the interaction between client and helper as primarily relational rather than strictly clinical. Using personal narrative, I intend to share with readers the advantages of this approach. I want to show that an ethic of care is an appropriate starting point for therapeutic recreation in its search for good and true practice that places social responsibility above professional status and financial reward. In particular, it creates an invitation, if not the imperative, to describe the therapeutic process in a way that balances a

medical approach to care with a holistic one founded on an ethic of care. Accordingly, using a relational ethic of care as my guide, I will present a case for shifting the way professionals apply the therapeutic recreation process of assessment, planning, implementation, and evaluation.

## Background

Medical science exploded in the twentieth century, producing unprecedented advances in knowledge and technology. Aided by science, medicine has been progressively able to predict and control disease. As medicine has become more and more scientific, the individual seeking help has been increasingly objectified as one of a number of variables in the disease process that needs to be controlled. Unique and unpredictable, human beings, however, are not well suited by their subjective nature to the scientific principles of predictability, standardization, and objectification. Being more amenable to scientific method, disease was successfully objectified and controlled, leading to more predictable results and effective treatments. In the process, the subjective individual with the disease receded from the focus. Medical treatment became more successful, but caring for persons with diseases suffered since the individual could be viewed as incidental to the disease without sacrificing clinical efficacy.

No doubt, great gains have been made in medicine by using the scientific method. However, those who receive treatment and those who give it have paid a price. It is instructive to note that not only do professionals claim to “treat” people, they also assert that they “care” for them, as well.

As such, before professionals implement treatment, the science of health care, they would be well advised to explore the nature of caring. Patients complain about being treated like objects, shuffled in and out of doctors' offices and hospitals, examined with a microscopic focus on clinical diagnosis that often overlooks individual needs, and given little time for building satisfying relationships with caregivers.

Moreover, the ultimate estrangement from an ethic of care is evident when 44 million Americans have no health insurance, a sad reflection on a government that regards health care as a privilege rather than a right. How did health care in America get so far away from the core social value of caring? And how did it abdicate to insurance companies the moral responsibility for the way care is delivered? Unfortunately, I suspect many professionals have not taken the opportunity to think about these questions and the ethical implications of caring. It is time we do.

The fallout from this disparity reaches to those who work in health care as well. Shortages in high-tech areas of nursing and burnout on the part of clinical staff in general point to a less than satisfying work environment for many. Cultural critiques label dubious trends with terms like "Doc in a Box" to describe the medical version of fast food. Bookstores stock shelves with guides for consumers on health care issues of all kinds with an emphasis on taking greater personal control of one's health care. The trust that many patients have wanted to place in their health care providers has been undermined by experiences of impersonal care in the wake of higher profit margins and tighter financial and time constraints. Caring, then, has lost touch with its foundational principles. Patients tell us that while they expect competence, they also want compassion and respect for their individuality in their care (Gerteis et al., 1993). To do so, we must move from an objectified to a relational concept of care.

Nursing has mounted an admirable effort to balance the medical model by advocating for the care of the whole person.

This is not a new idea, but a recovery of its historical commitment to person-centered care that formed the core mission of the field (Bishop & Scudder, 2001; Eriksson, 1994; Leininger, 1980; Pellegrino, 1985). Eriksson (1994) writes that caring science, as it is called, is based on the "caritas motive." The Latin word *carus* and the English word *cherish* are kin to *caritas*, which means human love and charity (Nygren, 1972). Caring, according to Eriksson, is integrally linked to being. This ontological reality creates a paradox that is critical to understanding an ethic of caring. Each person's distinctiveness calls for recognition of *the other* (Buber, 1958), an honoring of the sacredness of that person's story. Yet caring also requires that we recognize *ourselves* in the other, seeing "the other's reality as a possibility for my own" (Noddings, 1984, p.14). The ability to see ourselves in the joys and sufferings of others creates the bond that we call the human family.

Public policy is often an extension of moral values, so it is surprising that what Americans want for their own families hasn't translated into what we want for all our citizens. But just as family members do not always act for the good of the group, Green (1990) observes that "caring must be deliberately achieved, as freedom must be achieved... It is going to take political action now and then within and outside our institutions" (p. 30). The economic and political realities of health care interfere with altruistic sensibilities. Perhaps if cost were no object and availability of resources no constraint, the return to a relational model of caring would be easier.

Joan Tronto (1993) addressed the politics of caring in *Moral Boundaries: A Political Argument for an Ethic of Care*. She recognizes the critical challenge to change the value American society places on caring. With her colleague, Berenice Fisher, Tronto defined care as "a species activity that includes everything that we do to maintain, continue, and repair our world so that we can live in it as well as possible" (p. 103). It is a global and parochial moral

imperative, “greatly undervalued in our culture—in the assumption that caring is somehow ‘woman’s work,’ in perceptions of caring occupations, in the wages and salaries paid to workers engaged in provision of care, in the assumption that care is menial” (Tronto, 1998, p. 16). Similarly, Daniel Callahan (2001) writes that modern medicine has:

managed to make caring seem like a second-rate activity, something we do for the biological losers, something we try to hide from public view, something we hire the poor and near-poor to relieve us of at the minimal wage level, or the females in our families, who are expected to do it for nothing. (p. 14)

I highlight these views to support my contention that using a theory of care to frame the therapeutic recreation process takes courage. After all, therapeutic recreation has a history of concerns about being undervalued, underappreciated, underpaid, and underutilized. If caring is viewed as the work of lower paid and less educated personnel, why would we want to embrace it as the ethical foundation of the field? Nursing suffers from the same predicament as it struggles to maintain its professional integrity in a health care industry that increasingly seems geared more toward the technical and financial, and less toward the ethical and relational. The correct response to the question lies in the moral imperative to care. We care because it is the right thing to do both individually and collectively.

Tronto and Fisher (1993) defined a continuum of caring that they hope will help guide social and health care policy development and the allocation of resources in an ethical manner. It can be framed in four phases.

### **Caring About**

According to Tronto (1993):

Caring about involves becoming aware of and paying attention to the need for caring. Genuinely to care about someone, some people, or something requires listening to articulated needs, recognizing unspoken needs, distinguishing among and deciding which needs to care about. (p. 16)

This involves the initial awareness that we must care and helps organize all the voices of need within self and others that call for a caring response from society. The ethical imperative to care forms the heart of the codes of ethics of both the National Therapeutic Recreation Society and the American Therapeutic Recreation Association. It underpins the theoretical and philosophical ideals that justify the existence of the field.

### **Caring For**

Tronto (1998) observes that:

Caring for is the phase in caring when someone assumes responsibility to meet a need that has been identified. Simply seeing a need for care is not enough to make care happen; someone has to assume the responsibility for organizing, marshaling resources or personnel, and paying for the care work that will meet the identified need. (p. 17)

This is the phase that compels us toward action. It is where awareness of the needs of others generates leadership that works to address those needs. It is in caring for others that we find the energy to mobilize ourselves politically and socially to create programs that meet real needs. All decisions that move therapeutic recreation from idea to action must be based, first and foremost, on this premise. Therapeutic recreation leadership must take a higher road, encouraging innovative service delivery and affirming a broad range of services across all settings. The field’s direction from the 1980s that elevated the medical model and distanced itself from services to the poor, the

imprisoned, the uninsured, and those living in the community should be reversed and never again repeated.

### **Caregiving**

Caregiving, according to Tronto (1998) “is the actual material meeting of the caring need... It involves knowledge about how to care; although we often do not think of it this way, competence is the moral dimension of caregiving” (p. 17). It calls for a continuous commitment to excellence in the development of professional skills as well as the application of those skills in a framework of compassion that comes from caring about and caring for.

Therapeutic recreation is intrinsically linked to relational activities that foster caring and compassion between clients and their environments and between clients and therapeutic recreation personnel. Practitioners are ethically obligated to continuously improve their competence and skills over their years of service. To this end, affiliation with organizations that provide continuing professional development is critical. I favor professional development that unites disciplines and is grounded in sound theory rather than fads, politics, or self-promotion.

### **Care Receiving**

In this phase, the person being cared for responds, “whether the needs have been met or not, whether the caregiving was successful or not” (Tronto, 1998, p. 17). There is a complex dance between those who give care and those who receive it. The results can range from a satisfying sense of community to deep conflict or struggle. Essential to care receiving is the mutuality of responsiveness and attentiveness of both parties. I believe that in this aspect of caring lies the real benefit of working in the field—the potential for growth and great satisfaction embedded in the experience.

Tronto (1998) notes that:

Caring, then, is neither simple nor banal; it requires know-how and judgment, and to make such judgments as well as possible becomes the moral task of engaging in care. In general, care judgments require that those involved understand the complexity of the process in which they are enmeshed. Caring involves both rational explications of needs and sympathetic appreciation of emotions. It requires not an abstraction from the concrete case to a universal principle, but an explication of the ‘full story’. (p. 18)

Tronto (1993) adds, “Care is perhaps best thought of as a practice [involving] both thought and action” (p. 108). She further suggests that her “four phases of care can serve as an ideal to describe an integrated, well-accomplished, act of care” (p. 109).

Caring has always been integral to the mission of medicine, and many visionaries in medicine have spoken to the imperative of caring. In reflecting on the marvelous benefits of caring relationships with their patients, Dr. Bernie Seigel (1989), the cancer surgeon, wrote, “Too often, the result of maintaining our ‘professional distance’ is that we build a wall around ourselves. When we do this, our patients are not the only ones who suffer. We hurt ourselves as well” (p. 136). He adds:

The fact is, there seems to be a movement today to reintroduce medical students to their patients as human beings, not diseases, and I think that movement will spread because it will be successful for both patient and doctor. If nothing else, today’s consumer conscious patients will pass the word among themselves, and the doctors who have gotten the message will get their business. (p. 143)

Dr. Fred Epstein (2003) notes that:

throughout my career as a pediatric neurosurgeon, my young patients have been my most trustworthy teachers and

guides...I now realize I have received much more from my young patients than I have given...My colleagues and I have reached a paradoxical conclusion: we've become better healers—more compassionate, more resilient, and more creative problem solvers. The closer we've gotten to our patients and their families, the more strength and inspiration we've been able to draw from them. (pp. 4, 6, 18).

Eric Cassell (1991) has written extensively from the physician's viewpoint about the need for caring that is deeply personal and compassionate. He writes:

One of the skills in the art of great clinicians lies in coming as close as ethically possible to intimacy – for the access to the patient that it provides – while maintaining independence of action. Therein lies the capacity for maximum therapeutic power in the patient's behalf. (p. 79)

Finally, Patch Adams (1998), capturing national attention in *Gesundheit*, a book about his unorthodox approach to health care, laments that “the current focus on business rather than service is causing a lot of distress, both in the cost of medical care and in malpractice suits” ( p. 29).

Popular culture has responded to the issue by producing a number of films on the subject, such as *Awakenings*, *Beautiful Dreamer*, *The Doctor*, *Wit*, and *John Q.* Educators should have students watch films and read literature that offer a cultural critique of health care in the U.S. These media underscore the human experience of illness and treatment in ways that are powerful and inspiring. Some are highly critical of a system that can be unresponsive and alienating, but they challenge us at an emotional level to take action socially and politically. Because caring is a relational concept, both deeply personal and broadly social, it requires a complex approach to finding ways to give it to all who are in need.

## **Caring Applied to the Therapeutic Recreation Process**

How do we cultivate a way of relating that honors the individual person when the terms we use to describe the therapeutic process do not? Assessment, planning, intervention, and evaluation are words that have come to describe what we do *to* patients. They suggest a clear distinction between the professional who “takes the assessment” or “administers tests to gather data,” and the patient who is the recipient of the process. It is a language of professional dominance. Even the term “patient” implies passivity, someone who is worked *on* rather than worked *with*. It mirrors the scientific model that identifies problems and applies solutions that should predictably alter the disease or behavior of the objectified client. It doesn't leave much room for empowering the clients to chart their own course or at least be a partner in the process of care.

I understand that these terms give workers across disciplines a common language and system that fosters rationalization of treatment (efficiency, standardization, bureaucratization). But we are mistaken if we assume that this alone yields the best results in the long run. If the therapeutic process focuses too exclusively on what clinicians do, it misses the opportunity to see what clients can and should contribute to their own care. The objectification that has been a product of the medical model has kept those we serve from becoming therapeutic partners and, inevitably, principal agents of their own care.

One way we can offset the tendency to objectify persons we serve is to use terminology that freshens the mind's image of the person as central to everything we do. If the person receiving services is the core figure in the health care process, we could benefit from seeing assessment, planning, intervention, and evaluation from their point of view. By using my own experience, I hope to show how a relational ethic of caring moves us toward viewing the

therapeutic process from the place that matters most—the client’s perspective.

### **Assessment: Listening to the Client’s Story**

My earliest memory of encountering someone with a disability occurred in the mid 1950s when I was a young child. While on a family picnic with aunts, uncles, and cousins, I noticed an adolescent boy sitting on a quilt, about thirty yards away from the group, tethered to a tree by a rope around his waist. The boy seemed lost in a world of his own, unable to speak, but with no apparent physical impairments. This was my cousin, John (fictitious name). Later, when visiting my aunt and uncle’s house, I found that John was kept locked in what would have been the dining room of their narrow Baltimore row house, with only a mattress on the bare, hardwood floor, an arrangement necessary to prevent self injury. He spent much of his time perched in the bay window overlooking the back yard. He wore a diaper and chewed incessantly on a twisted piece of cloth. He was difficult to control and, at times, combative. He avoided eye contact and was unresponsive to most attempts to communicate. My guess now is that he was severely autistic. Needless to say, schooling was not available. I learned later that, as stressful as this arrangement was to the remaining children, it was considered better than the alternative of institutionalization. At night, my aunt would physically hustle John up the stairs and restrain him in a bed. They lived like this for almost twenty years until it was obvious to everyone that they could no longer go on. He died a few years later in an institution.

My aunt and uncle viewed their plight as a cross to bear, and that cross grew heavier when, in her early twenties, John’s sister, Ann (fictitious name), had to be hospitalized with psychosis. Whether it was the stress of having to live with John’s difficult behavior, or simply a genetic twist of fate that two siblings would be so ill, her college-educated mind gradually dissolved

into a world of delusions and paranoia characteristic of schizophrenia.

A thousand miles away from Baltimore, I finished my undergraduate degree in 1972 and found a job immediately as a patient activities coordinator on the acute psychiatric unit of our local general hospital. One day the staff gathered in the conference room with coffee and snacks to watch a film for continuing education credits. The lights went down and the film’s title stretched across the screen: “Family Counseling with the Paranoid Schizophrenic.” I almost dropped my cup! There was the psychiatric staff of a large hospital asking my aunt and uncle why my cousin, Ann, was so disturbed. As clinically proficient as they attempted to be, the questions they posed did not begin to mine the depths of difficulty that I knew had plagued this family. The outcome was a concise and neat assessment, but they completely missed the story.

As an objective observer in this weirdest of situations, I saw clearly how deficient the clinical assessment was. I couldn’t fault the professionals in the film. Brevity and simplification were required in our charting, too. I had just that week observed a psychiatrist tear up a social history in front of a large group of staff during walking-rounds because he considered it too in-depth. “Anything longer than a half a page is a waste of my time,” he growled.

I believe that the lived experience of illness reported in books, journals, and the popular press in the last two decades reflects a cultural awakening to the need to avoid superficial inquiry or selective data gathering and, instead, create a more complete picture of the client with “as little distortion as possible” (Tronto, 1998, p. 16). I encourage my students to change the way they view the assessment process, suggesting that instead of “taking assessments,” we invite people to “tell us their stories.” Hearing the client’s story can be done in a way that gathers much of the data needed for a baseline or for comparison to data from other clients. If, however, we fail to really grasp the person’s story, we

miss the nuances, the individual needs and preferences, and the insights that will help us provide the best service possible.

This may be disconcerting to those who have read about assessments in some of the therapeutic recreation textbooks that stress the importance of using valid and reliable standardized tests. Ideally, these types of assessments attempt to create an objective picture. The extreme form of defense for objective assessment lies in the contention that it is superior to subjective, qualitative means of gathering personal information and aligns therapeutic recreation with the hard sciences. Unfortunately, the constraints of time and the objectification of illness usually require that this be the dominant part of the assessment process. Writing the patient's problems in measurable, behavioral terms takes precedence over understanding the depth and causes of these problems and hardly makes room for equal attention to strengths and coping skills. Worse, it distorts the person's story by separating out what really should be put in context.

The gathering of objective data alone is never sufficient. If the goal of therapeutic recreation service is the development or restoration of the physical, social, psychological, and spiritual aspects of the human being, it is essential that we know more than objective assessments can tell. For many years I cringed at the term "functional outcomes" because it had become so identified with measurable, behavioral parameters. Overlooked was a balanced emphasis on the psychosocial and spiritual aspects of health, sometimes referred to as existential outcomes. The World Health Organization has clearly stated now that the total person must be the focus of care (Carter, Van Andel, & Robb, 2003). I hope that fields like therapeutic recreation can give more attention and respect to the subjective and uniquely individual perceptions of the client regarding his or her own state of health. "Outcomes" is hardly the word that I think patients would use to describe aspects of self. While I understand that its historical use comes from the health care industry's

desire to clearly identify benchmarks of recovery, the word fails to convey adequately the richness of the client's lived experience.

Gerteis et al. (1993) listened to thousands of patients in focus groups and learned that "People do not come in for diagnosis and treatment; they come to be made well, made whole, to recover the sense of health, of being well, fully alive, in-the-world" (p. 21). Among the newer methods being used to understand the client's sense of health is the personal narrative which honors self-reporting as a valid means of communicating one's story (Spaniol & Koehler, 1994). I have also used video technology as an important tool for capturing both the information and the emotion surrounding the patient's story. This method has been especially helpful for persons in the early stages of dementia because the video can be archived and shown later to staff who might care for the person at a more advanced stage of the disease. The problem, as I see it, is finding a balance between the urgency of time that limits the patient's access to professional help and the need for greater understanding of the patient's true situation, which ultimately helps caregivers provide better service. For the field of therapeutic recreation, the imperative is especially critical, because the meaningful use of time, particularly free time, is highly valued. If leisure is the freedom to become our true selves, as I believe it is, our efforts must be directed not only toward the concrete, measurable indicators of health but the intangible, subjective attributes as well. Only by getting the story right can we do our part well.

### **Is it a Plan or a Vision?**

Identifying objective, measurable treatment goals is the second part of the therapeutic process. These goals are the core of a plan to address problems that have been identified through the assessment. In many facilities, the staff creates the plan as they apply their expertise and knowledge of

standards to problems, deciding a rate or level of behavior that, after treatment, will be acceptable. In the early 1970s, when treatment planning was first introduced in my hospital, we gauged the quality of the plan by how concisely the goals were written in a neat, time-oriented, quantitative fashion. It never occurred to us to ask the clients about their goals. They were often not regarded as knowledgeable enough to have a valid opinion. We professionals knew best and set goals that were beautifully written but often neither desired nor understood by the patient.

When Bill Moyers (2000) interviewed a Zen hospice program director in San Francisco for a documentary on death and dying, I was struck by a single question asked by the staff of all patients: "What can we do for you to make the experience of dying the best that it can be?" In other words, can you paint a visual picture of your death that could be described as good? The skill of the clinician shifts, then, from percentages and numbers of repetitions of behaviors or measures of strength, range of motion, etc. to helping the patient articulate what "strength" looks like in action, what "a happy death" means experientially.

In my own practice, I worked with Susan (factitious name), a woman who was dying of cancer at the age of 35, leaving four young children and a loving husband. Had I worked with a traditional treatment team in an acute care hospital, we might have identified Susan's problems behaviorally as:

1. Frequent outbursts of crying (more than five per day)
2. Inability to carry out activities of daily living (ADLs) independently, particularly dressing, bathing, and meal preparation
3. Extended periods of fatigue with loss of appetite

When I asked her how we could help to make the experience of her death the best that it could be, she responded that she wasn't afraid of dying, but of leaving her children. She had no knowledge of any

action that she could take to alleviate the pain of that tragic reality. So I asked her to describe what a happy death would look like to her. She described a death that was peaceful, without pain, surrounded by her children and husband, and that allowed chances to say what she needed to say to everyone she loved. I used that vision of how she wanted her life to end as the springboard for the next part of the therapeutic process. Once she had a vision, we could keep it before her continuously. Knowing clearly what she was working toward, as subjective and intangible as that would have looked to a treatment team, made it work. We simply modified her daily routine around her level of energy and brought in help for the ADLs so she wouldn't have to expend energy on activities that had become essentially unimportant to her as time drew short. Then, with her vision before us all, we designed experiences together that would make her vision a reality.

A vision is an image, more complex than a goal, of how the patient sees the future. It encompasses hope, a value that is hardly measurable. I encourage my students to rethink the planning and goal setting part of the therapeutic process. I remind them that a goal is not worth writing if the client does not embrace it. Instead, I urge them to ask these questions to people who are going to receive therapeutic recreation services:

Can you create a vision in your mind of how you want your life to be? In that vision, how are you using your time? What are you doing that brings happiness and meaning to your life?

Proponents of the traditional method of goal setting claim that measurable, time-oriented goals create accountability, an essential need for a cost effective service. Susan's goals might have been stated as:

1. Reduce episodes of crying (quantified by number or percentage)
2. Perform ADLs with assistance



3. Increase periods of alertness (quantify hours of sleeping during the day)
4. Improve intake of healthy food (quantify calories/servings daily)

Her vision of a good death enabled her caregivers to frame her image of the last weeks of life in a way that addressed her true needs:

1. To embrace death without fear, but fully acknowledging the loss
2. To spend her time creatively with her family in activities that would bring enjoyment, peace, and good memories for the whole family
3. To be physically comfortable with a satisfying level of alertness

Susan would have seen the vision represented in the second set of statements as more personally reflective of her needs and wants. True accountability includes fulfilling our commitment to the client, not just the readers of our charts, and documentation should accurately reflect the richness of the vision held by the person in our care.

### **Is it an Intervention or Recreation?**

When members of the interdisciplinary team gather around the table to create the treatment plan, we address problems that have been stated in behavioral terms with concisely written measurable goals. Then we design interventions to address those problems. Like a salve that heals a wound, we want to apply something to make the lesion go away. That is the thinking that I learned thirty years ago, and it is a logical extension of the scientific method. While the approach isn't wrong, I believe it is insufficient, because it fails to embrace fully the unique characteristics and strengths of those we serve.

What professionals see as an intervention is an experience to those who are on the receiving end of care. By focusing on the concept of meaningful experience

rather than intervention, I am encouraged to concentrate on how the intervention looks to the client. I hope that this perspective reminds me to take into consideration all the individual's preferences, needs, and prior actions. Having a clearer idea of what the person envisions should make it easier to create, adapt, and facilitate something that the client might experience as meaningful.

After Susan told me about her vision of a happy death, I was able to offer a variety of ideas for activities that would help her. These ideas became experiences as we worked together to make them unique to her situation and needs. The "intervention" was creating videotapes for her husband, parents, siblings, and children that might allow her to say everything she felt necessary before her death and do it in a way that was enjoyable. What emerged was a series of satisfying, meaningful experiences, some involving videotapes but others involving the creation of memory boxes for each child, made from colorful, large hatboxes, imprinted with personalized brass name plates, and filled with cards and gifts for the future. Thinking of new things to add to her tapes and boxes energized her. Her fatigue and episodes of crying lessened remarkably. The experience of controlling each taping session gave her a feeling of power over time, and by leaving her legacy of values, memories, and directives to her family, she felt that a part of her would not die. The word "intervention" fails miserably in its ability to relate adequately what she experienced. And because the experience was hers and not mine, she controlled it. I did not dispense it. I suggest that the word *recreation* aptly describes these meaningful experiences because I believe it is a truer expression of the lived reality. We teach in leisure theory classes that recreation is a unique kind of activity because of its restorative and inherently wholesome features. Enjoyable, freely entered into, and health promoting, these activities re-create a positive sense of the inner self. It is a shame, really, that such a beautiful word isn't better respected.

## Reflecting on Efficacy: True Evaluation

For me, one of the most difficult parts of the therapeutic process was learning how to write *SOAP* progress notes in a way that sounded clinically sophisticated, yet personal. A supervisor who taught me how to write them in 1974 noted that having to write a subjective comment from the patient at least assured the reader that we had engaged in some contact. I knew why that was important because my own experience involved reading charts in which professionals rarely noted the client's thoughts or views. "Status quo, no change, and continue approaches" were commonly written on our charts before *SOAP* notes were instituted. In long-term care I had observed physicians who sat at the nurse's station writing monthly progress notes in scores of charts at a time without having seen any patients at all! Looking back, I am humbled by the apparent arrogance that we often demonstrated when we evaluated progress from a distance that gave the illusion of objectivity but was, in reality, terribly deficient.

In the end, the therapist's evaluation is one part of the picture that helps give feedback on the efficacy of the experience. A person-centered philosophy of care creates, at its foundation, the belief that the person who has the experience gains the most from it when he or she is able to make meaning of it and own that meaning. Something is made new again by processing the meaning of an experience in a way that adds value to life. The origin of the word "therapy" is *therapeuein*, meaning, "to attend to." Our service to clients involves helping people attend to the meaning of the experience, to reflect on it, and to incorporate it into the life story.

I have a friend who was the chief of pediatrics at our local children's hospital. After reading *Through the Patient's Eyes* (Gerteis et al., 1993), he decided to suggest to his interns and residents that we put blank progress note sheets in each patient's room, inviting the patient and family to write their own progress notes, stating how they

benefited from our therapies and if those services really helped them improve. He told me that when he finished making his pitch to the group, they stared back at him blankly and incredulously. "Why would we want to do that?" someone finally asked. Most of us who were trained in the last thirty years thought that it was the professional's evaluation that really counted. We might give a satisfaction survey to clients on their lunch trays or at discharge, but only a handful of us figured out that our best intentions and interventions fell short of the mark if they weren't seen as beneficial by the clients themselves. And I am sure that I've written progress notes that touted the efficacy of my intervention only to learn later that the client did not get anything at all from it. It seems to me that an essential element of efficacy is the client's affirmation that the experience was helpful in achieving the vision. As long as the medical model makes evaluation the action of the health care provider and fails to include the client as an equal partner, we won't address the real meaning of efficacy. Treatment truly works when both the objective observer and the person receiving the treatment see it as beneficial. A relational ethic of caring never fails to see this because it focuses on the partnership between the patient and service provider.

## Conclusion

The ideas I have shared in this essay call mainly for a shift in thinking. A therapeutic recreation professional can start tomorrow to carry out the same process but be aware of it, and address it, in a different way. My prediction is that practice based on an ethic of caring that springs from a nursing theory of relational care as I described here would be more satisfying to both the practitioner and the client.

I would be remiss not to add that that I believe our professional leadership should also embrace this ethic of care. The National Therapeutic Recreation Society (NTRS) and the American Therapeutic Recreation Society (ATRA) have a

particular obligation in this regard. “Caring about” demands that our field be faithful first to those we serve, putting the needs of others before our own. I am uncomfortable with a professional association vision that is all about us (our status, salaries, and recognition). I would prefer a vision statement that affirms a universal partnership between professionals and all those who could benefit from our services in bringing about enjoyable and meaningful life experiences that foster health and wellness. And since this philosophical framework for practice does not perpetuate a distinction between clinical and community settings, it can easily be applied to service environments from the hospital to the home. That could only help our field mend the longstanding rifts that have beset it. Once we are committed to caring, the next step, “caring for,” requires that we leave no stone unturned in our efforts to connect our services with those who can benefit from them. The common goal, then, of both associations must be to find creative ways to deliver therapeutic recreation services and to make them affordable and accessible. I challenge NTRS, ATRA, and all who work in the field of therapeutic recreation to become committed to securing health care as a right rather than a privilege in the United States.

The third phase of caring, “caregiving,” demands that we continue to grow professionally, to commit ourselves to new learning, service to the profession, and to *pro bono* work whenever possible. Finally, “care receiving” is the payoff phase that keeps us rooted in the real calling of therapeutic recreation. The emphasis on calling is intentional as pointed out by Sylvester (1998), who notes that the term “continues to be used by professions to distinguish themselves from occupations that are oriented to an entrepreneurial ethic of accumulation” (p. 5). In light of a relational ethic of caring, educators, students, and practitioners should frame their concept of ethical practice within a broader context of societal obligation to the health of the human community. And we

should share more about the personal enjoyment and growth available to us when we practice this kind of caring.

A person-centered, relational philosophy of care may put us at odds with people who accept the status quo and find it more practical to spend time getting better positioned within the existing system. Those who embrace it will struggle politically and socially because many interpret social justice as extreme liberalism or socialism. To really care means caring for all, not just for the insured, or the wealthy, or the smart, or the attractive.

We will, no doubt, continue to find ourselves on the current playing field of health care service delivery for some time to come. If the language of *Storying, Visioning, Re-creating, and Reflecting on Efficacy* helps us to remain true to the spirit of person-centered care until a time when the environment supports that philosophy, the therapeutic process will indeed be better, not measured by external standards but by the interior moral compass that matters most.

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