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Do unto others: moving from deficit based leisure assessments for people with disabilities to mutual, collaborative and relational models.

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Abstract
This paper contrastively examines two different approaches to leisure assessment. The paper takes a deconstructive and critical approach to examining the dominant therapeutic recreation model as outlined by Peterson and Stumbo (2000) arguing that the rhetorical focus on ability in this model masks its roots in a medical model of disability. A critique of the language and bodies of knowledge that inform this model, from a social model of disability, demonstrate its embeddedness in the medical model.

In contrast, it is argued that diversional therapists and other leisure practitioners in the field of disability would find professional benefit in moving towards a model of assessment and service provision that is informed by a social model of disability. The social model of disability developed by Oliver (1996) offers a powerful critique of the medical model and of its disabling practices and institutions. An alternative approach to assessment that draws on social constructionist bodies of knowledge and on an ethics of dialogical and communicative understanding is proposed.

Introduction
This paper seeks to examine the assumptions, values and practices that underpin Peterson and Stumbo’s (2000) model of assessment and to outline an alternative approach by which other empowering models of assessment might be developed and to engage diversional therapists in the debate through reflexive theoretical and applied practice. Reflexivity (Parker, 1992) requires a reflective and responsive approach to both knowledge and practice. It implies an ongoing developmental approach to one’s own profession and to the integration of knowledge. Reflexivity at the level of practice offers opportunities for diversional therapists to consider how new approaches might contribute to more enabling approaches to service.
In undertaking critique and outlining alternative approaches this paper argues that there are emerging bodies of literature in the social sciences that are based on critiques of traditional modes of power and which, propose more communicatively interactive, dialogical and negotiated approaches to human service provision (Gergen, 1999; McNamee (2002); McNamee & Gergen, 1999).

These writers take a social constructionist approach to social reality arguing that social life, which includes encounters between diversional therapists and their clients, is a mutually negotiated enterprise, that both parties bring a pre-existing reality, shaped by individual histories, into the space where the professional relationship emerges. This destabilises the dominant discourses and rationalities of the medical model, opening up spaces for exploration, collaboration and mutuality in the therapeutic relationship which is not possible where one party has the power to impose their own socially constructed status in the guise of 'professional knowledge' onto the relationship.

Thus, the aim of the critical approach taken towards Peterson and Stumbo’s (2000) model aims to destabilise the dominance of the medical model as it informs its approach to assessment and to open a space where practices that are underpinned by a social model may be more fully integrated into diversional therapy assessment. This is especially relevant given that much diversional therapy practice takes place within institutional settings where practices are often deeply conditioned by biases that are implicit in the medical model.

Before commencing the critical argument four points of clarity are offered. First, the paper focuses on the practice of assessment because this is such a critical point in the cycle of practice. Assessment often constitutes the point of entry into the professional relationship and it shapes the structure and tenor of the relationship. The provisional end point of initial assessment determines the kinds of decisions that are made and shapes the goals and strategies of intervention that are put into place in recreation and leisure as well as other human service settings. Assessment is traditionally an open process. It takes place at various points in the cycle of practice and is instrumental in conditioning the relationship between the recreation professional and the consumer.

Second, I identify my place in the field of theorists on a ground of communicative ethics. Communicative ethics embraces the values of discourse dissent, critical appraisal and argument backed by justification and reason. This encourages debate and focuses on the perceived value of what is recognised as the dominant norms - the values, attitudes and practices. It espouses that all participants are 'free and equal' and valued in their contribution to debate which is necessary to continually test the validity of the moral norms and standards of all aspects of life. It requires 'open conversation' where all diversity of experiences are valued and heard and the process part of an ongoing learning cycle (Johnson, 2005, citing Sylvester 2002).

The critiquing of Peterson and Stumbo’s model is not to diminish its contribution to the development of the profession of diversional therapy, nor to question its rigour or motivation. From a perspective of communicative ethics, it simply argues that we should subject its characteristics, norms, values and practices to critical evaluation in the spirit of the 'open conversation' referred to above.

Third, I make reference to the deconstruction as a mode of analysis informing critique in the paper. Deconstruction, a form of analysis based on the work of French theorist Jacques Derrida (1978), has emerged as an important mode of analysis in the humanities and social sciences over the last twenty years. While this paper will not address the complex theoretical arguments and ongoing debates that underpin deconstructive scholarly practice, it demonstrates how a critical approach to language, an important principle in deconstructionist method, allows for the development of critical insights into the therapeutic relationship when it is structured by the medical model.

And fourth, it is important to note that the application of the social model of disability (Oliver, 1986) as a critique of the medical model has a recent, important and distinguished history, not only in academic spheres but increasingly in the areas of policy and practice. This is particularly the case in Britain where theorists
such as Oliver (1990, 1996, 2004), Morris (1991, 1992), and Oliver and Barnes (1998) have integrated their scholarship with political and cultural activism. They have formed alliances across a range of sectors that extend beyond the traditional political strategy of interest group politics, including the British arts industry (Barnes, 2003) and policy work (Oliver, 2004; Oliver & Barnes, 1998). They have successfully mounted theoretical, practical and political challenges to the dominance of the medical model that have reverberated across multiple levels of culture, including the media, the arts, community care and education (Barnes Oliver and Burton, 2002).

The medical model in recreation assessment
The paper provides a critical examination of the medical model as it pertains to assessment in Peterson and Stumbo’s (2000) approach and to provide a contrastive construction of assessment based on the insights of constructionist and interpretive modes of scholarship. This section commences with a description of the medical model and moves on to a deconstructive analysis of the language used by Peterson and Stumbo (2000) in their definition of assessment and contrasts this with a definition informed by the social model. It then looks at the different values and assumptions that underpin the two approaches. Finally, it discusses how the different models translate into different assessment practices.

White (2004) described the medical model of health practice as being biologicist, mechanistic and scientific. The biologicist element of this model means that disease and illness are viewed as naturally occurring events independent of social relationships. The mechanistic element adheres to the Cartesian separation of mind and body. This perspective means that sickness is viewed separately from the whole person. Bacteria, viruses and other disease causing agents are seen as affecting parts of the body. The human mind is seen as separate from the body. Being ill from this perspective is constructed as a "biochemical or anatomical occurrence which is largely independent of our consciousness or social location" (White, 2004: p. 29). The scientific element of the medical model is evident in its regimes of practice. Disease is constructed in terms of deviation from statistical norms, and responded to by scientific interventions based in biomedical, electrical, anatomical and increasingly behavioural interventions. Lang (1995) argued that the medical model is punctuated by the dominance of professionals whose role is to identify, cure and correct "as far as possible the physical and mental manifestation of impairment/ disability" (p.1). The medical model and the regimes of practice that inscribe it carry their own discourses. These discourses construct illness and disability in ways that are consistent with the premises of the medical model - that is in biologicist, mechanistic and scientific terms. Oliver (1996) argued that the medical model is based on notions of pathology, deficit, lack, absence and of problems to be eliminated or at least remediated. The person with a disability is defined by these deficits. He argued that in the medical model human normativity is defined by idealised notions of the body and mind rather than by the diversity of actual human experience.

Peterson and Stumbo (2000: p.200) defined assessment as:

the systematic process of gathering and analysing selected information about an individual client and using the results for placement into a programme (s) that is designed to reduce the individual's problems or deficits with his or her leisure and that enhances the individual's ability to independently function in leisure pursuits.

In the definition of assessment identified by Peterson and Stumbo above we can see how the medical model is evidenced. Peterson and Stumbo take a selective approach to assessing need in the therapeutic relationship. The assessment is focused on the remediation of problems and elimination of deficits. The problems are seen as entities in themselves and their elimination as the goal or end of therapeutic intervention (2000: p.200). This perspective takes a partial view of the client with its concern on gathering 'selected' pieces of information. This selectivity forms a lens through which the client is viewed. The person is also seen from a highly individual and atomised perspective rather than within a complex social system. Furthermore, the definition used by Peterson and Stumbo (2000) is grounded in techno-rational forms of knowledge reflecting the dominance of science in this approach. This is evident where they refer to 'systematic processes' of data gathering and 'decision making'. This, possibly,
Professional Practice

contributes to a relational demeanour that is conditioned by rationality, distance and neutrality rather than by the values of communicative and relational understanding.

The social model in recreation assessment

This paper proposes an alternative definition of assessment, one that is grounded in a social model of disability that draws on the constructivist tradition of social science and narrative theory. The social model of disability focuses on the way in which social and cultural assumptions and practices contribute to impairments becoming disabilities (Oliver, 1996). From this perspective people with disabilities live in a disabling world where their human and citizenship rights are denied. Oliver and other disability theorists argue that the dominance of the medical model in social care is potentially one of the major disabling factors in the lives of people with disabilities. Relationality provides an alternative approach to exploring the needs, desires, abilities and capacities of people with disabilities that, overcomes some of the distancing, and imbalances in power that emerge from the dominance of the medical model.

From the perspective of relationality, assessment involves listening to the personal stories that indicate what of their leisure history is central to the identity of the individual, including their history of loss, so as to understand and work with their values, motivations, capacities, opportunities and narratives in ways that reinforce an emerging, integrative and evolving leisure identity.

Rather than viewing the individual through a set of behaviours, deficits and problems this latter definition views people from a holistic perspective and is concerned with identity rather than the remediation of problems. From this perspective the personal leisure narrative of the individual, regardless of their range of abilities, is central to assessment and to informing the therapeutic relationship. The person is viewed as part of a social whole, located symbolically through their own narrative constructions (which may, in some cases, be mediated by an advocate) within a social community. The therapeutic relationship is strongly conditioned by the life stories, leisure narratives and meanings ascribed by the individual rather than by systematic processes of techno rationality. In this model dialogue, mutuality, interaction and communication are important principles. Decisions are made by or with the client and may involve a range of possibilities, rather than being made ‘for placement’ as prescribed by Peterson and Stumbo’s (2000) model. It is a facilitative rather than deficit based model of assessment.

Values and assumptions underpinning the medical and social/relational models of assessment

This section examines the major values and assumptions that underpin the two contrasting models. It looks specifically at what is privileged in each model, how power is constructed and operates in each model and at differential ethical constructions that inform the two models.

The medical model which underpins Peterson and Stumbo’s (2000) approach assumes a privileged role for the professional. Power is embodied by the professional through the incorporation and imposition of a scientific paradigm and scientific discourses into the therapeutic relationship and the specific practice of assessment (Foucault, 1990). The leisure professional has the power to diagnose ‘problems’, to pathologise human conditions, and make classifications that inform decision making. This power is reinforced by instruments of techno-rationality, the use of schedules and other technologies to support classification and legitimate decision-making. As noted earlier the medical model also constructs the relationship in terms of an ethic of emotional distance and neutrality reinforced by the scientific rationalities that inform and structure the relationship.

In contrast the social model privileges the narrative of the individual. Power is a collaborative process, negotiated through dialogue, mutuality and understanding. Rather than operating as professional embodied power to classify and diagnose it is the opportunity to mutually and dialogically explore. Relational understanding is what should inform decision making rather than diagnostic classification. The ethics that underpin practice in a social model are communicative and dialogical. Of central importance here are questions such as: who defines the problems, who determines what is ‘problematic’ and how ‘problematic behaviour’ is interpreted. What are constructed as behavioural problems from the
Professional Practice

perspective of the medical model may, from a social model be seen as attempts at communication. From this perspective what is being communicated by particular behaviours or actions may range from discomfort to despair but if we focus on the problems rather than their meaning we risk practices that may perpetrate a kind of professional domination over our clients. The social model offers a way of opening up the relationship and the demeanour that we ourselves take within the relationship.

Its assumptions are premised on uncertainty and openness.

The therapeutic relationship emerges as a more collaborative, relational and communicative enterprise. This allows for spaces to emerge that allow for an exploration of what the meanings that leisure and recreation have for people rather than a diagnostic approach that looks at limitations and strengths and matching people into activities on grounds that are formulated primarily through a deficit approach. It allows for a more thorough exploration of possibilities for expression of a more fully expressed leisure identity. This allows for more qualitative and narrative material to be incorporated into assessment and for the utilisation of more creative processes of intervention, when exploring leisure opportunities and problem solving interventions.

Contrasting models of recreation assessment

Having outlined some of the issues associated with assumptions, values and power above, the next section explores contrastive assessment processes in the two models of disability. Some of the relevant issues here have been discussed above. Again it is important to analyse how the language used reflects the knowledge processes that underpin assessment. Peterson and Stumbo firstly focus on the establishment of an ‘information base’, from which decisions are made (200: 215). They outline a number of things that must be included in assessment including what are referred to as ‘client considerations’. They commence with ‘typical needs’ of the group in question and of the ‘clustering of needs’ (200: 215). This appears to imply that individuality and uniqueness of need are subverted to questions of typicality – of broadly conceived notions of aggregate need. Such an approach to screening cannot consider diversity and uniqueness. They then focus on ‘limitations’ in assessment (200: 215). Peterson and Stumbo go on to discuss in very technocratic language various processes of functionality in assessment including ‘defining parameters’, ‘basic screening’, ‘narrowing the problems’ and of remediation and improvement (200: 216-218). Here again the primacy of the medical model is evident in their approach to assessment. It also implies a deep attachment to logico-positivist rationality as the means of addressing human ‘deficits’, specifically through the deployment of scientific rationality in addressing problems. When assessment is constructed in such a deficit focused way and internalised uncritically by leisure practitioners it can have the effect of narrowing how assessment is approached, of limiting the options for exploration and problem solving and ultimately of diminishing the scope for empowering leisure practice. Even where practitioners are reflexively aware of issues of power that are associated with the dominance of the medical model, the fact that the very language and practices of this model structures and conditions the therapeutic relationship limits the capacity for countering the scientism of this model with a more relational approach.

The social model lies more in the critical and interpretive social sciences. It is concerned with interpretation, the construction of social meaning and of analysing and critiquing how power is symbolically constructed, for example, through logico-positivist science (Foucault, 1990). It is concerned with developing models of practice and action that take a more mutual and emancipatory approach to therapeutic leisure relationships. From this perspective rather than focusing on functional deficits, limitations and problems the assessment process is concerned with developing an understanding of the person’s ‘narratives’ of leisure, of the place and meaning that leisure has had in the person’s past and present as well as their leisure hopes for the future. The focus is on gaining an understanding of the meaning that leisure has had in the lives of people, of exploring the continuities and discontinuities in an individual’s leisure narrative, and the significance of loss and resilience in their leisure identity. It involves exploring possibilities and allowing a place for imagination in assessment. It is not prescriptive or limiting. The establishment of the relationship is more akin to Austin’s (2002) model of a therapeutic relationship based on empathy, caring, positive regard, hope, genuineness, autonomy and mutuality.
Professional Practice

From this perspective where a person's ability to communicate is compromised, reflexivity is central to the practitioner's approach. Such reflexivity would require the leisure practitioner to ask questions of him/herself. In the case of impaired communicative and cognitive capacity, examples of the types of questions a practitioner might reflect on are outlined below although this is in no way an exhaustive list.

- In what ways does this individual communicate?
- What might this person be attempting to communicate by this behaviour or that action?
- How does this person express happiness, pleasure, joy or delight?
- How does this person express displeasure, sadness, anger or frustration?
- What does it mean when this person does that?
- Who is this person closest to and who knows him or her best?
- Who does this person trust?
- What can those who know and love this person best contribute to my understanding?
- How do I demonstrate regard for this person’s capacities?
- How do I demonstrate respect for this person’s dignity?
- How do I communicate with this person in ways that empower him or her?
- How do I ensure the time is available to build relationships of trust and faith with this individual and his or her advocates?
- How do I know if my practice is empowering?

Leisure theorist, Arai (1997), has described her disabled sister's journey from social disruption and loss to what she refers to as empowerment in her social identity. She discussed how lengthy this process was, the importance of relational dynamics that translated into trust over an extended period of time and of viewing the individual holistically rather than looking at parts of the individual in isolation. She described how traditional models of engagement were inadequate, precisely because they did not provide a dialogical space in which her sister's loss and emotional experience could be honoured. Rather, this history of loss secreted into a range of emotional signifiers such as anger and withdrawal. Reassessing the strategies and exploring what Arai referred to as a community model which incorporates the values of the social model of disability were the catalyst for what, in the end, translated into an empowering and affirming experience for her sister. Arai's approach involved virtues and practices such as patience, restraint and overruling her own desire to 'fix' what was perceived as a problem. It required reframing the issue away from a problem to one of developmental opportunity associated with the acknowledgement of loss and the process of grieving. Most tellingly it involved ensuring that her sister's emotional signifiers were honoured rather than problematised. They were seen as communicative events that carried great weight and meaning rather than as problems that needed to be addressed through interventions. Trust was built by honouring the communicative meaning in such events and over time this trust translated into a scaffold on which positive interventions, which included the expression of choice by Arai's sister over time, could be built.

Conclusion

This paper has argued that a critical examination of Peterson and Stumbo's (2000) model of assessment revealed that it is deeply conditioned by a medical model of disability. It argues that such a model is restrictive in application, that it skews power inordinately towards the professional and that its focus on the reduction or elimination of problems and reliance on techno-rational forms of knowledge all limit the possibilities for more open and empowering relationships between recreation practitioners and the people they work with. It proposes that, in contrast, it is possible to develop a model of assessment that embodies the values and principles of the social model of disability. Such a model would take a more holistic approach to the individual, incorporate a constructionist approach to knowledge and be based on the values of dialogue, mutuality and relationality. This has the potential to consolidate the development of relationships and practices that may be more empowering and satisfying to both diversional therapists and the people they work with.

References


