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The Effect of Counseling on the Leisure Behavior of Patients Discharged from Lakeshore Mental Health Institute

Patsy Mitchiner Harris
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To the Graduate Council:

I am submitting herewith a thesis written by Patsy Mitchiner Harris entitled "The Effect of Counseling on the Leisure Behavior of Patients Discharged from Lakeshore Mental Health Institute." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Recreation and Leisure Studies.

Martha L. Peters, Major Professor

We have read this thesis and recommend its acceptance:

Kim Kriek, Patsy C. Boroviak

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Accepted for the Council:

Vice Chancellor
Graduate Studies and Research

THE EFFECT OF COUNSELING ON THE LEISURE BEHAVIOR OF PATIENTS DISCHARGED FROM LAKESHORE MENTAL HEALTH INSTITUTE

A Thesis

Presented for the

Master of Science

Degree

The University of Tennessee, Knoxville

Patsy Mitchiner Harris

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The author wishes to dedicate this work to her children, Patti, Julie, and Dave, and to her parents, Mr. and Mrs. E. C. Mitchiner, whose support made this study possible.

ABSTRACT

The purpose of this study was threefold: 1) to implement a three-month pilot study to determine the feasibility of setting up a leisure counseling program at Lakeshore Mental Health Institute, 2) to discover if leisure counseling influenced the utilization of the community resources following discharge of patients from Lakeshore Mental Health Institute, and 3) to begin an investigation into the influence of recreation and leisure counseling on the recidivism rate of patients at Lakeshore Mental Health Institute.

By random selection, the population, consisting of sixty-two Knox County patients housed in the Admission Unit at Lakeshore Mental Health Institute, was divided into two groups, an experimental group and a control group.

Both groups were evaluated as to their skills and interests by means of an interview and an activity questionnaire. Lists of Knox County recreational facilities and programs were given to subjects in each of the two groups. The experimental group received leisure counseling daily while hospitalized, and the subjects were followed after discharge by home visits and leisure counseling by the

researcher every two weeks for a period of three months. Referral was made to recreation resources in the community.

At the end of the study period, data which were collected indicated that, after discharge and as a result of the counseling, 56 per cent of the experimental group used the community resources. By comparison, only 9 per cent of the control group who were discharged used community recreational resources. It was concluded that a leisure counseling program could successfully be implemented at Lakeshore Mental Health Institute. It was determined that leisure counseling did influence the utilization of the community resources. It was concluded that it was too early to determine the effect that leisure counseling had on the recidivism rate.

It was suggested that the study be extended to last one year. In addition, the expansion of the recreation program at Lakeshore Mental Health Institute to include leisure counseling was suggested.

It was recommended that development of recreational/social resources for patients discharged from Lakeshore Mental Health Institute be made. The services of a leisure counselor were felt to be necessary in developing the program.

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CHAPTER I

INTRODUCTION

The rapid advance of technology, together with increased longevity, has given man a large measure of free time. The drastic and sudden nature of this change has caught man psychologically and emotionally unprepared to adapt himself successfully and creatively.

According to Dr. Alexander Reid Martin (1, p. 1A), "Where yesterday our concern for mental health led us to those who were underprivileged, exploited, overworked, and poverty-stricken, today we are forced to turn our attention to the problems of the 'leisure-stricken.'"

A report made by the committee on leisure time and its uses from 1948-1960 ascertained that self-sought or prescribed leisure time activities play a role in preventing mental illness or treating and rehabilitating the mentally ill patient. It was noted that the nature of man's leisure time pattern could be one of the earliest signs of recovery from emotional illness.

Increasing leisure time has forced us to give more thought to the great number of depressions, suicides, and

psychosomatic phenomena that occur during holidays and vacations.

Psychotherapists are beginning to realize that an incapacity for leisure characterizes a great deal of psychotherapy. In an observation by Dr. Peter Martin (2), the ambiguity in the use of such terms as leisure, free time, play, and mental health determines the need for the emphasis on play and fun as an absolutely fundamental human need. Leisure contributes to mental health, which is a subjective state of well being with a capacity for enjoyment and happiness.

Edward Lindeman once said, "Recreation is not a set or series of experiences. It is rather an attitude -- a gallant attitude toward life." If every person in the field of recreation attained this attitude in the full sense of its meaning and assisted others to incorporate such an attitude in their personal lives, the contributions to life in our world today would be immeasurable. "Herein lies the challenge of recreation" (2, p. 7).

A. Statement of the Problem

The purpose of the study was threefold: 1) to implement a three-month pilot study to determine the feasibility

of setting up a leisure counseling program at Lakeshore Mental Health Institute, 2) to discover if leisure counseling influenced the utilization of the community recreation resources following discharge of patients, and 3) to begin an investigation into the influence of recreation and leisure counseling on the recidivism rate of patients at Lakeshore Mental Health Institute.

B. Need for the Study

There has been little research done in the field of therapeutic recreation dealing with the influence of leisure counseling on the utilization of community recreation resources and on the recidivism rate of mental patients. The research has revealed that mental patients of all types do benefit from recreation, and the need for leisure counseling has been well documented by the literature.

C. Limitations of the Study

The study was limited to a survey of patients from Knox County who were housed in the Admissions Unit, Chota Center, at Lakeshore Mental Health Institute during the week of February 13, 1978, to February 20, 1978. This

limitation was imposed because Knox County was more readily available to the researcher. The rate of recidivism was followed for three months only, since it was a pilot study. Hospital authorities have indicated that an increasing number of readmissions occur within three months of discharge. Comparable data on the readmission rate was not available at Lakeshore Mental Health Institute.

D. Definition of the Terms

Recreation consists of an activity or experience, usually chosen voluntarily by the participant, either because of the immediate satisfaction to be derived from it or because he perceives some personal or social values to be achieved by it. It is carried on in leisure time and has no work connotations, such as study for promotion in a job. It is usually enjoyable and, when it is carried on as part of organized community or agency services, it is designed to meet constructive and socially worthwhile goals of the individual participant, the group, and society at large (Kraus, 1966, p. 7).

Therapeutic recreation is a generic term denoting services in the field of recreation with a special interest in the needs of the ill and disabled. The activities and the clients' participation in them are structured to be therapeutic in addition to providing each individual with an opportunity for the recreation experience (Gunn, 1975, p. 13).

Rehabilitation is the process of restoring a patient to satisfactory physical, mental, vocational, or social status after illness (Gunn, 1975, p. 11).

Catchment area is, in psychiatry, a term borrowed from English to delineate the geographic area for which a mental health facility has responsibility (Gunn, 1975, p. 3).

Recidivism is the readmission rate.

Mental illness is a marked deviation from the norm in an individual's relations to others and severe disturbances in role performance (Gunn, 1975, p. 63).

Depression is a morbid sadness, dejection, or melancholy, to be differentiated from grief, which is realistic and proportionate to what is lost. A depression may be a symptom of any psychiatric disorder

or may constitute its principal manifestation. Neurotic depressions are differentiated from psychotic depressions in that they do not involve loss of capacity for reality testing. The major psychotic depressions include psychotic, depressive reactions and the various major affective disorders (Gunn, 1975, p. 60).

Schizophrenia consists of a group of disorders manifested by characteristic disturbances of thinking, mood, and behavior. Disturbances in thinking are marked by alterations of concept formation which may lead to misinterpretation of reality and sometimes to delusions and hallucinations, which frequently appear psychologically self-protective. Corollary mood changes include ambivalent, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive, and bizarre (American Psychiatric Association, 1968, p. 33).

Manic depressive illnesses are disorders marked by severe mood swings and a tendency to remission and recurrence. Patients may be given this diagnosis in the absence of a previous history of affective

psychosis if there is an obvious precipitating event. This disorder is divided into three major types: manic type, depressed type, and circular type (American Psychiatric Association, 1968, p. 36).

Alcoholism is a category for those whose alcohol intake is great enough to damage their physical health, or their personal or social functioning, or when it has become a prerequisite to normal functioning (American Psychiatric Association, 1968, p. 45).

Drug dependence is a category for those who are addicted to or dependent on drugs other than alcohol, tobacco, and ordinary caffeine-containing beverages. Dependence on medically prescribed drugs is also excluded as long as the drug is medically indicated and the intake is proportionate to the medical need. The diagnosis requires evidence of habitual use or a clear sense of need for the drug (American Psychiatric Association, 1968, p. 46).

Leisure counseling is a formal intellectual process designed for those who need to explore life patterns and attitude changes, including those pertaining to recreation and leisure. Leisure, in this case,

is seen as an attitude, not a block of time. Leisure counseling helps clarify values in leisure utilization. Its goal is to motivate people to deal more constructively with their leisure (Eppleson, Witt, & Hitzhusen, 1977, p. 37).

CHAPTER II

REVIEW OF LITERATURE

Very little research has been reported in recreation and its influence on the hospital recidivism rate of depressed patients. However, many persons have formed ideas about leisure, recreation, and the value to the mentally ill, especially to the depressed. These ideas, along with the actual research done, have been reported in this chapter.

A. Philosophy

"The cardinal thesis of psychiatry is the conviction that patients are people, not simply instances of pathology," states Dr. Paul Haun (3). "The patient's need for play has only recently been understood as the inescapable counterpart of his need for purpose and for serious activity."

Stevens (4) states that recreators must adapt the program of recreation to accommodate those who are mentally ill, confused, depressed, or discouraged. A person does not lose his capacity for having fun when he becomes mentally ill. Therapeutic recreation is a human service based on

the philosophy that each man is responsible for meeting his own needs, and each man has a need for recreation experience.

Gerald O'Morrow (5) asks us to consider the contribution that leisure, recreation, and play make to the normal daily living experience. While wholesome recreation cannot substitute for the basic necessities of sustaining life, it does have the potential for therapeutic benefits for all people. Recreation contributes to physical, mental, and emotional fitness and to social stability.

O'Morrow (6) notes the concern of the medical recreator for carry-over values inherent in the recreation program. The patients have not learned to develop adequate leisure time pursuits. They are lacking positive attitudes toward the use of leisure time and have not developed skills that will permit them to actively pursue activities of interest to them.

B. Leisure Counseling

"The recreationist is the professional with direct contact to the community by virtue of his having knowledge about and association with the personnel and agencies that provide public recreation service," state Shivers and Fait (7). He will be responsible for initiating contact with

appropriate agencies and setting up diverse programs so that the social and recreational needs of the client can be met.

At the present time, states O'Morrow (8), one problem in the field of mental health is not the person who is institutionalized, but the person who has been discharged -- the former patient. It has been advanced by a variety of authorities that the inability to function efficiently in a community, whether at work or during one's leisure, is one of the major symptomatic factors contributing to reinstitutionalization for an emotional illness. One study reports that discharged psychiatric patients are not able to seek out independently or utilize opportunities for recreation and social experiences, according to O'Morrow.

One critical area is how the former patient uses his leisure time after institutionalization. Some patients never make use of their recreational experiences learned while hospitalized. The use of social recreation experiences to develop skills and attitudes for adequate use of leisure should be followed in involving the therapeutic recreation specialists in developing and planning programs which will serve the discharged patient. One approach to serving discharge needs has been in recreation counseling.

It has been indicated that recreation counseling can help discharged patients avoid the solitary ways that set the stage for readmission.

Acuff (9) points out that numerous surveys have shown that the typical discharged patient has an empty leisure life. A counseling program can help that patient to achieve a more fruitful and satisfying leisure life.

With sustained psychiatric treatment in the hospital environment, it has been found that withdrawn, depressed patients participate with enjoyment in social recreational activities. Contact with patients who have refused re-hospitalization indicates that some tend to lapse into solitary ways on discharge and thus set the stage for reactivation of old pathological problems, state Olsen and McCormick (10).

Where the mission of a psychiatric service is to return the patient to his home community within a brief period of time, one must be concerned with whether the environment to which he returns is calculated to foster recuperative processes. This mission is generally acknowledged.

Jackson (11), a recreation therapist with the University of Southern California Medical Center, notes that we treat the patients in the hospital and send them out without

support or follow-up during the critical first month following discharge. It is during this period that the difficult task of facing life outside the hospital setting is taking place. The recreational therapist should be a valuable person to assist the patient to make a satisfying adjustment to life within the community.

This approach will help in making life more enjoyable within the home and community, thus reducing the number of patients returning to the hospital and the number of patients being admitted to the hospital.

Frye and Peters (12) note the recreation counseling program which was instituted by the Veterans Administration Hospital at Kansas City, Missouri -- both group and individual counseling was given to one-hundred-fifty to two-hundred patients. The results showed a strengthening of existing affiliation, formation of new ties, knowledge of recreational facilities and how they can be used, and a mobilizing of community resources.

Meyer (13) observes that recreation programs that provide opportunities to be included, understood, and accepted and to gain self esteem not only contribute to aftercare services for the discharged patient, but also provide an atmosphere that is conducive to basic mental

health. The recreation program with these characteristics is also focused on a primary prevention strategy.

The value of recreation to the ex-patient undergoing the process of rehabilitation and adjustment to life back in the community is that it is a way for him to relax and to be refreshed from a day in the relearning process. It will help to overcome self consciousness and to counteract discouragement processes he will face in the rehabilitation. These are the thoughts of Meyer and Brightbill (14).

Kraus (15) speaks of recreation centers set up for discharged patients to help them adjust to social and recreational life in the community.

Corbin (16) feels that recreation can help the depressed patient overcome his morbid concern over his own welfare.

Carlson, Deppe, and Maclean (17) remark that patients returning to the community are not usually ready to operate at optimum capacity. Recreation helps bridge the gap.

"The patient needs diversion to offset his introversion," states Rathbone (18). "Recreation will take a patient's attention off himself as he is being helped to discover how much he has left, and finally to see himself as an asset to society, not a loss."

Avedon (19) notes that 50 per cent of institutions offering therapeutic recreation report pre-discharge counseling. This is offered with a variety of objectives in mind: to enable patients and clients to strengthen existing social ties and to form new social ties and to enable them to recognize the meaning of recreation in their lives.

"Recreation helps patients to satisfy social needs and to constructively use leisure time following discharge," says Bucher (20).

O'Morrow (21) traces the idea that recreation was once merely to fill free time of patients to the concept that recreation is an important aspect in rehabilitation to community life. Activities function as a diagnostic tool; increase the socialization of patients; increase growth and development; provide outlets for hostility, aggression, and other emotions; alter attitudes toward self, toward others, and toward the future; provide opportunities for creativeness, development of new skills and interests, and for utilizing existing skills; provide opportunities to have fun; and prepare the patient for activities of daily living. Those working with former patients in the community can apply the same values.

Bates (22) states that it would seem that one critical area is how the former patient uses his leisure after institutionalization. Some patients, after release or discharge, make full use of their recreative experiences offered to them during their institutionalization. Countless others, however, are unable to make use of their experiences to facilitate their adjustment after institutionalization. Thus, one aspect of rehabilitation is the use of social recreation experiences to develop within the patient skills and attitudes for adequate use of leisure. It would appear that therapeutic recreation specialists must become more involved in planning and implementing programs which serve the post-discharge needs of the patient. With greater awareness of the lack of continuity between activities of the institutionalized patient and his activities in the community, there are emerging ways to combat his breakdown in total treatment.

One approach therapeutic recreation specialists are using to meet post-discharge needs of the patient prior to discharge is recreation counseling. Rust (23) has indicated that recreation counseling can help discharged psychiatric patients avoid the solitary ways that set the stage for re-admission.

Thompson (24) suggests the following recommendations for recreation counseling program development: 1) recognizing the need for recreational counseling services; 2) gleaning the literature on recreational counseling; 3) inquiring about programs in which others are involved; 4) recognizing and evaluating the feasibilities and potentialities of developing or expanding a recreational counseling program; and 5) developing a system of organization.

Dickeson (25) discusses the feasibility of an activity in counseling techniques and the activity continuum (including activity, education, and therapeutic recreation). He lists the four requirements for a counseling program: 1) gather information about the community; 2) give appropriate information to the client; 3) help the client reach the agency; and 4) follow up the client's involvement. Dickeson also discusses the importance of concentrating on the individual's developmental and behavioral processes and social awareness in a recreation program for short-term psychiatric patients. For long-term recreation counseling, elements of community contact should be utilized in existing recreation programs.

Hitzhusen (26) states that recreation and leisure

counseling should commence when the patient initially enters the therapeutic recreation program, especially in short-term psychiatric centers for emotionally disturbed youth.

The scope of Lindley's article (27) is focused on leisure problems associated with the individual, whether in the institution or in the out-patient community clinic. Staff members from the institution, clinic, or public recreation agency may perceive the use of the community as their major leisure resource. Each member needs to be aware of the problems related to his involvement in the joint approach to the use of community recreation programs. Within the various agencies, the therapeutic as well as the community recreation staff have the objective to provide structured and nonstructured leisure experiences for group and individual needs.

Smith (28) notes that therapeutic recreators are using community facilities more regularly and that every effort should be made for communication and cooperation between the therapeutic recreator and the community recreator.

Jolicoeur (29) defines therapeutic recreation, leisure education, and recreation and describes settings in which these services are offered. Planning operational objectives and developing programs for special groups and individual

clients are discussed.

Wilson (30) describes a leisure counseling center. The process includes the client's completing the Miranda Leisure Interest Finder and receiving suggestions for leisure activities which fit his perceived needs.

Pain's article (31) presents some basic philosophical considerations relating to leisure counseling, and some useful techniques in practicing such a philosophy. Bridging the gap between the real and the ideal is the counselor's role. Leisure counseling represents a major step in the sound body of knowledge from which we can direct people toward one of the most neglected needs of our society, the greatest and most meaningful use of our recreation and leisure.

C. Depression

"Depression is a serious and prevalent disorder which yields readily to treatment, but goes untreated most of the time. Its impact on the family can be incalculable in emotional stress, social and economic chaos, and sometimes results in the tragic loss of the depressed person by his own hand," states Cammer (32). He cites two illustrations of recreation benefiting depressed persons. One is the rapid

recovery of a retired president of a large corporation suffering from depression after opening up a summer camp for low-income families. The other is in the case of a young woman suffering from a mild depression caused by the interference of her mother-in-law. Her depression was overcome when she became absorbed in painting, a hobby she developed. It is good therapy for persons to be maneuvered into paths of new accomplishments.

A tactic that can be used in mild depressions caused by excess fatigue or a recent depressing event is a change of scene. This applies particularly to the neurologically depressed individual who needs to regress to carefree vacation patterns. During the convalescent period, a vacation with planned activities, not just rest, may be best. It removes one from the environment in which he became ill and gives him a chance to orient himself to health again, but in a setting that also gives recreation.

Hunt (33) notes the disinterest and depression that many patients experience after changes when they engage in activities that allow them to regress acceptably. Pleasurable emotions that a patient has connected with a childhood activity may be spontaneously awakened in him when he repeats that activity.

Weissman and Paybel (34) report that friendships, participation in social groups, and recreation are normal human activities. These become more important as the psychiatric patient is discharged to the community, since the person outside the cloistered atmosphere of the hospital has many unplanned hours each day. How this time is spent may influence the course of the disorder. The patient who remains withdrawn and isolated from people and who does not have interesting hobbies or supportive friends may have a guarded prognosis.

Beck (35) states that, in recommending activities to a depressed person, the therapist should attempt to gauge both the tolerance for the stress involved and the probabilities for success. The particular tasks should not be too difficult or too time consuming. Successful completion of a task by depressed patients significantly increases optimism, level of aspiration and performance in subsequent tasks. Recreation has been found to reduce the duration of psychiatric depressions. Keeping active is one way of thwarting depression, according to observations of Freeman (36).

Acuff (37) mentions that, as the profession matures, therapeutic recreation will become more concerned with "preventive recreation." Preventive recreation, through

communication of healthful leisure attitudes, concepts, and skills, can, just as does preventive medicine, help forestall disability or, if encountered, ameliorate its effect.

D. Schizophrenia

Review of literature relating to the use of activities in the treatment of chronic schizophrenia cites several programs that combine activities and psychotherapy to produce effective modes of treatment. Also, a program is described which improved interpersonal relationships, reality testing, and self image, as well as helped them express problems and develop feelings of autonomy. Moriarty (38) believes that such combined programs help meet the basic needs of schizophrenic patients and alleviate their tendencies to withdraw from their surroundings.

Duncan (39) speaks of the importance of interpersonal contact in rehabilitation of the schizophrenic former patient. Meaningful involvement in activities promotes self confidence. The importance of social rehabilitation cannot be overestimated. Almost all schizophrenics have experienced major failure in social relationships. They have a feeling of isolation. What seems to characterize them is the inability to establish relationships, periodic

relations that alienate their friends, and an overwhelming sense of loneliness and failure. Rehabilitation processes are capable of intervening in the social area of a person's life. Social skills can be taught. This is extremely important.

The use of leisure time is an important ingredient of successful functioning in the community and it relates directly to whether a person requires re-hospitalization. There is nothing that is more debilitating than the overwhelming sense of loneliness that characterizes most former mental patients. No one tolerates this loneliness well. They need human interaction and social activity as a hedge against loneliness. This need is endemic in schizophrenics. Weekend social activities are especially important. Group activities where members feel free to react and chat are important. Such activities which could be included are athletics, cooking, sewing, crafts, newspapers, art, museum-going, concerts, bowling, and camping.

Groups could be formed focusing on the importance of social skills on such topics as the art of conversation, grooming and appropriate dress, role playing in dating, and correcting the mannerisms of mental illness through videotape feedback. Groups should be formed to provide skills former

patients can use to solve their own problems, to provide activities to keep them involved and interested, and to provide the experiences within which they may practice newly found social skills.

Former patients should be encouraged to become involved in community activities; e.g. bridge, bowling, church groups. They often are found to maintain marginal, nonproductive social adjustment.

Volunteers can be utilized to relate as a kind of friend to the patients. The extent and depth of social programs represents an important contribution to patient rehabilitation to the community. Social lives of patients have been inadequately programmed by treatment agencies or left to others.

Social activities, peer relationships -- both intimate and superficial -- are an absolutely crucial support system that can be taught and experienced.

E. Manic Depressive Illness

Bellek (40) describes how, in the process of socialization, the ego and the superego develop and how these are influenced by the life pattern. Socialization consists of a whole hierarchy of learning patterns,

superseding each other as time progresses. The ways of coping with a desire which were accepted at an early age are no longer acceptable at a more adult age. The degree of frustration tolerance and the ability to engage in detour behavior for the long-range achievement of pleasure are some of the aspects of the ego's strength. The outstanding factor in manic depressive psychosis is a weakness of the ego.

F. Alcoholism

Alcoholism is one of the oldest illnesses known to mankind. From time immemorial, alcoholism was looked upon as a voluntary excessive indulgence in drinking various alcoholic beverages. Caton (41) notes that it was not until the later eighteenth century that some in medical circles first began to understand that this condition, known today as alcoholism, is a disease.

Many changes are taking place in community life today, and this includes the increased attention being given to the medical and other needs of the alcoholic and his family. The community planning a comprehensive treatment program for the alcoholic should include attention to his immediate social environment. Halfway houses, sheltered

workshops, day-night recreation centers, as well as other approaches could be more fully developed.

G. Drug Addiction

Nyswander (42) describes drug addiction as a distinct medical entity which ravages the patient, destroys the entire fabric of his life and adversely affects the lives of his family and others close to him.

The most crucial stage in the treatment of a drug addict begins at the moment he is released from the hospital where he has been withdrawn from drugs and has spent from six weeks to four months in a drug-free environment. His return to social and work life depends to a great extent on beginning this part of the treatment at once.

To be successful the treatment planned for a drug addict must take in every area of his life. The drug addict's need to become part of a group immediately upon completing hospitalization cannot be overemphasized.

Addicts are not solitary people and benefit from support of friends. Referrals made to social groups other than to groups of addict friends are beneficial -- especially YMCA and YMHA.

H. Related Studies

Brockbank and Westby (43), in a test group of twelve-thousand aged people, asked several questions relating to mood and satisfaction. Analysis of the answers to these questions indicated three dimensions of morale, which are called depressions, irritability, and the will to live. Of all these dimensions, those who were active socially received higher scores than those who were less active -- the discrepancy being by far the most marked in the depression dimension. At first glance this appeared to be clearly an indication of the activist theory of aging. On the other hand, over a third of those reporting little social interaction were not depressed. About two thirds of them ranked high in the other two dimensions of morale. In the course of two years, those were pinpointed into two groups, those who had manifested some social withdrawal during that time and those who had not.

Findings in regard to level of social interaction and morale were confirmed through comparison of those who reported a decline in social contact with those who did not. Among those who had not withdrawn, 52 per cent ranked high on morale measures. At the same time, as many as 42 per cent of those who had withdrawn ranked equally high. Social

withdrawal, then, is not necessarily conducive to low morale. A further division took place. Involuntary pressure and withdrawal disengaged with voluntary withdrawal -- no pressures and unaffected engaged (no withdrawal, no pressures). The involuntary disengagers ranked lowest on morale clusters. The unafflicted engaged had low morale. The voluntary disengaged had relatively high morale. These findings, suggesting both disengagement theory and activist theory, are applicable. A person can disengage and maintain morale if the disengagement is voluntary, and he has an even higher morale if he has not disengaged at all. If a person experiences stresses of aging, he tends to have low morale, whether socially withdrawn or not. This suggests that it is these stresses themselves rather than isolation which result in low morale. What has been found is that some people have a need to withdraw as they grow older. Those who are forced to withdraw do not maintain a satisfying equilibrium as a rule.

In a study done by Costello (44), it was noted that a symptom of the depressed person is his inactivity, with loss of incentive. The purpose was to determine what activities a person has as an incentive and how many of these activities he participates in.

The assumption from which the research starts is that daily variations in mood are similar to variations in depression. The research entails obtaining from volunteers daily recording of mood and activities. Each day for twenty-eight days each person records mood and indicates on a checklist of three-hundred-twenty activities those in which he engaged. Pleasantness ratings are obtained each day. The volunteers read through the completed list of activities and check those in which they engaged during the day. On a five-point pleasantness scale, they indicate how much pleasure they get from each activity engaged in during the day. Summing of pleasantness ratings associated with activities checked each day is done. The assumption was made that pleasure obtained from an activity might change from day to day.

The incentive a person has for an activity may be as variable as his mood. Emphasis is on the strength of reinforcement. The prediction was that, even when the number of activities engaged in remained low, moods would improve with an increase in the pleasantness of these activities.

Depressed persons were found to engage in fewer activities and to get less pleasure than did nondepressed people. Daily mood shifts were associated with both the number of

activities and pleasantness ratings. In other words, people feel better on days in which they do more things and when they enjoy them more.

Incentives for activities are related to depression. Depression could be the antecedent of a loss of incentive or it could be the reverse. The loss of incentive should be regarded as the most particular characteristic of depressed people.

Czekszentmiholyi (45) made an analysis of the reported experiences of people involved in various play forms. These included rock climbing, chess, dance, basketball and music composition. The suggestion made is that the qualities which make these activities enjoyable are the following: 1) a person is able to concentrate on a limited stimulus field, 2) in which individual skills can be used to meet clear demand, 3) thereby forgetting personal problems, and 4) his or her own separate identity, 5) at the same time obtaining a feeling of control over the environment, 6) which may result in a transcendence of ego boundaries and consequent psychic integration with melapersonal systems. The concept that certain experiences are intrinsically rewarding, and its usefulness in understanding human motivation, are discussed.

Bultene and Wood (46) conducted a study of the recreational activities of retirement community residents. It was found that those who were most involved in leisure activities tended also to be persons with the most favorable outlook on their life situations (zero-order correlation was 20). This finding is consistent with a sizeable body of research which has found a low but positive association for the aged between participation and morale. Morale has also been revealed in previous research to be a function of the age, class standing, and health status of older persons. It was necessary therefore to control these three variables in assessing an independent effect for those respondents of leisure participation on morale. This control did not significantly alter the initial relationship obtained from .20 to .17.

Wood, Wylie, and Sheafer (47) reported on the measure of life satisfaction correlation with rater judgments. Morale was measured by a short form of the life satisfaction index. The proposition that activities of retirement community residents are consistent with their personal orientation toward leisure is explored in this study. The study was carried out in four planned retirement communities in Arizona. Three-hundred-twenty-two men who migrated

there subsequent to their retirement in the midwest were interviewed.

Espenschede (48) studied the role of exercise in the well-being of women thirty-five to eighty years of age. She noted that the importance of physical activity for health and well-being at all times in life is widely recognized. This study attempted to assess aspects of physical and psychological well-being of two groups of women who differed from each other in that one was known to have participated in vigorous physical activity in youth, while the other did not.

Recreational interests may give some indication of psychological and social well-being. Listings submitted by participants included a wide range of participation in social clubs, religious and charitable organizations. In answer to specific questions concerning recreational sports or dance activities, subjects' responses far outnumbered those of controls. Forty-eight per cent of the latter listed no such participation, whereas only 3 per cent of subjects indicated none. It is to be expected that the type of sport interest changes with age. Subjects participated more widely in recreation of a physically active type than did controls. A diary record was kept for one week

describing physical activities. Subjects showed more physical activity interests. The only indication that the greater participation of subjects in physical activity may make a positive contribution to their well-being rests with the Step test (a modified Schneider test). Since the test was self administered and taken by a smaller per cent of control subjects, the result must be interpreted with caution.

Lewinsohn (49) made a study of the relationship of the engagement in pleasant activities and depression level. He noted that previous studies have shown a low rate of engagement in pleasant activities to be a concomitant of depression. The crucial question addressed by Hammen and Glass (50) was whether an increase in pleasant activities would produce a decrease in depression level. Positive results would constitute strong evidence that low rate of engagement in pleasant activities is an antecedent of depression. The results of the Hammen and Glass study should not be considered conclusive, because neither an initial low pleasant activities level nor a significant association between mood and pleasant activity level was demonstrated for the subjects prior to the introduction of the experimental treatment.

In the study done by Hammen and Glass, mild to moderately depressed subjects were either induced to increase their participation in events they had rated as pleasurable or were assigned to one of several control groups. Contrary to an operant hypothesis of depression, increases in positive activity did not alleviate depressed mood. The results were replicated in a second study, which also demonstrated that the subjects who engaged in more of reinforcing activities actually rated the events less positively than subjects in groups that did not increase their activity levels. The findings are comparative behavior modification perspective or depression, which emphasizes individuals' evaluating of events as a determinant of the complex relation between activity and depression.

Lewinsohn (51) conducted another study with Libet. Three groups of ten subjects (depressed, psychiatric controls, and normal controls) were used. The subjects rated their moods and also indicated the number of "pleasant" activities engaged in each day over a period of thirty days. A significant association between mood and pleasant activities was found. There were large individual differences in regard to the magnitude of the correlation between mood and activity, but differences between groups failed to attain

statistical significance. The results are interpreted as consistent with the major tenet of the behavioral theory of depression, that is that there is association between rate of positive reinforcement and intensity of depression.

Effects of physical training on mood was the subject of a study done by Folkins (52). Thirty-six adult men at high risk of coronary artery disease were assigned to either an exercise or no exercise (control) group. Improvements in physical fitness were accompanied by improvements on two mood measures, anxiety and depression. No change was found on measures of adjustment, self confidence, and body image.

MacPhellamy and Lewinsohn (53) conducted a study on depression as a function of levels of desired and obtained pleasure. One-hundred-twenty paid volunteer subjects equally divided into depressed, nondepressed, and psychiatric control groups were administered the pleasant events schedule. Mean scores of the three groups were computed on scales purporting to measure obtained pleasure, activity level, and potential for being reinforced by a wide variety of events. As predicted, the depressed group scored significantly lower in these scales than the control group, which did not differ significantly from each other. A minor

hypothesis, derived from the nonanalytic theory of Bonime, that depressed subjects would have higher scores on a scale purporting to measure the level of desired gratification, was disconfirmed.

Lewinsohn and Graf (54) made another study on pleasant activities and depression. The relationship between engaging in pleasant activities and mood was examined as a function of age, sex, and diagnostic group. Ninety male and female subjects, evenly divided into three age groups (eighteen to twenty-nine, thirty to forty-nine, and fifty and over) and three diagnostic groups (depressed, non-depressed psychiatric, and normal controls) completed activities schedules and mood ratings for thirty consecutive days. The correlation with mood was obtained for total number of pleasant activities engaged in, as well as for individual activities. Results indicate that 1) a substantial and significant relationship exists between mood level and number of pleasant activities engaged in for all groups; 2) psychiatric controls and subjects aged thirty to forty-nine had a significantly larger number of mood correlated items; and 3) depressed subjects engaged in fewer pleasant activities. Activities and events frequently associated with mood were categorized into three groups:

incompatible effects, ego supportive, and social interaction.

Shearer (55) reports on a study he conducted concerning camping as a therapeutic experience for depressed and schizophrenic patients. Two groups were involved in the experience. One group consisted of four chronically depressed patients, the other of ten chronically disturbed schizophrenics; all were men. The depressed group camped at a state park about sixty miles from the day treatment center at the Veterans Administration Hospital in Atlanta, while the schizophrenic group camped at a mountainous national forest about ninety miles away. Throughout the trip, the schizophrenic group related well to each other, organized and carried out tasks well, and revealed overt pleasure and enjoyment over the camping experience. The depressed patients revealed a far greater degree of anger, apprehension, and resistance than did the schizophrenic group. The experience in living gave staff and patients from each group a view of the total person in a variety of situations and circumstances not usually evident in group sessions and in-house programs at the hospital. The dynamics of personality and behavior take a more realistic perspective when related to an extended experience in living.

Berube (56) conducted a study in survival camping

experience as a means of teaching behaviorally, emotionally, or mentally disturbed persons with low esteem to discover behavioral alternatives and cope with problems by seeing them in a different perspective. Fear-stress exercises were used to help participants realize that the group accepted him/her. Life-stressing experiments were conducted to promote feelings of independence and competence. Skill developments were aimed at strengthening feelings of self worth. Overall success of the camp was dependent upon the ability of leaders and participants to legitimize norms for operation by creating a socially and emotionally safe environment for interaction. Debriefing sessions followed all main camp activities. Outcome assessment was limited, but generally favorable.

Babow and Simkin (57) made a study of the leisure activities and social participation of mental patients prior to hospitalization. The findings of the study indicated that the majority of patients were not being reached in the community by agencies. The availability and accessibility of community resources varied. However, even patients who lived in counties with a variety of programs had not made use of the resources. A major finding of the study was the absence of support and social networks. Many of the

patients were disadvantaged. The data on the patients' ratings on the Onomio Scale and the Depression Scale suggested that a large percentage of them were experiencing a generalized despair and feeling of helplessness. Many patients were marginal in the labor force and had a considerable amount of "empty time." Improved competence in recreation and in leisure activities would appear to be a valid goal of improved functioning of patients in the hospital and when they return to the community. It may well be that deficiencies in community care in this field when patients return to the community are one of the main reasons why patients too often have to be readmitted to a mental hospital. Currently in California, for instance, 52 per cent of admissions to state hospitals for the mentally ill are readmissions. It is important to learn about the required network of services and to ensure delivery in the hospital and in various settings in the community.

The purpose of a study on psychiatric patients' use of leisure time, conducted by Mullaney and Sheeley (58), was to describe a sample of patients from St. Elizabeth's Hospital in Washington, D.C. on convalescent leave, in terms of background characteristics, therapies received while hospitalized and patterns of their leisure use, within and outside the

hospital. The focus of the study was on a systematic comparison along the three dimensions specified of those patients who were still in the community at the time of the research interviewing and those who returned to the hospital. Primary emphasis was placed on their use of leisure time. Even though patients were involved in recreational activities while hospitalized, they became isolated and inactive when they returned to the community. Departments of recreation in communities might represent an "untapped" resource for building programs for the returning patient.

Woloshin and Tomura (59) studied the value of an activities therapy program in a community mental health center. They concluded that an activities program can play a meaningful part in helping patients with early return to community living, participation, and productivity. It has a meaningful part to play within the rehabilitative adjustment philosophy of a community mental health center approach and can contribute to reinforcing task oriented appropriate behavior.

Pattison (60) conducted a study of the relationship of therapeutic recreation services to community mental health programs. The results suggest that leisure activities be used to provide activities that will restore humanness,

awareness, individuality, and meaning. The recreational therapist should develop a systematic rationale for using recreational therapy as a method of normal human activity in order to restore humans to their world and themselves.

In a study conducted at Western State Hospital, Fort Steilecoom, Washington, Dunham (61) concluded that individuals in our communities recuperating from acute mental illness and finding their way out of long-term isolation and dependence need help to become part of the community. Recreation programs geared toward the understanding of individual differences, belief in the capacity for growth toward acceptable social behavior, and the commonality of human social needs are vital to the successful treatment and rehabilitation process.

In a study of a large number of former psychiatric patients who were institutionalized, Huran, Rosenberg, and Morris (62) reported a number of unmet needs in recreation and family counseling which had not been resolved in pre-discharge planning and counseling or post-discharge counseling.

Blackman, Horne, and Pinksoe (63) used openest principles to design an activity for thirty handicapped elderly (aged sixty-eight to ninety-six years) women in a home for

the aged; the activity was monitored to study its impact on their levels of participation and social interaction. Results indicate that the residents' presence in the activity area fluctuated systematically with occurrence and non-occurrence of the activity. Social interaction between residents increased on activity days with especially high rates of interaction in the activity area.

Guthrie and Swenson (64) describe a therapeutic recreation program for chronically ill mental patients at a state hospital. The program, which has had a high success rate over its five years of operation, stresses the development of functional skills in all areas of life (social skills, attitudes, and habits)。 The orientation, philosophy, and goals of this "Social Improvement Program" are discussed. Three case studies and follow-up observations are included.

O'Morrow (65) states that as the emphasis in hospitals and institutions has changed from custodial care to rehabilitative and an increased emphasis has been placed on the importance of leisure to one's existence, consideration must be given to assisting the handicapped individual to make the best possible use of his leisure.

I. Summary

The literature revealed that many professionals, including psychiatrists and educators, recognize the value of recreation to physical, mental, and emotional health. Leisure counseling has become recognized, according to the professional literature, as a means to help discharged patients to make satisfying adjustments to life within the community.

The influence of recreation and leisure counseling in mental illnesses, such as depression, schizophrenia, manic depressive illness, alcoholism, and drug addiction, is recognized by many mental health professionals.

Related studies revealed that recreation and leisure counseling programs have helped in the rehabilitation process of mental patients, both while hospitalized and after discharge to the community. The literature states that as the emphasis in hospitals has changed from custodial care to the rehabilitative process, consideration must be given to assisting individuals to make the best use of leisure time.

CHAPTER III

METHODS AND PROCEDURES

This study, involving the feasibility of a leisure counseling program at Lakeshore Mental Health Institute, the utilization of community recreational resources, and the initiation of an investigation into the influence of recreation and leisure counseling on the recidivism rate of patients at Lakeshore Mental Health Institute, was conducted in four phases. The first phase was the development of the community recreational/social referral system for Knox County patients who were discharged from the Admission Unit, Chota Center, at Lakeshore Mental Health Institute during the study period from February 20, 1978, to May 20, 1978. The second phase was the implementation of the counseling program. The third phase was the determination of the use of community resources by the discharged patients. The fourth phase was the collection and analysis of the data gained from the first three phases.

A. Selection of the Sample

Subjects consisted of all sixty-two Knox County patients over eighteen years old who were housed in the Admission

Unit, Chota Center, at Lakeshore Mental Health Institute during the week of February 13, 1978, to February 20, 1978. All patients who enter Lakeshore Mental Health Institute are first admitted to Chota Center. They have varied psychiatric disorders, including schizophrenia, alcohol and drug addiction, manic depressive illness, and various personality disorders. The diagnoses are described further in Chapter V.

The sample population, as described above, was originally assigned randomly to two equal groups of thirty-one subjects each, an experimental group and a control group. Twenty-seven subjects in the experimental group agreed to participate in the study, and twenty-three subjects in the control group agreed to participate. This is discussed further in Chapter IV.

B. The Evaluation of Subjects' Interests and Skills

Subjects were asked to sign an informed consent form, after which both groups were evaluated as to their interests and skills by means of an interview and an activity interest questionnaire, a modified version of the Avocational Activities Scale developed by Weertz, Healy, and Overs. Subjects were asked to circle the activities they found most

interesting. There was space included for comments or any activities not included in the checklist. A copy of the questionnaire may be found in Appendix A.

C. Survey of Recreational Facilities of Selected Areas

Letters were written to the recreation directors of Knoxville and Knox County, requesting brochures and information about recreational facilities and programs. Lists of outdoor recreational areas and facilities were also obtained from East Tennessee Development District and East Tennessee Health Improvement Council. This information was combined into a written list and given to both the experimental and the control groups. A copy of the list may be found in Appendix A.

D. Leisure Counseling

The experimental group, in addition to the interview and activity questionnaire, received leisure counseling daily while hospitalized by the researcher who is a trained recreational therapist, followed by home visits and leisure counseling every two weeks after discharge.

The leisure counseling program was designed to help subjects clarify their leisure values and to find out if

they would freely choose and actively seek out enjoyable experiences. The program was designed to assist participants in clarifying their recreation interests. It was basically conducted in six phases. Phase 1, Identifying Recreation Objectives, introduced subjects to the program and clarified with the subjects how the terms leisure and recreation would be used. It involved listing twenty things they liked to do. Phase 2, Benefits and Alternatives, focused on the benefits of recreation. It involved offering alternative recreation activities. Alternatives were considered individually for personal use. The subjects considered the consequences of the alternatives they used. Strategies used were brainstorming, an alternative search, and a consequences search. Phase 3, Leisure Patterns and Priorities, encouraged subjects to discover how they spent their time. A "pie of life" chart was constructed and unfinished sentences were used to further illustrate this. Phase 4, Focusing on Changes, examined how the subjects actually spent their time and how they would like to spend it. Focus was centered on possible time utilization desired by the subjects and on searching for ways to implement desired changes. "Two ideal days" were planned by the subjects. Phase 5, Overcoming Barriers, continued to focus

on changes the subjects wanted to make and steps they planned to take. Focus was directed toward possible resources available in the community which could help implement changes. Barriers were examined which might prevent the subjects from doing activities they might enjoy. Phase 6, Planning for the Future, offered opportunities for subjects to plan for leisure after discharge. It incorporated all the alternatives selected, as well as desired changes. Focus was given again to resources which might help in accomplishing these plans. The final segment included an evaluation of the program. Tools used were a discussion about getting ready for the next session, a review, and evaluation questions.

The amount of time spent on each phase and the number of leisure counseling sessions varied according to the length of the attention span and the ability of the subjects. Community recreation leaders were asked to advise the subjects about available recreation resources and, if possible, to aid with transportation to and from the facility.

E. Collection and Organization of the Data

At the end of the study period of February 20, 1978, to May 20, 1978, personal data concerning the distribution

of the experimental and control groups on demographic variables of sex, age, race, marital status, children, religion, and education were compiled. This information was obtained from subjects' hospital charts, personal interviews, and the activity questionnaire.

Additional hospital data, consisting of the diagnosis, the legal status on admission, the number of admissions for each subject, and the per cent of time each subject spent in the hospital since the first admission, were collected.

Recreation data were obtained, including resources used, number of subjects using the resources, and number of post-discharge contacts made by the recreational therapist. Based on readmission data, comparisons describing the current admission status of the experimental and control groups were made.

Simple percentage comparisons were used in the treatment of the data. Other statistical tests were not used because of the small size of the sample.

CHAPTER IV

ANALYSIS OF THE DATA

The total population of patients from Knox County in Chota Center at Lakeshore Mental Health Institute at the time the sample was selected was sixty-two. These subjects were randomly assigned to a control group and an experimental group of thirty-one each. This is indicated by Table I.

Table II shows that of the thirty-one subjects in the experimental group 87 per cent agreed to participate in the study. This compares with 74 per cent of the control group. Ten per cent of the experimental group were unable to participate due to their mental condition, while 19 per cent of the control group were unable because of their mental state. Three per cent of the experimental group refused to participate, and 7 per cent of the control group refused. With the high per cent of subjects willing to participate, it was felt that the sample was adequate.

The distribution of demographic variables according to sex, age, race, marital status, children, religion, and education is indicated by Table III. Although the composition of the groups differed markedly in sex and race, there

TABLE I

DIVISION OF SAMPLE POPULATION

	Size of Sample
Experimental Group	31
Control Group	31

TABLE II

DEGREE OF PARTICIPATION

	Experimental Group		Control Group	
	Number	Per cent	Number	Per cent
Agreed	27	87%	23	74%
Unable	3	10	6	19
Refused	1	3	2	7

TABLE III

DISTRIBUTION OF THE SUBJECTS ON DEMOGRAPHIC VARIABLES

	Experimental Group		Control Group	
Sex				
Male	8	(30%)	17	(74%)
Female	19	(70%)	6	(26%)
Age				
20-30	10	(37%)	10	(43%)
30-40	4	(15%)	3	(13%)
40-50	4	(15%)	6	(26%)
50-60	3	(11%)	2	(9%)
60-70	5	(19%)	1	(4%)
70-80	1	(4%)	0	(0%)
80-90	0	(0%)	1	(4%)
Race				
White	24	(89%)	14	(61%)
Black	3	(11%)	9	(39%)
Marital Status				
Single	9	(33%)	11	(48%)
Married	7	(26%)	5	(22%)
Widowed	4	(15%)	1	(4%)
Divorced	5	(19%)	4	(15%)
Separated	2	(9%)	2	(9%)
Children				
0	14	(52%)	13	(57%)
1	4	(15%)	5	(22%)
2	6	(22%)	3	(13%)
3	1	(4%)	0	(0%)
4	1	(4%)	2	(9%)
7	1	(4%)	0	(0%)
Religion				
Baptist	15	(56%)	15	(65%)
Other Protestant	12	(45%)	8	(35%)

TABLE III (Continued)

	Experimental Group		Control Group	
Education				
Under 8th Grade	4	(15%)	2	(9%)
8th-12th Grade	12	(45%)	7	(31%)
12th Grade and Above	11	(41%)	4	(61%)

were no marked differences in the other demographic variables. The largest number, 70 per cent, of the experimental group were female, compared with 26 per cent in the control group. Thirty per cent of the experimental group were male, while 74 per cent of the control group were male. Eighty-nine per cent of the experimental group were white, and 61 per cent of the control group were white. Eleven per cent of the experimental group were black, while 39 per cent of the control group were black. The largest number of subjects, 37 per cent of the experimental group and 43 per cent of the control group, were between twenty and thirty years old. In comparing the marital status of the two groups, the largest number, 33 per cent of the experimental group and 48 per cent of the control group, were single. The number of children in each group ranged from zero to seven, with the largest percentage, 52 per cent of the experimental group and 57 per cent of the control group, having no children. The most prominent religion in each group was Baptist, with 56 per cent of the experimental group and 65 per cent of the control group, being of the denomination. A total of 45 per cent of the experimental group and 35 per cent of the control group belonged to other Protestant churches. In comparing the educational level of the two

groups, the largest percentage of the experimental group, 45 per cent, had an eighth to twelfth grade education, while the largest percentage of the control group, 61 per cent, had a twelfth grade or above education.

There were no distinct differences between the two groups in legal status on admission. The largest per cent in each group, 48 per cent of the experimental group and 61 per cent of the control group, were admitted under a regular commitment. This is indicated by Table IV.

The distribution of each group according to diagnosis is displayed in Table V. Categories of mental illness included mental retardation, organic brain syndromes, non-psychotic organic brain syndromes, psychoses, neuroses, personality disorders, and transient situational disturbances. No distinct differences in diagnosis were discovered. It is evident that, in both groups, the largest number of subjects, 63 per cent of the experimental group and 44 per cent of the control group, had a psychosis. Breaking this down into smaller categories, 15 per cent of the experimental group and 39 per cent of the control group were chronic undifferentiated schizophrenics. This was the most common psychosis in both groups.

A comparison of the number of admissions in each group

TABLE IV

LEGAL STATUS ON ADMISSION

Type of Admission	Experimental Group	Control Group
Voluntary	6 (22%)	6 (26%)
Emergency	7 (26%)	1 (4%)
Regular	13 (48%)	14 (61%)
Criminal Court Order	1 (4%)	2 (9%)

TABLE V

DIAGNOSES

Diagnosis	Experimental Group	Control Group
Mental Retardation		
Mild mental retardation	1	
	Total 1	
	Per cent 4%	
Organic Brain Syndromes		
Psychoses associated with organic brain syndromes		
psychosis with epilepsy	1	
psychosis with other and unspecified encephalitis	1	
alcohol deterioration		1
delirium tremens		1
	Total 2	Total 2
	Per cent 8%	Per cent 9%
Non-psychotic Organic Brain Syndromes		
Non-psychotic organic brain syndrome with epilepsy		1
Non-psychotic organic brain syndrome with drug association		1
		Total 2
		Per cent 9%
Psychoses		
Schizophrenia, chronic differentiated type	9	4
Paranoia	1	
Schizophrenia, paranoid type	2	2
Acute schizophrenic episode	2	
Schizophrenia, schizo-affective type	1	

TABLE III (Continued)

Diagnosis	Experimental Group	Control Group
Schizophrenia, residual type		1
Manic-depressive illness, circular type	1	
Manic-depressive illness, manic type		2
Involutional paranoid state	1	
Schizophrenia, other (and unspecified) types		1
	Total 17	Total 10
	Per cent 63%	Per cent 44%
Neuroses		
Anxiety neurosis	1	2
Depressive neurosis	2	
Hysterical neurosis		1
	Total 3	Total 3
	Per cent 11%	Per cent 13%
Personality Disorders		
Inadequate personality	2	
Habitual excessive drinking		2
Alcohol addiction		1
Drug dependence		1
Passive aggressive personality		1
	Total 2	Total 5
	Per cent 8%	Per cent 22%
Transient Situational Disturbances		
Adjustment reaction of late life		1
		Total 1
		Per cent 4%

is illustrated by Figure 1 and further shown in Table VI. Admissions ranged from one to thirty-four in the experimental group, with 33 per cent admitted for the first time. The range of admissions for the control group was one to ten, with 31 per cent admitted for the first time.

The total length of time each subject was hospitalized at Lakeshore Mental Health Institute since the first admission to Lakeshore is illustrated by Figure 2. There appeared to be some differences in the two groups. The largest number, 30 per cent of the experimental group and 52 per cent of the control group, spent between 0 and 9 per cent of their time at Lakeshore Mental Health Institute since their first admission. The largest per cent of time spent by a subject in the experimental group was 89 per cent, while the largest for a subject in the control group was 59 per cent. The average per cent of time that the experimental group spent at Lakeshore Mental Health Institute was 29.8 per cent, as compared with 15.7 per cent for the control group. The data were missing for 7 per cent of the experimental group and 4 per cent of the control group. It was their first admission, and they were not discharged at the end of the study.

The criterion by which to judge success of the

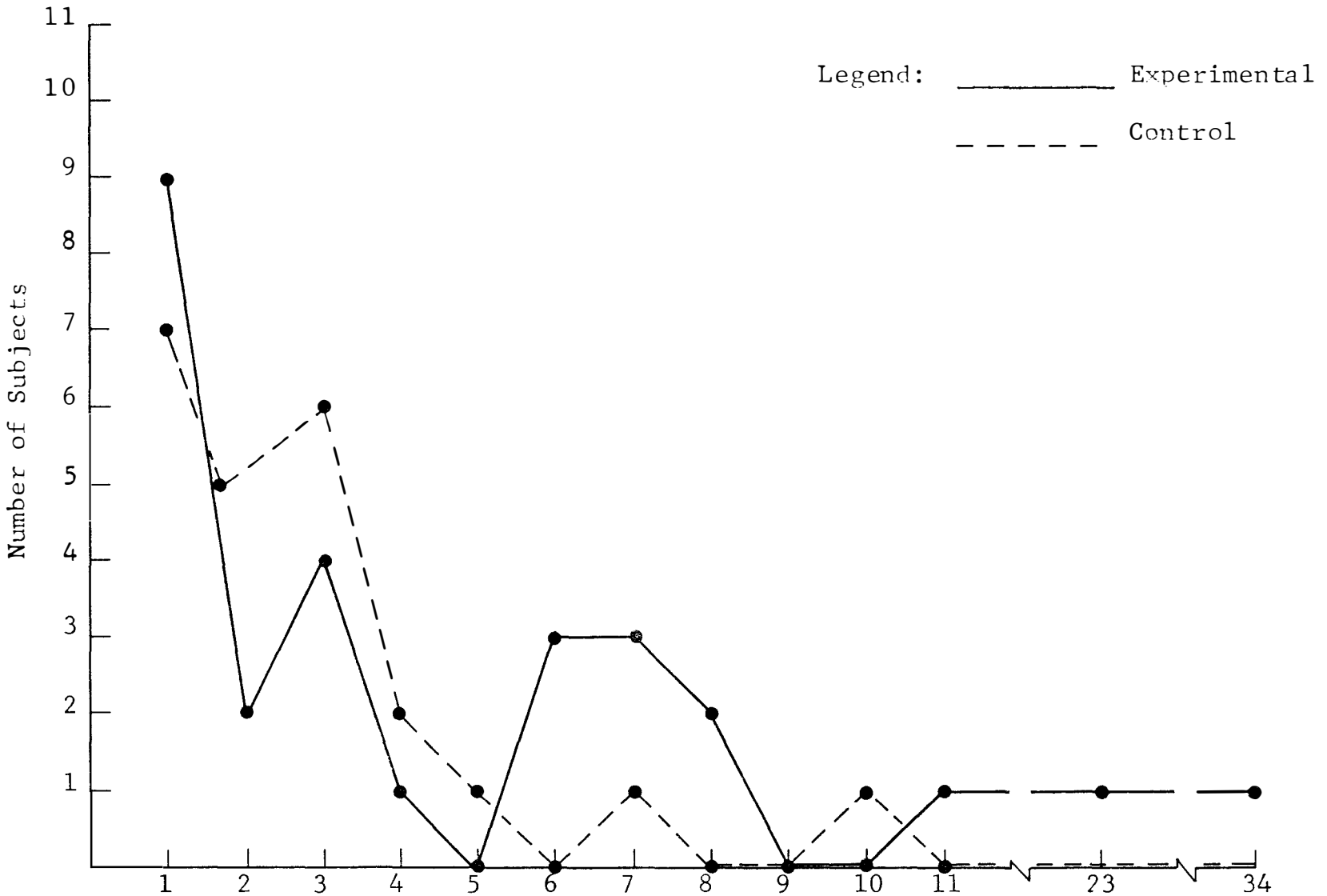

Figure 1. Number of Admissions to Lakeshore Mental Health Institute

TABLE VI

NUMBER OF ADMISSIONS

Experimental Group		Control Group	
Admissions	Subjects	Admissions	Subjects
1	7	1	9
2	5	2	2
3	6	3	4
4	2	4	1
5	1	5	0
6	0	5	3
7	1	7	3
10	1	8	2
		11	1
		23	1
		34	1

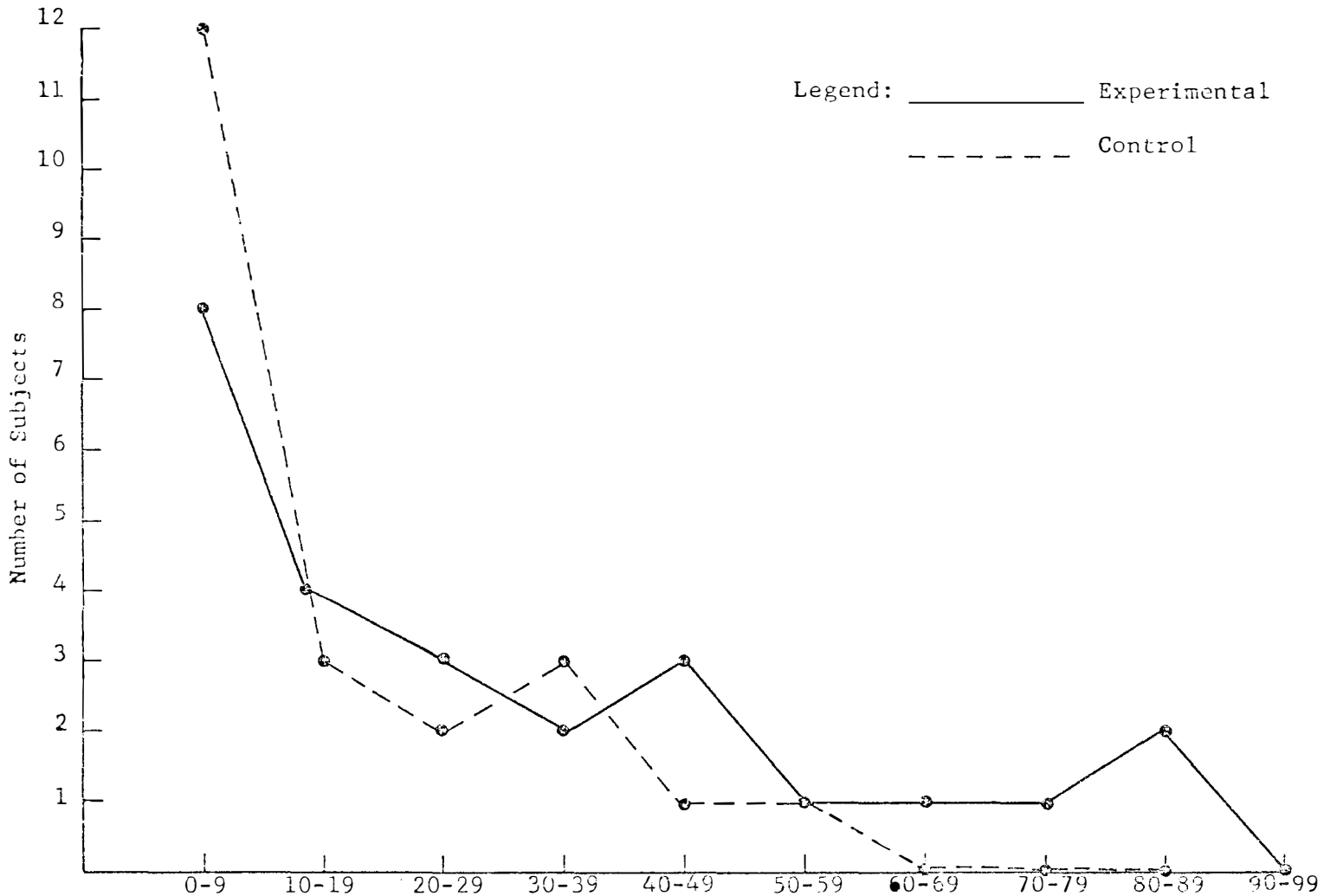

Figure 2. Per cent of Time in Lakeshore Mental Health Institute since First Admission

counseling is the use of community resources by the experimental and the control groups.

In a follow-up telephone call survey by the researcher, it was determined that only 9 per cent of the control group were involved in community recreational activities. One subject joined a bowling league, and one wrote songs for a church musical group. Table VII indicates use of community resources by the control group.

By comparison, 56 per cent of the experimental group became involved in community recreational resources. Church activities were the most popular choice of recreation for four subjects. Two subjects became involved in each of the following: community centers, hospital volunteer work, senior citizen centers, bowling leagues, and hobby groups. YWCA swimming, rescue squad volunteer work, university non-credit classes, and Sunshine Center recreation attracted one subject each. This is indicated by Table VIII. After a certain reluctance in the beginning to become involved, most of the group participated well in community activities. The Easter Seal bus was helpful in providing a way for subjects to attend senior citizen centers and a church social group. Several of the group lived within walking distance of the community centers, so transportation was no

TABLE VII

USE OF COMMUNITY RESOURCES -- CONTROL GROUP

Community Resource	Number of Subjects
Bowling League	1
Church Musical Group	1

TABLE VIII

USE OF COMMUNITY RESOURCES -- EXPERIMENTAL GROUP

Community Resource	Number of Subjects
Church Recreation Activities	4
Community Centers	2
Hospital Volunteer Work	2
Senior Citizens' Centers	2
Bowling Leagues	2
Hobby Groups	2
YWCA Swimming	1
Rescue Squad Volunteer	1
University Non-credit Courses	1
Sunshine Center Recreation	1

problem. The hospital volunteer work was one of the most successful activities, and provided a way for two former teachers to use their particular skills in working with young people. Rescue squad volunteer work was very beneficial in helping an extremely depressed subject to regain his self esteem. The group, as a whole, became more self sufficient, renewed old interests, and socialized more than before. Families were cooperative and helped in planning future recreational involvements. Church groups were more helpful in coordinating activities than public recreation agencies.

Six of the activities and community resources used by the subjects in the experimental group were listed on the survey and handout given earlier to the two groups. These included the community centers, senior citizen centers, bowling leagues, YWCA swimming, Sunshine Center recreation, and church recreation activities. The hospital volunteer work, the rescue squad volunteer work, university non-credit classes, and hobby groups were undertaken as a result of exploring former interests of the subjects. Both resources used by the control group were listed on the handout given to them at Lakeshore Mental Health Institute.

The number of hours spent in leisure counseling while

the experimental group was hospitalized at Lakeshore Mental Health Institute is demonstrated by Table IX. The average number of hours was 19.7. The range was from three to thirty-two.

The number of post-discharge contacts between the researcher and the subjects is indicated by Table X. The average number of visits was 4.5. The range was from three to seven.

Although 70 per cent of the experimental group were discharged, only 56 per cent were followed with further counseling and home visits by the researcher. Fourteen per cent of the discharged subjects in the experimental group were not followed with further counseling and home visits. One subject committed suicide, one was discharged to another hospital, one was discharged to jail, and one returned to Lakeshore Mental Health Institute. Table XI indicates this.

It is apparent that the leisure counseling given the experimental group did indeed have an influence on the use of community resources. Fifty-six per cent of the experimental group became involved in community activities, while only 9 per cent of the control group participated in community recreational activities. Table XII

TABLE IX

HOURS SPENT IN LEISURE COUNSELING
(HOSPITAL CONTACTS)

Hours	Subjects
3	1
4	1
8	1
10	1
12	3
13	1
15	1
16	3
20	2
21	2
22	2
25	1
28	1
30	4
31	1
32	2

Average Number of Hours - 19.7
Range - from 3 to 32

TABLE X

NUMBER OF POST-DISCHARGE CONTACTS
EXPERIMENTAL GROUP

Contacts	Subjects
3	3
4	5
5	4
6	2
7	1

Average Number of Contacts - 4.5
Range - from 3 to 7

TABLE XI

DISCHARGED STATUS -- EXPERIMENTAL GROUP

Status	Subjects
Involved in Community Activities	15 (56%)
Deceased -- Committed Suicide	1 (4%)
Discharged to Prison	1 (4%)
Discharged to another Hospital	1 (4%)
Returned to Hospital	1 (4%)

TABLE XII

PER CENT USING COMMUNITY RESOURCES

	Per cent
Experimental Group	56%
Control Group	9%

shows that the difference was marked.

The current status of subjects tested, as indicated by Table XIII, shows that 70 per cent of the experimental group had been discharged at the end of the experimental period, while 30 per cent remained at Lakeshore Mental Health Institute. This compares with 87 per cent of the control group who had been discharged and 13 per cent who were still at Lakeshore Mental Health Institute. There was no valid reason for the difference in the two groups in the per cent of those discharged. It was by chance that a larger per cent of the control group were discharged.

Another criterion by which to evaluate the effect of the counseling is the readmission rate. At present 16 per cent of the experimental group and 15 per cent of the control group have returned to Lakeshore Mental Health Institute. Eleven per cent of the experimental group and 10 per cent of the control group have again been discharged. This is indicated by Table XIV. At this point, it is too early to determine the effect that the leisure counseling had on the recidivism rate.

TABLE XIII

CURRENT STATUS OF SUBJECTS TESTED

	Experimental Group	Control Group
Discharged	19 (70%)	20 (87%)
Not Discharged	8 (30%)	3 (13%)

TABLE XIV

READMISSION STATUS

	Experimental Group	Control Group
Readmitted	3 (16%)	3 (15%)
Readmitted and Discharged Again	2 (11%)	2 (10%)

CHAPTER V

SUMMARY AND RECOMMENDATIONS

A. Summary

In analyzing the data collected for this study, the following summarizations may be made. Of the thirty-one subjects in the experimental group, 87 per cent (27 subjects) agreed to participate in the study. Seventy-four per cent (23 subjects) of the thirty-one subjects in the control group agreed to participate.

Relatively equal distribution of the two groups was seen in terms of demographic variables, legal status on admission, diagnoses, number of admissions, and per cent of time spent at Lakeshore Mental Health Institute since the first admission there.

Fifty-six per cent of the experimental group used community resources, while only 9 per cent of the control group did. The average number of hours spent in leisure counseling for the experimental group was 19.7. The average number of post-discharge contacts between the subjects and the researcher was 4.5. Community resources used by the experimental group were church activities,

community centers, hospital volunteer work, senior citizen centers, bowling leagues, hobby groups, YWCA swimming, rescue squad volunteer work, university non-credit courses, and Sunshine Center recreation. Resources used by subjects in the control group were a bowling league and a church musical group. Participation was good in the experimental group. The difference was marked between the two groups.

Seventy per cent of the experimental group were discharged, while 87 per cent of the control group were discharged. Sixteen per cent of the experimental group and 15 per cent of the control group were readmitted to Lakeshore Mental Health Institute. Eleven per cent of the experimental group and 10 per cent of the control group were discharged again. It is too early to determine the effect that the leisure counseling had on the recidivism rate.

The analysis of the data did reveal that a leisure counseling program at Lakeshore Mental Health Institute is feasible. It also showed that leisure counseling did influence the utilization of the community resources following discharge of patients. Although readmission data was limited to a three-month period, an investigation was begun into the influence of recreation and leisure

counseling on the recidivism rate of patients at Lakeshore Mental Health Institute.

B. Recommendations

The study was designed as a pilot study to determine the feasibility of a leisure counseling program at Lakeshore Mental Health Institute. It was concluded that such a program can successfully be implemented. It is suggested, however, that the study would be more conclusive if the duration of the study period were extended to last one year.

Attendance at leisure counseling sessions was good. The average number of hours spent in counseling was 19.7. The expansion of the recreation program for patients at Lakeshore Mental Health Institute to include leisure counseling is suggested. Attendance at leisure counseling sessions was voluntary. Eighty-seven per cent of the experimental group attended, seemed to enjoy the sessions, and felt they benefited from learning to use leisure time wisely.

As a result of the counseling, 56 per cent of the experimental group used community resources. It is therefore recommended that development of recreational/social resources for patients discharged from Lakeshore Mental Health Institute be made, in order to ease the transition

from the hospital environment to community life, and to replace lost institutional programs. It would appear that the services of a trained leisure counselor would be necessary in the development of the community recreational/social referral, in the evaluation of the improvement of patients adhering to individually prescribed post-discharge programs of social/recreational activities, and in the comparison of readmission rates of those individuals who participate in the post-discharge programs with those who do not.

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APPENDICES

APPENDIX A

A. Informed Consent (Experimental Group)

You will be asked to answer questions about your interest in recreational activities. The written questions will take about ten minutes.

With your written permission, after discharge, I will refer you to a recreation agency appropriate for your particular activity interests. The referral will include some information about your interests and past leisure experiences and any medical problems you have that would keep you from doing certain things.

Regular visits will be made to your home every two weeks for a period of two months after you are discharged to help you take advantage of recreation activities in the community.

Community recreation leaders will help you also to learn new skills and to tell you what is available to you concerning your recreation interests.

At the end of the two month study period, a follow-up visit will be made to you by the recreation counselor to see how you feel about your participation.

There are no discomforts or risks to you. If you wish to discontinue your participation, you are free to withdraw your consent at any time.

Any questions that you might have will be answered by the recreational counselor.

Benefits to you will be counseling on the wise use of your leisure time, evaluating your special interests and getting you involved in community recreational activities. All information in the study will be confidential. Your name will be available only to the recreational counselor.

Results of the study will perhaps help to improve recreational programs at Lakeshore Mental Health Institute.

I, _____, agree to participate in the preceding recreational study of my own free will. I understand that I am free to withdraw this consent at any time and to discontinue my participation.

Date: _____

_____
(Signature of Patient)

_____
(Signature of Witness)

B. Informed Consent (Control Group)

You will be asked to answer questions about your interest in recreational activities. The written questions will take about fifteen minutes to complete, and the oral questions will take about ten minutes.

You will then be given a list of recreational resources available to you after you are discharged. It is hoped that you will participate in them.

There are no discomforts or risks to you. You will be doing this of your own free will.

Any questions that you might have will be answered by the recreational counselor.

All information in the study will be confidential. Your name will be available only to the recreational counselor.

Results of the study will perhaps help to improve recreational programs at Lakeshore Mental Health Institute.

I, _____, agree to participate in the preceding recreational study of my own free will. I understand that I am free to withdraw this consent at any time and to discontinue my participation.

Date: _____

_____ _____

(Signature of Witness) (Signature of Patient)

C. Activity Interest Questionnaire

Name _____ Age _____

Home Address _____ Phone _____

Ward _____ Educational Level _____

Sex: Male _____ Religious Preference _____

Female _____

Marital Status: Single _____ Married _____

. . . . . .

Circle the activities you find most interesting

Activity

Arts and Crafts

Auto Mechanics	Basketry	Beadcraft
Block Printing	Book Binding	Cabinet Making
Cake Decorating	Carving Soap	Carving Wood
Ceramics	Cookery	Decoupage
Drawing	Dyeing & Coloring	Embossing
Embroidery	Etching	Fabric Decorating
Finger Painting	Furniture Refinishing	Glass Blowing
Home Decoration	Jewelry Making	Knitting
Lapidary	Leathercraft	Macrame
Map Making	Metalcraft	Millinery
Model Aircraft Construction	Modeling	Model Rocketry

Mosaic Crafts	Needlework	Painting
Paper Folding & Cutting	Photography	Plastic Crafts
Pottery	Printing	Quilting
Rugmaking	Scrapbook Making	Sculpture
Sewing	Ship Model Building	Sketching
Stagecraft	Taxidermy	Toy Making
Weaving	Woodworking	

Music

Vocal	Performances
A Cappella Chorus	Band Concerts
Barbershop Groups	Cantatas
Choruses	Glee Club Concerts
Community Singing	Jazz Concerts
Glee Clubs	Music Competitions
Informal Singing Groups	Music Festivals
Opera Groups	Old Fiddlers' Contests
Quartets	Operas
Singing Games	Orchestral Concerts
Whistling Groups	Organ Recitals
Instrumental	Recitals
Accordion	Record Concerts
Bands	Rock Festivals
Bell Choirs	Talent Shows or Contests

Chamber Music Groups

Harmonica Bands

Instrumental Choruses

Guitar Groups

Marching Bands

Rhythm Bands

String Quartets

Wind Ensembles

Miscellaneous

Composing Music

Listening Groups

Music Appreciation

Music Camps

Drama

Attending the Theater

Community Theaters

Dramatic Stunts

Festivals

Masquerades

Motion Pictures

Pageants

Play Production

Puppetry

Stage Lighting

Vaudeville Acts

Carnivals

Creative Dramatics

Fairs

Impersonations

Minstrel Shows

Musical Comedies

Pantomime

Play Readings

Scenery Making

Storytelling

Workshop

Charades

Doll Fashion Shows

Fashion Shows

Marionettes

Monologues

Musical Dramas

Parades

Play Writing

Stagecraft

Variety Shows

Dancing

Acrobatic

Clog

Ballet

Folk

Classic

Gymnastic

Interpretive	Modern	Social
Square	Tap	

Sports

Archery	Aviation	Bicycle Riding
Boating	Bobsleding	Boxing
Canoeing	Coasting	Cross Country Running
Diving	Fencing	Field Events Discus Throwing Jumping Pole Vaulting
Figure Skating	Fly Casting	
Go-Kart Racing	Horseback Riding	Ice Skating
Jogging	Judo	Karate
Kite Flying	Model Airplane Flying	Model Boat Sailing
Motor Boating	Motorcycling	Parachute Jumping
Pistol Shooting	Rifle Shooting	Roller Skating
Sailing	Skiing	Swimming
Track Events	Trapshooting	Water Skiing
Weight Lifting	Wrestling	

Individual and Dual Games and Activities

Badminton	Gymnastics and Stunts
Baton Twirling	Apparatus Work
Billiards	Bag Punching
Boccie	Baton Twirling
Bowling	Calisthenics
Box Hockey	Rope Jumping

Croquet

Darts

Frisbees

Golf

Handball

Hand Tennis

Horseshoes

Indoor Bowling

Paddle Tennis

Quoits

Shuffleboard

Table Tennis

Tennis

Tetherball

Slimnastics

Trampoline

Tumbling

Group or Team Games

Baseball

Basketball

Field Hockey

Flag Football

Football

Ice Hockey

Kick Ball

Lacrosse

Soccer

Softball

Speedball

Touch Football

Volleyball

Nature and Outing Activities

Astronomy	Auto Riding for Pleasure	Bee Culture
Bird Walks & Watching	Camping	Caring for Home Grounds
Caring for Pets	Dog Obedience Classes	Excursions or Trips
Exploration	Fishing	Flower Arrangement
Gardening	Hiking	Hunting

Making Nature Trails	Mountain Climbing	Nature Crafts
Nature Games	Nature Hikes	Nature Study Collection
Outdoor Cooking	Pet Shows	Identification
Picnicking	Terrariums	Travel
Weather Study	Zoos	

Literary, Language, and Related Activities

Book Clubs	Charm School	Creative Writing
Debates	Discussion Clubs	Foreign Language Study Groups
Guessing Games	Lectures	Magic
Mathematics	Mental Games	Poetry Groups
Public Speaking	Puzzles	Reading
Reciting	Riddles	Spelling Bees
Storytelling	Study Groups	Television Shows
Tricks	Writing Letters	

Social Activities

Banquets	Barbecues	Barn Dances
Basket Suppers	Candy Pulls	Card Games
Clambakes	Conversation	Corn Roasts
Dating	Entertainment	Family or Club Reunions
Fun Nights	Get-acquainted Stunts	Marshmallow Roasts
Parties	Pencil & Paper Games	Pot-luck Suppers
Progressive Games	Puzzles	Quilting
Scavenger Hunts	Social Dancing	Square Dancing

Table Games	Treasure Hunts	Visiting
Weiner Roasts		

Collecting

Antiques	Armor	Autographs
Books	Bottles	Butterflies
Buttons	China	Clocks
Coins	Dolls	Etchings
Firearms	Furniture	Glassware
Indian Arrowheads	Lamps	Match Covers
Medals	Miniatures	Musical Instruments
Paintings	Pictures	Postcards
Poetry	Seashells	Ship Models
Silver	Stamps	Tapestries
Toys	Weapons	Woodcuts

Service Activities

Group leadership in settlements, boys' or girls' clubs, recreation building, playground, or youth center

Service as scoutleader

Coaching or managing junior teams in baseball or basketball

Directing glee club, orchestra, or dramatic group

Helping conduct a hobby, craft, or nature project

Service as assistant at playground or recreation center

Assistance in organizing a holiday celebration or a campaign for civic improvement

Assistance with publicity, money raising, or public relations program of a recreation or other agency

Teaching a Sunday school class

Transporting aged or handicapped to recreation centers

Assisting with the recreation program at a hospital, correctional institution, or home for the aged

Serving as a teacher's aide by helping individual children

Showing slides and taking drama, music, or dance groups to hospitals, nursing homes, and other institutions

List any other activities:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Comments:

D. Recreation Facilities Inventory

Bowling Alleys

Brunswick Starlite Lanes 5700 Oak Ridge Highway	588-1312
Fountain Bowling Lanes 3315 Broadway NE	687-4611
Palace Bowling Lanes 4901 Chapman Highway	577-5573
Western Plaza Bowling Lanes 122 Western Plaza	584-9867
Family Bowl Hayfield Road	637-1705
University of Tennessee University Center	

Campgrounds

Camp-tour Do Do Beemor Street	523-2400
Hickory Star Resort Hickory Star Road, Maynardville	992-5241
Knoxville Camp Ground Campbell Station Road, Concord	966-1559
Knoxville North KOA Raccoon Valley Road, Heiskell	947-9776
Sequoyah Marina and Campgrounds Sequoyah Landing Road, Norris	494-9920
United Safari International Inc. 1111 Northshore Drive	584-8536
Venture Out at Gatlinburg Highway 73, Newport	623-2507

WA-NI's Village Resort Route 3, Rutledge	828-5547

Health Clubs

Body Builders of America 2407 Broadway NE	522-4622
Continental Health Spa Western Plaza	588-8563
Golden Door Health and Beauty Retreat 6703 Kingston Pike SW	588-1367
Halls Health Spa Grant Plaza, Halls Crossroads	922-7506
Paschal International Spa, Inc. 8025 Kingston Pike NW	693-9323
Vic Tanny Health and Racquet Club 1501 Kirby Road	588-6461
Universal Health Spa 9725 Kingston Pike NW	690-0681

Museums - Art Galleries

Armstrong Lockett House 2728 Kingston Pike SW	637-3163
Dulin Gallery of Art 3100 Kingston Pike	525-6101
Students Museum 516 Beemor, Chilhowee Park	637-1121

Skating Rinks

Ice-Chalet 1001 Lebanon Street, NW	588-1858
Lakemont Skating Rink Alcoa Highway	573-4151

Skatetown 115 Sherlake Road NW	693-9929
Skatetown #2 5713 Broadway NE	687-9884
Tennessee Valley Skating Center Chapman Highway	573-2512

Skiing Centers and Resorts

Gatlinburg Ski Resort Ski Mountain Road, Gatlinburg	546-9545

Riding Academies

Davy Crockett Riding Stables Highway 73, Maryville	448-6411
Red Gate Stables Highway 33, Maynardville	992-3303
Harold Sherrill Stables and Saddlery Sherrill Lane	693-1272

Rifle and Pistol Ranges

Volunteer Rifle and Pistol Club, Inc. Rifle Range Road NE	687-9945

Clubs

Alamo Club Flatiron Building	522-9478
American Legion Post No. 80 2111 McCalla Avenue	546-2927
American Legion Post No. 138 Alcoa Highway	577-9150
American Legion West Knoxville Post No. 223 Kingston Pike NW	693-4531
Beaverbrook Golf and Country Club, Inc. Cunningham Drive	689-4479

Bird Cage Lounge 2401 McCalla Avenue	522-9251
Cedar Bluff Racquet Club 423 Depot	690-5700
Cherokee Country Club 5138 Lyons View	584-4637
Cherokee Whist Society Chapman Highway	577-9209
City Club 601 Walnut SW	522-8133
Deane Hill Country Club 430 Morrell Road, SW	690-2411
Eagles Club 203 Walnut SW	522-5814
Lake Loudon Yacht Club Lakefront Drive	690-6636
Fox Den Country Club North Fox Den Drive, Concord	966-9771
Holston Hills Country Club 5200 Holston Hills Road	523-4119
Hurricane Club 319 Chestnut Street NE	546-9121
Indoor Racquet Club 5535 Lonas Drive NW	588-9252
Jack Rollers Association 2412 McCalla Avenue	546-9911
Karns Youth Center Beaver Ridge Road	588-9266
Kiwanis Club of Knoxville 918 State SW	546-2181

Knights of Columbus Council 5207 550 Idlewood Lane NW	693-9798
Knoxville Civitan	588-6178
Knoxville Gun Club Chris Haven Drive	577-9386
Knoxville Racquet Club 5535 Lonas Drive	588-1323
Knoxville Women's Club 3930 Kingston Pike	584-5021
Ossoli Circle 2511 Kingston Pike SW	523-6698
Rotary Club Burwell	523-8252
Society for the Preservation and Encouragement of Barber Shop Quartet Singing in America 501 20th Street	522-5101
The Sportmans Club 2247 McCalla Avenue SW	522-9284

Dance

Academy of Dance 5324 Broadway Street NE	687-8500
Arthur Murray School of Dancing 708 Gay SW	524-7423
Charlotte Ann's School of Dancing 6604 Candy Lane	577-0385
Dancers Studio 5107 Kingston Pike SW	588-8842
Fred Astaire Dance Studio 6302 Clinton Highway, Powell	947-2361

Karen's School of Dance 5722 Oak Ridge Highway	584-8821
Odell School of Dance 7517 Northshore Drive SW	584-9621
Rolling School of Dance 4607 Bruhin Road	688-2633
School of Ballet Arts 1183 Keowee Avenue SW	588-0720

Karate, Judo, Jiu-Jitsu, and Kung Fu

Academy of Sins Tae Kwon Do 5320 North Broadway	688-6881
Academy of Sins Tae Kwon Do 6504 Kingston Pike	584-1312
Chang's Academy of Taekwon-Do 5710 Kingston Pike SW	588-0266
Harold Long School of Karate 315 Main Avenue SW	546-2691

Music

Knoxville Symphony	523-1178
Appalachian Academy of Music 5802 Kingston Pike SW	588-6701
Godwin Piano Studio 5528½ Kingston Pike	584-3301
Lynn's Guitars 2830 Broadway NE	637-1644
Lynn's Guitars 5410 Kingston Pike	584-3501
Music House Piano and Organ Centers 3000 Broadway NE	688-4691

Music House Piano and Organ Centers West Town Mall	693-6270
Music World Center 5802 Kingston Pike SW	588-5363
Pete and Jerry's Music 9115 Executive Park Drive	690-5463
Pick 'n Grin 5802 Kingston Pike SW	588-8422

Golf Courses - Miniature

Broadway Country Club 3428 Broadway NE	687-9711
Putt Putt Golf Chilhowee Park	523-9313

Golf Courses - Private

Bays Mountain Country Club, Inc. Chris Haven Drive	577-8172
Beaver Brook Golf and Country Club, Inc. Cunningham Drive	689-5177
Cherokee Country Club 5138 Lyons View Drive	584-4637
Deane Hill Country Club 430 Morrell Road SW	690-2411

Golf Courses - Public

Cedar Hills Golf Club Martel Road, Lenoir City	546-6454
Chilhowee Golf Range Presser Road and I-40	637-9121
Colonial Golf Course and Driving Range Chapman Road	573-1161

Dead Horse Lake Golf Course Off I-40 at Mabry Hood Road Sherrill Lane	693-5270
Gatlinburg Municipal Golf and Country Club Pigeon Forge, Sevierville	453-3912
Lambert Acres Golf Club Old Walland Highway, Maryville	982-9838
Laurel Valley Golf Club Laurel Lake Road, Townsend	448-9309
Lost Creek Golf Club Knoxville Highway, Jefferson City	457-9661
Oneida Golf Works and Repair Services 2828 Rennoc Road NE	689-5941
The Orange Tee 8919 Kingston Pike	693-0562
Pine Lakes Golf Course Singleton Station Road, Maryville	577-9156
Whittle Springs Golf Club Valley View Road NE	525-1022

Tennis Courts

Indoor Racquet Club 5535 Lonas Drive NW	588-9525
Knoxville Racquet Club 5535 Lonas Drive	588-1323
The Court House Indoor Tennis 1540 Amherst Road NW	584-4522
Knoxville City Tennis Program City Parks	

Theatres

ABC Southeastern Theatres 318 Erwin Drive	584-0281

Capri Cinema 5304 Kingston Pike NW	588-2813
Capri-70-Cinerama 5308 Kingston Pike NW	584-6146
Capri Terrace Theatre 315 Mohican Street	584-6148
Chapman Highway Drive-In Theatre Chapman Highway	577-9467
Dixie Lee Drive-In Theatre Kingston Pike, Concord	966-1801
Family Drive-In Theatre 4300 North Broadway	687-1910
Fox Theatre 7900 Kingston Pike NW	693-1551
Kingston Cinema Four 8315 Kingston Pike SW	690-6480
Knoxville Drive-In Theatre 123 Forest Park Blvd, NW	588-3613
River Breeze Drive-In Theatre Asheville Highway	522-6796
Simpson Theatres Inc. 5308 Kingston Pike NW	584-6146
Studio One 2301 Magnolia Avenue NE	522-0622
Tennessee Theatre 604 Gay SW	523-8144
Westown Theatre 7600 Kingston Pike SW	693-9262

Drama

Play Group Theatre 1538 Laurel Avenue SW	523-7641

Morris Walter Lee 5308 Kingston Pike NW	584-5641
Hunter Hills Theatre Gatlinburg	
Clarence Brown Theatre University of Tennessee	974-5161
Carousel Theatre University of Tennessee	974-5161

Billiards Parlors

Greenway Sport Center 4664 Walker Blvd, NW	687-9815
McDonald's Billiard Supply Company 6014 Chapman Highway	573-8202
Play and Play Sports Center 3603 Chapman Highway	577-9276
Varsity Recreation Center 1501 White Avenue SW	523-1689
Western Plaza Bowling Lanes 122 Western Plaza	584-9867

Amusement Places

Chilhowee Park	
Goldrush Junction Pigeon Forge	523-0640
Hilltop Amusement Company 3015 Chapman Highway	577-1021
Play Palace - Family Amusement Center Westown Mall	690-5341
Porpoise Island Highway 441, Pigeon Forge	546-6218

Baseball Clubs

Knoxville Baseball Club Bill Myers Baseball Stadium	637-9494

Boats - Rental and Charter

Anchorage Yacht Basin Inc. Alcoa Highway	577-1692
Hickory Star Resort Hickory Star Road, Maryville	992-5241
Thirty-Three Bridge Marina Highway 33, Maynardville	992-3091

Senior Citizen Programs

Winona Senior Citizens Center

Cagle Terrace

Walter P. Taylor Homes
2234 Vine Avenue

KCDC Daily Living Center 546-1560

Nonprofit Agencies

Kiwanis Club - Fresh Air Camps
Lions Club - Swimming
Optimist Club - Handicapped
YMCA - Varied activities
YWCA - Varied activities
Red Cross - Swimming, Sailing
Knoxville Boys Club
Knoxville Girls Club

Church Recreation Programs

Central Baptist of Bearden	588-0586
Fountain City Central Baptist	688-2448
Meridian Baptist Church	577-6617
First Baptist Church	546-9661
Jewish Community Center	690-6343
Second Methodist Church	524-1689

Wallace Memorial Baptist Church 688-7270

Municipal Recreation Centers

Western Heights Recreation Center
Fairview Recreation Center
College Homes Recreation Center
Croft Recreation Center
New Hope Recreation Center
Lamar Street Recreation Center
Cal Johnson Recreation Center
Austin Homes Recreation Complex
Walter P. Taylor Recreation Center
Jessamine Street Recreation Center
Dandridge Avenue Community Building
South Knoxville Recreation Center
New Prospect Recreation Center
South Knoxville Neighborhood Center
West Haven Community Center
Lonsdale Recreation Center
North Knoxville Recreation Center
Christenberry Recreation Center
Alice Bell Recreation Center
Holston-Chilhowee Recreation Center
Deane Hill Recreation Center
Happy Homes Recreation Center
Inskip-Norwood Recreation Center
Cumberland Recreation Center
Legion Recreation Center
Crestwood Hills Recreation Center

Municipal Parks and Recreation Areas

Bearden Park
Logan Park
Sequoyah Park
Forest Glen Park
Lyonsview Park
Sequoya Hills Park
Talahi Park
Third Creek Bike Trail
Karns Community Park
West Powell Park
Powell Community Park
Corryton Park
Mesest Park

Betts Community Park
Skaggston Community Park
Gibbs Community Park
American Zinc Park
City Hall Park
James White Park
Bicentennial Park
Grand Avenue Park
Terrace Avenue Park
White Circle Park
Tyson Park
Montcastle Park
Douglass Street Park
Dameron Avenue Park
Beaumont Park
Leslie Street Park
Malcolm Martin Community Park
4th & Gill Park
Gill Street Park
Folsom and Bluff Park
Bethel Park
5th Avenue Park
6th Avenue Park
Nichols Avenue Park
Preston Street Park
Linden Avenue Park
Cal Johnson Park
Winona Park Complex
Morningside Park
Island Home Park
Glen Park
Rock City Park
Mary James Park
South Knoxville Optimist Park
Riverside Pool
Ijams Park
Hawthorne Street Park
Scottish Pike Park
Spring Drive Park
Montgomery Village Park
Mary Vestal Park
Fort Dickerson Park
West View Park
Ohio Street Playgrounds
Buck Toms Park
Sycamore Park

Badgett Park
West Haven Park
Lonsdale Park
Chevannes Park
Sharps Ridge Park
North Knoxville Park
North Hills Park
Alice Bell Park
Sandland Street Park
Union Square Park
Sarah Moore Green School Park
Castle-Wilson Park
Skyline Park
Chilhowee Park
Volunteer Park
Deane Hill Park
Rocky Hill Park
West Hills Park
West Central Park
Ridgedale Park
Meade Field
Cumberland Park
Fenwood Park
Fountain City Park
Legion Park
Inskip Park
Adair Park
Lions Club Park
Power Park
Marine Park
Looney Island Area
Thorngrove Park and Playground
Carter Community Park
I. C. King Park
Kimberlin Heights Park
Admiral Farragut Park
Carl Cowan Park
Cedar Hills Park
Bluegrass Park
Hickory Creek Park
Melton Hill Park
Concord Park
Ball Camp Park

Sources:

1. Knoxville, Knox County Metropolitan Planning Commission. Recreation Facility Inventory Knox County 1977.

2. East Tennessee Development District. Inventory of Outdoor Recreation Places. 1973.

3. City of Knoxville Quarterly Report 1974-75-76.

4. East Tennessee Health Improvement Council.

APPENDIX B

A. Letter to Directors of Recreation

615 Hemlock Road
Knoxville, Tennessee

April 24, 1977

Director of Recreation
Knoxville, Tennessee

Dear Sir:

I am a recreational therapist at Lakeshore Mental Health Institute and a graduate student at The University of Tennessee. As part of my requirements for a Master of Science Degree in Recreation, I am conducting a study. The subject I have chosen involves a study to determine the value of recreation in reducing the recidivism rate of severely depressed patients at Lakeshore Mental Health Institute. Since I plan to refer these patients, upon discharge, to recreational activities in their home communities, I need to know what is available (both indoor and outdoor) in the way of recreational facilities in certain selected counties.

Please send me any brochures or information available concerning recreation in Knoxville and Knox County.

Thank you very much for your cooperation.

Yours truly,

Patsy M. Harris

B. Approval Letter from Human Subjects Committee of The University of Tennessee

THE UNIVERSITY OF TENNESSEE, KNOXVILLE
KNOXVILLE 37916
OFFICE OF THE VICE CHANCELLOR FOR
GRADUATE STUDIES AND RESEARCH
404 ANDY HOLT TOWER
AREA 615
TELEPHONE: 974-3466

February 13, 1978

Dr. L. Evans Roth
Vice Chancellor for Graduate
Studies and Research
404 Andy Holt Tower
The University of Tennessee
CAMPUS

Dear Dr. Roth:

Ms. Patsy Harris, Department of Health, Physical Education & Recreation, has submitted a project entitled "The Effect of Recreation and Leisure Counseling on the Recidivism Rate of Patients at Lakeshore Mental Health Institute," CRP #496. The departmental human subjects committee has reviewed and approved this project. In their judgment, this project comes within that section of their approved guidelines which permits the Chairperson of the Committee on Research Participation to give approval to the project on behalf of the Committee.

After reviewing this project, I certify that it does conform to Committee and Departmental guidelines. Therefore, acting on behalf of the Committee, I have approved this project.

The responsibility of the project director includes the following:

1. Prior approval from the Committee must be obtained before any changes in protocol are instituted.

2. Signed consent statements from each experimental subject must be kept for the duration of the project and for at least three years thereafter.

3. The Committee must be informed of any physical or psychological effects on subjects for re-evaluation of the protocol approval.

4. A statement must be submitted (Form D) at 12-month intervals attesting to the current status of the project (protocol is still in effect, project is terminated, etc.)

The Committee wishes the project director success in her research endeavors.

Sincerely,

William Konnert, Chairperson
Committee on Research Participation

WK:sa
cc: ✓Ms. Patsy Harris
Hugh Welch

VITA

Patsy Mitchiner Harris was born in Greenville, North Carolina. She moved to Henderson, North Carolina at the age of three and attended public schools there. She attended the University of North Carolina at Chapel Hill and received a Bachelor of Arts degree in French. Following ten years of volunteer work at Moses Cone Hospital and Wesley Long Hospital in Greensboro, North Carolina, she moved to Knoxville, Tennessee. For five years she worked as a volunteer at Lakeshore Mental Health Institute. In the winter of 1974, she accepted a position as a recreational therapist at Lakeshore Mental Health Institute. In September, 1975, she entered the Graduate School of The University of Tennessee, Knoxville, and began study toward a Master of Science degree with a major in Recreation. This degree was awarded in August, 1978.

The author is a member of the Tennessee Recreation and Parks Association and the National Recreation and Parks Association.