Leisure and Health Relationships: Challenges for Recreation Education

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Introduction

Knowledge of how leisure impacts on an individual's well-being, including physical health and mental health, should be of particular importance to leisure professionals. Although well-being may also include factors such as social well-being (Green & Shellenberger, 1991), zest for life, and spiritual factors, people's physical and mental health appear to have pervasive influences on well-being. Understanding the relationships between leisure and health helps considerably in understanding how leisure effects well-being. The ways that leisure can influence the health of participants will increasingly be incorporated into curricula in recreation education institutions. But what is the scope of health benefits of leisure? How can we be sure that curricular content is not biased by common beliefs and enthusiasm? How are health benefits best presented in leisure and health programs?

Health can vary in degrees of positive health and not merely in terms of the absence of illnesses (Compton, 1994, Iso-Ahola, 1996). Thus, health can be seen to fluctuate from grave illness to vital "wellness". Unfortunately, the view that health is just freedom from illness is commonly held. This view is sustained in part by the dominance of medical ideas and professions with curative medical treatments in health institutions. This dominance persists in spite of the medical profession's awareness of the positive aspects of health and that health is but one component of well-being. A change in focus away from illness towards extended "wellness" calls into play ideas of proactive preventive health practices rather than reactive remedial health maintenance.

Expanded conceptualizations of health and health practices offer considerable opportunities (and responsibilities) to the field of recreation. The benefits of recreation in rehabilitation from illnesses or developmental problems have long been argued and specific professional recreation foci and practices (e.g. therapeutic recreation) developed around them (Carter, Van Andel & Robb, 1995). The broadening of the concept of health to incorporate its positive sense highlights a therapeutic meaning in almost all aspects of recreation. Thus, an understanding of leisure-health relationships is important for a broad spectrum of recreation and leisure professionals as well as students.

In what ways is leisure connected to health? Some people engage in various leisure activities specifically for health reasons. For example, feeling good, and improved fitness

and health are dominant motives for engaging in physical activities. On the other hand, many may jeopardise their health status through leisure apathy. Furthermore, some participants chose to ignore health risks associated with activities in which they engage (e.g., participation in extreme sports, binge drinking at parties). Analysis of the ways that leisure enhances and endangers health from several perspectives, including leisure as a set of activities and leisure as an experience, can assist in understanding complexities of leisure-health connections which present challenges in devising leisure-health curricula. This paper will highlight a selection of connections between leisure and health that demonstrate the need for comprehensive and careful attention to content in recreation curricula that focus on leisure and health.

Leisure Activities and Experiences Enhance Health Status

From an initial perspective, some leisure *activities* can be seen as health promoting. For example, regular physical activity enhances physical health. Additionally, intellectually stimulating activities are believed to help retain mental alertness and capacity (Caldwell, Smith, & Weissinger, 1992). As well, certain leisure *experiences* are believed to have the capacity to enhance health. For example, Coleman and Iso-Ahola (1993) argued that a sense of self-determination in leisure and leisure companionship had indirect impacts on health.

The clearest examples of health promoting activities include the many activities that involve physical action. In leisure, people can engage in a variety of physically active pursuits, including many sports (e.g. basketball, tennis, soccer), outdoor adventure pursuits (e.g. rock climbing, hiking, canoeing), exercise (e.g. walking, running, swimming, cycling, gym training, aerobics), dancing (e.g. aerobic and ballroom) and some hobbies (e.g. wildlife observation). The direct contribution of physical activity to fitness and health has been clearly demonstrated (Wankel & Berger, 1990). Regular participation in sessions of aerobically stimulating leisure activities for sufficient duration and intensity has been demonstrated to enhance physical fitness and aspects of health (Paffenbarger, Hyde, & Dow, 1991). Continual physical activity not only reduces the likelihood of heart-related and other illnesses but also delivers positive health. People report strong positive outcomes, such as "feeling good," as a result of regular physical exercise. Sustained physical activity has also been shown to lower the likelihood of depression and thus enhance mental health (see Iso-Ahola, 1997). There is no doubt that physically active leisure pursuits are an important element in the leisure-health link. In recognition of this distinct contribution, this benefit often features strongly in the leisure and health literature. Unfortunately, contributions of other kinds of activities, such as the benefits of mental activity, are often neglected in both the leisure literature and in curricular content.

Many leisure activities involve primarily mental processes, including perceptiveness, recall, problem solving and creativity (e.g. many arts, playing cards and other games, playing music, hobbies). Other leisure activities incorporate mental actions as part of the activity (e.g. sport, outdoor pursuits, social interactions). Social and mental processes required for these activities are believed to maintain a healthy mind. This is most obvious in older people where the commonly expected reduction in abilities with

age appears to be thwarted by continued use of mental processes in leisure and life. It is more difficult to demonstrate the health maintenance associated with mentally active living in comparison with physical activity. This may be one reason why mental activeness features less in leisure curricula. An example of this bias is the tendency of many students on reading the words "active leisure" to immediately, and often wrongly, assume that only physical activeness in implied instead of both physical and mental activeness. Both are important components the leisure-health connection and need to be incorporated in leisure-health curricula.

Does leisure, regardless of the activity, in some way enhance health status? Some claim that the qualities inherent in all leisure experiences are conducive to health maintenance (e.g. Coleman & Iso-Ahola, 1993; Iso-Ahola, 1996). That is, the experience of free choice of activities pursued for their own sake leads to enhanced mental and physical health. Because the effect of the experience of leisure is likely to be small and occurs indirectly and over the longer term, rather than the medium or short term, it is difficult to demonstrate this contribution to health. As a result, such contributions may be neglected in leisure health curricula.

Full understanding of the contribution of leisure experiences to health also requires consideration of the role that stress plays in one's life. Stressful life circumstances, daily hassles and work stress induce feelings of distress which, if unaddressed, can increase the likelihood of mental and physical illnesses. However, the impact of stress on health is usually not fully realised because the impact is partially moderated as people adopt various coping strategies. Leisure participation facilitates coping with stress through resistance against the perceptions of stress and reduction of stressful feelings that occur due to salient or chronic stressful situations.

Leisure can help prevent illnesses by fostering enduring dispositions that have the capacity to insulate people against stressful events and situations (Coleman & Iso-Ahola, 1993). Leisure induced stress insulation includes a sense of companionship or support and dispositions reflecting self-determination (e.g. internal locus of control). A predisposition towards intrinsic interest may also provide some buffering effect against stress. These dispositions appear to work by altering the perception of people in stressful times such that the extent of threat in a stressful situation is devalued or altered to become a challenge. People with these dispositions see themselves as capable of handling stress and as a result have an internal means for health maintenance. That the characteristics found to buffer people against stress are defining or central characteristic of leisure, heightens the importance of the relationships to leisure scholars and professionals. Thus, these less obvious but significant long term outcomes of leisure help provide health benefits through healthy lifestyles. This makes them very important components of leisure-health curricula.

Another way that leisure reduces the impact of stress is by helping people, albeit temporarily, adjust their moods. Two ways that this is effected are immediately apparent and illustrate the processes; people escape negative situations to positive situations and people adjust their levels of arousal (Iso-Ahola, 1994). Leisure is said to provide a physical

and psychological "escape" from physical and social environments that are stressful thus providing temporary respite from chronic stress. Short term changes to positive moods (e.g. happiness, enjoyment, friendship), that are common in leisure, block the negative feelings of distress for short periods. Leisure can be used to adjust the level of arousal, usually by providing relaxation in a hectic lifestyle (but also by providing excitement in a distressing, boring life). Although the latter coping states generated by leisure are temporary in nature, they may have the capacity to initiate longer term benefits.

Leisure Activities and Experiences that Jeopardise Health

Some activities are more health compromising (e.g. sedentary activities, smoking and excessive alcohol consumption). Generally, health compromising activities are identifiable amongst a number of other negative or socially less acceptable leisure behaviours. The wider set of negative leisure activities include excessive gambling, adolescent and gang aggression, graffiti painting, purple leisure, etc. As well, several negative leisure experiences reflect failure to perceive and derive value from leisure, thus blocking achievement of potentially healthier lives (e.g. constraints, boredom) (Iso-Ahola, 1997).

Sedentary leisure is increasingly common in western societies (as is sedentary work). Many leisure activities are physically passive in nature. Furthermore, people often adopt ways of participating in leisure activities that reduce the extent of physical exertion (e.g. intensive use of golf buggies). Epidemiological studies have linked (causally) sedentary behaviour with such illnesses as hypertension, coronary diseases and strokes. Sedentary activities and the resultant lack of fitness are also believed to inhibit attainment of positive levels of health. Considerable attention in recreation polices and promotions has been directed at reducing sedentary leisure. Authorities in many countries have tried, to little avail, to alter the behaviors and attitudes of people who do not engage in physically active leisure. If leisure professionals understood more clearly the nature and impact of sedentary leisure and sought fruitful ways to assist people to escape it, they would make a greater contribution to the well-being of their clients and the community.

Smoking is common in many western countries. This includes smoking by youth (increasingly by girls in Australia). Smoking is a behavior of free time. For some it is an identifiable separate leisure episode or behavior and for others a behavior closely associated with leisure activities. Controls on work place smoking in some countries are thrusting smoking more clearly into the leisure arena. Although many leisure managers (e.g. restaurants) control smoking, others fail to do so. Some leisure administrators continue to be supportive of smoking in such ways as sponsorships or sales of tobacco products. Yet smoking has a demonstrated impact on health leading to or aggravating many grave chronic illnesses (Sheridan & Radmacher, 1992). However, people who smoke often ignore or discount the impact of smoking on their health. Furthermore, many reject the increasing evidence of the health impact of passive smoking. Although smoking is a recreational habit with serious health consequences, leisure researchers

have not yet devoted much attention to the leisure meaning of smoking. Still, it deserves a place in leisure curricula.

Alcohol consumption (and the consumption of other recreational drugs) is also a free time activity for many. Similar to smoking, it is a separate identifiable leisure activity for some (e.g. "to go out drinking") and for others, a natural adjunct to other leisure activities (e.g. parties, dining out, sports spectatorship). In many of these instances alcohol is not consumed in sufficient quantities to be a serious health detriment. However, some events where alcohol is consumed are directly oriented towards drunkenness (in Australia young people "binge" drink) or participants fail to avert excessive consumption of alcohol by individuals. Short term drunkenness is detrimental to health and is often associated with serious injuries through driving and other accidents (Sheridan & Radmacher, 1992). More importantly, longer term excessive alcohol consumption is a contributor to many illnesses. As well, excessive alcohol consumption blocks opportunities for participation in more healthy leisure activities and inhibits achievement of positive health states.

Consideration of these two examples shows it is important for leisure professionals to understand the association between unhealthy activities and leisure. Leisure professionals' training should help them advocate and develop leisure climates that reject or limit activities that can jeopardise health. This can be achieved more effectively if these negative leisure activities are dealt with as part of the leisure studies curriculum.

Negative "leisure" states are also commonly experienced during free time and in leisure settings (e.g. constraint, boredom). One's free time can be impacted by such factors as lack of time, external pressures or situations, lack of resources or lack of information. For some, a sense of helplessness or lack of esteem induces an internal constraint leading to inaction. As a result, many people end up spending much of their free time doing things they have not chosen and in which they are not intrinsically interested. This can generate a variety of feelings including apathy, frustration, and boredom.

Facing constraints sometimes lead to redirection or substitution of leisure. Temporary boredom is a useful psychological mechanism that alerts people to waning interest and lowered levels of arousal. In the extreme, for some, leisure is characterised by excessive restrictions or chronic boredom. If people are unable to resolve continual leisure boredom the levels of both physical and mental health are likely to be reduced (Iso-Ahola, 1996). In particular, boredom is associated with depressive states and depression is believed to lead to physical illnesses. Furthermore, experiencing long term, seemingly insurmountable constraint and boredom are contrary to achieving positive levels of well-being.

Although the image of "leisure" for many leisure scholars and professionals is of relaxation, excitement, challenge, and social and rewarding experiences, for many people free time brings about boredom or frustration. Boredom and constraint are *fundamental* leisure problems; they are an antithesis of states which define leisure. Leisure professionals

need to have knowledge so that they can address these conditions and understand how boredom lapses from a warning to a chronic experience. They also must be able to stimulate intrinsic interest and appropriate arousal from extreme opposite states. Having this knowledge will better equip them to make contributions to the communities they serve. These contributions are not only in quality of life but in terms of people's overall health.

Complexity of the Leisure-Health Relationships

Generally, leisure activities and environments have both health promoting and health jeopardising components. For example, skiing has physical and mental contributions to health but may involve considerable risk of injury or exposure. Illustrating this from an alternative perspective, smoking and consumption of alcohol, two activities previously described as jeopardising health, may be associated with companionship and stress reduction. Furthermore, many physical activities may be engaged in debilitating ways **or** in safe, health securing ways. Likewise, people may engage in activities for quite different reasons and at different intensities. Even though activities may contain health generating components, participants may avoid these aspects or they may participate insufficiently to derive benefits. Thus, as well as providing health benefits, most leisure activity has some potential for inducing illnesses or injuries. Subsequently, some leisure activities may fail to effect enhanced health levels and could be detrimental to health.

An associated complicating factor in the reality of leisure-health relationships is that there is likely to be more than one health delivery process operating on individuals at any one time. People with a sporting orientation are likely to derive benefits from the strengthening of cardiovascular systems (one of the processes that has been clearly demonstrated) but at the same time may gain in confidence, develop a sense of self-control, and also establish leisure friends amongst those with whom they share their sport. The latter two processes could contribute to health enhancement or illness prevention as well as the direct impact of physical activity.

It has been argued that the full understanding of leisure's contribution to health requires understandings of a third health determinant, the role of stress. Leisure may make its greatest contribution to health by reducing stress or buffering people's health against the detrimental impact of stress (Coleman & Iso-Ahola, 1993). Thus, one needs to understand stress-health relationships before clear understandings of leisure's impact on health are grasped. Here we see leisure as not providing a direct contribution to health, but rather acting as a moderator of the impact of stress on health.

An understanding of the stress-health relationship also requires one to understand intervening steps. How might stress induce physical illnesses? This multi-step process requires familiarity with the body's endocrine and immune systems. The complicated subtle influences of thoughts and feelings on body tissues and fluids become important carriers of some of leisure's impact on health.

One implication for leisure service training on this positive/ negative duality, as well as the variability of leisure health connections in leisure settings, is that leisure

professionals are going to have to make somewhat different decisions in different situations and for different participants. These professional capacities require training based on broader, well-founded understandings. They also underline the need for a variety of learning strategies to be adopted (e.g. value clarification, skills development, case studies). The implications of health's indirect impact on leisure include the need for curriculum planners to place leisure and health in a broader health context. It is important that students see leisure's contribution in comparison with other contributions and acting in conjunction with the large number of psychological, biological and social determinants of health. Demonstrations of leisure's influences on health rely on psychological conceptualizations and processes (coping, stress responses), sociological understandings (demographic variations and companionship), immunological processes (reduced killer cell capacities), epidemiology (population mortality evidence), behavioral medicine (health behaviors), medicine (injuries, illness, symptomatology). Research by and collaboration with these and other disciplines will be needed to fully develop a professional understanding of the capability of leisure to influence health. The approach to studying leisure and health, like most areas of recreation studies, needs to be multi-disciplinary.

The Impact of Health on Leisure

The impact on health on leisure also needs to be incorporated into leisure and health curricula. Strong values supporting the instrumental capacities of leisure often lead to neglect of this "reverse" process in curricula. Similar orientations may also influence the interpretation of research evidence demonstrating leisure's impact on health.

The effect of health on leisure is more apparent than the effects of leisure on health. Health can enhance and illness can reduce participation in leisure activities. This could easily be demonstrated with physical illnesses and physical activity, but also occurs with emotional illnesses and both mental and many physical activities. Health is also likely to interfere with leisure experiences in general. Illness is likely to reduce intrinsic interest and self-determination and may lead to leisure boredom. This reverse causal relationship between health and leisure may occur during a short illness or, with greater impact as a result of chronic illnesses. Furthermore, some would point out that ill health *clearly* leads to reduced participation, and illness is a *potent* reducer of leisure activity. Likewise, it is believed that vibrant health facilitates increased leisure involvement. People who feel well are more likely to do things in which they are interested.

This reverse impact of health on leisure could often be what researchers observe in their studies (e.g. Coleman, 1993). Correlational studies involving leisure (e.g. participation rates) and health (e.g. illness symptoms) measured at the same time *cannot* demonstrate that leisure influences health. It is very difficult to determine which is the cause and which is the outcome. The correlations between leisure and health are just as likely (maybe more likely) to occur because healthy people take up more leisure as they are because leisure causes people to become more healthy.

Leisure curricula should acknowledge the strong clear influences of health on leisure. As well, those seeking research foundations for their leisure and health curricula need to be aware of the difficulties in interpretation of two variable correlational studies due to the cyclic nature of leisure and health relationships.

Conclusions

The scope of the leisure-health curriculum places demands on curriculum designers. For leisure professionals to understand the relationship between leisure and health and develop appropriate health values and leisure service skills means consideration of health from its broadest perspective. The common view of health as absence of illness associated largely with curative aspects of health needs to be supplemented with understandings of positive health and preventive health practices. It also means that knowledge of health endangering leisure activities and experiences, as well as the positive influences of leisure, need to be conveyed. Leisure scholars, and I fear, leisure service professionals, often promote positive conceptualizations of leisure and point out favourable relationships between leisure activities and health. Due attention should be placed on the impact of health on leisure participation and experiences. This impact is strong and is worthy of inclusion in leisure and health programs for its own sake. The sequencing of this programatic area and the integration of a balanced view of the link between leisure and health requires special attention.

Essential information and evidence about the nature of links between leisure and health are available in the literature of several disciplines. Curriculum designers must realise that clear demonstrations of leisure's effects on health are difficult to actualize. Implementation of experimental studies that would confirm causal effects is difficult. Also, the cyclic relationship between leisure and health confounds many correlational demonstrations, as do parallel relationships of various kinds that are usually active at any one time. Thus, leisure educators preparing programs need to be aware of the literature of other disciplines and need to be critically aware of the status of the knowledge about leisure and health so as not to overstate the magnitude of effects.

In spite of these difficulties, a body of evidence demonstrates the need to inform both students and professionals of the impacts of quality leisure activity and experiences, as well as the absence of negative leisure activities and experiences on health. This knowledge provides a valuable base for the development of a leisure-health curriculum.

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