LEISURE, HEALTH, AND DISABILITY: A REVIEW AND DISCUSSION

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ABSTRACT

There is growing evidence that leisure is an important aspect of people's lives. The satisfactions gained from leisure often outweigh those gained from employment or other work activities. Individuals with disabilities are no exception to this phenomenon. Opportunity to engage in leisure activities of one's choosing is paramount to a disabled person's health and well-being. The purposes of this article are to: (a) describe the potential benefits of participation in recreation and leisure to individuals with disabilities, (b) describe what is currently known about leisure and disability, and (c) suggest research directions. An enabling model of leisure and mental health is offered.

There is growing evidence that leisure is an important aspect of people's daily lives. The satisfactions gained from leisure often outweigh those gained from employment or other work activities. Individuals with disabilities are no exception to this phenomenon. Opportunities to engage in leisure activities of one's choosing are paramount to a disabled person's health and well-being. Unfortunately, little attention is given to the benefits of leisure experiences in most journals concerned with disability. With the recent emphasis on viewing disabled persons from a wholistic perspective, leisure and recreation behaviour should be considered important aspects of a person's quality of life.

The purposes of this article are to (a) describe the potential benefits of participation in recreation and leisure to individuals with disabilities, especially in the context of mental health, (b) describe and reflect upon what is currently known about leisure and disability, and (c) suggest research and program development ideas. An enabling model of leisure and mental health is presented at the end of the paper to summarize and place in perspective the literature reviewed and ideas discussed.

LEISURE AND MENTAL HEALTH

It is important at the onset of this paper to make the connection between

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mental health and leisure. What is leisure and how is it a mental-health issue? Leisure has been defined from a number of perspectives. An objective definition of leisure juxtaposes it with work: Leisure in this context is considered that time free from the obligations of work. Subjective definitions of leisure are also supported; these emphasize the individualistic and phenomenological nature of the *experience* of leisure. Basic elements of leisure in this perspective include: enjoyment, relaxation, freedom of choice, intrinsic motivation, commitment, control, and challenge (Csikszentmihalyi, 1975; Gunter, 1987; Iso-Ahola, 1979; Mannell, 1980; and Shaw, 1985). Evidence suggests activities or experiences that are voluntary, enjoyable, self-efficacious, have elements of personal control, and in which a person's skills are appropriately matched with a challenge, are leisure experiences.

While leisure is most commonly thought of as being closely associated with physical and physiological health, it is also closely related with mental health (Caldwell & Smith, 1988). To experience leisure is idiosyncratic and intensely personal; therefore it is not surprising that it is associated with mental health. Experiences in which people feel an element of self-determinism and perceived control are intrinsically motivating and often result in psychological benefits (Deci, 1980; Langer & Rodin, 1979; Maddi & Kobasa, 1981). Feelings of self-determinism and perceived control are two of the keystones of the leisure experience. For example, Iso-Ahola (1982, 1983) suggested meaningful leisure reduces feelings of helplessness and lack of control and therefore contributes to a person's self-efficacy and self-empowerment. Further, direct deprivation of personal control (e.g., institutionalization, disability) or indirect deprivation (e.g., through repeated exposure to failure) mitigates or blocks the ability to pursue or engage in optimally arousing and challenging leisure experiences.

In the Health and Welfare Canada publication *Mental Health for Canadians: Striking a Balance* (1988), current concepts of mental health are defined as:

- psychological and social harmony and integration;
- quality of life and general well-being;
- self-actualization and growth;
- effective personal adaptation; and
- the mutual influences of the individual, the group, and the environment.

It seems self-evident that leisure is one way in which to achieve mental health as defined above. Through participation in leisure and recreational activities, individuals are afforded opportunities to develop or enhance social relationships, to be creative and self-expressive, to acquire skills and develop abilities, and to become self-actualized.

One other point should be noted with regard to leisure and mental-health issues. Benefits accrued from leisure can be both short and long term (Caldwell & Smith, 1988). Caldwell and Smith (1988) suggested that the *immediate* relaxation, joy, spiritual and physical benefits, and increased feelings of self-worth derived from leisure experiences are all important. But, they pointed out, the potential contribution of years of leisure interests and experience to successful and healthy aging and adaptation to life is probably most notable. That is, participation in leisure can have not only short-term benefits, but these benefits can also cumulate over the lifespan to contribute to an on-going high quality of life.

The introduction of the notion of disability into the preceding discussion of leisure and mental health raises a number of questions and issues. These will be the focus for the remainder of the paper. Since leisure is viewed as a critical component of life quality, the particular benefits and challenges facing Canadians who are disabled with regard to leisure need to be examined. Three main types of issues can be identified: (a) issues related to rehabilitation, (b) issues surrounding complete community involvement and integration, and (c) health promotion and problem prevention.

LEISURE AND REHABILITATION

From a general perspective, individuals with disabilities of any nature can benefit from leisure because leisure affords opportunities to exercise control, to be self-determining, to be self-efficacious, and to provide for enjoyment and relaxation. These opportunities are not always available to persons with disabilities. This is especially true during the rehabilitation process when often institutional constraints mitigate self-determinism, individual control, and self-expression. Further, in many institutional settings, the terms wellness and health promotion are not even recognized as being a part of the rehabilitation process (Marge, 1988).

Leisure and recreation services are beneficial for two reasons in a rehabilitation environment. First, these services provide daily enjoyment, relaxation, escape from institutional routines, and in general provide those leisure experiences that are important for all human beings. Second, leisure and recreation services are often utilized in a clinical manner to help individuals acquire and develop life skills and abilities. Many institutions and rehabilitation settings offer therapeutic recreation (also known as recreation therapy) programs to meet leisure needs of clients. These programs have specific goals and objectives and are operated in conjunction with interdisciplinary treatment teams. Through the use of leisure assessments, documentation, and evaluation, individuals may improve social skills, physical functioning, and cognitive abilities. Leisure education and leisure counselling programs are also important aspects of rehabilitation and will be discussed later in this paper.

The following is an example from a case study of the importance of recreation services in the rehabilitation process. In an interview with an individual who sustained a severe head injury, recreation's contribution to the rehabilitation process was stated to be the carry-over to other life situations of what was learned as a part of recreation activities (e.g., balance, coordination, concentration, sequencing of events, communication skills, social skills, etc.). Noted as most important was an improvement of self-image as a direct result of recreation participation (Wallace & Vetter, 1987).

A noticeable omission in the literature, and one that is reflective of current practice, is the lack of research and discussion regarding transitional programs. Transitional programs are a necessary and natural bridge from hospitalization to community living, yet few of these programs exist. Leisure skills and attitudes learned in a "sterile" institutional environment are not necessarily directly transferable into a community setting. Although most therapeutic recreation pro-

grams offer outside trips in which clients begin to learn to transfer newly acquired skills (e.g., social skills, activity skills, etc.), these minimal programs are not enough to facilitate successful social and recreation (re-)integration into a community setting.

It is clear from the review of literature that a paucity of transitional programs exist, as well as research to demonstrate efficacy of various types of program formats and content. These transitional programs often fall through the cracks; there is no clear-cut view on who should be administering them. Does the onus of responsibility lie on community recreation personnel or institutional personnel? Obviously this is a fertile area for program and research efforts.

COMMUNITY INVOLVEMENT

As a disabled person, the ability to actively participate in one's community depends on a number of things. The literature reviewed revealed that two important aspects of participation are (a) friendships and social relationships and (b) obstacles and opportunities.

There is growing evidence of the critical need for social relationships in the lives of people with disabilities. For example, Jowet (1982) conducted a study to gather information about the employment histories of young disabled people after leaving St. Loye's College for Training the Disabled for Commerce and Industry, Exeter (N = 153). As part of this study, Jowet queried the respondents about their personal development. She found many of the young people were socially isolated, even though they enjoyed social activities while at the college. Most of the respondents did not know how to structure their time, membership in clubs and organizations was limited, and many were dissatisfied with their social life. Self-rating scales about social interaction indicated that social skills training was needed as respondents had great difficulty in social interactions.

Lord, Hutchison, and Hearn (1987) found similar results in a study undertaken when Tranquille, an institution in British Columbia, closed. They found that staff in group homes tended to view community living and leisure in functional, skill-oriented terms rather than to place an emphasis on social relationships and networks. This emphasis is problematic because it is likely that true, long-term community integration is predicated on the more emotional response to community life (i.e., friendships and relationships) rather than technical how-tos. It does not matter whether you know how to use a bus to go to a movie if you have no one with whom to go.

Interestingly, in the Lord et al. (1987) study, group-home service providers frequently underutilized or did not make contact with the local recreation and parks departments. Many recreation and parks departments have community integration facilitators (or the equivalent) and are eager to work with community service providers to foster social-relationship building of disabled consumers.

Another study on the perceived effects of disability on leisure and friendship found that most of the 150 moderately to severely disabled Canadian adults surveyed (spinal-cord injury, multiple sclerosis, or stroke) identified major lifestyle changes in work, leisure, and relationships as a result of their conditions (Lyons, 1987). Lyons found that in general, the leisure behaviour of the

respondents typically changed as a function of their conditions. Interestingly, satisfaction with leisure did not seem to depend on a return to the pre-injury or pre-onset lifestyle but rather the development of a new lifestyle based on present abilities, which included social-relationship building.

Because social isolation is anathema to positive mental health, steps must be taken to increase the social ability of people with disabilities. An example of a successful program is the West Island Citizen Advocacy (WICA) of Pointe Claire, Quebec. Operating for 12 years, WICA has been involved in a variety of activities designed to integrate disabled persons into the social, recreational and occupational life of the community. To ease possible difficulties encountered with social skills, volunteers are recruited to work one-to-one with people who have disabilities. Other successful programs of this nature are found in many Canadian communities.

Social ability is of great concern to the complete integration of an individual to a community setting; it is also of great concern to leisure because of the circular relationship of the two. Often participation in leisure activities is predicated on having friends and social skills. On the other hand, through recreational activities, many people develop social skills that allow them to be successful not only in leisure pursuits, but in everyday life as well.

OBSTACLES TO PARTICIPATION

Obstacles of many types are often encountered by disabled persons in the pursuit of the leisure activity of their choice. While these are sometimes specific to type of disability, age, and geographic location, there is evidence that many people do experience obstacles to participation.

Transportation is commonly thought to be the biggest problem facing disabled Canadians. The issue of transportation was seen to be so important that the Ontario Advisory Council on the Physically Handicapped and the Ontario Advisory Council on Senior Citizens (1987) cooperated to prepare a report outlining the steps needed to achieve fully accessible transportation and ultimately, increased independence. Transportation was identified as the "essential link between home, work, medical facilities, religious centres, shopping, volunteer and social activities" (p. 3).

A recent report by the Canadian Rehabilitation Council for the Disabled (Butler, 1987) presented statistics pertainng to transportation services available for disabled persons in various communities across Canada. Data indicated that while there is a range of services available, not all are available for travel to or for recreation purposes, and fewer than one-half are available all days of the week (Butler, 1987). Butler saw this as a major deficit in the service delivery system to disabled individuals.

A study conducted by the Disabled Individuals Alliance (DIAL), the Halifax affiliate of the Nova Scotia League for Equal Opportunities (Singleton, Shields, Jamieson, Johnston, & Snair, 1986), indicated that 15% of respondents felt transportation was an obstacle that prevented participation in activities outside of work and personal care. Further, 75% of those surveyed who used Access-a-Bus felt this service needed to be expanded.

Ferris (1987) indicated that based on the Canada Fitness Survey Report *Physical Activities Among Activity-Limited and Disabled Adults in Canada*, lack of transportation was not a major problem to the 22,000 persons who completed questionnaires. Respondents were from both urban and rural areas.

Similar results were reported in a study sponsored by the Ontario Ministry of Tourism and Recreation which examined the leisure and social lifestyles of individuals post-discharge from a rehabilitation facility. On a question which assessed the degree to which 14 barriers interfered with participation in leisure, respondents rated transportation a mean of 2.84 on a response scale from 1 to 10 where 1 = not at all deterred and 10 = completely deterred (Adolph, Caldwell, & Gilbert, 1988). In fact, 57.5% of the respondents rated the question as "1," indicating that transportation was not at all an obstacle to participating in leisure and recreation.

The evidence cited above indicates that there is inconclusive evidence as to how much transportation is a barrier to participation in recreational activities. There is some encouraging evidence that perhaps transportation is not as big a problem as commonly thought. Another explanation is that there are other more pressing obstacles to participation that are seen as more serious than transportation.

Ferris (1987) cited the following as other obstacles to participation in recreational activities (the percent indicates the number of people who felt the item was an obstacle): health and injury (48%), lack of time due to work/school (46%), lack of energy (19%), no facilities nearby (12%), costs too much (12%), lack of self-discipline (12%), no time due to other leisure (11%), lack necessary skill (5%), inadequate facilities (0%), and no leaders available (0%).

There is other evidence to support Ferris' finding that injury or handicap appears to be a large obstacle to participation in leisure pursuits. One-third of the participants in the Singleton et al. (1986) study listed their disabilities as their main barrier. Other barriers provided by these respondents were lack of general accessability (20%) and lack of available services (15%). Financial condition was a problem for 10% of respondents and miscellaneous obstacles accounted for 7% of the responses.

While many of these obstacles are common to every person, disabled or not, there are barriers that are also specific to those with a disability. Transportation barriers that have been reported are most likely a direct result of disability. Also, clearly "health and injury" and "disability" as cited reasons are specific to disabled persons. Barriers such as finances, lack of ability, and lack of facilities/opportunities may be less specific to disabled persons; nonetheless, they are still barriers.

PARTICIPATION CHOICES AND PATTERNS

Despite various barriers to participation there are a number of activities which are popular. Ferris (1987) found the 10 most popular activity choices of disabled Canadians were (in rank order with the most popular listed first): walking, gardening, bicycling, swimming, home exercise, outing activities, other aquatics, dancing, other individual sports, and jogging and running. Singleton et

al. (1986) found participation in activities such as support groups (e.g., Canadian Paraplegic Association and DIAL) were popular (more so than church going). Also popular were visits to taverns, social activities (such as conversations with friends), shopping, and movie and theatre going.

Adolph et al. (1988) found the three most popular recreational activities of those discharged from a rehabilitation facility were (a) sports and exercise, (b) socializing, and (c) reading. Other activities cited including watching T.V., getting out, fishing, playing cards, canoeing and boating, and listening to music.

Ferris (1987) found 44% of the respondents were most likely to participate in activities at home; 40% participated outside the home using no special facility; 14% utilized a recreational facility; 9% used a commercial facility or private club; 8% used a park; and the remaining 30% utilized work, university, or other facilities.

ENABLING LEISURE THROUGH POSITIVE FREEDOM

The previous discussion about obstacles to and choices surrounding recreation participation raises issues regarding concepts of choice and freedom. These two concepts, as previously discussed, are central elements of the leisure experience.

It appears that many "external" obstacles, such as transportation and architectural barriers, have been at least partially removed so as not to cause major problems for the majority of individuals. What remains troubling, however, is that other barriers exist which are more difficult to overcome. These barriers are "internal" in nature and include such things as personal motivation, social skills, attitudes, perceived competence, and so on. Many of these are directly related to disabling or impairing conditions.

In essence, what seems to have happened is that individuals with disabilities have been afforded "freedom from" obstacles—a concept referred to as negative liberty (see Bregha, 1985; Sylvester, 1985) and defined as "the absence of duress, coercion, and interference" (Hemingway, 1987, p. 5). What continues to be a problem area, however, is related to the concepts of positive liberty or "freedom to." Green (1893, v. 3) states, "The mere removal of compulsion, the mere enabling of a man to do as he likes, is in itself no contribution to true freedom . . . the ideal of true freedom is the maximum of power for all members of human society alike to make the best of themselves" (pp. 371-372). Green's statement can be interpreted to mean that to remove or minimize barriers is not in itself a necessary and sufficient condition to ensure community leisure involvement. For example, accessible park and recreation programs and facilities may exist, but there may be a number of other obstacles that prevent participation. In order to make a true choice, one must be aware of alternatives and understand the implications of the alternatives. Moreover, individuals must have personal skills and attitudes in order to take advantage of opportunities that exist. Social skills and feelings of personal competence and efficacy are two examples of necessary skills for maximum freedom and choice.

Therefore, we must actively facilitate and educate individuals to empower them to make true choices. One powerful mechanism for empowering individuals

with disabilities with the reasoned ability and desire to make informed decisions and choices is through leisure education.

EDUCATION FOR A HEALTHY LEISURE

The term "healthy leisure" implies harmony with the physical, emotional, and mental aspects of leisure behaviour. Healthy leisure is more than participation in a variety of activities. Peterson and Gunn (1984) state that "a cognitive understanding of leisure, a positive attitude toward leisure experiences, various participatory and decision-making skills, as well as a knowledge of and ability to utilize resources appear to be significant aspects of satisfying leisure involvement" (p. 22).

Because one is not born with attitudes and values toward leisure and in fact learns them, the role of "leisure education" becomes clear. A recent issue of *Recreation Canada* (May, 1989) was devoted to "Wellness." In that issue, Ballantyne advocated for leisure life-skill development for all individuals. In his article, he cites selected statements of proposed revisions to the current Canadian Parks and Recreation Association (CPRA) National Policy on Education for Leisure. They are presented here as they are relevant to this paper:

- Leisure time offers individuals the opportunity to fulfil themselves holistically, and to experience personal growth and self-worth. Education for leisure is an on-going process in which leisure service providers across the country have an integral role to play in making leisure time more meaningful to individuals.
- That happiness, continual personal growth and the opportunity to experience leisure are the right of all Canadians regardless of capacity, race, creed, or gender.
- That we must assist in educating individuals to discover that increased leisure time can be productive, personally satisfying, and contribute to the overall quality of life.
- That the provision of education for leisure programs become the responsibility of every provincial social service organization; educational institution; and private, commercial, or publicly funded leisure service provider; and furthermore, that CPRA be a leader in promoting this concept (p. 29).

In the lives of persons who are disabled, leisure education may play a number of roles. Ballantyne advocates for early intervention in the lives of youth; in this way leisure education serves to promote healthy and balanced lifestyles. Using a leisure education program in the classroom helps youth clarify and understand their values and leisure needs. A program of this nature also reinforces at an early age the importance of life-long leisure interests. This type of program may also be effective as it helps youth (and others) learn to replace socially unacceptable and "negative" leisure behaviours, such as drinking and alcohol abuse, with health-enhancing, socially acceptable, and personally fulfilling activities. These leisure education programs are equally effective in classrooms as well as various treatment programs such as drug and alcohol addiction programs.

A further value of leisure education is its use in transition programs from institutions/facilities to integrated community activities. Leisure education programs facilitate the acquisition of new skills, attitudes, and knowledge for people

about to be or newly discharged. Often after an injury, an individual can no longer participate in former favourite activities due to lack of skills or ability. Moreover, individuals are likely unaware of the importance of leisure and of the opportunities that are available. Fifty percent of all disabled Canadians are unemployed (Statistics Canada, 1988). Given that, plus problems of enforced leisure, minimal financial resources, lack of leisure knowledge and skills, and lack of friends and social networks, it seems clear that there is a challenge and necessity for leisure education.

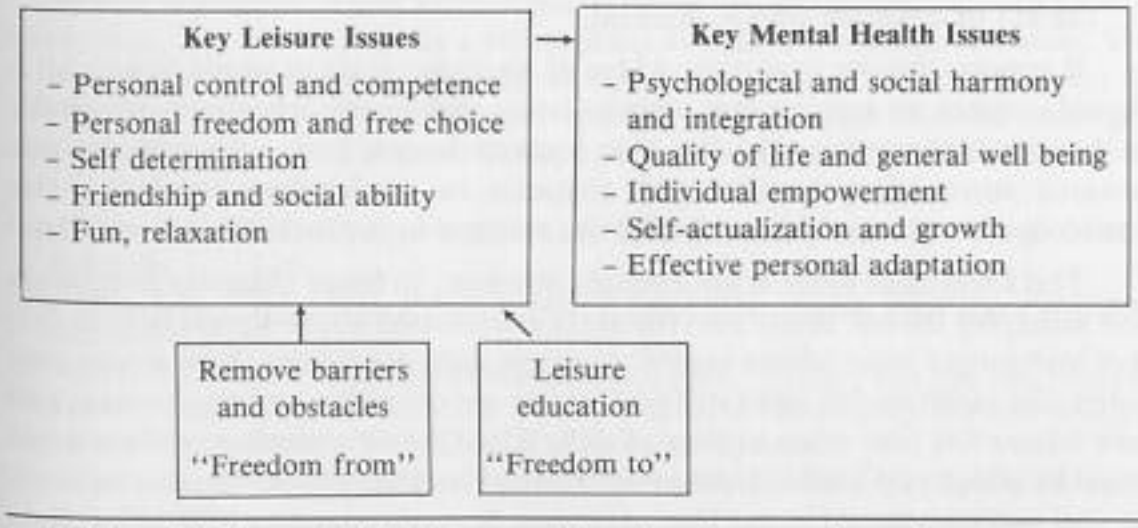
AN ENABLING MODEL OF LEISURE AND MENTAL HEALTH

To summarize and put into perspective the preceding discussions, the following model is offered (see Figure 1). The model applies to rehabilitation, transitional, and community environments. Theoretically, the relative degrees of leisure and health grow greater as one moves from an institutional to a community environment. Nevertheless, the model is applicable in each setting.

Overall, the model suggests that leisure experience leads to positive mental health. No attempt has been made to specifically link the key elements of leisure with key elements of mental health. Empirical research along this line is lacking and is needed to determine the exact nature of these relationships. The concept of freedom is introduced in the model in the form of removal of barriers and obstacles to participation (freedom from) and the availability of leisure education (freedom to). It is really these two latter elements of the model that form the foundation for enabling leisure experience and concomitantly positive mental health.

FIGURE 1

An Enabling Model of Leisure and Mental Health[1]



1. Model applicable to rehabilitation, transitional, and community settings.

RESEARCH IMPLICATIONS

This paper has highlighted a number of important issues relevant to disabled persons and leisure. Recent research (Bullock, McGuire, & Barch, 1984; Tait, 1989) has emphasized the need for an interdisciplinary approach to research and programming. Quality of life for all Canadian citizens involves every aspect of life, including leisure. Collaboration by researchers in various disciplines will give a clearer and more encompassing perspective on this whole-life view. As an initial step along this path, a conference entitled "Community for Everyone" was held at the University of Waterloo in 1988. Co-sponsored by the University of Waterloo, The Association for Persons with Severe Handicaps (TASH), and the Waterloo Separate School Board, the focus of the conference was to bring together researchers and practitioners concerned with educational, leisure, and vocational aspects of disabled persons' lives. This highly successful conference spawned greater interest and resulted in the creation of the Canadian Centre on Habilitation Education and Research which is housed at the University of Waterloo. One mandate of this newly created organization is to foster interdisciplinary and multidisciplinary research that will elevate the quality of lives of individuals who are disabled.

The following areas of enquiry are important topics in the area of leisure and disability:

(1) measuring the efficacy of leisure education programs, especially from a longitudinal perspective;
(2) evaluating treatment, transitional, and community programs that focus on leisure and disability;
(3) designing tools and assessments that validly and reliably assess life functioning, especially as it relates to leisure behaviour;
(4) applying substitution theory (see Iso-Ahola, 1986) to examine the process of substituting one leisure behaviour/activity for another as a result of injury or illness;
(5) development and evaluation of social-skills training programs, again especially from a longitudinal perspective;
(6) examination in detail of the specific relationship between leisure and health in the life of a person who is disabled.

It appears that we have a good idea of what people do or would like to do; it should come as no surprise that these activities and leisure behaviours are similar to non-disabled participants. We even seem to have a body of knowledge and research surrounding barriers and obstacles to participation, although this knowledge is not very systematic and has resulted in inconsistent information.

This knowledge alone is not enough, however, to foster complete integration and satisfying leisure. Study into the areas enumerated above should help us further understand what leisure means to people with disabilities, how service providers can facilitate full and satisfying leisure opportunities and experiences, and how leisure fits into other aspects of daily life. Clearly a number of these areas could be effectively studied from an interdisciplinary approach. Because leisure is so vital and interwoven in our lives, the quest for understanding how to facilitate leisure and recreation opportunities for all individuals seems a high priority.

RESUME

Il est de plus en plus établi que le loisir constitue un aspect important de la vie. La satisfaction puisée dans le loisir dépasse souvent celle qu'on peut tirer d'un emploi ou de d'autres activités de travail. La possibilité de s'impliquer dans des activités de loisirs de son choix est cruciale pour la santé et le bien-être de la personne handicapée. Les buts de cet article sont de: (a) décrire les avantages potentiels d'une participation active des personnes handicapées à des activités récréatives ou de loisirs, (b) décrire ce qu'on sait aujourd'hui sur le loisir et le handicap, et (c) suggérer des orientations de recherche. Un modèle de développement des habiletés, en loisir et en santé mentale est présenté.

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