

From a Focus on Function to Rediscovering the Self: A Case Report of an Individual with Post-Stroke Depression

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Abstract

This case study describes a collaborative therapeutic process, jointly undertaken by therapists within Recreation and Music Therapies in a physical rehabilitation centre in Eastern Canada. The case provides a report of their engagement, from initial screening to discharge, with a 40 year old man who had experienced a CVA, and was readmitted to the physical rehabilitation centre after encountering difficulties managing at home. The original therapy goals were designed to address functional impairments. However, eventually it became clear that it was necessary to reorient the therapeutic process to explore and affirm a new aspect of his identity as a musician. The case report includes reflections by the therapists on what they learned through this case, and suggests implications for practice.

KEYWORDS: *Identity Change, Music Therapy, Post-stroke Depression, Recreation Therapy, Stroke Rehabilitation*

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Introduction

Each year in Canada, 1.2% of the population (approximately 50,000 adults) experience a 'brain attack' or sudden loss of brain function that will lead to death or serious disability (Heart and Stroke Foundation of Canada, [HSFC], 2009). The United States reports a similar level of prevalence, with 2.6% of the population (almost 6 million adults) reporting a history of stroke (Neyer et al., 2007). Of those who have a stroke, 15% will die, 10% will recover completely, 25% will recover with minor impairments, 40% will experience moderate to severe impairments and 10% will live with impairments so severe that they will require long term care (HSFC). Many of the factors that impact how well people are able to manage post-stroke cannot be changed (e.g., age, gender, pre-morbid lifestyle, site of lesion). How people respond to and learn to live with a stroke, however, *are* aspects of recovery that can be altered.

The focus of rehabilitation is to help individuals regain or maintain an optimal quality of life, even with the existence of impairment (Sandstrom, Lohman, & Bramble, 2003). This includes preparing people for return to community living, reestablishing previous occupational and leisure interests, and learning to manage the ongoing effects of their impairments. Increasingly, there is growing recognition of the need to address psychosocial issues, such as depression, that persist post-stroke (e.g., Schepers, Visser-Meily, Ketelaar, & Lindeman, 2005; Sobel, 1995).

The purpose of this case report is to report on a collaborative therapeutic process, jointly undertaken by therapists within Recreation and Music Therapies in a physical rehabilitation centre in Eastern Canada to address functional impairments and depression post-stroke. The case provides a report of their engagement, from initial screening to discharge, with a man who had experienced a stroke and was readmitted to the rehabilitation centre after encountering difficulties managing at home. Before presenting information about Mr. S. and describing the therapeutic change processes, a brief review of relevant supporting literature is presented. We end the case report with reflections on what was learned through this case, and suggest implications for practice.

Literature

Living with the Effects of Stroke

Many individuals who have experienced a stroke face physical and cognitive challenges that greatly affect their quality of life (e.g., Astrom, Asplund & Astrom, 1993; Gillen & Burkhardt, 1998; Hochstenbach, Anderson, van Limbeek, & Mulder, 2001). Depending on the location of the cerebral hemorrhage and how much damage occurred, a stroke can impair people's abilities to move, see, remember, speak, reason, and read and write (HSFC, 2009). More specifically, people may experience impairments such as: weakness or paralysis, neglect (e.g., forgetting or ignoring objects, including one's own limbs), impaired depth perception or difficulties distinguishing between front/back and up/down, trouble learning or remembering new information, and difficulties following instructions or impaired judgment (HSFC). Often even more challenging for individuals who have experienced a stroke and their caregivers are psychosocial issues that accompany loss of function (Remer-Osborn, 1998).

The most common psychological responses post-stroke include fatigue, depression, anxiety, sleep disturbance, and increased emotional lability (Gillen & Burkhardt, 1998; Hochstenbach, Prigatano, & Mulder, 2005). Anxiety is often exacerbated by financial stressors, family issues, fears of dying, or uncertainty of recovering as well as frustration at one's inability to perform tasks or intolerance to the general busyness of life. Closely related to anxiety is depression. High rates of depression have been reported following stroke, occurring within 20% to 60% of stroke survivors (e.g., Anderson, 1992; Astrom et al., 1993; House et al., 1991). Residual impairment and distress can contribute to loss of self-esteem and perceived control (Morrison, Johnston, & MacWalter, 2000). There is a reciprocal effect between depression and perceived disability; increased disability can exacerbate depression, but higher rates of depression may impede immediate recovery and long-term outcomes such as perceived quality of life (Morrison et al.). As Gillen and Burkhardt noted, "the consequences of depression after stroke are numerous: hospital stays are longer, cognitive impairment is greater, and motivation decreases" (p. 23). More-

over, individuals with post-stroke depression are less likely to return to social activities than those without depression (Sife, 1998). Thus, a key focus of recreation and allied therapies (e.g., music therapy) is to address psychosocial factors that can positively and negatively impact individuals' quality of life.

Recreation and Music Therapies and Post-Stroke Recovery

Therapeutic recreation/recreation therapy (TR/RT) involves purposeful interventions designed to bring about emotional, social, physical or other positive changes in individuals with disabilities. Therapeutic recreation seeks to help individuals increase independence and develop skills for improved quality of life (Therapeutic Recreation Association of Atlantic Canada [TRAAC], 2009). While there is growing evidence of the role of leisure and recreation as a resource in coping with and adjusting to an acquired disability (e.g., Hutchinson & Kleiber, 2005; Kleiber, Reel, & Hutchinson, 2008), a limited amount of research has focused on the effectiveness of TR interventions on addressing psychosocial outcomes post-stroke (e.g., Nour, Desrosiers, Gauthier, & Carbonneau, 2002; Ryan, Stiell, Gailley, Gillian, & Makinen, 2008). We could not find any published studies on the role of TR in addressing depression and identity change following stroke.

Outside of TR, rehabilitation researchers have reported that patients and caregivers see the need for information and preparation for return to social and leisure activities as a priority for the development of stroke services (Jones, Auton, Malcolm, Burton, & Watkins, 2008) and are increasingly advocating for post-stroke leisure education (Hartman-Maeir, Soroker, Ring, Avni, & Katz, 2007; Parker, Gladman, & Drummond, 1997; Sveen, Thomassen, Bautz-Holter, Wyller, & Laake, 2004). For example, based on an assessment of individuals' ($n = 56$) satisfaction with life one year post-stroke, Hartman-Maeir et al. noted that there is a "compelling need for rehabilitation services with a focus on participation in...leisure activities, in order to improve the satisfaction of this population" (p. 559).

Music Therapy is the skillful use of music and musical elements by an accredited music therapist to promote, maintain, and restore

mental, physical, emotional, and spiritual health (Canadian Association for Music Therapy [CAMT], 1994). Music has nonverbal, creative, structural, and emotional qualities. These are used in the therapeutic relationship to facilitate contact, interaction, self-awareness, learning, self-expression, communication, and personal development (CAMT).

Music Therapy (MT) has been shown to be an effective treatment modality in a variety of settings, particularly to address issues associated with functional or mobility impairments following stroke. In a study on music and rhythmic stimuli in the rehabilitation of gait disorders (Staum, 1983), the results indicated that all participants evidenced gains in rhythmic gait, even walking, and/or consistency in walking speed. In a study on musical instrument playing in the improvement of hand grasp strength and functional tasks with stroke patients in rehabilitation settings, Cofrancesco (1985) found that hand grasp strength improved in all participants concomitant with implementation of music therapy treatment. Using singing instruction, Cohen (1992) found that 67% of her treatment participants made improvements in speaking fundamental frequency variability, rate of speech and verbal intelligibility. Cohen (1993) also examined the effects of singing and rhythmic instruction on the rate of speech and verbal intelligibility of neurologically impaired persons. The results indicated significant differences between groups in verbal intelligibility with the singing group making the most progress. Hurt, Rice, McIntosh, and Thaut (1998) found that after 5 weeks of daily rhythmic auditory stimulation (RAS) training, 62.5% of patients' mean velocity increased significantly by 51% and there was significant improvement in cadence and stride. Haneishi (2001) rated the effects of a Music Therapy voice protocol on speech intelligibility of individuals with Parkinson's disease; statistically significant increases were found in speech intelligibility as rated by caregivers. Kerr, Walsh, and Marshall (2001), found that a music assisted reframing intervention was more efficacious than the typical reframing intervention in modifying affect.

Despite evidence of the benefits of music therapy for functional improvements almost no research has been conducted on the contributions of music therapy to addressing

psychosocial outcomes in persons with stroke (see, as exceptions, Nayak, Wheeler, Shiflett, & Agostinelli, 2000; Wheeler, Shiflett, & Nayak, 2003). Nayak et al. investigated the efficacy of music therapy techniques as an aid in improving mood and social interactions after a traumatic brain injury (TBI) or stroke. Results indicated that there was a significant improvement in family members' assessment of participants' social interaction in the music therapy group relative to the control group. Results lend preliminary support to the efficacy of music therapy for social functioning and participation in rehabilitation with a trend toward improvement in mood during acute rehabilitation. Wheeler et al. further investigated the relationship between changes in mood and behaviour and the number and setting (individual or group) of music therapy sessions received by people who have had a stroke or TBI. The number of music therapy sessions seemed to influence several behavioural measures, with group sessions appearing to affect social interaction and individual sessions marginally affecting motivation for treatment. There is a need for further studies of the role of music and recreation therapies in addressing depression and other psychosocial issues post-stroke.

Case Report

Background Information

Mr. S is a 40 year old gentleman who experienced a Right Medial Cerebral Artery (MCA) Hemispheric Stroke following Aortic Valve replacement in April, 2005. After stabilization he was admitted to a physical medicine rehabilitation facility in Eastern Canada. At his admission he was unable to ambulate, use his left arm or hand, and had difficulty with cognitive (e.g., remembering, organizing, problem-solving) and psychosocial issues (depression).

The rehabilitation centre is a provincial resource that provides care to adults who experience amputations, spinal cord injuries, acquired brain injuries (including stroke) and other disabling conditions. There are 68 inpatient beds and outpatient services available. Rehabilitation service is provided through an interdisciplinary team including: Occupational Therapy, Physiotherapy, Physical Medicine, Nursing, Social Work, Neuropsychol-

ogy, Nutrition, Speech Pathology, Recreation Therapy, and various support staff. There is no designated Music Therapist on site.

Recreation Therapy services are provided by 1.5 FTE Recreation Therapists, 1.5 FTE Recreation Therapy Associates and Therapeutic Assistants. The Recreation Therapists and Associates also mentor students on internships; the case reported here was primarily undertaken by a student intern under the supervision and mentorship of one of the Recreation Therapists. This same therapist worked with Mr. S. during his first admission to the rehabilitation hospital. The Recreation Therapy department follows the Leisure Ability Model (Stumbo & Peterson, 1998); services are provided through individual functional interventions, individual and group leisure education and group recreation participation opportunities. Referrals to be seen individually by a Recreation Therapist are generated based on client needs for specific leisure goals that cannot be met through the group-based recreation and leisure education programming.

Prior to his first admission to the rehabilitation centre (April, 2005) Mr. S. was living with his wife and family in a rural community. He worked full time as a carpenter and was the only source of income for his family. In his free time he played in a rock and roll band at local bars. He enjoyed listening to music, woodwork, household maintenance, and 'hanging out with his friends'. He valued creative accomplishments. He had made his own guitar, reworked his favourite chair by adding in a speaker system, and remodeled parts of his home. He enjoyed spending leisure time with his daughter; they would participate in activity such as board games. He stated he enjoyed substance use (e.g., drinking, smoking) as part of his past and present leisure experiences.

As a result of his initial 6 week rehabilitation treatment, Mr. S. was able to achieve independent ambulation and some functional use of his left arm and hand as an assist in activities of daily living. However, cognitive and psychosocial issues, including perseveration of thoughts, decreased initiation of activity and depression persisted post-discharge. Discharge recommendations identified the ongoing need for structure and routine in his daily life, involvement in physical activity, monitoring of

mood, and support to reconnect with his cohort groups. At that time he was discharged to his home community in a rural area to live with his common-law wife and their daughter.

Following his initial discharge from the rehabilitation centre, Mr. S.'s return to his home and home community did not go as well as he hoped. As a family, they had difficulty with the transition to life in a rural community with limited resources for engagement in any meaningful activities and limited financial resources because Mr. S. was unable to return to work. In addition, support from friends waned over time. Mr. S. was readmitted approximately one year later (August, 2006) for further rehabilitation, to explore vocational options, and for ongoing issues relating to depression.

The RT screen and assessment interview completed at re-admission revealed that Mr. S. was previously employed as a carpenter, but had been unable to return to work after his first admission. Mr. S. had also been unable to establish a daily routine and structure. His primary social networks had decreased. At that time Mr. S. mainly spent time with his wife and daughter, although he occasionally spent weekends with his mother who lived in an urban area. When asked specifically about his current day-to-day routine in his home community he indicated it involved going to the local coffee shop and watching television.

As it relates to constraints to leisure activity participation and community involvement, Mr. S. described having transportation limitations as he was no longer able to drive and lived in a very rural community with no public transit system. Additionally he and his family were experiencing financial challenges. Mr. S. was able to identify and discuss a wide variety of leisure possibilities, but indicated he was unable to follow through without support from his spouse. His spouse, who was present for the assessment, stated that she was unable to provide the type of structure he required for his activities of daily living, including leisure. His wife and daughter were unable to visit during this re-admission; however his mother lived locally and visited regularly. Mr. S.'s presentation of self at re-admission included very flat facial affect, perseverative conversation topics, slow response to questions, tangential conversations, and little initiation of activity.

The Treatment Process

Recreation Assessment

As a standard first step in the treatment process upon re-admission to the rehabilitation hospital, a RT screen was completed by the RT student intern under supervision by a Certified Recreation Therapist Specialist (CTRS). The screen is a facility-based tool used to address basic information such as interests, strengths and needs and to communicate inpatient programming information. The information is gathered through client and family interviews, chart review and observations. Background information from the screen regarding Mr. S.'s past leisure interests and current participation was presented in the previous section. From this initial screen interview, Mr. S. established plans to participate in a wide variety of in-house programs on a regular basis throughout his stay. He stated that he valued these opportunities as he liked to hang out with people. The plan was that RT staff would support his involvement by cueing him for program times, place and purpose.

Three weeks into his admission Mr. S.'s needs were assessed by the CTRS to be beyond the scope of the RT group programming being offered. In order to obtain a more comprehensive assessment of his leisure functioning, the Leisure Competence Measure (LCM; Kloseck & Crilly, 1997) was completed by the student intern. Information was gathered by the student intern and supervising CTRS through observations of Mr. S. in a variety of interactions and tasks, along with conversations and from the initial screen. The results indicated Mr. S.'s lowest scores were related to leisure awareness and skills. He also scored low on social contact, community participation, and integration skills (initial scores on the LCM are provided in Appendix A). Based on this assessment, a plan for individual RT treatment was established.

Recreation Therapy Plan

Mr. S. stated he wanted to improve the use of his left arm/hand so that he could return to playing his guitar. He felt if he could play again everything would be okay. The following goals and recreation therapy plan was established with Mr. S.:

1. To establish a daily structure and routine that includes meaningful leisure activities.

2. To increase his leisure skill competence.
3. To re-establish connection to a community-based leisure activity post discharge.

To address these goals, individualized leisure education and skill development initially focused on: (a) using the recreation program calendar to make personal choices for activity involvement for the upcoming week; (b) weekly debriefing with RT staff focusing on activity performance and selection of individual activity experiences for the upcoming week; (c) playing his guitar to improve functional use of his left arm/hand; and (d) information gathering, resource identification, exploration of barriers, creating and completing a community-based recreation activity with support from RT staff prior to discharge. These treatment foci were established as performance measures.

Progress Toward Goals

The first and last goals (to establish a routine and re-establish leisure participation) were followed by the student intern and supervising CTRS. Throughout his admission Mr. S.'s interest in participating in RT sessions and activities increased as he developed a sense of routine and a relationship with the RT student intern and staff. He began to show more comfort and interest in developing (and relearning) leisure skills other than the guitar playing and, at discharge, was pursuing employment in a supported woodshop. Mr. S. exceeded the performance measures for those two goals. His success with these goals was likely due to his journey with the second goal, which was to increase his leisure skill competence by playing his guitar to improve functional use of his left arm/hand. The rest of this case study explores the progress toward achieving this second goal.

The interdisciplinary team had identified that Mr. S. had difficulty understanding how a variety of functional tasks and arm/hand therapy could be generalized to his guitar playing. Thus it was suggested by the CTRS to explore the possibility of involvement in the treatment plan by a Music Therapist. It was felt that a Music Therapist would have the skills and abilities to look at the functional challenges related to his guitar playing. At the time of this case report the first author was an accredited Music Therapist (MTA) working at another facility within the same health care sys-

tem. The interdisciplinary team supported the referral to the MTA and then arrangements were made to assess Mr. S. The Music Therapist worked with Mr. S. over five sessions. The RT student intern was present for these music therapy sessions with Mr. S. in order to support and reinforce learning and skills transfer.

Music therapists are required by their standards of practice to assess, plan, intervene and evaluate. Musical activities are specifically designed to assess the skills of the patient. Using music and its elements during assessment of a client is part of what contributes to the uniqueness of music therapy as a treatment modality. Particular to this case, as the therapeutic relationship deepened, the music therapist continued to learn new things about Mr. S. in each session (assessment). At the same time she continually observed how the activities were affecting the outcomes (evaluating) and treated Mr. S. Due to the short amount of time available to work with Mr. S., the processes of assessment, intervention and evaluation became more of a composite process. The following section documents the collaborative MT/RT treatment process. Then, a summary of Mr. S.'s discharge from MT/RT is provided. The MTA and supervising CTRS have co-authored this case.

Facilitating Change through Music/Recreation Therapy Intervention

Narrative summaries of debriefing conversations, MT progress notes, and journal entries by the student intern provide the basis for this case report. Additional information has been added to explain and introduce aspects of the treatment process. These narratives are intended to illustrate the dynamic nature of the TR process, with descriptions focused on the ongoing processes of implementation, evaluation and additional planning that are necessary to address the evolving understanding of client needs. The case report begins with a description of a meeting with the CTRS and student intern, to prepare Mr. S. for his upcoming involvement with the Music Therapist. As the therapeutic process unfolds, it is important to watch for a shift from a focus on functional skills to address issues associated with how Mr. S. came to see himself.

RT debriefing: “If at first you don’t succeed...”

The RT student intern and supervising CTRS assisted Mr. S. in preparing for his first session with the Music Therapist. Here is what the student intern wrote about this session in a student journal entry, and communicated to the Music Therapist prior to her initial session:

At our scheduled time for our first appointment, I went to his room to get him. He was seated on the side of his bed attempting to get his compact disc (C.D.) player to play. He could not get it to work. With cursing he checked for batteries only to realize there were no batteries in it. He said he really wanted to be able to listen to his music and could I get him some batteries. When given some batteries it took him about 20 minutes to complete the task as he kept putting the batteries in backward. He was unable to orient the batteries to the diagram on the C.D. player. During this period he did not display any frustration with his lack of success and after 20 minutes accepted my offer of assistance. I demonstrated how to put in the batteries. Once he had the C.D. player working, we spent the remainder of our time together looking at his C.D. collection and discussing his favourite artists.

The following five sessions were facilitated by the MTA. A brief description of the purpose of each session precedes a more complete description of Mr. S.’s participation in the session. After each music therapy session description, notes from follow-up debriefing sessions by the RT student intern or CTRS are presented.

Music Therapy Session #1: Getting to Know You

This was the Music Therapist’s first session with Mr. S. In this session, Mr. S. was assessed for emotional, physical, cognitive, spiritual and social strengths and weaknesses. Mr. S. was assessed using background information supplied by the RT, observation of behaviours in musical activities and interview. During the

assessment Mr. S. showed an interest in music therapy and it was noted that his eyes “lit up” when he described his musical history. This consisted of playing bass guitar in a band with his friends. As he described the times they had spent playing together he was smiling. In this session the MTA became aware that Mr. S. did not have his bass guitar with him at the hospital. The CTRS was notified of this and arranged for it to be brought to the facility. Initial goal areas from this first session were:

1. To increase fine motor control through the renewal of past musical skills.
2. To increase opportunity for meaningful social interaction while in the hospital through the development of a musical relationship with the Music Therapist.

The MTA anticipated that the accomplishment of these goals would also lead to an increase in positive affect as the patient presented with low mood, low self esteem, and poor self concept.

RT debriefing: “Try, try, try...again and again.” The student intern communicated the following observations with the supervising CTRS and Music Therapist:

As his first session of guitar playing approached, [Mr. S.] showed excitement at the opportunity of playing for the first time in a very long time. He was enthusiastic about meeting with the Music Therapist and called his wife to arrange to have his guitar brought to the hospital. He eagerly went with me [the intern] to purchase a piece of technical equipment needed for amplifying his bass. Prior to meeting with the Music Therapist he wanted to try out the amplifier. He had a great deal of difficulty connecting the amplifier; he was insistent that he could figure it out. He was observed to be repeating the same process again and again. Eventually, he agreed to use the instruction sheet, and was able to get it properly connected. At the end of the session the intern and Mr. S. reviewed how that had gone for him. He said it was “OK,” and that this amplifier was different than the one at his home. I asked about Mr.

S.'s reluctance to use the instruction sheet. He said he liked to try to figure it out himself.

Music Therapy Session #2: Exploring the Past

The focus of this second session was to continue with the MT assessment. The MTA assessed Mr. S.'s playing ability (residual function) and musical preferences and gauged his insight and frustration levels, as well as emotional losses. The Music Therapist noted that this session was somewhat compromised as Mr. S. had his bass guitar and amplifier but it was not set up and ready to play when the MTA arrived for the session. Most of this session was spent with the therapist chatting to him while he attempted to set up his amp through a radio. He eventually attempted some walking bass lines with guidance. The RT student intern was also present at this time. In this session assessment of musical preferences was more accurately completed since Mr. S. had his bass and was suggesting several songs that he had played in the past. Unfortunately the types of bands and songs were mostly of the heavy metal genre and were far beyond the grasp of what Mr. S. was able to play at this point in his rehabilitation.

One song that they were able to play was "Touch of Grey" by the Grateful Dead. The MTA knew the words and chords and they attempted to play it together, although the bass line was challenging for Mr. S. The frustrations this patient faced due to his loss of motor skills, as well as the associated emotional losses, were very apparent throughout this session. The MTA suggested beginning with some walking bass lines. She played a 12 bar blues progression while Mr. S. attempted to play a walking bass line in the key of E and then A. Mr. S. was able to play these with some success, and the Music Therapist believed that if he practiced this until his next session it may be possible to move on to something new. At the end of this session the recommendation was for Mr. S. to practice the two walking bass lines in the keys of E and A until their next session together.

RT debriefing: "*Practice, practice, practice.*" The intention of the debriefing session this week was to follow through with the recommendations from the MTA by supporting Mr. S. in establishing a practice routine.

The following is from a conversation and journal entry following the session; these reflections were also communicated to the Music Therapist:

During the week, it was noticed that he wasn't practicing the bass lines the Music Therapist had suggested. When he was encouraged to practice, he would redirect the conversation to another topic. It was difficult to redirect him to his 'homework.' Knowing that structure and routine were the most helpful to him we [the student intern and supervising CTRS] helped him schedule one half hour a day for practice. This was written into his schedule posted at his bedside. The next day, at the scheduled time, he did come to the recreation area on his own with his guitar. He was observed to spend the next 25 minutes tuning the guitar.

Music Therapy Session #3: More Than a 'Touch' of Grey

This session proved itself to be an integral part of the Music Therapy assessment and treatment process. Previous to this session, the MTA had been informed by the CTRS that Mr. S. had been diagnosed as being clinically depressed. The Music Therapist returned this week to evaluate the rate of improvement in Mr. S.'s musical and motor skills. The MTA attempted to get Mr. S. to go back over the objectives they had set together and to play the walking bass lines, but he was becoming increasingly frustrated and apathetic about the whole situation. Throughout this session, as his attempts at playing became more frustrated by the minute, he openly expressed his emotions to the Music Therapist.

Mr. S. expressed that he had a lot of anger and that he was feeling really "low" and did not have any hope of restoring his past skills. He spoke of the loss of music in his life as the loss of his spirit and said that he felt empty and that his spirituality was dead. The Music Therapist responded with supportive listening, validation and by assuring Mr. S. that he did have skills that could be restored. She remained positive about his rehabilitation. In this session the MTA understood the patient as someone

who had experienced many losses; physical, cognitive, social and spiritual. Overall loss of autonomy and self-concept were very apparent when Mr. S. spoke of his loss of musical skills and the ensuing isolation from his friends as a result of this loss.

RT debriefing: “When all else fails...”

During the weekly team conference, the neuropsychologist related further concerns of Mr. S's depression. The RT intern was able to update the team regarding Mr. S.'s sense of loss and obvious emotional distress during his music therapy sessions. The team plan became one of assisting Mr. S. to find and celebrate his successes. As a follow-up to both the Music Therapy session and the team conference, the intention of the supervising CTRS and student intern was to provide emotional support to Mr. S. by exploring other recreation options that would be personally successful. The following is a summary of the progress and shift in the RT treatment goals and follow-up debriefing session with Mr. S. that was reported to the interdisciplinary team and the Music Therapist:

Mr. S had begun participating in in-house recreation programs on a regular basis. He indicated to the intern during their weekly coffee and chat session that the programs “got him out of himself” for a little while. The intern and supervisor met to discuss how we could best support Mr. S. Our discussion explored what Mr. S.'s strengths were and how could we maximize those. Our plan was to ask Mr. S. to assist us in getting supplies for programs and help out as needed. He agreed that ‘doing’ kept him from thinking too much.... The intern encouraged Mr. S to think about how he has contributed to the others in the programs in a positive way and what that might mean to them.

Collaborative Problem Solving

After leaving the last Music Therapy session, in which Mr. S. was increasingly frustrated and expressed his sense of loss, the Music Therapist communicated to the CTRS that she thought the best treatment plan at this

point would be to abandon the previous goal of restoring past musical skills and to instead focus on learning something new, i.e., to which he would not have prior attachment and history.

As Mr. S. was depressed and did not seem to have either the initiation or emotional endurance to work to renew his bass skills, both therapists felt it would be better to engage him in an activity where he was focusing on something new. They both recognized that he needed something that would promote immediate success and leave him with a feeling of fulfillment. The Music Therapist felt that drumming could also be a good method to channel his frustrations. Drumming is a recognized therapeutic medium for releasing frustrations and anger in a physical yet non-violent manner. Drumming also had the advantage of only using one element of music: *rhythm*. Because of this Mr. S would only need to focus on one musical element instead of the multiple elements involved in the physical coordination required to play his bass (which would require the use of both hands and the simultaneous mental processing of melody and rhythm). When the Music Therapist introduced the idea of bongos it corresponded exactly with the reassessment by the RT intern and supervising CTRS. When the student intern mentioned it to Mr. S., he indicated he would be willing to ‘play.’

RT debriefing: “Something old, something new.” The student intern crafted subsequent discussions with Mr. S. to support anticipation of a new experience. The following is a summary of his student journal progress notes, communicated to the interdisciplinary team, supervising CTRS and Music Therapist:

At this point, Mr. S.'s routine is well established. He is using his bedside schedule as a guide for his day to day activities. He is engaging in a variety of leisure activities and roles such as assisting staff with events planning and offering to assist with supplies. He is sharing funny anecdotes and insights about the recreation programs. It was also during our weekly trip to a local coffee shop, he spoke of his excitement about this new adventure in music (the drumming). Mr. S. is less tangential in conversations than previously and it is easier to redirect conversations to positive experiences.

Music Therapy Session # 4: Goin' Down the Road Feelin' Bad

In this session Mr. S. was given a set of bongo drums to use. The RT intern as well as another patient whom the Music Therapist had been working with joined them. The Music Therapist chose the song "Goin' Down the Road Feelin' Bad." This is a traditional tune adapted by the Grateful Dead. She began singing the repetitive lyrics while playing the guitar. Since no one else knew the song she asked them to listen first and then join in with singing and drumming when they felt ready. Mr. S. began to drum almost immediately. His left hand was able to drum out the main beats in straight time while his right hand was able to play more difficult, syncopated rhythms. As he played he began to sing the words. The other patient sang, as well as the student intern. It was a great 'jam session' and clearly promoted a more successful experience for Mr. S. than playing the bass had. Even though he was not playing anything particularly difficult, he was enjoying himself, learning a new skill, singing and playing at the same time, experiencing success through music and regaining the social experience of playing music with others.

RT debriefing: "Movin' on." Again the following summarizes progress reported by the student intern to the supervising CTRS, treatment team and Music Therapist:

With the implementation of the bongos, a new instrument for him, Mr. S. appeared to find success in being able to play alongside the Music Therapist. His obvious pleasure in participating in a music 'jam session' was apparent for all to see. The 'jam' sessions were held in a room on his unit; other staff could hear the music and gave Mr. S. positive feedback on how well he played. During this week's debriefing meeting with the intern, the nature of the discussions focused on the improvements in how Mr. S. was feeling, not on physical function. At this point in his rehabilitation there was a significant shift in focus as Mr. S. talked less about what was missing in his life and more about what he was doing presently. It was noted that

his affect was less flat. He began to consider options relating to his discharge; where he could live, what he might do for fun, special activities with his daughter, was there employment options. He agreed to meet with a Vocational Counselor. The intern speculated that perhaps Mr. S.'s success with music left him open to consider other opportunities.

Music Therapy Session #5: Goin' Down the Road Feelin' Better

Mr. S. was seen one last time to process his previous experience as well as to provide closure. Mr. S.'s overall affect seemed much brighter in this session and there was plenty of smiling and laughing. He was able to verbalize the difference between the drums and his bass, stating that when he played the bass he became depressed about the loss of his past skill, although with the drum he did not have this association. Mr. S. agreed that the drumming had required fewer skills, had not been associated with past losses, and was a success. They repeated the song they had played during the previous session. Mr. S. again sang and played along with the Music Therapist. The patient was left with the recommendation to continue to pursue drumming as a leisure activity, and to use this new skill to develop some musical relationships.

"Movin' Out" (Discharge from RT)

Eight weeks after admission Mr. S. was discharged from both RT and the rehabilitation hospital. Prior to discharge, the Leisure Competence Measure was repeated (see Appendix B). His scores showed improvements in Leisure Awareness, Attitude, Skills Social Contact and Community Participation. He had also made significant progress in identifying changes he wanted to make in his life following discharge. Mr. S. recognized that his need for ongoing support was more than his wife could assist with at present and so decided to live with his mother in a more urban centre. He planned to continue his relationship with his common-law spouse and daughter through regular visits. His future plans included exploring supported employment through vocational counseling and occupational therapy. He and his mother received an information package

on recreation resources in his new community and guidance on establishing a leisure plan for the future, which included attending a weekly group drumming session. Contact information for Recreation Therapy was also provided should questions or needs arise in the future.

Reflections on Practice

The following reflection summaries by the Music Therapist and CTRS provide further insights into effective processes for working with adults who have experienced a traumatic change in their abilities that has led to a sense loss of self or identity.

Reflections on Music Therapy in Post-Stroke Recovery

From the perspective of the MTA, while she realized that the initial goals were not accomplished, this also highlighted how important the assessment process is in determining the course of treatment. She reflected that her inability to fully assess the patient's strengths and weaknesses made it difficult to accurately identify "the challenges" to address. From her perspective, this could have been due to the limited amount of time available to be on that site as a consult or as a result of her inexperience with this population. She reflected that although she had no experience in rehabilitation she did have experience working in mental health, which ended up being the core issue that needed to be addressed. The following is her reflection on the shift in focus from therapist-driven to patient-driven goals:

I remember thinking that there was so much that I had not known about when Mr. S. reported that he felt like his "spirit was dead." After spending two sessions working on renewal/restoration of music skills and fine motor skills without much success, I quickly decided to change the focus of the goals for this patient. In all likelihood it was the patient's decision, as had I attempted to continue on this path he would not have been able to follow me down it.

As I re-read what happened while I was writing this I found myself wondering if the complete breakdown, and subsequent suffering the patient

experienced, was destined to happen in order for us both to explore other possibilities in his sessions? If he had not been so deeply and existentially depressed and hopeless about his life perhaps we would have plodded along in a similar manner, making mild progress with the physical goals, but no progress would have been made with the existential issues and the transcendence that finally occurred.

It is interesting to me that while I approached the case how I 'thought' a Music Therapist in a rehabilitation setting should do (e.g., setting fine motor and restorative goals), it ended up being a case of existential therapy that echoed my philosophical background as a therapist. The song choice of "Goin' Down the Road Feelin' Bad" occurred organically; partly because I knew that the patient was familiar with one Grateful Dead song and partly because I thought at the time that the song was simple, a good tune to jam on, and something that would be repetitive enough that if he didn't know it he would easily catch on. It didn't occur to me at the time that the lyrics carried a message of validation and that this was what that particular patient seemed to need at that time more than anything else. I remember thinking while I was singing the song for him to listen to first that "this is exactly how he feels":

Goin' down the road feelin' bad

Goin' down the road feelin' bad

Goin' down the road feelin' bad

Don't wanna be treated this old way.

As I sang he began to sing with me, smiling and playing the drums while singing. Although he didn't know the song and his drum playing was still a bit of a struggle, the mood was joyous it and felt like he was accom-

plishing something. He was singing with me, playing with me and having a good time in the process. There was no judgment, no baseline from which to measure his past skill level on the bongos and Mr. S. and the music and I had created a space where the patient seemed to re-invent himself instead of clinging to the past. It was truly an instance of transcending the emotional and physical struggles that he had been facing since his stroke and just having a good time regardless of his ability level. This case reflects the importance of being adaptable and spontaneous. It also indicates a need for change as well as familiarity.

Recreation Therapy Reflections on Post-Stroke Recovery

From a Recreation Therapy perspective, in reflecting upon this case, it seemed as if the initial challenge of the batteries for the Discman was a metaphor for the challenges that Mr. S. was experiencing not only in the therapy process, but in his life overall. No matter what was suggested, Mr. S. just could not stop putting those batteries in, again and again, even though the Discman failed to work every time. His cognitive challenge of perseveration in his thoughts was revealed in very concrete terms. Perseverating on his guitar playing would also not allow him past this self identifier to rediscover his sense of self in a new way. Reflecting on the entire RT therapeutic process, the supervising CTRS reflected that:

Maybe at the end of the day, this experience with the Music Therapist broke the perseveration of self identity to get him to a new place? The use of the LCM certainly identified challenges in functional areas. Upon reflection those areas still fit, but what about from an identity perspective?

As a CTRS in a physical rehabilitation centre, I find RT service always starts with what are the present leisure choices for that individual. Ensuring that people have the skills

and abilities to participate in preferred leisure choices is a concrete direction that clients often find easier to understand. People understand the activity of leisure easier than the existential issues related to participation. Other therapies within the rehabilitation centre focus on the concrete abilities needed for day-to-day; that is the nature of a physical rehabilitation centre. Sometimes, we have the unique opportunity to move beyond function because the patient is ready. It is our calling to recognize when to be able to go beyond the functional abilities and provide support to people like Mr. S., who have experienced such an assault on their sense of self.

The perspectives of the Music Therapist clearly resonate with those of the Recreation Therapist. Together, they recognized that being successful in a new activity would allow Mr. S. to rediscover valued aspects of his identity, and assist him in dealing with his grief and depression.

Discussion

The intent of this case report was to illustrate “what matters” to individuals who are recovering from stroke. Although there are numerous points that could be made from this case in connection with the literature on stroke rehabilitation and leisure, a discussion of two key issues follows: (a) the value of recreation substitution as a focus for supporting return to meaningful activity participation in the face of ongoing constraints, and (b) the need to incorporate a focus on identity change when addressing psychosocial issues post-stroke.

For Mr. S., it was essential that he establish new roles, regain independence (e.g., through using a planning aid), experience enjoyment and meaning in his social and leisure activities, and have something to look forward to (for him, it was to be successful playing music). However, this case demonstrates that the journey to achieving these goals is not always straightforward. To achieve these goals required a reorienting of the therapeutic processes and goals of both the Music and Recreation therapies from a focus on functional intervention to address existential issues related to loss of identity.

Meaningful activity engagement was clearly at the core of this for Mr. S. While the emphasis in therapeutic recreation (and other disciplines) is most often to help people to *return* to previously valued activities, this case highlights how this may not be a feasible goal in all cases. Instead, for this man, it was important to find alternate ways for him to continue to identify himself and express himself as a musician. Ways that were commensurate with his remaining skills and abilities. This is an example of the effective use of recreation substitution, which has been discussed in the leisure theory literature (Mannell & Kleiber, 1997). Recreation substitution implies replacing one activity with another in order to obtain the same psychological benefits; in this case substituting the drums enabled Mr. S. to experience a sense of achievement and success, to receive recognition from others and, perhaps most importantly, to again play music with others.

This case also illustrates how profoundly disruptive a sudden acquired injury can be to a person's sense of self or identity. Mr. S. experienced constraints not only to previous leisure activity pursuits, but also constraints to affirming and expressing valued identity characteristics (e.g., himself as a musician). While people may experience tremendous constraints to returning to valued leisure pursuits after a severe injury or when living with a chronic illness (e.g., Hutchinson & Kleiber, 2005), leisure can also provide a way for people to maintain a sense of self as well as to explore new ways of being (Kleiber et al., 2008). Rediscovering and reclaiming a valued sense of self was clearly at the core of the success of this therapeutic process. Existential issues related to the self are foundational to the meanings people derive from their leisure, and need to be recognized as an important focus of rehabilitation efforts following a traumatic injury, like a stroke.

Implications for Research and Practice

While some research has been conducted on the importance of maintaining internal continuity of self following injury or illness, this has been discussed most often as a focus for coping and adaptation (Hutchinson, Loy, Kleiber, & Dattilo, 2003; Kleiber, Brock, Lee, Dattilo, & Caldwell, 1995; Kleiber, Hutchinson, & Williams, 2002). A need exists for further research which looks specifically at self

or identity change following stroke and other sudden acquired injuries which result in people experiencing profound disruptions to their roles, relationships and sense of self. From this more specific guidelines for practice can be developed. For example, initial efforts to support community reintegration post-stroke have focused on leisure education related to community/leisure resources and returning to leisure activities (e.g., Nour et al., 2002; Ryan et al., 2008). There is a need to incorporate education related to self or identity change and reconstruction in the leisure education process as well.

Two other issues that were viewed by the participating therapists as fundamental to the success of this therapeutic process warrant attention: (a) "readiness" for change and (b) shared engagement in the therapeutic process.

First, it is often difficult to accurately assess what level of independence stroke survivors will regain; as a result most people who experience stroke believe—or hold on to the hope—they will regain full function. Because most people are focused on regaining physical function, they often do not consider the importance of addressing how they will meaningfully structure their days when they return home. In other words, at least initially, patients may not be ready to fully benefit from leisure education or other interventions designed to address adaptation to change until they are more accepting of the permanency of their impairments. The therapists reflected that, in some ways, it was likely beneficial that Mr. S. had experienced failure when he was home, as this likely helped him to be more receptive to address leisure-related issues during this re-admission. Moreover, in their reflection notes, both therapists indicated that they believed that one of the reasons Mr. S. was ultimately willing to try playing the drums was because he had experienced repeated failure during the initial stages of the most recent therapy process (e.g., with the amplifier and guitar). They suggested that some level of suffering and "readiness" was necessary in order for him to be willing to accept change. This has implications for the investment of program resources into outpatient or community-based rehabilitation services.

Second, the therapeutic process represented a highly collaborative experiential in-

tervention that involved the Music Therapist and Mr. S. engaging in a *shared* activity and follow-up efforts by the student intern to help Mr. S. transfer what he was learning in these sessions to his life more broadly. Without the music therapist putting *herself* into the experience with the client, it is unlikely she would have fully understood the feelings of loss and frustration he experienced. Without the debriefing sessions it is also unlikely that Mr. S. would have been able to generalize his experiences to start to plan for his time when he returned home. Over time, both the therapies necessarily shifted from a main focus on improving physical function to one that addressed the losses, grief and change in his sense of identity that Mr. S. had experienced as a result of his stroke. This is unlikely to have occurred had the Music Therapist been unable to establish the kind of therapeutic relationship that allowed Mr. S. to share his feelings and to trust her enough to try something unfamiliar. While much attention has been paid in the music therapy literature to the importance of rapport-building and being authentic in therapeutic relationships, this case highlights the value of engaging *with* clients in a guided process of shared exploration and discovery in order to support both the process and outcomes of therapy.

As it relates to the issues of resources, the Music Therapist who provided services to this client was not an employee of the rehabilitation centre. Although she was clearly very successful working with Mr. S., the Music Therapist was challenged in creating a therapy plan without being part of the interdisciplinary team or participating in team meetings. While the willingness of the Music Therapist, RT student intern and supervising CTRS to closely collaborate helped to overcome some of these constraints, the case demonstrates two things: (a) the value of Music Therapy for addressing psychosocial issues post-stroke, particularly when people's prior leisure interests include music, and (b) the value of collaborative or interdisciplinary interventions.

Conclusion

Both therapists felt this was an important case to share as it illustrates that physical rehabilitation approaches may not address the identity issues of patients who experience ac-

quired injuries. This case report illustrates the importance of responsiveness in patient care, and a successful collaboration between two therapies, highlights the need for a variety of professional services in stroke rehabilitation, and demonstrates the value of using debriefing in creating/supporting positive change. Additionally, it speaks to the importance of addressing the mental health of clients in order for other forms of health care or rehabilitation treatment to be effective. Finally, and perhaps most importantly, this case reveals the need for therapeutic recreation to focus on *both* functional and existential outcomes when addressing the leisure and overall health and well-being needs of individuals who have experienced a stroke.

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APPENDIX A

Leisure Competence Measure Scores

On Re-Admission: Mr. S.

Leisure Awareness – 3: Client requires assistance to identify benefits of leisure involvement. Client has unrealistic expectations regarding leisure involvement. Client requires assistance setting realistic goals. Client is able to identify 1 to 2 activities.

Leisure Attitude – 5: Client requires cueing to initiate leisure involvement and periodic encouragement to maintain involvement. Client demonstrates discomfort with developing new leisure interests/skills. Client may or may not demonstrate feelings of enjoyment and/or satisfaction regarding leisure involvement and participation.

Leisure Skills – 4: Client is able to make leisure choices based on personal interests. Client possesses the skills necessary to participate in chosen leisure activities, but requires reassurance regarding his/her competence. With cueing client possesses the ability to locate and utilize leisure resources.

Community Integration Skills – 3: Client initiates choosing community-based leisure activities. Client requires assistance planning and following through with chosen community-based leisure activities.

Social Contact – 4: Social contact occurs primarily in the home. Client requires assistance to initiate social contact with others. Social contact consists primarily of short phrases.

Cultural / Social Behaviors – 6: Client displays socially acceptable manners, hygiene and dress, but occasionally displays poor judgment in these areas. Client is courteous and tolerant of others.

Interpersonal Skills – 7: Client is able to participate independently within various types of individual and/or group situations.

Community Participation – 4: Client participates in specialized community programs. Client may require assistance with participation. Client leaves the home to do routine activities such as taking walks, shopping, going to church, and visiting family and/or friends. Leisure activities are both active and passive in nature.

APPENDIX B

Leisure Competence Measure Scores at Discharge: Mr. S.

Leisure Awareness– 5: Client requires cueing to identify personal benefits of leisure involvement. Client requires cueing to identify own leisure strengths and weaknesses. Client has realistic expectations and is able to set goals regarding leisure involvement. Client is able to identify 3 to 4 activities.

Leisure Attitude – 6: Client takes initiative for own leisure involvement once a program schedule has been provided. Client displays a willingness to develop new leisure interests/skills. Client demonstrates feelings of enjoyment and/or satisfaction regarding leisure involvement and participation.

Leisure Skills – 5: Client is able to make leisure choices based on personal interests. Client possesses the skills necessary to participate in chosen leisure activities, but requires reassurance regarding competence. With cueing client possesses the ability to locate and utilize leisure resources.

Community Integration Skills – 3: No change.

Social Contact – 6: Client has a mixture of in-home/ community, and family/friend social contact. Client initiates social contact with family/friends, and interacts appropriately with same. Client does not initiate social contact with others, but interacts appropriately in response to others. Social contacts are of both long and short duration.

Cultural/Social Behaviors – 6: No change.

Interpersonal Skills – 7: No change.