

Recreation Programs for Caregivers of Older Adults: A Review and Analysis of Literature from 1990 to 1998

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Abstract:

Due to social, economic, and medical factors, more adults are choosing to care for ill or disabled relatives at home. Although leisure and recreation have particular benefits for informal family caregivers of older adults, caregivers often have limited social and leisure lives. The purpose of this paper is to use an integrative review technique (Jackson, 1980) to identify common factors in recreation and leisure and related programs for caregivers of older adults. A total of 22 journal articles were reviewed yielding five categories of programs. All programs were reviewed separately and recommendations for practice and future research are presented.

KEYWORDS: Caregivers, leisure, programs, respite, social, intervention

Article:

Many factors are enhancing the longevity of older adults in the United States; however, living longer often brings with it illnesses or diseases related to aging. As a result, more adults are finding themselves caring for ill or disabled family members in their homes without pay. Additionally, these informal family caregivers (Cantor, 1983) are finding themselves with multiple roles such as being employed and having to care for children. To attempt to juggle these many responsibilities as well as the burden of caregiving, many informal family caregivers abandon or greatly reduce their recreation and leisure pursuits. This is a great concern to professionals who do or can provide leisure and recreation opportunities for this population.

Leisure has been found to provide unique benefits to people of all ages and situations. For example, leisure can serve as a buffer to stress (Coleman & Iso-Ahola, 1993). Therefore, leisure and recreation have particular benefits for caregivers of older adults. Unfortunately, caregivers have limited social lives; engage in few recreation activities, go out to dinner rarely, and infrequently visit with friends (Thompson, Futterman, Gallagher-Thompson, Rose, & Lovett, 1993; Wilson, 1990).

Much of the caregiver literature of the 1980s cited a desire for leisure identified by caregivers (e.g., Bedini & Bilbro, 1991) but rarely identified research that explored these needs and perceptions. Caregivers seemed to want recreation and leisure in their lives, but because of a variety of barriers and stigmas due to caregiving, they had reduced or forsaken it altogether (Bedini & Guinan, 1996). Although some recreation and leisure programs have been developed for caregivers, "The literature is silent on the relative effectiveness of social, recreational, educational, service, and advocacy groups [for caregivers]" (McCallion & Toseland, 1995, p. 22). Therefore, the purpose of this paper is to use an integrative review methodology to identify common factors in successful recreation and leisure and related programs for caregivers of older adults and compile recommendations for practice and future research about these and similar programs. For the purposes of this study leisure was defined as social activities, hobbies, relaxation, recreation, and free time activities.

METHODS

An integrative review technique (Jackson, 1980) was implemented to conduct this analysis. According to Jackson (1980), an integrative review ". . . should explore the reasons for the differences in the results and

determine what the body of research, taken as a whole, reveals and does not reveal about the topic” (p. 439). Six refereed journals dealing with recreation/leisure and/or aging published between the years of 1990 and 1998 were reviewed to identify articles that addressed the topics of caregiving and programs in recreation, leisure, or social support that facilitated the pursuit of leisure. Articles were solicited from *Activities, Adaptation & Aging*, *Annual in Therapeutic Recreation*, *Journal of Gerontology*, *Journal of Gerontological Social Work*, *The Gerontologist*, and the *Therapeutic Recreation Journal*. Additionally, six databases (CINAHL, ERIC, Medline, PsycLIT, Social Sciences Abstracts, and Sport Discus) were searched for the identified topics. Key words for the search included leisure, recreation, interventions, programs, activities, socializing, hobbies, free time, leisure education, unobligated time, caregivers, elderly, aging, and strategies. A total of 22 journal articles which met the criteria (i.e., addressed programs in recreation, leisure, or social support that facilitated the pursuit of leisure for caregivers of older adults) were identified and reviewed for this study. The articles included both proposed as well as empirically tested programs and models, and addressed leisure and recreation as either the primary focus or a secondary finding of the research. The review analysis questions addressed purpose of study, theoretical/conceptual framework, methods used, conclusions, effectiveness of programs analyzed, and implications and recommendations for both researchers and practitioners. Data analysis consisted of constant comparison technique (Henderson, 1991) whereby two researchers read through all the articles, sorted them into topical categories, and analyzed them based on the integrative review questions identified above (i.e., purpose, framework, methods, results, implications).

SUMMARY OF FINDINGS

A total of 22 journal articles were reviewed to determine the status and successfulness of programs that provided training, opportunity, or time for the leisure and recreation of caregivers of older adults. Five groups or categories were identified by this procedure. Category topics included interventions (n = 2), respite (n = 5), support groups (n = 4), education/training (n = 4), and a combination of support group and education-training group (n = 7).

Purpose

Fourteen of the 22 articles scientifically evaluated the effectiveness of a leisure, recreation, or social support program for caregivers of older adults. Only one article actually tested the effect of a leisure/recreation program specifically. Overall topics within the articles included subjective burden (n = 7), support networks (n = 5), social support (n = 4), knowledge and use of community services (n = 4), time use (n = 2), activity restriction (n = 2), life satisfaction (n = 1), life upset (n = 1), and self-care (n = 1). Seven articles proposed the benefits or effectiveness of selected programs based on literature and conceptual logic, however, were not empirically tested. These topics included balance of caring responsibilities for self and care-recipient (n = 5); leisure information, skills, and resources (n = 4); identifying and using community resources (n = 3); social support (n = 2); social network (n = 2); relief of caregiver burden (n = 1); decreasing leisure constraints (n = 1); and leisure involvement (n = 1). The remaining article described an assessment tool that dealt with perceived social support and had direct implications for the leisure of caregivers of older adults.

Theoretical/Conceptual Base

Theoretical or conceptual frameworks are sets of logically related statements that explain phenomena and offer guidance for the process of conducting research (e.g., Fawcett & Downs, 1986; Henderson, 1991). Six of the articles presented a sum total of seven different conceptual or theoretical frameworks. Fourteen articles presented rationales for the programs described through literature reviews that ranged from a few paragraphs to several pages. They did not present any theoretical or conceptual framework, however. One article discussed a review of programs but indicated no conceptual framework on which they were built. The six articles that used conceptual frameworks presented theories such as stress theories, crisis theory, and the stress-buffer hypothesis; however, they did not cite references. Other articles based their programs on models such as the Model of Linkages (Noelker & Bass, 1989), the Leisure Education Model (Peterson & Gunn, 1984), or the Open Systems' Model (Schopler & Galinsky, 1993).

Methods Used

Seven different research methods or combinations of methods were used in the articles that tested the effectiveness of the programs proposed. They included interviews and questionnaires (n = 7); questionnaires alone (n = 2); focus groups (n = 2); in-depth interviews (n = 1); experimental design with control group (n = 1); observations and interviews (n = 1); and a combination of observations, questionnaires, and interviews (n = 1). Scales and instruments used in these studies included the “Yesterday Interview” (Moss & Lawton, 1982) Subjective Burden Scale (Zarit, Reever, & Bach-Peterson, 1980), Support Network Checklist (Enright & Friss, 1987), Life Satisfaction Index (Wood, Wylie, & Sheafor, 1969), Jaloweic Coping Scale (Jaloweic, Murphy, & Powers, 1984), Montgomery-Borgatta Burden Scale (Montgomery & Borgatta, 1986), Life Restriction Scale (Poulshock & Deimling, 1984), and Stokes Social Network Scale (Stokes, 1983). Additionally, several self-developed scales on coping, perceived social support, and stress were used.

Results and Conclusions

The five categories of programs were: (a) interventions, (b) respite, (c) support groups, (d) education/training, and (e) education-training/ support group combination. Each will be presented separately for what we learned from these articles as grouped.

Intervention. The first category of articles presented two different recreation interventions; one in music and one in horticulture therapy. Both of these articles noted the potential of the recreation interventions to relieve stress and burden in caregivers of older adults and to improve the relationship between the caregiver and the care-recipient through joint participation in the intervention described. Smith and McCallion (1997) described a horticulture therapy program for caregivers of frail elderly. Proposed benefits of this program were that the caregivers were present in the home, it was flexible to caregiving demands, the cost was low, and it built upon existing interests and skills of the caregivers. Although no testing was conducted for this program, the authors presented anecdotal evidence from the literature to support suggested positive outcomes. For example, they estimated the success of a horticulture therapy program since other studies found that plants decreased the use of pain medications, assisted in post-surgical recovery, and increased positive behaviors and affect (e.g., Sneha & Trista, 1991; Williams, 1989). The authors suggested that in providing this type of intervention, it is important to assess what type of gardening activities the caregivers currently enjoyed or had enjoyed before becoming caregivers. Additionally, they recommended that the caregiver determine how functional the home is for beginning and maintaining horticulture activities (i.e., light, space, storage, irrigation). Finally, they suggested that caregivers consider to what extent the care-recipient can participate if the one of the goals of intervention is joint participation.

Dupuis and Pedlar (1995) discussed the role that a structured family leisure program played in enhancing family visits and alleviating caregiver burden for family members of institutionalized older adults with Alzheimer’s disease. The specific structured leisure program presented in this study was a family music program which took place during family visits with their care-recipients. The authors proposed that the benefits of this type of shared music program would include facilitation of communication and perhaps bring family members closer together. Although the content of the sessions varied based on the interests of the family group, the structure of the sessions was consistent. For example, the music session began with greetings to each participant and then a greeting song. A topic for the session was introduced and briefly discussed. Then songs relevant to a chosen topic were used to help evoke memories and enhance discussion. The final 20 minutes of each session were reserved for playing and singing residents’ and family members’ favorite songs. The described music program was tested with evaluation methods to determine its effectiveness on four residents and their family groups. Data were collected through examining the results of structured observations of the residents’ facial and bodily expressions, behaviors, and interactions with family members, staff, and other residents. Additionally, post intervention, in-depth interviews were conducted with family members. The authors identified four resulting outcomes: (a) enhanced quality of visits, (b) leisure programs as serving as social support, (c) leisure programs as serving as coping mechanisms, and (d) enriched relationships.

In summary, the two articles about interventions for caregivers of older adults can help service providers understand several things. First, for interventions to be effective, they need to be of interest to the participant. Second, interventions that facilitate positive caregiver and care-recipient interactions can strengthen and improve these relationships. Third, these interventions can serve as a context for development of social networks. Finally, the above mentioned interventions have the potential to decrease stress of caregiving by providing positive and enjoyable experiences.

Respite. Five articles addressed the second category, respite care, as an avenue to providing free time and time for leisure specifically for caregivers of older adults. The foci of these articles included time use during respite, activity participation during respite, sample respite programs, use of programmed videos to provide respite, and evaluation of a model respite program for caregiver well-being.

One of the articles described respite programs that had been developed but not empirically tested. Feinberg and Kelly (1995) described five types of respite programs currently used in California's Caregiver Resource Centers. These programs included in-home care, adult day care, overnight respite, weekend retreats, and other respite options such as emergency respite and respite transportation subsidies. Although no formal evaluation was conducted, the authors reported that annual client satisfaction surveys were consistently positive and attributed this satisfaction to flexibility, choice, and consumer control.

Four articles described empirical studies which examined or measured the effectiveness of different types of respite programs on caregivers' time use, activity participation, and reduction of burden. Lund, Hill, Caserta and Wright (1995) presented a "Video-Respite" program in which video tapes created specifically for individuals with dementia were used to capture their attention, thus providing caregivers opportunities for free time. Pilot study video tapes filmed actual family members who "interacted" with their care-recipient via the video. Results from the pilot study suggested that the video tapes did engage the care-recipients' attention and the caregivers had increased free time as a result of the video's effectiveness. A larger implementation of this same study used generic videos rather than custom made versions with family members. Preliminary results showed that over three-quarters of the care-recipients attended well and that 67% of the caregivers used the videos as a way to create respite time for themselves. An additional benefit from these videos was that caregivers had the opportunity to attend support groups knowing their respective care-recipients were engaged by the video in a nearby room.

Moss, Lawton, Kleban, and Duhamel (1993) examined time use and activity participation by caregivers before and after the institutionalization of their care-recipients. The authors asked subjects to complete a time budget called the "Yesterday Interview" which asked the subjects to recount all activities they participated in the day before. The activities were grouped into three main categories: (a) direct assistance to the care-recipient, (b) obligated time (necessary for caregiver survival such as self-care, house care), and (c) discretionary activities, such as self chosen recreation or social interactions. Results showed that when the care-recipient was institutionalized, there was a statistically significant decrease in the amount of time spent helping the care-recipients as well as increased time toward discretionary activities. Specifically, recreation showed a statistically significant increase of 23 minutes per day after the care-recipient was moved to a nursing home. Also, the results showed an increase in social time with members of the household and an increase in time spent outside of the home following the care-recipient's move to a nursing home.

Berry, Zarit, and Rabatin (1991) conducted a comparative analysis of female caregivers who used home care and day care for respite. A modified version of the "Yesterday Interview" was used in this study as well. Three categories identified included (a) caregiving with the patient, (b) caregiving without the patient, and (c) non-caregiving activities. Differences between adult day care and home care caregivers were found in life satisfaction, quality of caregiver/care-recipient relationships, and time spent away from the care-recipient. Home respite users demonstrated higher ratings on life satisfaction and quality of relationships, however, adult day care users reported more time away from the care-recipients. Ironically, caregivers who used day care respite spent more time on caregiving activities but respite provided large blocks of free time to pursue other

activities. A notable result, however, is that the free time provided by respite was mostly spent working or catching up on chores rather than engaging in family or social activities.

Deimling (1992) documented the effects of respite on caregivers of patients with Alzheimer's disease regarding care related strain, depression, health, and activity restriction. Findings showed a significant decrease in depression and a decrease in activity restriction as a result of respite. Moderate amounts of respite, however, did not provide adequate time for caregivers to pursue social and recreational activities. Rather, caregivers did "catch-up" work and chores. The author suggested that larger blocks of time would be necessary for caregivers to pursue their leisure.

Overall, the research about respite programs and their effect on recreation and social activities and pursuits of caregivers is fairly consistent. First, respite does increase time for caregivers to pursue "other" activities. This time, in turn, may affect satisfaction levels of caregivers. When providing respite to caregivers of older adults, it is important to provide large amounts of time through in order to encourage recreation pursuits. The most successful use of respite for providing recreation opportunities, according to these studies, was the transfer of the care-recipient to a nursing home.

Support groups. Four articles addressed support groups as a factor that affected caregivers' social and recreational opportunities and pursuits. Three of these were studies that measured the effectiveness of model programs on psychosocial variables and situational factors that dealt with life satisfaction, social networks, or social support. The fourth article described the development of an instrument to measure perceived social support of caregivers of adults with Alzheimer's disease.

Burks, Lund, and Hill (1991) questioned 490 caregivers about benefits of caregiver support groups. Results showed that there existed a positive correlation between the number of support group meetings attended and higher sense of perceived help as well as caregivers' use of community services. Interestingly, the more meetings attended also correlated with decreased life satisfaction. The researchers were not able to determine a predisposition regarding life satisfaction, however. This study suggested that those caregivers who attended too many or too few support group meetings were also at risk. In light of these issues, the authors suggested that caregiver support group organizers consider topics broader than just caregiving responsibilities to address potential issues of life satisfaction.

Mittleman et al. (1995) examined the effects of a comprehensive support program on the depression of spousal caregivers. Specifically, the level of caregiver satisfaction with social networks was examined as a measure of program effectiveness. Results showed that the effect of increase in caregivers' satisfaction with social networks through social groups led to decreases in levels of depression.

Thompson, Futterman, Gallagher-Thompson, Rose, and Lovett (1993) examined the relationship among six types of social support and five types of caregiver burden. The six types of social support examined were: (a) intimate interaction, (b) material aid, (c) advice, (d) supportive feedback, (e) physical assistance, and (f) social participation. To measure social participation, the authors developed the Social Life Restriction Scale (modified from Poulshock & Deimling, 1984) which included recreation and leisure participation.

In discussing the findings, the authors stated that not all types of social support were equally helpful in reducing caregiver burden. They summarized the results of the study by stating, "Engaging in social interaction for fun and recreation appears to be the most important in diminishing the burden of caregiving" (p. S245).

Goodman (1991) developed an instrument to measure perceived social support of caregivers of adults with Alzheimer's disease based on the stress-buffer hypothesis. The development of the scale was based on context from Leiberman's (1979) benefits of support groups (i.e., emotional support, catharsis, information and guidance, links to practical assistance, and simulation of problems). Factor analysis and subsequent statistical analyses found evidence of validity and reliability to measure perceived social support with this scale.

In summary, support groups seem to have potential for many benefits (e.g., the perception of getting help as well as emotional support, and the identification and use of resources and information). It is important, however, to examine and match the types of support provided to the needs and situations of the caregivers.

Education/Training. Three of four articles in this category specifically addressed the role of leisure education as a valuable tool to facilitate caregivers' coping mechanisms. Keller and Hughes (1991) and Hughes and Keller (1992) proposed that provision of leisure education programs within a caregivers' support group context could facilitate caregiver leisure participation. The authors noted that leisure participation can increase coping behaviors among caregivers of people with Alzheimer's disease, however, barriers often prevent leisure participation by caregivers. They proposed a leisure education program based on the Peterson and Gunn Leisure Education Model (1984) which offers four components: leisure awareness, leisure activity skills, knowledge and awareness of leisure resources, and social skills. An education program, such as the one proposed, can address and remove barriers to leisure, thus increasing opportunities for leisure participation. The authors also suggested that a leisure education program can help the caregivers balance time and responsibility for care of the care-recipients and themselves. Additionally, this proposed program can help caregivers adjust to changes and constraints that caregiving places on their leisure involvement. Finally, a leisure education program can assist caregivers in identifying personal, family, and community resources that could enable them to engage in meaningful leisure experiences while providing care.

Hagan, Green, and Starling (1997/98) also described a leisure education program that was designed to reduce the stress associated with caregiving. They offered three specific goals of the program: (a) provide an opportunity to develop personal time management skills, (b) provide an opportunity to gain knowledge related to leisure activities, and (c) provide an opportunity to gain knowledge related to leisure and support resources. The program content and design consisted of a progression of five levels or components lasting 90 minutes each. The authors stated that the program could be implemented through support groups and care groups for families at hospitals, nursing homes, skilled nursing facilities, and Alzheimer's disease specialty units. The primary components of the model included time management, identification of leisure interests, identification of resources, and application of leisure skills. The authors suggested that the benefits, in addition to the identified goals, included increased leisure participation as well as increased social networks.

The last article of this group empirically tested a program called the Caregiver Support Project. Barusch and Spaid (1991) designed a study that provided 6-week sessions aimed at increasing coping skills and decreasing the sense of burden that comes from caregiving. Two groups were tested: family member participation condition (caregiver brought a family member), and the individual condition (caregiver came alone). Data were collected through interviews of each caregiver, Zarit et al.'s (1980) measure of subjective burden, and a self-developed 34 item coping inventory. Results indicated a small (4%) amount of improvement in all treatment groups but no difference between the family participation condition and the independent condition. Also, caregiver coping effectiveness demonstrated a statistically significant improvement of 18%. Since there was no control group in this study, however, the effects of maturation cannot be completely distinguished from treatment effects. Although it remains unclear whether there was increased benefit by involving family members (as opposed to only caregivers), caregivers did show an increase in coping skills, and a decrease in subjective burden as a result of participation in the Caregiver Support Project.

In summary, only one model was tested from the education/training group of articles, but that study provided support for the education/training approach to addressing caregiver leisure needs. Interesting to note, the empirical study found that a group approach was superior to the in-home/one on one approach. It is possible, due to this result, that there was an added effect of social support accompanying training for this group. The one on one leisure education model suggested group formats as well. The rationale is strong for giving people information directed at alleviating barriers as well as providing/encouraging support for leisure/recreation pursuits. The potential benefits of education/training as proposed by these articles include increased use of community resources, increased time management, increased social networks, decreased subjective burden, and increased coping skills.

Combination of education/training and support groups. A total of seven articles made up this group. Three of the articles described programs that combined an education or training component with a support group component. Smyth and Harris (1993) presented a telecomputing (computing through telephone lines) based project designed to provide not only information (i.e., about Alzheimer's disease), but also support through functions such as chat rooms. The authors argued that using computers offered many benefits to caregivers regarding education and support. In addition to the obvious benefits of information, telecomputing offered an opportunity to communicate with others and to gain resources independently from within their own homes. Additionally, telecomputing allowed caregiver anonymity. The project described had several components. Participants could learn about the Alzheimer's Disease Support Center in Cleveland that sponsored this project. Also, users could find common questions and answers about topics such as dementia, treatment, and behavior. The information rack provided users with bibliographies, video lists, and brochures that can be ordered. A bulletin board about Alzheimer's disease was also available. The Caregiver Forum included helpful hints for caregivers as well as an electronic support group.

Two articles described educational support groups for caregivers of older adults; one in the community and one in a hospital. McCallion and Toseland (1995) described four categories of group interventions: (a) mutual support groups; (b) psycho-educational groups; (c) social, recreational, and education groups; and (d) service and advocacy groups. Mutual support groups provided opportunities for caregivers to come together to discuss common concerns and share information. Psycho-educational groups, on the other hand, utilized and identified a leader and focused on problem-solving to address specific issues. Additionally, the psycho-education groups had specific goals and specific agendas for the meetings. The social, recreational, and educational group was identified as perhaps the most important group. The authors stated, "Of all the kinds of social support available to caregivers of the frail elderly, some evidence suggests that the most important is the opportunity to socialize and be engaged with friends, family and acquaintances" (p. 17). The last category, service and advocacy groups, allowed the caregivers an opportunity to engage in meaningful social roles. In the context of advocating for services or interests of caregivers, social relationships among caregivers are formed and provide a forum to make use of and pass on their experiences, strength, and hope in caregiving. The authors stressed how these group interventions provided an arena for addressing specific concerns or issues as well as increasing the social network of caregivers.

Hamlet and Read (1990) reviewed the goals, development, and evaluation of a caregiver education and support group provided through the local hospital in which the care-recipient was a patient. Ninety minute sessions focused on group determined topics such as interpersonal relationships, coping with personal feelings, and utilization of community resources. The education and support group presented educational information on these topics as well as provided for open discussion among participants. This program was able to address needs of two different caregiver types: those who sought specific information about caregiving responsibilities, and those who wanted longterm emotional support.

The remaining four articles in this group evaluated the effectiveness of combined educational and support programs. Goodman and Pynoos (1990) discussed a model telephone support program that considered two components: (a) peer networks, and (b) information provision. The peer network component grouped four to five caregivers who called each other over a 12-week period for informal supportive conversation. The information provision component consisted of 12 taped lectures on topics relevant to Alzheimer's disease (i.e., medical, legal, financial) which the caregivers accessed via phone (one per week). Results indicated that all participants improved on a Subjective Social Support Measure (Zarit, Reever, & Bach-Peterson, 1980) and on knowledge of Alzheimer's disease. The authors noted that one consequence of the network component, however, was a reduction in the utilization of friends and family for emotional support in deference to the support gained from the network caregivers. Conversely, those who listened to the information tapes actually increased their support from friends and family. In light of this, the authors stressed the importance of maintaining existing natural support systems if an alternative support system is offered as part of a caregiver support program. A unique strength of telephone interventions for caregivers is that participants do not have to

worry about respite care, transportation, or guilt of leaving their care-recipient, all noted barriers to participation in caregiver programs.

Roberto, Van Amburg, and Orleans (1994) described the development, implementation, and evaluation of the Caregiver Empowerment Project which was designed to enhance churches' roles in supporting caregivers of older adults within their communities. The Project included (a) community education model, (b) social support model, and (c) support group model. The community education model (n = 13) presented workshops about the aging process, financial and legal concerns, emotional aspects, and spiritual needs of caregiving. It also addressed resources and service options. The social support model (n = 13) first provided transportation to the meeting site for those who required it. This model also provided a home delivery shopping service for caregivers who were homebound as well as an interactive resource information forum. The support group model (n = 10) created a formal support group for caregivers which met monthly and was facilitated by two community volunteers. The effects of these three models were evaluated by a focus group made up of volunteer staff from each of the three model groups. The evaluation noted the following specific positive outcomes: (a) the development of new friendships, (b) learning how to identify the needs of older adults and their caregivers, (c) greater awareness of resources, (d) relieving isolation felt by caregivers, and (e) connecting with other programs outside of the immediate community.

Toseland, Labrecque, Goebel, and Whitney (1992) examined the effectiveness of a multi-component group program for spouses of frail aging veterans. The authors used a single blind randomized control group design to evaluate perceived self-efficacy, knowledge and use of community resources, informal social support, and self-ratings of personal change. They also examined measures of burden, coping, depression, stress, anxiety and marital relationships. The intervention group consisted of 8 weekly 2-hour sessions, each of which had four components: (a) support, (b) education and discussion, (c) problem-solving, and (d) stress reduction. The results suggested short term benefits for support group involvement by caregivers. For example, there were significant decreases in stress, severity of problems, and subjective burden. There were significant increases in use of coping strategies, knowledge of community resources, personal changes in ability to cope with the caregiving situation, and perceived independence in marital relationship. The authors recommended that in providing support group programs, professionals need to emphasize to caregivers the importance of maintaining or increasing social support networks.

Hagen, Gallagher, and Simpson (1997) evaluated an education and support program for family caregivers in underserved communities. The goals of the program were to provide: (a) an opportunity for family and friend caregivers to experience being in a support group, (b) caregivers with experience of being supported in their roles, (c) caregivers with an opportunity to learn more about issues related to caregiving, and (d) caregivers with knowledge about and access to other community services. Each session included an hour of education or discussion on a predetermined topic followed by an hour of an open mutual support group. In-depth interviews conducted three months after the program revealed the following benefits from the program that were related to recreation and social support: (a) "sharing and fellowship," (b) improved communication between caregivers and their family members, (c) increased awareness of community services, (d) increased awareness of own stress and importance of taking care of themselves, (e) increased assertiveness, and (f) being supported in the role of caregiver.

CONCLUSIONS

Upon reviewing the summaries of the studies, several conclusions were evident. First, the combination of education/training and support group in programs showed many benefits for caregivers of older adults. In many cases, there seemed to be similarities and discrepancies between articles that proposed models and programs but did not test them and those articles that did test or measure program effectiveness. For example, a number of articles proposed that education programs would help caregivers balance time and responsibility for their care-recipients and themselves. Rather, based on the programs that were tested, it was the combination of education/training and support groups that demonstrated an effectiveness to this end. In other examples, combined education/training and support groups were not only proposed but actually proven to increase social

support for caregivers. Similarly, several of the articles which only proposed programs suggested that the education/training category as well as the combined education/training and support group category would increase caregivers' knowledge and use of community services. No solo education/training program directed at improving caregivers' knowledge and use of community services was tested; however, the combination programs did prove to be effective. Education/training in combination with support groups was associated with an increase in coping skills and a decrease in subjective burden of caregivers. Additionally, one article showed the effectiveness of support groups alone in increasing the caregivers' knowledge and use of community services. Perhaps, the combination of education/training programs with or in the context of support groups is more effective than either type of program alone. This result could be due to the fact that the education component gives the caregivers the information they need, while the support of other caregivers enables them to put that information into action (i.e., using community services and taking care of self).

Second, another proposed benefit of the programs examined was to increase the size of and/or satisfaction with caregivers' social networks. Of the four programs with this focus, two were tested and found to be effective. Additionally, from the articles within this group, Mittleman et al. (1995) found secondary benefits to increasing caregivers' satisfaction with their social networks. They noted, "The effect of an increase in the caregivers' satisfaction with his or her social network, . . . was also associated with a decrease in depression at all follow-ups" (p. 800).

Third, when caregivers made use of respite opportunities, their discretionary time increased. Unfortunately, however, caregivers tended to use this time to run errands or do chores rather than pursue leisure or social experiences. This result, although puzzling, could be due to functional or attitudinal barriers in the caregiver. Either they required a larger block of time to allow for completion of chores before they engage in leisure, or they needed to develop a more positive, guilt-free attitude toward pursuing leisure. In either case, the priority the caregivers place on leisure in their lives seems to be an issue to be considered.

Finally, the purpose of this study was to analyze leisure, recreation, and social programs for caregivers. In the data collection process, however, it became obvious that there were very few programs or interventions for caregivers that used leisure or recreation specifically. Most programs utilized a variety of support group contexts to increase social networks, increase social support, and improve interactions and relationships among families. Perhaps, programmers could consider using recreation and leisure environments as vehicles to achieve these same objectives.

RECOMMENDATIONS

Based on this analysis of recreation/social programs for caregivers of older adults, we offer recommendations for both researchers and practitioners. The first recommendation is directed to both researchers and practitioners. As noted earlier, very few of the implemented or proposed programs were built on or anchored in a theoretical/conceptual framework. For researchers, if research is conducted without a theoretical framework, the generalizability and usability of results will be greatly limited for researchers and practitioners. For practitioners, where programs are successful, without a theoretical/conceptual framework, we cannot say why they are effective. We recommend that designers use a theoretical/conceptual framework to guide them in developing programs such as those described herein. Also, for those programs that are built based on the results of existing literature, it is important to provide a logical and clear link for the reader between the components of the program and the relevant literature. As Miller and Montgomery (1990) noted, "without a comprehensive theory . . . , we can suggest only ad hoc explanations" (p. 90). Therefore, both researchers and practitioners should base their research or programs on clearly identified theoretical/conceptual frameworks.

The second recommendation for practitioners addresses the design of interventions or recreation/leisure programs for caregivers to do on their own (i.e., not facilitated by a professional). The research suggests it is important that such programs be: (a) designed for flexibility of caregiver time and routine, (b) of minimal cost, (c) something that can be done in the home, and (d) built on the existing interests and skills of the caregivers (i.e., Dupuis & Pedlar, 1995; Smith & McCallion, 1997).

Finally, a second recommendation for researchers is to continue to research the efficacy of programs specific to leisure and recreation for caregivers of older adults. Although social and educational programs can provide the knowledge or opportunities for caregivers to pursue their leisure, the lack of proven leisure interventions is notable.

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