

Research

Lessons Learned from *Take Care* *A Brief Leisure Education Intervention for Caregivers*

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Abstract

Caregivers often struggle to address their own needs related to self-care while also supporting their care recipients to be more self-determined in living with a chronic health condition. Despite this need, caregiver attendance at multi-session programs is challenging if it takes time away from caregiving responsibilities. To address these issues, a brief three-hour leisure education intervention, named *Take Care*, was developed. The workshop aimed to introduce caregivers to skills that would enhance their self-efficacy for engaging in leisure-based self-care and self-management support. The workshop was piloted at four different community-based sites; evaluation was conducted by administering a questionnaire to participants (N = 11) before and after attending one of the four workshops. There was a statistically significant change in perceived self-efficacy related to helping care recipients set and achieve goals. Workshop participants expressed satisfaction with being able to share their experiences with other caregivers. Challenges with recruitment and implementation are discussed and recommendations are made for future research and program development.

Keywords: *Caregivers, leisure education, self-care, self-efficacy theory, self-management support*

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Persons living with chronic conditions do not live their lives or manage their health in isolation; family members and friends often provide myriad forms of practical and emotional supports to help them manage their condition and maintain quality of life (Keefe, Hawkins, & Fancey, 2006). Yet, most family members and friends find themselves in this new role with little or no preparation. Caregivers may experience stress and burden with this new role, yet feel guilty about taking time for themselves (Keefe et al). As a result, they can neglect their own health and well-being as their energies and efforts are directed to the person receiving care (Zarit & Femia, 2008). Moreover, care providers' efforts to ensure the safety of their loved one may result in a tendency to "take over" decision-making and undermine the ability of persons with chronic health conditions to remain as self-determined as possible.

Whether living with or supporting those with chronic conditions, it is important that people "live well" despite the presence of a chronic condition. Often this means remaining actively involved in valued leisure pursuits (Nimrod & Hutchinson, 2010). However, few resources are available to help family members and friends learn ways to address their own leisure-based self-care needs (Sanford-Son & Hutchinson, 2009) while simultaneously developing skills to provide care that empowers others to self-manage their chronic condition.

To begin to address these issues, we developed a brief leisure education intervention, entitled *Take Care*. In this program, caregivers are introduced to skills designed to enhance their self-efficacy for engaging in leisure-based self-care and self-management support. The purpose of this paper is to describe the development of the *Take Care* workshop and to present process

and outcome evaluation results from a pilot study following initial program development. Challenges with recruitment and implementation are discussed, along with recommendations for future program development and research. Prior to describing the program development, a brief overview of chronic disease self-management interventions is provided, followed by a review of caregiver interventions within and outside the field of therapeutic recreation (TR).

Background Literature

Chronic Disease Self-Management Interventions

Chronic disease self-management (CDSM) interventions have been developed to help adults of all ages with chronic conditions develop the skills and confidence to better manage their health conditions (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Lorig, 1996; Lorig & Holman, 2003) with the goal of increasing "involvement and control in their treatment and its effect on their lives" (Newman, Steed, & Mulligan, 2004, p. 1523). Typically, this involves helping people to follow treatment plans, modify lifestyle behaviours (eating, smoking, physical activity), and adjust their lives to accommodate "symptoms and functional limitations, and deal with the emotional consequences" of the health condition (Lorig et al., 2001, p. 1218).

Most CDSM interventions are explicitly designed to increase participants' self-efficacy or confidence to undertake important tasks (Lorig, 1996). With their focus on building skills and persons' confidence to use these skills in everyday life (Lorig), CDSM interventions are consistent with TR philosophy and practice (Shank & Coyle, 2002). Self-efficacy theory suggests

that self-efficacy can be strengthened by: (1) developing skills mastery, (2) receiving modelling from others perceived to be similar to themselves, (3) reinterpreting experiences and (4) verbal persuasion (Bandura, 1977). CDSM interventions may vary in length (one to 40 hours), delivery format (individual or group; in person or online), and leadership (lay-leader versus professional). Despite these variations, Lorig and Holman (2003) suggested that for CDSM interventions to be effective, they must address five core self-management skills: problem solving, decision making, resource utilization, taking an active role in partnerships with health providers, and taking action. These same principles were the focus of the brief caregiver intervention we developed.

While family caregivers have the option to participate in most CDSM programs, the relevance of these programs to their needs is limited. Programs focus on how persons with chronic conditions can self-manage the consequences of their own health problems. The important role that family members can play in supporting persons in this challenging task is typically not addressed. As a result, the programs do not incorporate education regarding strategies to support or facilitate CDSM; nor do they provide family caregivers with the skills they need to ensure that the support and care they provide is not given at the expense of their own health and well-being. Caregivers need education designed specifically to address their needs related to self-care, as well as to learn how they can support their care recipient in better self-managing his/her chronic health condition.

Leisure Education for Caregivers

Addressing the psychosocial well-being and leisure-related needs of family

caregivers has been emphasized in the literature regarding leisure (Dunn & Strain, 2001; Dupuis & Smale, 2000; Weinblatt & Navon, 1995) and therapeutic recreation (e.g., Bedini & Bilbro, 1991; Bedini & Guinan, 1996; Bedini & Phoenix, 2004; Rogers, 1997). Leisure education focuses on the development of leisure-related knowledge, skills, and awareness needed to (re) establish valued activities or social connections within one's everyday life (Stumbo & Peterson, 2009). Often leisure education interventions involve using cognitive-behavioural strategies within a supportive learning environment to provide participants opportunities to learn and practice necessary skills that will transfer to their lives outside the intervention (Shank & Coyle, 2002). This approach to skills development is consistent with the processes of CDSM interventions described earlier.

Leisure-based support and education programs have been designed to reduce stress experienced by family caregivers of persons with dementia (e.g., Dupuis & Pedlar, 1995; Keller & Hughes, 1991) and to enhance awareness of self-care needs that can be met through leisure (e.g., Bedini & Phoenix, 1999; Charters & Murray, 2006). For example, Bedini and Phoenix developed a model for a leisure wellness program for family caregivers of older adults entitled *How to be a Better Caregiver*. Topics addressed included: (1) resources (e.g., financial, legal, respite and recreation), (2) physical and mental wellness (e.g., time management, social support, coping with guilt, patterns and habits, and problem-solving), (3) managing stress (e.g., stress reduction and relaxation techniques), and (4) leisure education (e.g., leisure awareness, leisure values, constraints and strategies). Evaluation evidence using this model has not been published.

Charters and Murray (2006) also developed a leisure education program for

family caregivers of older adults living in a residential facility. The six-session (1.5 hours per week) *Learn to Take Care of Yourself Too!* program was designed to enhance participants' knowledge, skills, and awareness of their leisure needs. Although program evaluation was based on a small number of participants (N = 4), when pre-program interviews were compared with post-session reports, the program appears to have enhanced the leisure knowledge and self-care practices of participants. Charters and Murray noted that program modifications recommended by the caregivers included having participants pair off to practice problem-solving skills and incorporating "delegating of caregiving tasks to others" as a leisure resource.

Overall, while there is recognition of the need for education to address the leisure-related self-care needs of caregivers, limited evaluation evidence is available from caregiver interventions in TR practice. Moreover these interventions have not incorporated a focus on learning strategies to support self-management behaviours by persons receiving care, nor utilized behaviour change theories (e.g., self-efficacy theory) to guide program development.

Caregiver Interventions in Related Fields

Outside of the TR literature, evidence is available from myriad education interventions designed to assist informal caregivers to learn about the importance of taking care of themselves, and to learn specific caregiving (e.g., medication management) and self-care (e.g., relaxation techniques) skills. Most caregiver education programs incorporate a focus on coping strategies, as well as skills to manage the care needs of persons with a specific disease condition such as dementia (e.g., Logsdon, 2008), multiple sclerosis (e.g., Finlayson, Gar-

cia, & Preissner, 2008), and Parkinson's Disease (e.g., Habermann & Davis, 2006). Some interventions have been designed to address specific issues such as depression (e.g., Mellor, Russo, McCabe, Davison, & George, 2008) or palliative care (e.g., Hudson et al., 2008). Although many programs are designed to be offered in conjunction with other health or residential care services (e.g., Lopez, Crespo, & Zarit, 2007), others have been developed for delivery to caregivers in community settings (e.g., Curry, Walker, & Hogstel, 2006; Mahoney & Shippee-Rice, 1994).

The Powerful Tools for Caregiving program (Boise, Congleton, & Shannon, 2005) is an example of a community-based program designed for caregivers of any person with a chronic condition. Modelled after the Stanford Chronic Disease Self-Management program (Lorig et al., 2001), this six-session education program (2.5 hours per week) targets family caregivers of older adults. The program utilizes lay-leaders (trained community professionals and volunteers) who provide participants with opportunities to develop their action planning and problem-solving skills in relation to six topic areas. These include: (1) taking care of you (e.g., challenges of caregiving and the importance of caregiver self-care); (2) identifying and reducing personal stress; (3) communicating feelings, needs, and concerns; (4) communicating in challenging situations; (5) managing difficult emotions; and (6) mastering caregiving decisions. Evaluation results identified that participants reported using the tools learned during the program, and showed significant improvements in self-efficacy, emotional well-being, and self-care behaviours. However, as with many other multi-session caregiver interventions, attendance at the *Powerful Tools for Caregiving* program by caregivers dropped off over time.

Summary

Overall, the need to help caregivers develop knowledge and skills to take better care of themselves, while supporting others with a chronic condition, has been well established. While there is some evidence of caregiver interventions that incorporate principles of chronic disease self-management support (e.g., Finlayson et al., 2008), none have been specifically designed with this focus. Further, no examples of brief caregiver interventions were available in the TR, chronic disease management, gerontology, or caregiving literatures. Based on this review of literature, the *Take Care* brief caregiver leisure education intervention was developed.

Methods

Research Design

A single group pre-post research design was used whereby participants who provided informed consent to participate in the evaluation of the *Take Care* program completed a pre- and post-workshop questionnaire designed to evaluate changes in their self-efficacy. Participants were also asked to provide open-ended comments about what they liked about the program and suggestions for program improvement. Approval to evaluate the program was obtained from the authors' Research Ethics review board.

Intervention

A three-hour, single session *Take Care* workshop was developed for persons caring for seniors.¹ Goals included enhancing participants' self-efficacy in relation to: (a) setting and achieving goals related to their own self-care and (b) their ability to support the care recipient to address their own self-care needs. The plan was to use

this brief intervention to introduce participants to the concepts of leisure-based self-care and self-management support. Although designed to support the aims of other available CDSM programs, the *Take Care* program was designed as a stand-alone workshop. Our goal was to evaluate the effects of the program on caregiver self-care and self-management support behaviours and to use preliminary evaluation results to guide subsequent program development.

The workshop was developed with the input of an advisory committee comprised of seniors (one male and three females) who provided support and care to a senior family member with a chronic condition. They recommended that the workshop target those at the beginning of their "caregiving journey" with the idea of helping caregivers develop healthy habits related to their own self-care and caregiving responsibilities. They also highlighted the need for a program that would help caregivers: (a) embrace the need to take time for themselves, (b) develop strategies for dealing with the feelings of guilt often associated with taking time for themselves and away from the care recipients, and (c) learn how to effectively support care recipients to "get on with life" regardless of their health condition. It was also developed as a single three-hour workshop with the hopes of attracting more caregivers who may be reluctant to give up more than one block of time for an educational program.

The workshop was designed to build on the theoretical foundations of other CDSM programs by targeting the development of participants' self-efficacy in goal setting, planning and problem solving. More specifically, the workshop was designed to provide participants with opportunities to: (a) learn and practice goal setting, planning and problem solving skills (skills mastery); (b) examine and reframe

common excuses for not taking action on self-care goals (reinterpretation); and (c) receive encouragement and feedback from workshop facilitators and other program participants so participants could more readily recognize those things they are already doing to address their own self-care needs and coach care recipients to do the same. In an effort to incorporate modeling into the workshop, it was designed to be co-facilitated by two experienced caregivers (i.e., one senior caregiver and one student enrolled in university-level health professional program).

For the pilot workshops, three seniors, three TR students, and four nursing students with caregiving experience were trained to facilitate the *Take Care* workshop. As part of their training, they were coached on how to use their own personal experiences to illustrate teaching points (modelling). The topics addressed within the workshop are outlined in Table 1.

To ensure the workshop content was presented in a consistent manner, a Facilitator’s Manual was developed. It was divided into three sections: (1) key background information about the workshop (e.g.,

Table 1
Take Care Workshop Content

Topic Area	Content
Taking Care of Yourself	Reinforced the importance of taking time for one’s self; encouraged self-reflection regarding valued activities that help re-energize; introduced the idea of the “five-minute vacation.”
Bridging the G.A.P. (Goal-setting, Action Planning and Problem-Solving)	Introduced goal-setting, action planning and problem solving as a skill set to reduce the gap between what they want to do and what they do, and dealing with potential obstacles; participants created a personal action plan and identified plans for addressing potential obstacles.
Strengthening Your Circle of Support	Highlighted that strengthening their own circle of support can help them and the person for whom they provide support to take better care of themselves; identified strategies to use when asking others for help.
Caregivers as Coaches	Introduced the concept of being a self-management coach; identified effective coaching behaviours; considered how they could support the person for whom they provide support set and achieve goals related to their own self-care.
Resources and Next Steps	Reviewed available resources in folder; elicited ideas from participants for other valuable resources.

what is chronic disease self-management, what it means to be a caregiver/support provider, how to be an effective lay leader, how to create a positive learning environment); (2) the workshop content, learning activities and format including time allotments and facilitation tips; and (3) copies of worksheets and handouts for the participants. An Evaluator Guide was developed to direct the evaluators for each workshop session on how to obtain participants' informed consent, how to complete the workshop process evaluation, and when and how to administer post-workshop questionnaires.

A provincial non-profit association for caregivers (Caregivers Nova Scotia) coordinated the registrations for the *Take Care* workshops. The workshops were promoted by disseminating information to a variety of community groups, and by personal invitation. The workshops were open to all persons who identified that they provided support/care to a senior with a chronic health condition (with the exception of those supporting/caring for persons with moderate to late stage dementias), and who wanted information, tools and resources that would help them in their caregiving role. The workshops were provided free of charge; funds to cover the costs of respite care were provided if requested. A schedule of workshops was developed based on the availability of the facilitators. Five workshops were scheduled in four different communities in Nova Scotia during November and December 2009; one was cancelled due to lack of registration. Efforts were made to offer the workshops at different times and days of the week.

Sample

Anyone who participated in one of the *Take Care* workshops and who consented to participate in the evaluation of the

pilot program was included in the study. In total, 12 persons participated in four workshops. All 12 agreed to participate in the evaluation of the *Take Care* workshop, although some data for one participant are missing (she left the workshop early due to personal illness).

Procedures

After providing informed consent, participants provided the evaluators with responses to the pre-workshop questionnaire. In addition to providing some details about their caregiving situation (e.g., years as a caregiver and their relationship to the person receiving care), participants were asked to rate their level of confidence using a 10-point scale (1 = "not at all confident" and 10 = "totally confident") in relation to: (a) setting personal goals, (b) achieving personal goals, (c) helping family members set goals, and (d) helping family members achieve their goals. Although developed specifically for this study, the format of these questions was comparable to items included in chronic disease self-efficacy scales developed to evaluate the Stanford Self-Management Programs (Lorig et al., 1996). Immediately following the workshop, participants completed a post-workshop questionnaire while blind to their pre-workshop questionnaire ratings. In addition to rating their self-efficacy related to the above tasks, they used a 5-point rating scale (1 = "strongly disagree" and 5 = "strongly agree") to rate the extent to which the workshop helped them to: (a) identify goals for taking care of themselves, (b) develop an action plan for achieving their goals, (c) identify strategies to achieve their plans, (d) identify strategies to use when coaching others to take better care of themselves, and (e) think about how to strengthen their "circle of support." These questions were related to the workshop content areas. Participants were also asked

to describe what they liked and did not like about the program and to provide recommendations for improving the workshop in the future.

Results

Twelve adults participated in this pilot study. Their level of caregiving experienced ranged from 0.5 years to 27 years (Median: 3 yrs). It should be noted that several participants identified that they cared for more than one family member (e.g., both parents, two adult children, an adult child and parent). However, when asked to identify the primary person for whom they provide care, they reported caring for parents ($n = 4$), spouses ($n = 2$), adult children ($n = 2$), extended family members ($n = 2$) and others ($n = 2$). Although many reported that the person for whom they provided care had multiple health conditions, they identified the primary health condition as neurological (e.g., stroke, spina bifida, multiple sclerosis, dementia; $n = 7$), age-related

($n = 2$), terminal illness ($n = 1$), cardiac ($n = 1$) and kidney disease ($n = 1$).

All 11 participants who completed the post-program questionnaire either “agreed” ($n = 5$) or “strongly agreed” ($n = 6$) that the workshop helped them: (a) identify goals for taking care of themselves, (b) develop an action plan for achieving their goals, (c) identify strategies to achieve their plans and (d) identify strategies to use when coaching others to take better care of themselves. Most ($n = 7$) “strongly agreed” that the workshop helped them think about how they might strengthen their ‘circle of support,’ with the other participants either “agreeing” with this ($n = 2$) or “neither agreeing or disagreeing” ($n = 2$). While participants generally rated their confidence level in their own ability to set and achieve their personal goals higher after participating in the workshop, only their ratings of confidence in relation to helping their family members set ($t = -2.61, p = .03$) and achieve ($t = -3.24, p = .009$) their goals were statistically higher (see Table 2).

Table 2

Pre and Post-Workshop Mean Ratings of Self-Efficacy and t-test Values (n=12)

Level of confidence	Pre-Workshop Mean (SD)	Post-Workshop Mean (SD)	t-test
Setting personal goals	6.83 (2.04) (range: 4-10)	7.67 (0.98) (range: 6-9)	-1.28, $p=.23$
Achieving personal goals	6.58 (2.47) (range: 3-10)	7.63 (1.11) (range: 6-9)	-1.69, $p=.12$
Helping family member set goals	6.08 (2.64) (range: 1-9)	8.09 (1.14) (range: 6-10)	-2.61, $p=.03$
Helping family member achieve goals	5.83 (2.69) (range: 0-8)	8.36 (1.12) (range: 7-10)	-3.24, $p=.009$

Participants reported that the workshop clearly met their expectations. Specific comments included: *“Met and exceeded my expectations. The problem-solving format is extremely helpful”* and *“Very informative with lots of discussion around tangible issues that I could relate to.”* Participants identified that they particularly liked the sharing with others, the relaxed atmosphere, and the focus on goal setting. One participant noted that he/she *“loved the fact that we as participants were asked our input. I learned a lot [from] the other participants also. So helpful and comfortable format.”* Another participant noted that he/she liked that there were opportunities for *“brainstorming/sharing ideas”* while another liked the time allotted for *“finding ways of setting realistic goals and that it was achievable.”* There was little identified that the participants did not like about the workshop, other than perhaps more time for discussion. Indeed, the only consistent suggestion across participants was to extend the workshop length and increase the number of participants, which is an issue we return to in the discussion.

Discussion

The idea that caregivers need to better address their own self-care needs is not a novel one (e.g., Zarit & Femia, 2008). Most research on the experiences of caregivers describes the burden of caring for others (e.g., Keefe et al., 2006). Thus, most caregiver interventions are designed, at least in part, to enable caregivers to take better care of themselves. However, rather than just helping caregivers become aware of the importance of self-care, the *Take Care* workshop enabled participants to acquire and practice problem-solving and decision-making skills they could use to realize their self-care goals. Most often, these goals reflected a desire to spend more time and derive greater satisfaction from leisure and

social activities. Leisure education is a key vehicle for addressing these leisure-based self-care goals.

We recognize that, for many caregivers, the need to help others will take precedence over the need to take care of themselves. Rather than trying to change this perspective, the *Take Care* program was designed to help caregivers redefine how to incorporate leisure back into their lives as a strategy for self-care. Caregivers and others with multiple health challenges of their own may find it particularly challenging to take time to do things they enjoy. That is why it is important to help people identify how they can incorporate moments of enjoyment into their everyday lives and expand their social support resources.

While CDSM interventions are designed to help people manage their chronic conditions, the findings of this preliminary study suggest that the underlying principles of self-efficacy are relevant to caregivers as well. Opportunities for skill mastery, modelling, reinterpreting experiences, and verbal persuasion stimulated positive changes in caregivers' self-efficacy for self-care and self-management support. The comments made by the participants suggested that they valued having opportunities to share and discuss their experiences with and learn from experienced caregivers.

The participants' level of change in relation to their self-efficacy for setting and achieving personal self-care goals approached, but did not realize, statistical significance. This may be, at least in part, a reflection of the small sample size although other factors may also be in play. Participants' relatively high initial ratings of self-efficacy on these particular items suggested that most believed that they *“could”* set and attain self-care goals whether they actually did so or not. Although the items were modelled on those

used to evaluate changes in self-efficacy in other self-management programs (e.g., Lorig, Chastain, Ung, Shoor & Holman, 1989), the broadly worded questions about self-efficacy for setting and taking action on self-care goals (e.g., “How confident are you that you can set ‘achievable’ personal goals related to taking care of yourself?”) may not have been sufficiently precise. In other words, participants may have generally considered their level of confidence to set and achieve personal goals without accounting for the realities of their current caregiving situation. Thus, their initial self-efficacy ratings may have been somewhat inflated. Through participation in the workshop they may have come to have a more realistic appraisal of the steps needed to identify and take action on a personal self-care goal and more acute recognition of what often gets in the way of following through on these goals.

In contrast, a statistically significant change was found in the participants’ level of self-efficacy to assist their care recipient to set and achieve personal goals to take care of themselves. This finding may reflect the participants’ previous lack of success in effectively coaching others with chronic health conditions to set and achieve their personal goals. However, it is also important to recognize that participants’ ratings completed immediately at the conclusion of the workshop reflect their sense of efficacy at that point in time; whether their heightened sense of self-efficacy is maintained when immersed in the realities of their everyday lives cannot be determined by looking only at ratings made immediately after program participation.

Despite positive trends in findings from this pilot study, challenges were experienced with the timing of the workshop and recruitment. Although the workshop only required participation in a single three-hour workshop, it was clear that some

participants “squeezed” the workshop into their day. Even so, some participants indicated that they wanted more time to learn and practice skills; perhaps once they were there they realized the value of attending. Thus, alternate delivery formats (e.g., on-line, home-based, telephone-based, or self-directed formats) should be explored.

Moreover the current format did not provide participants with the time and opportunity to implement their goals and action plans and further develop their new skills. Offering the program content over two shorter sessions might address this issue. Following the first session in which participants would set a self-care goal, participants would be encouraged to implement their action plan and report on the results during the second session. This structural change would also ensure the program is more consistent with the theoretical underpinnings of the program related to self-efficacy. Regardless of what changes in program format are made, it will be essential that some key program features are retained. This includes opportunities: (a) to master skills in setting achievable personal goals, (b) to incorporate peers who have been successful in taking care of themselves while managing their caregiving responsibilities, (c) to reframe patterns of thinking that create obstacles to achieving one’s goals, and (d) to receive support and encouragement from peers.

There may also be merit in reconfiguring the content into two separate stand-alone workshops, with one focused on self-care and the other on self-management support strategies (though both would require goal-setting, action-planning and problem-solving as foundational skills to foster self-efficacy). From our perspective, the leisure-based self-care portion of the workshop is not only relevant to persons in caregiving roles but also to those who

live with chronic conditions. As such, this workshop could be offered to caregivers, persons with chronic conditions, and/or both in order to remind participants that chronic disease “self-management” is best accomplished when persons with chronic conditions and their family members both “take care” of their own self-care needs. In contrast, the self-management support (coaching) portion of the workshop will benefit those who are supporting persons who are actively involved in making decisions about their own activities and care needs. This component of the workshop is likely less relevant to caregivers caring for persons who are unable to actively participate in the goal setting process (e.g., persons with late-stage dementia).

Efforts to reach those who were in the early stages of their caregiving journey were not realized. Of the 12 participants, only one had a family member whose diagnosis was given within the past year. When speculating about the reasons for lack of attendance by new caregivers we questioned the extent to which they even identify themselves as “caregivers.” Instead, the caregiving role seems to be one that persons come to identify with only after some time. How to recruit this target population is an important issue that we are still unsure how to address. One way to do this may be to invite family members or friends of persons diagnosed with chronic conditions to attend a program without using the label of “caregiver.”

Similarly, the recruitment of peer facilitators, particularly seniors with caregiving experience, was a challenge. We came to realize that the majority of those who are currently supporting or caring for a family member with a chronic condition cannot assume the additional responsibility of delivering an education program. Although there is evidence that lay-led programs are

as effective as professional led programs, and more cost-effective (Lorig et al., 2001), practitioners with an interest in and/or responsibility for services to caregivers may be equally effective in delivering the program in their own settings, particularly if they have personal caregiving experience they can share with workshop participants.

Conclusion and Next Steps

Increasingly, TR practitioners are expected to deliver services that are family-centered; yet few program protocols exist for which there is evidence of program effectiveness. The relevance of the *Take Care* program, which was grounded in self-efficacy theory and principles and processes of leisure education, was clear to members of the advisory committee and program participants, all of whom were seniors and/or caring for seniors. It was critical to them that they were reminded of simple ways to build enjoyable moments of self-care into their everyday lives. They also benefitted from having the chance to learn practical skills and strategies to overcome barriers to engaging in self-care from others who were facing similar challenges.

While a brief intervention may be effective in *introducing* ideas about leisure-based self-care and self-management support, the design of this pilot study does not enable us to determine whether participants integrated these new skills into their everyday lives. There is a need for follow-up evaluation to determine whether or not a brief educational intervention can have *lasting* effects on beliefs and behaviours. Further evaluation is also needed following modifications to the program outlined above. We are planning to move forward with the “leisure-based self-care” portion of the workshop as a stand-alone program, recognizing that the self-management support (“coaching”) portion of the workshop

requires more focused efforts to recruit program participants. However, the potential for continued development of both of these components of the *Take Care* program is considerable, particularly if linked to other family or caregiver-focused programs and supports.

Finally, we hope to expand beyond this initial pilot project and make the workshop and training materials more widely

available to TR practitioners who provide supports or education to caregivers. By making the *Take Care* program resources available to TR practitioners who are willing to facilitate the workshop and its evaluation it may be possible to disseminate the program in a variety of community, health and residential settings in which caregivers and persons with chronic conditions live their everyday lives.

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Notes

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