Psychotherapy Guidebook

Horticultural Therapy

Paula Diane Relf

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Table of Contents

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DEFINITION

Horticultural Therapy is the utilization of a more or less structured series of contacts between a trained therapist and a client; the therapist, employing the media of horticulture, tries to produce certain beneficial changes in the client's emotional state, attitudes, and behavior. The therapeutic influence is primarily exerted by words, acts, and rituals within the horticultural milieu, in which the client and therapist and group (if there is one) participate jointly.

HISTORY

Gardening has long been advocated for its beneficial effects on mentally ill individuals. Dr. Benjamin Rush noted in 1812 that "digging in the garden" was one of the activities that often led to recovery of patients in the mental hospitals. From the time Friends Asylum for the Insane opened in Philadelphia in 1817, patients have been involved in vegetable gardens and fruit production. Pontiac State Hospital, opened in 1878, made extensive use of agriculture. However, in the early stages of the program, as with many

others, the goal was production and any therapy was a fortunate by-product.

The idea of gardening as a kind of labor beneficial to patients was given support by Dr. Thomas Kirkbride, founder of the American Psychiatric Association. He wrote in Hospitals for the Insane, published in Philadelphia in 1880, that vegetable gardens "will be found [to be] the very best dependence for outdoor labor for the patients."

During the latter part of the 1800s, horticulture gained recognition as being of value to ease the stressful lives of the urban poor and as an aid in teaching retarded individuals.

The early 1900s brought significant changes in the utilization of horticulture in patient treatment. In 1919, Dr. C. F. Menninger and his son, Karl, established the Menninger Foundation in Topeka, Kansas. From the start, plants, gardening, and nature study were integral parts of the patients' activities. Between 1920 and 1940 almost all Occupational Therapy books mentioned gardening as an adjunctive program.

After World War II, the use of horticulture as a therapeutic tool had a significant increase in veterans' hospitals as part of the treatment of returning GI's. Professional occupational therapists were joined by thousands of volunteer garden club members to bring flowers and horticultural activities to the hospitals. This wide use of horticulture as an adjunctive therapy set the

stage for the development of Horticultural Therapy as a profession.

In the late 1940s and early 1950s, perceptive proponents working individually throughout the country acted as the catalyst to create the profession. Rhea McCandless at the Menninger Foundation and Alice Burlingame in Michigan were two of the prime forces in this early development. In 1959, the New York Institute of Rehabilitation Medicine Center, under the direction of Dr. Howard Rusk, added a Horticultural Therapy greenhouse.

An important step in the evolution of the idea of Horticultural Therapy — from that of simple outdoor work to a fairly well-defined concept of the behavioral benefits of gardening and related activities — was made with the establishment of a cooperative program between the Menninger Foundation and Kansas State University to train students for degrees in Horticultural Therapy. In 1973 Clemson University offered a graduate degree in Horticultural Therapy. In that same year a national professional organization was formed under the auspices of Melwood Horticultural Training Center, a vocational school for the mentally retarded in Upper Marlboro, Maryland. Today the National Council for Therapy and Rehabilitation Through Horticulture has approximately eight hundred members throughout the United States and several foreign countries.

At a conference by the Department of Health, Education and Welfare on new and emerging careers, held in Washington, D.C., in the spring of 1976, Horticultural Therapy was recognized as one of the top ten most significant new careers in the United States today.

TECHNIQUE

A Horticultural Therapy program may use a variety of activities and settings to accomplish its aims. Many of the programs are conducted out-of-doors, but outdoor space is not a prerequisite for a successful Horticultural Therapy program.

The types of horticultural activities that have been used successfully in therapy and rehabilitation programs include: vegetable gardens, greenhouse projects, lawn and ornamental plant care, commercial production of various crops, indoor gardening with or without lights, flower arranging, nature crafts, as well as many other plant-related projects.

Depending on the goals of a specific program, the plants, garden services, or other horticultural products may be sold for a fee, given to worthy causes, or utilized by the participants in the program. Through sales of services and products, some programs are able to generate sufficient income to be partially self-supporting.

The specific goals of a Horticultural Therapy program may differ distinctly from one institution to another and from one population of handicapped individuals to another. However, the ultimate goal of these programs is the improved physical and mental health of the individual. The benefits may be seen in four areas: intellectual, social, emotional, and physical development.

The projects or activities may be conducted on an individual, one-to-one basis or with groups. However, a small group of approximately five individuals seems to predominate in most programs. The activities may be so geared as to bring about interaction between client and therapist, between members of the group, or between clients and nonclients, as in programs where mentally retarded patients sell plants they have grown to the general public.

APPLICATIONS

Horticulture has been used effectively as a part of the therapeutic program with a diverse population of individuals. Among the facilities utilizing Horticultural Therapy are: old-age and nursing homes, schools and homes for the retarded, institutions for the mentally ill and emotionally disturbed, correctional and rehabilitative institutions for youthful and adult offenders, schools and homes for the physically handicapped and sensory

impaired, private and public hospitals for the chronically and acutely ill, Veterans Administration hospitals, community centers for inner city residents, centers for alcohol and drug abusers, halfway houses, and schools for the blind and the hearing impaired.

Programs now exist in each type of institution, both public and private, large and small. Most of them are supported in varying degrees by state and federal funds. Some programs are considered primarily vocational rehabilitation, and their ultimate goal is placement of the client in a job. However, the majority have as their primary goal the change in attitudes and behavior of the client.