

UTILIZING OUTREACH THERAPEUTIC RECREATION TO
DETERMINE THE LEISURE EXPERIENCES OF
RECENTLY HOSPITALIZED OLDER ADULTS

by

PAUL W. GALLANT

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Department of Education

The University of British Columbia
Vancouver, Canada

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ABSTRACT

The purpose of this study was to analyze the subjective meaning that leisure experiences and involvement in a Therapeutic Recreation Outreach Program (T.R.O.P.) had for eight recently hospitalized older adults. The specific research questions were: What were their leisure interests? How did participants describe the benefits of leisure? Did they benefit from T.R.O.P.? What were the facilitating factors which contributed towards their enjoyment of leisure? What were the constraints which prevented participants from achieving their leisure goals and interests? What were the relationships between leisure satisfaction and life satisfaction?

A total of eight participants were recruited over a five month period and agreed to participate in T.R.O.P. They met the following inclusion criteria. Participants were: in-patients of St. Paul's Hospital; at least 55 years of age; able to speak, read, and comprehend English fluently; living in the Lower Mainland area of British Columbia; and, returning to non-institutionalized community living.

The case study design entailed a number of data collection strategies that occurred during the in-hospital and outreach phases of the T.R.O.P. intervention. These included two semi-structured interviews with each

participant, observations and field notes throughout T.R.O.P., and a review of medical charts. In addition, the participants completed three forced-choice leisure worksheets which examined their leisure interests, leisure needs, and leisure constraints. Data analysis was based on Huberman and Miles (1994) interactive model of data display, conclusion drawing, and verification.

The participants perceived leisure benefits to be: "enjoyment", "time to think and forget your troubles", "relaxation", "a sense of satisfaction", and "maintaining an interest in life". These benefits are similar to those described in the literature. Many of the leisure interests of the participants were solitary and spectator types of experiences which tended to occur within their home or near their home. An additional finding was that participants were frustrated by not being able to pursue many of their leisure interests due to declining health. The main benefits of T.R.O.P. were identified as knowledge of resources and increased social contacts. The leisure constraints most frequently reported were related to poor health status, physical disability, lack of physical skills, lack of knowledge of resources, procrastination, and lack of social support.

Social support and social relationships were perceived to be major facilitating factors towards leisure enjoyment. Several of the participants' experiences in the hospital were

perceived to alleviate social isolation, a finding that has not been explored in the leisure literature. Social relations were also perceived to be important contributors towards the leisure satisfaction and life satisfaction.

The findings also revealed that the most pertinent information related to leisure meaning and involvement was obtained through visiting and conversing with participants in their homes, and not through formal in-hospital leisure assessment procedures. The nature of the findings of this study have implications for future research and practice.

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CHAPTER ONE

Introduction

The Leisure Experience and Health

The study of the leisure behaviour of older adults and their participation in discretionary forms of activities has become one of the "classic areas of investigation" in the gerontology field (Lawton, 1994, p. 138). Many attempts have been made to try to understand the specific characteristics of the leisure experience and specifically the leisure experience of the older adult. Leisure researchers have shown that when individuals participate in recreation activities they often experience "involvement, fun, enjoyment, pleasure, spontaneity, freedom, timelessness, relaxation, adventure..." and encounter a variety of other positive experiences (Lee, Datillo & Howard, 1994, p. 196).

However, leisure experiences were not always positive or pleasant. Throughout the life-cycle, individuals may encounter a variety of stressful and unpleasant leisure experiences. These troublesome experiences may be characterized by feelings of exhaustion, apprehension, nervousness, disappointment, frustration, and guilt (Lee, et al., 1994, p. 203).

Individuals also encounter a number of constraints which confront them and impact upon their leisure. Examples of these constraints include: lack of knowledge regarding leisure resources and facilities, lack of a partner with whom to

participate, lack of income, and lack of physical ability (Jackson, 1990; Searle & Mahon, 1993; Heywood, 1994).

Leisure experiences are also threatened by significant life events such as disease, illness, or disability. These events are even more threatening to older adults, who frequently live alone in their homes (Lyons, Meade, White & Archibald, 1993, p. 253). The changing demographics of this segment of our population will likely result in increased attention to how health and leisure resources are allocated to the older members of our communities.

The Demographics of Older Adults

In British Columbia, the percentage of the population aged 65 and above was 13.2 % or approximately 423,500 individuals in 1990 (BC Population Forecast [BCPF], 1990). This figure is expected to reach 626,000 (15.2 %) by the year 2006 (BCPF, 1990). The declining birth rate, the aging of the baby boomers, and a longer life expectancy are increasing both the number and proportion of seniors in the population (Greater Vancouver Regional District [GVRD], 1993, p. 5). It is predicted that the largest population of older adults in the province will continue to be in the Vancouver and Surrey areas (GVRD, 1993).

Statistics Canada (1988) reported that as age increases, so does the incidence of disease and health problems. The number of disabled individuals aged 55 years and older in

British Columbia accounted for 25-35 % of the total population in 1988. Approximately 52,580 of these persons resided in Vancouver households (Statistics Canada, 1988). Examples of the health problems that some older adults experience include: cardiovascular and related diseases, orthopaedic disabilities, depression and loneliness (Riddick & Keller, 1991). Many older individuals have also sustained inevitable losses or changing life circumstances which have made additional emotional demands on them. These life changes often include: loss of a spouse, retirement, declining health, change of residence, and a decreased number of friends. Ultimately a loss of meaning in life is experienced by some older adults (Burbank, 1992, p. 21).

On the other hand, many older adults were healthy, active, and have not experienced the losses previously mentioned. These "healthier" older adults were not at the same risk of loneliness, depression, and hospitalization as those who experience dramatic life changes and declining medical conditions. Many older adults have the ability to adequately function in their communities without the provision of additional supports such as home-making, Meals on Wheels, home nursing care, and outreach or therapeutic recreation services.

However, there is a significantly higher percentage of older adults aged 65 and above, who are utilizing health services. For example, persons 65 years of age and over occupied 228 inpatient hospital days per 100 persons in 1990.

This figure is more than four times higher than the 51 inpatient days per 100 persons in the under 65 age category (Greater Vancouver Regional District, 1993, p. 10). In Canada, 40 % of the health care services are used by persons 65 years of age and older (Neufield, 1991, p. 235). These individuals frequently undergo evaluations and treatment by a variety of medical and supportive professionals such as: physicians, geriatric specialists, nurses, social workers, pastoral care workers, dieticians, physiotherapists, occupational therapists, speech therapists and recreation therapists. These professionals, frequently work as part of an multidisciplinary team to provide rehabilitation services to older adults.

Rehabilitation Services

According to McLellan (1992), general rehabilitation services perform a variety of functions, which include:

- (1) assessments of persons with a disability to identify self-perceived objectives and needs;
- (2) the identification of objectives and needs of disabled individuals and the establishment of priorities for health maintenance;
- (3) the identification of likely outcomes related to health and disability if there is no intervention;
- (4) the assessment of the individual's potential to obtain new skills, respond to a specific form of therapy or treatment, and the likely result of such therapy or treatment;
- (5) the need for adaptive equipment or modification of the physical environment. The assessment of other pertinent environments, such as the workplace or leisure time, are also essential to the overall assessment process.

(6) the implementation of the plan;

(7) assistance in the host community through education and planning of health promotion and disability awareness activities (McLellan, 1992, p. 56).

Therapeutic recreation services, as a component of the rehabilitation program, perform these same functions. However as Lyons (1993, p. 258) has indicated, there is sometimes a problem with "introducing the notion of (therapeutic) recreation as a legitimate rehabilitation service...". She contends that "often there is resistance to the idea that recreation and leisure perform substantive functions in our lives" (Lyons et al., 1993, p. 258). At St. Paul's Hospital, the department responsible for therapeutic recreation services, has equal status among the other patient services departments involved in the rehabilitation of patients. The recreation therapists, nurses, physiotherapists, occupational therapists, social workers, speech language pathologists, dieticians, and pharmacists have an important contribution to make towards their patients' care. However, there have occasionally been problems establishing the legitimacy of the service with some patients and other staff members who are unfamiliar with the role of recreation therapy. In a work-oriented society, which frequently relies heavily on the medical model of health care provision, "people undervalue leisure and recreation and miss its potential for increasing well-being" (Neulinger, 1981).

Resources

Many of the health care resources, although designed to address the physical and mental health of older adults, do not address specific issues such as loneliness, quality of life, life satisfaction, and the utilization of leisure. Services which focus on the individual's awareness and utilization of leisure resources, although relatively new to the health care system, are becoming widely recognized for the role they play in the rehabilitation of the geriatric community (Riddick & Keller, 1991).

The need for additional community supports for older adults when they leave the hospital setting has frequently been cited in the literature (Biette, Matthews, & Schwenger, 1983; Core Services Report, 1994; O'Neill & Reid, 1991; Peat & Boyce, 1993). However, hospital-based recreation therapists have typically not been involved in outreach, home-based services (Bullock & Howe, 1991). A recent survey of larger British Columbia Hospitals and rehabilitation facilities indicated that therapeutic recreation services, when present, seldom followed through to support clients after their discharge into the community (Gallant, 1993). Of the 16 surveys returned from hospitals and rehabilitation centres in Gallant's study, only two respondents indicated that follow-up consisted of visits to the clients' home.

Through the provision of outreach therapeutic recreation services in clients' residences and in their community,

recreation therapists can work on a more extended basis to meet their clients' goals. Goals which have been frequently desired by the clients and the professionals for such services include: facilitating integration into the community, increasing awareness of self as a leisure resource, increasing socialization, and, most importantly, an overall improvement in life satisfaction through leisure (O'Neill & Reid, 1991; Steinkamp & Kelley, 1987). The future of outreach therapeutic recreation as a health resource will depend, in part, on the future direction of health care.

New Directions in Health Care

Health policies of the 1990's are likely to focus more on maintaining people's health and keeping them out of hospitals and in the community. The Provincial Government of British Columbia has established new priorities for health care based on the recommendations of the Royal Commission on Health Care and Costs. These priorities include:

1. Whenever appropriate, deliver health services as close to home as possible instead of in hospital.
2. Make the promotion of good health and the prevention of illness and injury a major new emphasis of government policy.
3. Give priority attention to removing obstacles that now result in some British Columbians falling through the cracks in our system (British Columbia Royal Commission on Health Care and Costs [BCRCHCC], 1991).

These priorities further support the need for

therapeutic recreation practitioners to become more responsive to individuals in their communities. The promotion of good health through leisure and outreach education, which includes seeking ways to remove barriers to leisure, seems to be reflect the overall new direction in health care.

Leisure and Life Satisfaction

A number of researchers have found correlations between leisure satisfaction and life satisfaction (Purcell & Keller, 1989). There was also considerable support in the literature for the contention that leisure or recreation participation contributes to the psychological health of older adults (Gilbert, 1992; Searle & Mahon, 1993). A potential increase in leisure satisfaction through therapeutic recreation intervention, can also contribute to an increase in general life satisfaction (Brown, Frankel & Fennell, 1991).

Regarding life as more meaningful, becoming happier, having higher self-esteem, and becoming more satisfied with one's social contacts are areas of life satisfaction which may be influenced by leisure education (Datillo & Murphy, 1991). Leisure is an area in which individuals, who are not satisfied or happy with their life in general, can attain some degree of satisfaction (Mobily, 1984). Through participation in leisure education sessions, individuals' increased awareness, knowledge and skills often leads to new leisure insights, interests, and a potential increased satisfaction within their

leisure (Riddick & Keller, 1991; Searle & Iso-Ahola, 1988; Wilhite, 1992).

Leisure Education and Leisure Counselling

There are a variety of well-known and accepted models of leisure education and leisure counselling available to therapeutic recreation practitioners (Allen & Hamilton, 1980; Datillo & Murphy, 1991; McDowell, 1983; Whittman, Kurtz & Nichols, 1987). The specific approach used by the therapist will depend on the particular needs and characteristics of each individual client, the values and ideology of the recreation professional, and the policies of the organization or service provider. Providing information on particular community facilities, programs, and resources is one method of facilitating the clients' involvement in leisure. Counselling clients, in a supportive manner, to take more control of their own leisure is another method utilized by recreation therapists to promote the future leisure freedom of the individual. According to Mobily (1984), leisure may be one of the last areas elderly individuals are able to exhibit personal control and choice. Increased dependency on services, decreased health, and a lack of choice in the traditional medical system are likely to affect older adults' life satisfaction. It is therefore crucial that a leisure education and counselling approach be adopted to encourage clients to exhibit some degree of choice and control in their lives.

Leisure education and counselling are typically utilized by recreation therapists to facilitate client progress towards established goals. Goal setting within this context is frequently done with input from the clients. Increasing the clients' awareness of leisure through education and counselling is designed to lead to increased leisure satisfaction, which is linked to overall life satisfaction (Datillo & Murphy, 1991; Kelly, Sainsbury & Bruce, 1994; Steinkamp & Kelly, 1987).

Problem

Statement of the Problem

This study examined the subjective meaning that leisure and involvement in the Therapeutic Recreation Outreach Program (T.R.O.P.) had for eight recently hospitalized older adults.

Research Questions

The investigator was interested in describing the perceived benefits of leisure, facilitators of leisure enjoyment, constraints to leisure, and leisure satisfaction of older adults. Also, given that previous research studies have found a positive relationship between leisure satisfaction and life satisfaction, the investigator was interested in the participants' perception of this relationship. As a result, the following research questions were formulated.

1. How did older adults describe the benefits of leisure?
2. How did older adults feel that they benefitted/did not benefit from T.R.O.P.?
3. What were the self-perceived facilitating factors which contributed towards enjoyment of leisure?
4. What were the leisure interests of the participants?
5. What were the self-perceived constraints which prevented participants from achieving their leisure goals and interests?

6. What were the perceived relationships between leisure satisfaction and life satisfaction among participants?
7. What additional unanticipated factors warrant further exploration and impacted upon the participants' leisure, leisure satisfaction, and life satisfaction?

Definitions

Leisure: The term "leisure" has been conceptualized in a number of ways. The term's meaning has been frequently discussed and debated in the literature. Definitions of leisure often contain some reference to non-obligatory time and activities, subjective experiences and a sense of freedom (Lee et al., 1994). Defining leisure in terms of recreational activity or free time is too limiting because they do not focus on experiences (Dattilo and Murphy, 1991). The investigator has chosen Dattilo and Murphy's definition of leisure because it reflects the role of therapeutic recreation services. Leisure was conceptualized as "a state of mind involving the perception of freedom to choose to participate in meaningful, enjoyable, or satisfying experiences" (Dattilo and Murphy, 1991, p. 3).

Leisure Constraints: These refer to the self-perceived barriers which prevent or limit the participants' enjoyment of leisure, or their attainment of leisure goals (Jackson, 1990).

Leisure Counselling: a problem-centred facilitation process which may be viewed as a subset of leisure education. Leisure counselling assists individuals with problem solving,

decision-making, and conflict management with regard to leisure interests, awareness, values, and opportunities (Chinn & Joswiak, 1981).

Leisure Education: is designed to provide the individual with opportunities to increase their awareness, knowledge, and skills in those areas which facilitate leisure involvement (Dattilo & Murphy, 1991).

Leisure Interests: Leisure interests refer to the participants' past, present, or future leisure preferences.

Leisure Satisfaction: the degree to which individuals are content or pleased with their general experiences and situations as they relate to leisure (Beard & Ragheb, 1980).

Life Satisfaction: taking pleasure in daily activities, regarding life as meaningful, goodness of fit between desired and achieved goals, positive mood tone, positive self-concept, perceived health, financial security, and satisfaction with social contacts (Salamon & Conte, 1984).

Older Adult: an individual age 55 years of age and above.

Therapeutic Recreation: The purpose of therapeutic recreation is to facilitate the development, maintenance, and expression of an appropriate leisure lifestyle for individuals with physical, mental, emotional and social limitations (National Therapeutic Recreation Society, 1982; Schleien and Yermalkoff, 1983).

Therapeutic Recreation Outreach Program (T.R.O.P.): an outpatient based program, which takes place in the client's residence or in a community based recreational setting, as opposed to a more traditional inpatient based program.

Social Support: "the interaction or non-interaction of a set of persons mobilized or relied on in special times" (Rubenstein et al. 1994, p. 62).

CHAPTER TWO

Review of the Literature

Characteristics of Leisure

Numerous authors have attempted to understand the characteristics of the leisure experience. There has been a recent shift in the orientation of leisure professionals towards understanding the subjective perspectives people have about leisure (Lee et al., 1994). In contrast, past views of leisure have emphasized the activity or state of mind approaches (Hultsman, Black, Seehafer and Hovell, 1987).

Lee et al. (1994, p. 202) defined the subjective nature of leisure in relation to three prominent elements: enjoyment and fun, relaxation, and the condition of freedom of choice. Kelly, Steinkamp & Kelly (1987) concur that leisure is more than a time filler for an empty life, because it is generally integrated into the life patterns of people's roles and resources. Leisure is an important factor in the coping process, especially for those who have been consistently involved in their own self-development and community affairs (Kelly et al., 1987, p.114). Leisure, which has the potential to induce a sense of responsibility and control, has provided opportunities for older adults to meet their needs to demonstrate responsibility and control in their lives (Purcell & Keller, 1989, p. 24). Through leisure, older adults can meet these needs by a variety of means and personal choices. For

example, merely choosing what specific form of leisure to pursue, who to pursue it with, and when to pursue it, exercises one's ability to make choices.

Lee et al. (1994) contend that leisure is characterized by various forms of experience, including stressful or unpleasant ones. Informants in their study, which included two older adults, did not view leisure as consisting entirely of positive experiences. For example participants also recalled feelings of exhaustion, apprehension, nervousness, disappointment, frustration, and guilt when asked to discuss their leisure experiences (Lee et al., 1994, p. 203).

Mannell, Zuzanek, and Larson (1988) used the term "serious leisure" to refer to externally motivated activities which were freely chosen. "Serious leisure" appears to require more effort, commitment and obligation on behalf of the individual rather than freely chosen, more intrinsically motivated activities.

"Being at leisure" is often attained through recreational forms of experiences (Ballantyne, 1987). These recreational experiences are the result of participating in some form of recreational activity which may be social, physical, creative or intellectual in nature and which takes place in our leisure time (Ballantyne, 1987, pp. 1-2). To emphasize the importance of the "experience" of leisure, activities are commonly grouped into categories such as: social, physical, creative, intellectual, spectator, and solitary (Ballantyne, 1987). From

a leisure education perspective, it is important for individuals to be exposed to a balance of activities from each experience category (see Appendix One for examples).

Leisure Satisfaction and Life Satisfaction

Munson and Munson (1986) remarked that the achievement of meaningful and satisfying leisure is a major developmental task for older adults. Russell (1987) studied retired persons aged 60 years and over residing in age-segregated situations. Russell found that older adults' satisfaction with recreation had a significant positive relationship with their life satisfaction. However, this same study revealed that the frequency of participation in recreation activities was not significantly related to life satisfaction (Russell, 1987). This and other studies have maintained that satisfaction with recreation and leisure contributed more to life satisfaction than did activity participation per se (Ragheb and Griffith, 1982; Keller, 1983).

Brown, Frankel and Fennell (1991) examined the relationship between leisure and happiness or psychological well-being of adults. Their study, which also contained a large sample of older adults, described the relative contribution of the variables of leisure activity, age, gender and leisure satisfaction to well-being. They concluded that leisure satisfaction is the most important variable in predicting life satisfaction (Brown et al., 1991, p. 369).

The Leisure Interests of Older Adults

A number of recent studies have identified patterns of leisure involvements among older adults. Patterson and Carpenter (1994), in their research on older adults who were widows and widowers, found that the most popular leisure activities of older people were "home-based activities such as reading, watching TV, gardening, hobbies, and socializing with family and friends" (Patterson & Carpenter, 1994, p. 114). Very few of the most popular activities were agency-dependent. This suggests that what mattered most to older adults were involvements with family, pleasant surroundings, physical health, relaxation, being with others, and fun and enjoyment (Patterson & Carpenter, 1994).

According to O'Neill and Reid (1991), the top ranked physical activities of 199 healthy, adults over the age of 55, in a Montreal based study were "walking, swimming, calisthenics, bowling and dance" (O'Neill and Reid, 1991, p. 395).

MacNeil and Teague (1987) noted that as age increases there is a trend away from activities which are physically exerting and took place outside of the home toward activities, to activities that are less physically demanding and more home-centred (MacNeil & Teague, 1987). Similarly, Patterson and Carpenter (1994, p. 107) found that the core of lifetime leisure activities for older adults of relatively accessible and informal leisure activities, such as "conversations in the

household, reading, watching television, walking, shopping" (Patterson & Carpenter, 1994, p. 107). The social experiences gained through leisure participation are believed to be beneficial to the maintenance of positive morale among the elderly (Patterson & Carpenter, 1994). "Social interaction is a common element of the leisure lifestyle of most adults" (Sneegas, 1989, p. 30).

Yet, Kelly et al. (1987, p. 190) noted that the range of interests and social interactions for many older becomes smaller and smaller with increasing age. They contend that this reduction is due to "reduced mobility and social resources rather than a personal choice". There is also a declining tendency to seek novelty through new leisure interests as one advances in age (Iso-Ahola, Jackson & Dunn, 1994).

In contrast, it has been suggested by Argyle (1992) that leisure which consists of work-like qualities are more socially acceptable than the experiences cited above. Argyle's examples of these more socially accepted forms of leisure included leisure that: was serious, was of use to others, met high standards, required skill, and lead to the recognition of excellence (Argyle, 1992).

Constraints to Leisure

O'Neill and Reid (1991) found that the number of perceived barriers to physical activity for older adults was

significantly related to age and illness or handicap. The primary barrier to physical activity was knowledge based, and may have represented either a negative attitude toward or lack of knowledge about exercise and leisure experience. For the older adult, frequently living alone in their home, such life events may magnify leisure constraints.

Forbes, Hayward and Agwani (1991) analyzed the data from the Health and Activity Limitation Survey and the General Social Survey. Both of these Canadian surveys were used to estimate the prevalence of various mental, agility, mobility, sight and hearing impairments in the older population. The risks for impairments was estimated based on income, marital status, housing tenure, and living arrangements. The survey revealed that low income appeared to have the greatest impact on self-reported impairments among older people residing in the community.

Mannell and Zuzanek (1991, p. 346) reported that the most frequently reported constraint by 92 active older retired adults was "being too busy". This finding was contrary to the stereotypes of older adults as being isolated and idle.

A number of older adults are not able to spend their leisure as they wish. In fact there is frequently a discrepancy between what they actually do and would like to do. Leisure constraints research reveals that a lack of knowledge regarding where to learn a specific activity, where to participate in an activity, and lack of a partner with whom

to participate, have a significantly constraining effect upon leisure behaviour among older adults (Searle and Mahon, 1993).

Jackson (1990) refers to "antecedent constraints" as another form of leisure constraint. Antecedent constraints reflect "a modification of an individual's preferences rather than a general lack of interest". Examples of such antecedent constraints include sex-role socialization, accessibility of facilities in a given area, or family circumstances (Jackson, 1990, p. 67).

Heywood (1994, p. 14) discusses age specific labelling as another potential constraint. He contends that this type of labelling is common, it "serves as a deterrent to older adults being universally accepted as vibrant, active, contributing members of society". While the frail elderly may be a "special population" that needs to be treated separately, older adults in general, are not (Heywood, 1994, p. 14). A further constraint may be the older adults' hesitancy to become involved in specific programs due to their negative perception of that program. Older adults are becoming reluctant to use community services of any kind, due to an increased social welfare/social service stigma which may be attached to the centres (Heywood, 1994, p.16).

Health Status of Older Adults

This section reflects some of the most common health problems experienced by the older adult population. This is not to say

that most older adults experience these problems. In fact the majority of older adults aged 65 and older have no disabling condition and live fairly active community lives, this also includes a large number of seniors with disabilities (Statistics Canada, 1988).

Ebersole and Hess (1994, p. 549) stated that depression is the problem of greatest frequency and magnitude in the aged population". It has been estimated that among older adults residing in the community, between 10 and 25% have clinically diagnosed depression. In particular, the losses or stressors associated with age (such as widowhood, declining health, and decreasing social and economic resources) have been found to be strongly associated with depression and loneliness. Feelings of loneliness can predispose elderly persons toward physical and mental health problems (Rubinstein, Lubben & Mintzer, 1994).

Two orthopaedic disabilities, osteoporosis and osteoarthritis, are also common physical health problems in the geriatric population (Riddick and Keller, 1991). The National Center for Health Statistics (1988) reported that nearly half of all persons over age 65 suffer from some form of chronic arthritis. Riddick and Keller (1991, p. 154) suggest that leisure education programs have a role to play in the maintenance and restoration of muscular health and functioning for individuals with these and other orthopaedic problems.

Chronic illnesses affect most older adults to varying degrees (Verbrugge, Lepkowski, and Imanaka, 1989). Where older adults experience episodes of illness, with increasing frequency, progress towards improvement is often slowed (Hickey-Stilwell, 1992, p. 1).

There are obvious differences between older adults' experiences of chronic conditions and their acute illnesses which require a multi-dimensional approach to the management of disease and overall health care (Hickey & Stilwell, 1992, p. 2). It is important to develop and customize treatment strategies which are consistent with the individual's beliefs and attitudes. This is especially important if adherence to a treatment regimen is to be maintained over an extended period of time (Hickey & Stilwell, 1992, p. 2).

Implications of Health

Older adults are like other people, in that health, not age, is the determining factor of their differences (Heywood, 1994, p. 12). Based upon a Canadian research study involving 340 subjects aged 55 and above, it was demonstrated that participants' health had a direct positive effect on rate of participation in leisure and the number of activities in which they participated (Searle & Iso-Ahola, 1988).

Hickey and Stilwell (1992) referred to changes in health status, which were attributed to age. They stated that the impact of illness and disability on people's personal autonomy

and life-style, represented a significant challenge for both older people and health care professionals (Hickey-Stilwell, 1992, p. 1). However, Sainsbury and Bruce (1994) found that older adults who participated in their study reported improved life satisfaction in spite of poor or failing health. This was accomplished with the assistance of a multidisciplinary team, which included therapeutic recreation.

A number of authors have emphasized the importance of leisure education in the reduction of specific health-related problems. Riddick and Keller (1991) stressed that therapeutic recreation programs should be designed to:

stress leisure education, exercise, and relaxation in order to reduce the risk of cardiovascular and cerebrovascular diseases and illnesses in geriatric populations (Riddick and Keller, 1991, p. 154).

Other authors see additional related avenues for recreation therapists. In discussing reintegration to normal living after amputation, Nissen and Newman (1992) recognized that recreation therapists may need to spend more time assisting patients to find acceptable, alternative recreation experiences, or some adaptive means to continue their previous interests.

It has been noted that individuals suffering from depression often require help learning how to enjoy themselves in leisure pursuits, learning relaxation, and learning socialization (Riddick and Keller, 1991, p. 155). There are also obvious ramifications for addressing loneliness in the geriatric populations, through the promotion and facilitation

of socialization opportunities through leisure education and therapeutic recreation programs (Riddick and Keller, 1991).

As there is an apparent lack of literature on outreach therapeutic recreation for the frail older adult, sources on other target groups were reviewed. For example, Clark and Curran (1994) developed a model for leisure outreach for overcoming isolation in urban youth and young adults. This model recognizes the interdependency among all persons and the community in which they live. Clark and Curran (1994, p. 30) emphasize the importance of regular communication linkages as one way of overcoming feelings of isolation and sustaining the involvement of participants in community-based recreation and leisure.

Unavoidable multiple changes in life events (e.g., failing health, loss of finances, retirement, widowhood) are "shocks" to older persons and result in individuals losing faith in their ability to affect the environment or in feelings of helplessness. These feelings can prevent older persons from acting to compensate for losses and consequently it influences their sense of mastery over the environment (Riddick & Keller, 1991, p. 158).

Social Support

Leisure has a capacity to provide individuals with feelings of social support and it can be a source of coping when persons are faced with life crises. "People appear to be

able to cope psychologically with life stressors, if they feel that they would be supported when in difficulty" (Coleman 1993, p. 352). Rubinstein et al. (1994, p. 60) stated that "social relations" are frequently identified by older adults as being a fundamental need. They provided empirical evidence to support the important contributions of social networks and social support towards the health and well-being of older adults (Rubinstein et al., 1994, p. 58). There have been increased limitations placed upon families to be a source of support for its older members. This decline is in part due to the decline in multi-generational households and the increasing geographic distances between the elderly and their families (Ross, 1991). The re-entry women into the workforce is an additional factor as women are the primary in-home caregivers. These changing demographics highlight the importance of looking towards alternative sources of support for older adults.

Coleman (1993) suggested that social support buffers the impact of life stresses on health, but only when these life stresses are high. He indicates that this effect had been consistently demonstrated, but cautioned that too many social contacts could actually be "detrimental to health" (Coleman, 1993, p. 359). For example one's stress may be increased by inappropriate or conflicting advice being offered by friends or family.

Friedland and McColl (1992, p. 573) suggest that while

the relationship between social support and health seems to be established, there was evidence that "social support intervention may be difficult to implement". Their suggestions for providing social support intervention includes ensuring that:

- i) a client-centred approach is central to the program;
- ii) the therapist's role is to be an advocate for the client promoting social support;
- iii) the network, not the client, is the target for intervention;
- iv) the informal support system is of special importance; the importance of social support to well-being must be conveyed by the therapist to both client and network members;
- v) intervention should be provided at a time when the individual is actively adjusting;
- vi) the program needs to be of sufficient intensity and duration to provide a "critical exposure".

(Friedland & McColl, 1992, p. 576)

Leisure Education Strategies

Traditional leisure education and leisure counselling roles have recently been scrutinized. Hutchison and McGill (1994) describe leisure education and leisure counselling as failing to focus on identifying the needed supports for individuals, because traditional practices have relied too heavily on diagnostic kinds of assessments.

The term "leisure education" has been the subject of numerous debates over the past 15 or more years. Some view leisure education as the "umbrella" term which is frequently

used in a variety of clinical and community settings. This perspective encompasses "leisure counselling" and other related techniques which focus on guidance and instruction towards leisure awareness, skills and knowledge (Bedini, 1990). In the past, others have preferred to view leisure education and leisure counselling as separate approaches (Chinn & Joswiak, 1981). These earlier perspectives viewed leisure counselling as "problem focused" and designed to resolve specific issues (Chinn & Joswiak, 1981; Munson & Munson, 1986).

The leisure education process is constructed to assist individuals in determining their specific needs and action plans for achieving them. The process is not based on some externally formulated model of what comprises "good leisure" and what comprises "unhealthy or bad activity". Rather, the goal of leisure education is to create "personally satisfying lifestyles, not lifestyles which mimic some model" (Searle and Mahon, 1993, p. 11).

Leitner and Leitner (1985, p. 125), in their book on leisure counselling for the elderly, stated that both leisure education and leisure counselling referred to "helping processes designed to facilitate maximal leisure well-being". They described leisure education as a self-directed process and leisure counselling as an individualized or small group process lead by a leisure counsellor. They suggested the following techniques when conducting leisure counselling

interventions for older adults:

- (1) plan sessions for a duration of 30 to 45 minutes;
- (2) conduct sessions a minimum of once per week;
- (3) at the start of each session, define and state the purpose;
- (4) tape record and take notes on sessions;
- (5) choose a suitable style of counselling and be flexible enough to change styles
(Leitner and Leitner, 1985, pp. 135-136).

Caldwell, Adolph, and Gilbert (1989) found that in a study of patients who were hospitalized in a rehabilitation facility and who received leisure counselling, a lower self-perceived number of barriers was related to higher leisure satisfaction. Also, patients participating in the leisure counselling also felt better prepared to deal with their post-discharge free time as compared to patients who did not receive leisure counselling. However, one surprising result of this same study was that individuals who received leisure counselling perceived more internal barriers to participation and felt more bored than those who did not receive leisure counselling.

Heywood (1994, p. 14) recently stated that the later stages of life is:

an ideal time to cultivate dormant or even new interests and expand personal and professional horizons and relationships. To do so requires recognition of the potential of older adults and realization that addressing their potentials is as important as addressing their problems.

A variety of approaches to leisure education were described by Leitner and Leitner (1985). They suggest that the Leisure Resource Guidance Approach is the most appropriate strategy for healthy older adults who are seeking information regarding recreation opportunities, but who are not interested in broadening their horizons beyond their current interests (Leitner and Leitner, 1985, p. 127). The resource guidance approach involves:

- (1) an initial interview to get acquainted with the client;
- (2) administration of leisure interest inventories and collection of demographic data;
- (3) data analysis;
- (4) matching of client's interests and demographic data with appropriate recreation programs;
- (5) discussion of results with client and referral to suitable programs;
- (6) a follow-up meeting to examine the client's satisfaction with the programs to which they were referred;
- (7) termination of the counselling once the client has been satisfactorily matched and is participating in one's desired recreational activities

(Leitner and Leitner, 1985, pp. 127-128).

The Developmental-Education Approach is utilized to assist the participant in identifying an "ideal leisure lifestyle" and help them move towards decreasing the distance between their actual leisure and ideal leisure. The steps involved in this include:

- (1) pre-assessment;

- (2) building rapport;
- (3) defining concepts related to leisure, ideal leisure and work;
- (4) identifying leisure needs;
- (5) identifying leisure goals;
- (6) identifying and discussing obstacles to goal achievement;
- (7) identifying performance criteria through refining goals;
- (8) explore leisure alternatives and consequences;
- (9) disseminate information;
- (10) participation and evaluation;
- (11) termination and follow-up
(Leitner and Leitner, 1985, pp. 129-133).

The Therapeutic-Remedial Approach is appropriate for lower functioning older adults or those with specific leisure related problems such as boredom, loneliness, depression, chronic television watching. This approach requires establishing a close empathic relationship with the participant. The counsellor should become more directive and focus on specific problems. Leitner and Leitner recommend that the steps outlined in the Developmental-Education Approach be utilized with these objectives in mind when working towards specific problems of older adults' leisure:

- (1) identify leisure-related problems and their causes;
- (2) identify desired changes to alleviate the problems;
- (3) develop an individualized program of recreation activities to assist in community leisure

integration;

- (4) initiate involvement in activities with supervision;
- (5) develop a positive self-image and attitudes towards community living;
- (6) develop community contacts to enable the client to participate in the community without supervision (Leitner and Leitner, 1985, 133-134).

Counselling older people towards leisure can assist them in adapting to "changing circumstances and overcome life crises and barriers to leisure fulfilment" (Munson and Munson, 1986, p. 13). What begins as a form of therapy, leads clients towards more aware, independently participating individuals, who have hopefully attained a greater sense of satisfaction and freedom in their own leisure and life.

CHAPTER THREE

Methodology

This chapter describes the case study utilized to explore the research problem and research questions. Authors who have used qualitative methods in their research, have recommended describing the methodology in the sequence that it occurred (Henderson, 1991; Mactavish, 1994; Patton, 1980).

Research Design

Henderson reminds us that leisure has perhaps always been best understood through a subjective paradigm (Henderson, 1991, p. 195). She contends that the highly complex nature of leisure can no longer be deciphered only by positivistic and quantitative terms (Henderson, 1990, p. 173).

The primarily qualitative approach used in the case studies of the older adults permitted a greater depth of analysis and allowed for access to data which could not have been gathered through quantitative methods alone. The investigator's earlier experience with many of the older adult patients at St. Paul's Hospital had revealed the uniqueness of these patients. This uniqueness was partially attributed to differing life experiences, medical conditions, perceptions of leisure, and available support systems. The expected diversity of the participants' experiences presented eight unique case studies.

The use of qualitative methods, which was supplemented by some quantitative data derived from the leisure worksheets, provided the researcher with opportunities to examine and describe the subjective meaning that leisure and involvement in the T.R.O.P. had for the participants. The individualized approach utilized in the T.R.O.P., which is explained later in this section, yielded additional insights which would not have been adequately revealed in a strictly quantitative design. The case study design was intended to be responsive to the participants' needs rather than a researcher's predetermined research design. The expected diversity of each participants' medical conditions and often unpredictable prognosis, supported the investigator's choice of a variety of forms, time-lines and content of T.R.O.P. sessions. Therefore, the therapeutic recreation inpatient and outreach sessions were not identical for each participant. In fact, each participants' T.R.O.P. was somewhat unique. The purpose of this design was to facilitate a supportive relationship between the investigator and each participant. This relationship helped to establish goals, while making realistic adjustments to the method in order to accomplish them. When the situation warranted goal or method revision, it was within the scope of the intervention to make the necessary adjustments.

Given the research problem, research questions, and the need for flexibility within the method, the most appropriate

case study design was a combined qualitative and quantitative approach. As Patton stated, qualitative and quantitative data collection measures are not "mutually exclusive research strategies". They can both be utilized in the same study (Patton, 1990, p.14). Henderson supports the use of both approaches, stating that the value of considering both approaches "lies in giving the researcher more tools with which to work" (Henderson, 1991, p. 179).

The use of three in-house tools comprised the quantitative data collection dimension. These leisure education worksheets were developed to encourage individuals' to explore their leisure interests, leisure needs, leisure constraints, and ways of overcoming leisure constraints (Ballantyne, 1987; BC Rehabilitation Society, 1989; Witt & Ellis, 1989). The worksheets are frequently utilized as in-hospital assessment tools and by clients of specific outreach programs for adults with physical disabilities. They were adapted by the British Columbia Rehabilitation Society from Ballantyne (1987) and Witt and Ellis (1989).

Participants completed the three forced-choice leisure worksheets which provided a way of comparing frequencies of choices. The worksheets also provided a resource for the investigator to facilitate additional responses from the participants in the subsequent qualitative data collection phase. The qualitative methods included interviews, observations, and field notes. It appeared from the results of

the pilot study, that the more detailed qualitative forms of responses were more informative than the responses which were indicated on the worksheets.

Pilot Study

A pilot study, similar in format to this research project, was completed May 17, 1994. The pilot study examined the impact of a therapeutic recreation outreach program on two older adults, who were patients at St. Paul's Hospital. It was designed to familiarize the researcher with the practical procedures involved in implementing the research design. It also provided the investigator with an opportunity to critically examine the appropriateness of the interview questions and to determine the actual time-frame required.

The complete results of the pilot study are found in Gallant (1994). Highlights of the results of the study are included in the results section of this report. The pilot study revealed a need for slight revisions to the methodology in terms of the interview questions. The order and number of the concluding interview questions was revised. It seemed more appropriate to start the interview with a more concrete question related to the T.R.O.P. itself, rather than the more abstract questions on leisure. The second change resulted in the addition of a question to determine if the participants perceived any negative components to the program and to obtain any feedback for future improvements. This additional question

provided a natural concluding point for the interviews. Appendix Two contains a list of the concluding interview questions.

Investigator's Role

The researcher was one of the instruments of data collection and analysis (Merriam, 1991). He had a dual role as researcher and the professional responsible for implementing the specific T.R.O.P. He implemented the leisure education inpatient sessions as part of the normal course of treatment which specific patients would undergo at St. Paul's Hospital. The use of semi-structured interviews, tape-recorded sessions, and formalized field notes were not associated with the usual professional duties of the investigator, but were directly related to his role as researcher. The continued liaison with the patient after their discharge from the hospital and the conducting of outreach sessions were also not within the existing responsibilities of the professional. This dual role of researcher and recreation therapist presented a number of specific advantages as well as limitations.

One advantage was related to the credibility of the investigator. His professional experience included the interviewing of patients, observing patients' behaviour, and treating patients with a variety of medical conditions. These brought valuable elements to this research project. As Merriam (1991, p. 34) commented, "training in observation and

interviewing, though necessary, is not readily available to aspiring case study researchers". Related to this advantage of professional experience was his familiarity with other members of the patients' or participants' multidisciplinary team. The recreation therapist's familiarity with the team and the patients, enhanced the referral process and exchange of information related to the patients' care, which otherwise would have been difficult to obtain. There was, in all likelihood, a closer more effective relationship established as the result of the researcher also being the recreation therapist. The researcher's general familiarity of the hospital routine facilitated a smoother delivery of the research program. As Henderson (1991, p. 107) stated, "the ideal research setting is where the researcher obtains easy access, establishes immediate rapport, and gathers data related to the research interests.

One limitation of this dual responsibility was the demanding nature of combining research with professional duties. For example, the recreation therapist who was conducting the leisure education program could not always observe all the participants and be attentive to the discussion occurring between different participants. It should also be noted however, that the relationship between the participant and therapist/researcher became more trusting over time.

An additional limitation or potential problem area was

discussed in Merriam (1991). This issue reflects a common concern in qualitative studies. That is, the researchers becoming involved in the issues and situations they have attempted to study, likely has some effect or influence on the participants. Patton (1980) also stated a similar "evaluator effect" which may be experienced by the participants and staff due to the presence of the evaluator" (Patton, 1980, p. 333). Such an effect may have resulted in the participants overstating the positive benefits of leisure participation. Participants may have purposefully presented themselves and their "stories" in a manner which they perceived the investigator would have "wanted" them to have appeared, reacted, or commented. Related to this potential "evaluator" effect was the potential for the investigator to influence the hospital staff's performance and interactions with the investigator and participants. However the investigator believes that the staff were likely to experience only minimal effects due to his presence, as the evaluator was a familiar colleague performing a familiar role, as far as they were concerned.

Patton (1980) discussed several additional evaluator effects which are important to consider. The evaluator does not remain a constant. That is, there are likely changes which occur to the investigator through the course of the study. These changes are central to the method of participant observation. They occur as the evaluator becomes personally

involved with the participants. The researcher's sensitivity to the full range of events occurring in the setting is decreased when he or she becomes involved with the very "subject" under investigation (Patton, 1980, p. 334-335).

However, Howe (1991) cautioned that while there are some researchers who believe that separating the researcher from the participants facilitates objectivity, "it is through interaction with the participants that the most accurate and revealing data are collected" (Howe, 1991, p. 50). The use of a person-centred approach requires that the investigator become involved in the process.

Person-Centred Approach

The investigator practised a person-centred philosophy when he interacted with participants in this study (Egan, 1990). This enabled him to be flexible enough to discuss any of the concerns arising from the participants. Therapeutic recreation services have frequently utilized a person-centred approach and treated patients or clients as unique individuals with "unknown potential for growth and learning" (Hutchison and McGill, 1994, p. 12). The use of a person-centred approach enhanced the responsiveness between the participants and the investigator. Pedlar, Gilbert, and Gove (1994) found further support for a person-centred approach. In an investigation of a leisure integration program with older disabled adults, these authors found that "not allowing for people's strengths

and self-awareness in terms of leisure preferences proved to be frustrating and aggravating to participants". More was learned about the older adults' interests and capabilities by simply inviting them to talk about who they were and what interested them, than by having them complete standard leisure assessment tools (Pedlar et al., 1994, p. 25).

Participant Selection and Recruitment

To participate in this study participants were required to be inpatients of St. Paul's Hospital, to be at least 55 years of age, and be able to speak, read and comprehend English fluently. An additional selection criteria was that the participants' usual place of residence was in the Lower Mainland of British Columbia in a non-institutional setting. These criteria were designed to ensure that the outreach visits would be within a suitable distance for the investigator to travel. The relatively short distances involved enabled the researcher to maintain direct contact with the participants, and thereby increased the potential for building effective relationships between the researcher and the participants (Flynn, Volpe, Boschen, Lewko, Salhani & Shea, 1993).

Because of the "outreach" nature of the study, patients were excluded if they were awaiting placement in a Long Term Care Facility or similar institutional setting which may restrict their participation in the community. Also

individuals known to have a cognitive deficit exceeding "mild", as determined by the occupational therapist, physician or other qualified staff involved in the assessment of the patient, would not be eligible to participate. Persons with a probable terminal illness and with life expectancy of less than six months were also excluded from participating in this study.

It was originally planned to recruit a total of eight participants, aged 55 years and above for this study. A letter containing an outline of this proposal was distributed to all medical and nursing staff serving the potential participant base in order to notify them of the study. All St. Paul's Hospital inpatient Nursing Units, with patients potentially age 55 and above, were informed and encouraged to notify the investigator of potential participants, through an informal referral process. The investigator sought the voluntary consent of the patients to participate in this project. The investigator reviewed the charts of referred participants to confirm their eligibility based on the inclusion criteria. A brief description of the study and a consent form (Appendix Three) was presented to each participant. The signed form of each consenting participant was kept on their medical chart. A copy of this form was also given to the participant for their records.

The recruitment of eight eligible participants required a longer than anticipated amount of time due to a number of

circumstances. The inclusion criteria immediately dismissed a high proportion of the available participant pool. In some instances, there were less than ten percent of patients aged 55 and above who qualified for the study. Three non-consenting patients appeared reluctant to sign due to the "wordiness" of the consent form. Another patient stated that he did not think he had enough time to participate. One patient, who initially consented later, could not participate in the study because of changing circumstances regarding her discharge location.

The Therapeutic Recreation Outreach Program (T.R.O.P.)

T.R.O.P. consisted of a combination of inpatient and outpatient interviews, leisure education sessions and therapeutic recreation interventions, which assisted the participants in exploring their leisure interests, leisure needs, constraints to participation, and leisure goals.

T.R.O.P. began in the hospital with the initial interview. It continued with a combination of group and one-to-one leisure education sessions on the Rehabilitation Unit and Geriatric Unit of St. Paul's Hospital. T.R.O.P. concluded with a number of outreach sessions and a concluding interview.

The specific leisure education strategies utilized by the therapist included the techniques recommended by Leitner and Leitner (1985) and consisted of a combination of the three leisure education approaches which are also described in Chapter Two. This combination of the Leisure Resource Guidance

Approach, the Developmental-Education Approach, and the Therapeutic-Remedial Approach (Leitner & Leitner, 1985) provided the therapist with enough strategies to work with the different abilities, needs, and "problems" participants' presented.

Each participant attended a variety of therapeutic recreation sessions and completed four leisure worksheets which will be described later in the methodology. The list outlined below represents the minimum participation required to complete the program:

Initial Interview

Group Session(s)

Leisure Interests Worksheet

Leisure Needs Worksheet

Challenges to (Leisure) Participation Worksheet

Goal Setting/Overcoming Challenges Worksheet

Outreach Session 1

Outreach Session 2

Concluding Interview

Initial Interview

Immediately following informed consent, demographic information was sought by the investigator through a semi-structured initial interview (Appendix Two). This interview format was similar to that described in Howe (1988). A core of interview questions was developed but the interviewer was

permitted to deviate in order to "explore emergent areas with greater depth" (Howe, 1988, p. 308). The initial interview was designed to be a non-threatening method of gathering basic demographic information which may or may not have been on the participants' medical chart. The interview also provided an opportunity for the participants to express their reaction to being hospitalized, and information regarding their activity levels within the hospital.

Efforts were taken by the investigator to establish rapport with each participant prior to the interviews. For example, the investigator and participant discussed the role of the recreation therapist. Then the investigator told the participants about his research and university studies, in an effort to disclose some personal information which would help "break the ice".

The initial interview was designed to be 20-40 minutes in length. Interviews were audiotaped and transcribed. Field notes were also taken during and after the interview to highlight observations made by the investigator and to emphasize key points or issues mentioned by the participants.

Group Inpatient Sessions

Inpatients attended a minimum of one group leisure education session which was held in the Activity Room of the Rehabilitation Unit at St. Paul's Hospital. Participants of T.R.O.P. and other hospital patients were also invited to

attend additional recreation activities in the hospital as part of their normal hospital treatment course. These groups occasionally included participating in such activities as baking, bingo, current event discussions, gardening, musical entertainment, social "pubs", and community outings.

All inpatient sessions were scheduled in coordination with physiotherapy, occupational therapy, nursing, and other members of the patient's care team. Prior to the participants' discharge from St. Paul's Hospital, the investigator met with each participant to discuss future visits outside of the hospital. Arrangements were made for follow-up visits during these discussions.

Participants were informed at least one day in advance of an upcoming session, and were encouraged to invite any family, friends, or other significant individual to attend the sessions with them. Participants sat around a table and were in a position which ensured they could see the other patients, the investigator, the slides, and the television monitor. The volunteer offered the patients refreshments which complied with any diet restrictions.

The investigator facilitated information sharing related to previous and current leisure behaviours and interests. The investigator and all of the participants in the group session gave a brief introduction about themselves and were invited to share their interests and concerns related to leisure at anytime during the session or after the session in private.

These comments were recorded by the investigator.

Conversations among the participants and the investigator were promoted through the use of a variety of slides, a videotape, overheads, and brochures related to leisure and life enjoyment. The slides revealed the investigator's personal leisure interests, needs and some facilitators to leisure. There were additional slides of community facilities, in hospital leisure pursuits and leisure adaptations. The 12 minute video contained information about various Vancouver community recreation resources and facilities.

Recreation and community information brochures were distributed to participants. These brochures were specific to the participants' neighbourhood and community. They contained information on local recreation centres, events, time schedules, and costs.

Overheads and an erasable marker board were occasionally utilized to highlight specific points discussed in the session. These points were often presented by both the participants and the investigator.

Towards the conclusion of each group session, if time permitted, participants completed one of the leisure education worksheets. If there was not sufficient time for the subject to complete a specific worksheet during the group session, it would be completed later, on a subsequent visit by the investigator.

A total of four worksheets were completed by each

participant during the program (Appendix One). These explored the participants' leisure interests, needs, constraints, and goals (Ballantyne, 1987; Ellis & Witt, 1986; Witt & Ellis, 1989).

One-to-One Sessions

One-to-one (1:1) sessions refer to any session or interaction between only the investigator and the participant. Such sessions were conducted both inside and outside of the hospital setting. They included the initial and concluding interviews and the majority of the outreach sessions telephone interactions with the participant.

During 1:1 sessions, the participant and investigator frequently worked towards the identification and prioritizing of challenges to participation. Steps towards obtaining participant goals were also discussed thoroughly at these sessions.

Outreach Sessions

At least one week following the participant's discharge from the hospital and their return to home, the investigator telephoned each participant to schedule the initial outreach session. These telephone calls were scheduled at least one to two days in advance of a visit, based on the participants preference. If it was then found inconvenient for a participant to be visited for an outreach session, the planned

session was scheduled for a more convenient time.

The outreach sessions consisted of one-to-one interactions between the participants and the investigator. The investigator also made several telephone calls to each of the participants to schedule or confirm the next session. Telephone calls were also made to check on each participant's progress and to establish the focus of the next session.

Concluding Interview

The concluding interview was held in the participants' home, in a room of their choice. The aim of this interview was to assess the participants' subjective perception of T.R.O.P. The concluding interview sessions lasted from 30 to 45 minutes.

Data Collection

Data collection was accomplished through a variety of methods as outlined below.

Medical Chart Review: Review of the participants' medical charts assisted the investigator in obtaining a brief medical history on the participants. Information obtained from the chart included: reason for admission to hospital, other medical conditions and medical history, living situation, date of admission to hospital, and medical procedures or treatments the participant is undergoing. Progress notes from the participants' nurses, doctor, social worker which were present

in their medical chart were also reviewed. Information which the investigator believed was relevant to the participants' involvement and progress in T.R.O.P. was recorded as part of their profile. Review of patients' medical charts is a common hospital procedure utilized by recreation therapists and other hospital staff.

Field notes: Field notes were recorded chronologically on each participant, usually immediately following each session and data gathering opportunity. Occasionally brief field notes were taken during a session. These were designed to remind the investigator of observations which could be recorded in greater detail following the session. These field notes included both intuitive and objective writing (Malkin & Howe, 1993, p. 266). The information collected, included notes on: where people were sitting, date, place, social circumstances, intimacy, interaction and initiation, barriers and unforeseen events. Note-taking assisted the investigators recording, interpreting and describing the interviews, conversations and observations.

Interviews: At least two formal interviews were held with each participant. The initial interviews were conducted in the hospital at the start of the program. The concluding interviews were conducted in the participants' homes at the conclusion of the program.

Conversing with participants: On occasion, informal and formal conversations between the participants and the

investigator provided additional data. These conversations frequently took place when the investigator would briefly visit the participants in their hospital rooms to remind them of upcoming sessions. Other conversations consisted of brief telephone contacts with the participants in their homes.

Conversing with staff: Occasional conversations with the participants' other care-givers in the hospital provided the investigator with information on individuals' progress, prognosis and discharge dates to their home.

Information from family members: Occasionally, unsolicited information was mentioned to the investigator by one of the participants' family members. The investigator found this additional information helpful in establishing the degree of support the participant had from their family.

Participant observation: Observations of the participants in the leisure education group and one-to-one sessions were also noted. The participants' willingness to interact and their contribution at each session were observed. Observations of the participants' living conditions were also helpful in determining physical comfort and access, leisure interests, and lifestyle in general.

The investigator's field notes were reviewed throughout T.R.O.P. These additional reviews of the field notes were designed to increase the investigator's depth of understanding and to help him gain any further insights into the subjective world of the participants.

Leisure worksheets: Four leisure education worksheets were utilized to obtain information from the participants about their: leisure interests, leisure needs, constraints to participation, and leisure goals (Ballantyne, 1987; Witt and Ellis, 1989). These worksheets consisted of lists of items which participants checked off. These items described their interests, values, and perceived constraints to leisure participation (Appendix One). The goal setting or "constraints" worksheet provided a format for more open-ended, participant generated strategies for change. Participants were encouraged to suggest ways to overcome up to three previously identified constraints and to set goals related to their leisure experiences.

Data Organization

Computerized data files were created on the participants and organized chronologically by the date of the occurrence, and also by the types of experiences that the participants were involved in. As Malkin and Howe have stated,

the idea is to create records of clients' TR (therapeutic recreation) interventions that permit review of the experience from natural start to a natural end (Malkin & Howe, 1993, p. 265).

Participants' experiences included their leisure prior to hospitalization, initial interviews, participation in group leisure education sessions, one-to-one sessions and outreach sessions. Other experiences during the program, and in certain

cases, experiences which followed the formal completion of the program, were also included.

A data display, consisting of comparative tables was created (Henderson, 1991; Huberman & Miles, 1994). These assisted the investigator in reducing the data to more manageable chunks. The tables also provided an initial means of comparing all the participants' responses to the specific interview questions. Summary tables were also developed to review selected data related to each specific research question.

A participant profile was created for each individual in the study. These profiles contained information obtained through the investigator's field notes, the participant interviews, and the leisure education worksheets. These initial profiles presented information related to the participants' health and health history, social support and living situation. The profiles were then expanded to include additional data on the participants' leisure history, involvement in T.R.O.P., constraints affecting leisure, and their general perception of leisure.

Key phrases, which verified emergent findings, were isolated from the data and were included in the text and tables of the results section. These phrases were related to the specific research questions.

Confirming Data

Triangulation refers to the use of multiple methods for data collection or the use of different evaluation strategies or sources to study the same program (Patton, 1980, p. 329; Merriam 1991). Triangulation is one of the best established methods of increasing the convergent validity of qualitative research (Malkin & Howe, 1993, p. 287). The use of multiple methods for obtaining data assisted the researcher in clarifying the findings (Howe & Keller, 1988). This form of "methods triangulation" was widely utilized in this specific research project.

While the majority of the data collected was through qualitative methods, the use of quantitative measures was also necessary and beneficial. The integration of quantitative and qualitative methods has been favourably viewed by numerous researchers (Flynn, Volpe, Boschen, Lewko, Salhani & Shea, 1993; Patton, 1980). Howe and Keller (1988) stated that there has been considerable debate regarding the compatibility of these two approaches. However, the investigator believed there was a need to utilize aspects of both approaches in this particular study.

Source triangulation refers to comparing multiple data sources (Malkin & Howe, 1993, p. 288). This form of triangulation provided a means of data comparison, and of cross-checking the information consistency obtained at different times and by different methods of data collection

(Patton, 1980, p. 331).

Data Analysis

Data analysis was on-going. As information was obtained through T.R.O.P. sessions, interviews, and field notes, a form of constant comparison was utilized.

The investigator frequently reviewed each piece of information in the participants' files to study their responses. Following the participants' discharge from the hospital, the investigator reviewed their medical charts on several additional occasions. This analysis of secondary data was designed to bring further meaning to the existing information, and to fill in some of the unknowns.

The data analysis included reviewing transcripts of the participants' interviews and noting key points which were mentioned by the participants or observed by the investigator. The investigator looked for repetitious words, phrases, and physical actions to assist him in isolating and identifying symbolic language.

Audiotapes were reviewed to ensure that the transcribed responses were accurate and to analyze the participants' responses for additional details. Characteristics such as enthusiasm, sadness, laughter, reflective moments and other properties of their verbal responses which might add further meaning to the transcriptions were noted.

Information obtained from the interviews and the

completed worksheets was frequently supported when the participants provided similar or consistent responses over a period of time on similar questions. Information was also supported, on occasion, through reports or feedback from other staff involved in the participants'/patients' treatment. The contents of the social worker's notes on the medical chart were reviewed in all cases, to confirm participant responses and to seek additional information when possible. The participant responses to questions regarding their leisure goals were also accounted for in the analysis.

Ethical Review

This study was submitted for approval to both the St. Paul's Hospital Ethics Committee for Human Experimentation and the University of British Columbia Behavioural Sciences Screening Committee. The project was approved by both of these committees in January, 1994 (see Appendix Four).

Due to the apparent reluctance of some patients to provide written consent, who otherwise appeared to verbally agree and endorse T.R.O.P., the investigator discussed potential revisions to the consent process with the St. Paul's Hospital Ethics Committee for Human Experimentation. Based on feedback received from this Committee, no changes were made to the initial consent form or process.

Confirming portions of the data and ensuring its authenticity through verification could have presented certain

ethical issues. For example, confirming some information may have "hurt" the participants emotionally. The investigator had to decide when it was appropriate to seek confirmation from the participant and when it was not. It was not appropriate for the investigator to confirm with one participant the rather negative unsolicited information offered by a close family member after the interview, as this information related to specific relationship problems beyond the scope of this study. Some information could be verified without "harming" the participant through medical record review and discussions with other members of the patients' care team.

CHAPTER FOUR

Results and Discussion

Overview

The results section begins with a brief summary of findings from the two pilot study participants. A profile of each of the eight participants of the main study follows. These profiles include selected demographic data collected from the interviews, medical records, and field notes. Summaries of the leisure interests, challenges and goals worksheets are presented next. The results which are relevant to the specific research questions and interview questions completes this chapter. Any reference to a specific participant is denoted by their code letters, either at the beginning of the sentence or following the statements made by the participant. Six out of the eight participants in the main study completed the entire course of the program. Two participants became ineligible to continue as they both required extended re-hospitalization. However, their incomplete results have been included.

Pilot Study

The results of the pilot study revealed that T.R.O.P. could provide an additional community support for two recently hospitalized older adults who were experiencing a multitude of medical problems. "MA" was a 58 year old woman who was in renal failure and awaiting a kidney transplant.

She has also had 14 operations in less than two years due to a spinal curvature, and she was allergic to a variety of common substances.

The second participant (TU) was a 75 year old man. He was a non-insulin dependent diabetic, with a below-the-knee amputation of his right leg. Also, he had a history of alcoholism and angina.

In response to questions related to what had helped her enjoy her leisure, the first participant stated that "having really good friends" was a facilitating factor (Gallant, 1994, p.30). In response to the same question, the second participant stated, "I guess sometimes the company you're with" (Gallant, 1994, p.45).

Other results of the pilot study indicated that both participants viewed leisure satisfaction and life satisfaction as being interrelated. The first interviewee stated: "They go together. That's largely where I would improve my life by improving the leisure things I do" (Gallant, 1994, p. 31). The other interviewee stated: "I think they go hand in hand...Well I would say if you're not happy with your life in general it's going to be very hard to be happy with individual things (such as leisure)" (Gallant, 1994, p. 46).

Both participants in the pilot study described the following benefits related to T.R.O.P. MA stated "it has focused my interests a bit better". She was referring to

leisure education helping her to clarify her interests and make decisions. TU stated, "I enjoyed your programs...it broke the routine up".

Main Study Participant Profiles

This section provides a profile on each of the eight participants who were involved in the main T.R.O.P. study. Each profile presents information related to the participants' health and physical appearance, early background and social support, work and leisure history, involvement in T.R.O.P., constraints to leisure, and perceptions of leisure.

TG

Health and Physical Appearance

T.G. was a 56 year old woman, admitted to hospital with a fractured left leg due to a fall. There was no other history of medical problems. The majority of her hospital admission and treatment was on the Rehabilitation Unit. She shared her semi-private room with one other woman. T.G. was expected to return to her previous level of functioning.

T.G. was a tall in stature and had a medium build. While in the hospital and during the outreach sessions, she usually appeared casually dressed in sweat pants and a t-shirt.

Early Background and Social Support

T.G., who had been divorced, lived alone in her Kitsilano house, where she had resided for 30 years. She had two sons, who lived in British Columbia with whom she stated that she was very close. She said that she had some difficulty finding friends available during the daytime as many of her friends were still working and she was not. She had numerous visitors and a variety of cards and flowers were displayed on her bedside table.

Work and Leisure History

T.G. was recently retired from her job in administration with a local utility company. She continued to be highly active in a variety of community service organizations and recreation pursuits including: attending

baseball games, swimming, socializing with numerous friends, and holding three volunteer positions. There was no initial indication of a particular religious affiliation on her medical record. However, later on her medical record there was some mention of her receiving some assistance with her meals on a short-term basis from a church.

Involvement in T.R.O.P.

During her participation in the T.R.O.P. sessions she was consistently cheerful, grateful, and interactive. She was a very outgoing, motivated and resourceful individual both in the hospital and community. In the hospital she could often be found reading novels and magazines or conversing with other patients and staff. TG stated that being hospitalized made her aware of how lucky she has been in life so far and how thankful she was to be alive. The investigator felt she demonstrated excellent insight into her medical condition and leisure constraints. In this regard, TG stated:

when I'm repaired to the point where I think
I will be...I will be exactly the same as before
my accident...if not better because I will be a
stronger person. Wilfully stronger.

During T.R.O.P., she was particularly interested in a specialized swimming pool program, of which she was previously unaware. We initiated an application to attend this swimming program. She also inquired about available programs for an isolated disabled friend of hers. T.G.

achieved her additional goals which consisted of going to Gambier Island and resuming driving.

Constraints to Leisure

While her knowledge of non-specialized community facilities and services was impressive, she was sometimes unaware of specific programs offered at these facilities. She also appeared to have a good understanding of her leisure constraints. She indicated, "I just never have enough free time. I think I may change my lifestyle somewhat...slow down a bit". She was also aware of another constraint, as she stated:

My problem right now is that I don't have anybody in my own age group who is financially able...physically able...or without other incumbersomes like husbands to (be able to) travel with me".

There was no indication of any emotional, spiritual, cultural, or financial barriers which affected TG's leisure involvement.

Perception of Leisure

T.G. appeared to value being active, but she also perceived the need to slow down and enjoy her leisure even more. She recognized that leisure could be "so many different things". She appeared to be happy with her lifestyle prior to the accident and she was highly motivated to return to her previous level of leisure involvement.

FB

Health and Physical Appearance

F.B. was a 58 year old retired man, most recently admitted to hospital due to internal bleeding in his left leg. He had been previously admitted, in October of 1992 due to a right stroke. This was followed by another admission in January of 1993 due to a left stroke. He continued to have some difficulty with his speech clarity as a result of these strokes.

F.B. was well-dressed, well-groomed, and he usually wore glasses. He was overweight and slightly leaned towards one side, when he stood.

Early Background and Social Support

F.B. was born in Italy and he continued to maintain close connections to the Italian community in Vancouver, where he had lived for approximately 30 years. He recently moved to an apartment at a seniors complex, where he lived alone.

F.B. was divorced and had two sons with whom he was in contact with on a weekly basis. One son lived in the Vancouver area and the other lived in Manitoba. F.B. lived with one of his sons, in a Burnaby apartment, for approximately one year. F.B. recently moved to an Italian apartment complex, where he lives alone. He regularly attended a stroke social club and several events at the Italian Community Centre. He stated he was happy in the

comfort of the hospital with company around him. He was extremely well liked by the hospital's staff and well-known to them due to his previous admissions. Although he seemed to make friends easily in the hospital, he did not appear to have anyone with whom he regularly spent his leisure time.

F.B.'s one bedroom apartment appeared neat, cozy, bright, and clean. Several religious pictures and statues could be seen in the apartment. There was also a garden outside the living room which seemed well looked after. There were several types of vegetables and flowers growing in this garden area.

Work and Leisure History

F.B. worked as a truck driver for a logging camp and also as a plant foreman. He stated that he had a marked reduction in his participation in leisure pursuits which used to include: opera singing, cooking, writing poetry, painting, walking with his sons, and a variety of other interests.

Involvement in T.R.O.P.

F.B. stated he that he enjoyed being involved in the program because he learned to "become interested in things and in life again". The investigator found it was inspiring to talk with F.B. as he had encountered a number of recent, rather substantial medical setbacks, yet he retained a good sense of humour and spirit. F.B. appeared generally positive regarding his future. He was insightful into his condition

and had realistic outlook towards his future, considering his uncertain prognosis and significant disability. He stated:

"I had it in my mind for the last few years there was still a hope of getting better and married and now...all hope is gone. I would like it to happen, but I don't see it happening".

F.B. stated that the investigator had provided opportunities for socialization, discussing problems, and "bringing ideas to my mind". At times during the interviews, FB became tired and his speech coherence decreased. This seemed to frustrate him during portions of the interviews and education sessions.

F.B.'s goals were to continue going to the stroke club and to improve his physical skills enough to return to walking outdoors. He was able to meet his first goal however his medical problems did not totally resolve prior to the completion of T.R.O.P.

Constraints to Leisure

F.B. required an assistive aid to become mobile, thus he frequently used a scooter or cane to commute short distances around his apartment complex and neighbourhood. He also stated that financial and physical concerns restricted his leisure.

Perception of Leisure

It appeared that F.B. felt leisure played an important role in his life. His interests in opera and music were very important to him. More recently he reflected on leisure and

stated: "certain things are good. They keep me interested in life, and in the world." He seemed to be adjusting emotionally to his declining health status, yet still hoped for physical improvements in the future which would permit him to enjoy walking outdoors once again. This now seemed to be an unlikely goal to achieve, but certainly not an impossible goal.

VB

Health and Physical Appearance

V.B. was a 70 year old woman who was admitted to St. Paul's Hospital Geriatric Assessment and Treatment Unit due to some abdominal pain she was experiencing. This pain was associated with internal bleeding, for which she received treatment and from which she recovered. According to V.B.'s medical record, she was also diagnosed as having major depression and difficulty adjusting to the aging process. This depression became her most significant problem requiring treatment. V.B.'s medical record indicated that she had become increasingly isolated recently.

V.B. frequently seemed concerned about how she looked. She always appeared neat, well-dressed, and she usually wore a small amount of make-up.

Early Background and Social Support

She has been widowed for seven years and since then she has lived alone in her Burnaby apartment. The investigator observed her apartment to be dark and cluttered. She appeared to seclude herself from others, yet in practice she frequently spoke of the need to be around others. V.B. opened her curtains a little when the investigator visited and was anxious during the initial portions of many of the inpatient and outreach sessions.

She has two daughters who live in the Lower Mainland, with whom she has been in contact on a regular basis. VB's

medical record also indicated that "very little has ever satisfied her". Family visitors remarked that VB "is happier and more positive now (in the hospital)" than they have seen her in a long time. During conversations with the investigator, VB frequently spoke about her sister, who lives in Edmonton.

Work and Leisure History

VB stated she had worked since she was in her early teens. Before retiring she worked at a small care home for older adults. VB was highly independent while in the hospital. She often spent a part of her day off the hospital unit, or talking with one of the three women, with whom she shared her hospital room.

She would frequently go outside the hospital for a walk and she was involved in a variety of therapeutic recreation programs while in the hospital. These included: crafts, gardening, observing live music entertainment and attending discussion groups. V.B. also enjoyed reading and listening to music while in her hospital bed. Her recent leisure interests and activities consisted of going outdoors for walks, occasionally attending her local community centre to have a coffee with a few women friends, and planning a trip to Edmonton. Upon the completion of this study, V.B. travelled to Edmonton to accompany her sister to eastern Canada on a one month driving vacation.

Involvement in T.R.O.P.

V.B. was an energetic, stimulus seeking woman who was also frequently anxious and lacking in self-confidence during many of the T.R.O.P. sessions. She was frequently busy doing crossword puzzles, listening to music, and attending social recreation programs while she was hospitalized. V.B. described herself as restless and was not used to being alone. She had no physical limitations and she seemed to benefit primarily from the social contact through the inpatient T.R.O.P. sessions. Home visits confirmed the investigator's beliefs regarding V.B.'s anxiousness and low self-confidence. Her leisure goals included to find out more about volunteer opportunities with seniors, to start travelling, and to find out what programs and facilities were available. Prior to their completion of T.R.O.P. she met all three goals with some degree of success. She travelled to Edmonton to accompany her sister on a one month drive towards eastern Canada and also obtained information on volunteering and community recreation programs. She was uncertain of when she would be physically and mentally ready to pursue any volunteer work.

Constraints to Leisure

During the interviews there were no indications of any cultural, financial, or spiritual concerns which affected her. However, she did indicate that money was a constraint when responding to the leisure worksheets yet her choice of

goals and her list of steps to overcoming barriers did not indicate that money was a barrier. V.B. focused on her lack of companionship towards the end of this study. At her home, she complained that she lacked the social stimulation which she was exposed to in the hospital.

Perception of Leisure

V.B. indicated that leisure was important to her. She appeared to have a good understanding of the role it plays in her life. Her diverse and active lifestyle while she was hospitalized helped her to cope with some of her leisure needs. V.B. seemed to function very well within the structure of the hospital and hospital recreation programs. She seemed much more anxious, somewhat overwhelmed, and disorganized once she was discharged back to her apartment. She emphasized her enjoyment in having other people around all the time and seemed to prefer social forms of leisure, especially in the hospital. She stated,

I'm not used to being alone. I've been away (in hospital) for quite a while you know...I think I'd be better off if I just stayed there (in hospital) having things to do and people around me.

JN

Health and Physical Appearance

J.N. was a 71 year old male who was admitted to St. Paul's for a right below-the-knee amputation. He was on the Rehabilitation Unit, in a room with three other men. Previously J.N. had a left below-the-knee amputation. He also had a history of angina, and according to his wife, he has been "sick" for 12 years.

J.N. dressed in worn, slightly torn clothes. He was small in stature and had a roughly shaven face.

Early Background and Social Support

J.N. was born in Finland but grew up in a Montreal orphanage and has lived in Vancouver for 25 years. He lived with his wife in a West End apartment building, which they were responsible for managing. J.N. was divorced from this same wife for 22 years, but remarried her five years ago. They have five children, all living in Winnipeg, Manitoba. There appeared to be a high level of care-giver stress. This was documented in the medical chart and observed by the investigator. The apartment was cluttered, dusty, and had a stale smoky smell. There was a small, old dog present and a pet bird lived in a cage in the living room. During the first outreach session their investigator asked if the television volume could be turned down, as it was too loud to converse.

Work and Leisure History

Earlier in his life he worked as a labourer in the copper mines. His previous leisure interests included: repairing electronic equipment, hunting, fishing, relaxing, going to the horse races, attending a neighbourhood community centre with his wife, playing chess and watching television. He has not participated in most of these for a long period of time.

Involvement in T.R.O.P.

J.N. was reluctant to initiate conversation with the investigator or other patients in the hospital. Although he stated he did not like to socialize, he stated that he did enjoy the visits by the investigator and the therapeutic recreation program. He appeared to overstate his desire to become involved in specific leisure interests, citing he would like to start going out more with his scooter, begin water-colour painting, resume his electronics hobby, and find a chess partner. He achieved one of these leisure goals by finding a chess companion. This was achieved through the assistance of the investigator, who suggested that JN contact two community centres. The investigator contacted these centres as JN appeared reluctant to take the initiative to make the phone calls. Another goal was to obtain information on West End programs. The investigator believed J.N. was sincere in his expression of this interest, yet he was unmotivated to follow-through with any

specific action related to pursuing other interests. He seemed to lack problem-solving abilities related to reaching his goals and he appeared to expect others (such as health providers and his wife) to solve problems for him. In retrospect, the investigator believed that J.N. overstated his abilities and presented goals which were beyond his present abilities and perhaps interests. He may have provided responses which he perceived would be pleasing to the investigator.

Constraints to Leisure

J.N. seemed to have poor insight into his own daily needs. He had refused home-making services, which were recommended by both his social worker and his wife, thus placing increased responsibilities and demands upon his wife. J.N. used a scooter to move about the West End area. J.N. had limited financial resources and there was no indication that he had any friends.

Perception of Leisure

It was difficult to ascertain how J.N. perceived leisure as he seemed to have some difficulty articulating his responses. His past and more current leisure behaviours suggested he did enjoy doing several activities, but his level of participation appeared to be declining. JN did not, however, generate any definitive responses which might reveal his leisure perceptions.

JR

Health and Physical Appearance

J.R. was a 71 year old woman, admitted to St. Paul's Hospital as the result of a fall and a fractured left hip. Her previous medical history included a failed left total hip replacement and a right total hip replacement, a congenital dislocated left hip, narcolepsy since childhood, and severe arthritis of the spine with scoliosis.

She was a neat, petite, frail woman. During the investigator's first visit with J.R. she was in bed with the curtains fully drawn around her bed. There were a number of novels and crossword puzzle books at her bedside, along with several "get well" cards and an arrangement of flowers.

Early Background and Social Support

J.R. was born in Moosejaw, Saskatchewan. She was never married and had lived alone in a seniors apartment complex in the Kitsilano area of Vancouver for 10 years. Her small one bedroom apartment was cozy, decorated with a number of hand-made rugs, macrame, and paintings. There were also many books and puzzles in the living room area where the outreach sessions took place. J.R. stated that she had one sister who lived in Seattle, Washington and a sister-in-law who lived in Vancouver, British Columbia.

Work and Leisure History

J.R. continued to volunteer as the secretary-treasurer for her senior's complex. There was no history of any paid

employment during her lifetime. Her leisure interests included: bingo, knitting, volunteering, attending church, reading, and going on short trips with her brother, who is now deceased. She stated on several occasions, that she now has too much time on her hands.

Participation in T.R.O.P.

JR appeared very reserved in her responses and interactions with the investigator and other patients. She responded only briefly to each question during the interview, and rarely made eye contact with the investigator. She was somewhat reluctant to accept information. This lead to some degree of disappointment for the investigator who was interested in providing J.R. with some community recreation information but found it difficult to "reach" her. J.R. indicated three goals which were: to obtain a means of transportation, get information on programs, and initiate a swimming program application. She did successfully achieve these goals, however she did not appear interested in pursuing swimming once her application was approved.

Constraints to Leisure

J.R. required her wheeled walker to move around her apartment, and she stated it was increasingly difficult for her to get around. She required a variety of assistive reaching devices for completing daily tasks such as dressing. Although J.R. stated she was satisfied with her

life, her responses sometimes suggested that she has had a difficult life with very few close friends. She also stated that most of the friends she did have were no longer alive and that she now had too much time on her hands. There did not appear to be any financial concerns.

Perception of Leisure

J.R. indicated she often gets bored but "usually finds something to do". During the same interview she stated she had "too much leisure and not enough to do in it". Thus, there was some uncertainty towards her ability to utilize her "leisure time". Certainly, she appeared to equate leisure with time and she also saw leisure as something which could help people forget their troubles.

PP

Health and Physical Appearance

P.P. was a 73 year old female, admitted to St. Paul's Hospital, Geriatric Assessment and Treatment Unit, due to a fall and depression. Her other medical problems included: a dependency upon sleeping pills, osteoarthritis of her right hip and right knee, a left wrist injury, degenerative disk disease, breathlessness and coughing when anxious, and a previous history of alcohol abuse. P.P. stated that she was not satisfied with her life, and that she was happy to be hospitalized.

She was small in stature, neatly dressed, and had a strong Scottish accent. She walked slowly and laboriously and she frequently coughed when she was conversing.

Early Background and Social Support

P.P. was born in Glasgow, Scotland and has lived in Vancouver for 37 years. She was divorced and lived alone in a West End apartment. She did not have any children but she had two sisters, one living in Vancouver and the other in Edmonton.

Her apartment was particularly bright in appearance. It was also tidy, clean, well organized and spacious.

Work and Leisure History

She stated she has not seen much of the city due to her busy work schedule prior to her retirement as a security officer. She also stated that she had a very difficult time

coping with her retirement. Previously, she regularly socialized, cooked, and attended shows with two close friends who have since moved away. She used to ballroom dance and volunteer with a non-profit organization (People with AIDS). She also enjoyed reading, swimming, and walking. She continued to attend a seniors' awareness group in her neighbourhood, on a weekly basis. She watched television, enjoyed talking "letting them (people) know someone cares".

Involvement in T.R.O.P.

P.P. was extremely receptive to conversation with the investigator and she revealed personal information about herself. She lacked self-confidence and frequently worried about not being able to contribute to T.R.O.P. She also seemed very concerned over phone calls she received early in the morning but did not answer. PP indicated she was afraid of being hurt again, as she was emotionally and physically abused as a child. She was also frustrated as she could not foresee any future improvements to her health. The investigator believed that this was a reasonable self-prognosis due to the multitude of medical conditions she experienced. She was anxious at times, but she had made some progress towards her leisure goals. One of these goals was to be begin writing to her two friends, who had moved away. She accomplished this by purchasing an electric typewriter at the suggestion of the investigator. She was quite proud of her accomplishment. Her other goals were to find out what

programs were available and to pursue volunteer work again. She did review information on available recreation programs and volunteer opportunities, but felt her health was not suitable to currently pursue these interests any further. The investigator felt this was a realistic outlook.

In response to the investigator's question "What is the outcome of your hospitalization?", PP responded: "I think an awful lot better than I had been before going into the hospital...I feel like a different person getting back to what I used to be." She referred to her success in no longer being addicted to prescription drugs.

Constraints to Leisure

P.P.'s major constraints seemed to be her declining physical ability and her social isolation. She did not indicate any financial constraints to leisure which was evident in her recent rather spontaneous purchase of the electric typewriter.

Perception of Leisure

P.P. appeared to perceive leisure to be somewhat negative. She obviously enjoyed many recreational activities a number of years ago. She stated "I used to love ballroom dancing...go to the Queen Elizabeth Theatre for different shows...I can't walk the way I used to...I used to read a lot", but she felt most of her enjoyment in life came from being at work. "I was at my happiest when I was working."

RC

There was limited data collected on R.C. because he became was re-admitted to hospital for an extended amount of time and could not complete the program. He did attend two inpatient education sessions.

Health and Physical Appearance

R.C. was a 75 year old widowed male. He was admitted to hospital for hip replacement surgery and later re-admitted due to a hip dislocation which occurred after he fell in his bedroom. During his initial hospital stay he was in a four person room on the Rehabilitation Unit. He had a 15 year history of back pain resulting in decreased mobility and dependency on an electric scooter.

R.C. was a tall and overweight gentleman. He frequently smiled and his appearance generated a sense of warmth. He wore glasses and usually could be found reading in the dining room on the hospital unit or in his bed.

Due to a re-admission to St. Paul's Hospital as the result of a fall, the investigator withdrew him from the study prior to conducting any outreach sessions. R.C. continued to be hospitalized for at least another three months.

Early Background and Social Support

He had lived at his present Richmond apartment for six years. He previously resided in Kelowna. With the exception of one niece, who lived in the Vancouver area, there was no

other mention or documentation of relatives. R.C. indicated he had several close friends in the Richmond area. The wall behind the head of his bed had several cards from friends and there were numerous flower arrangements at his bedside.

Work and Leisure History

R.C. did not mention what he worked at prior to retirement. His previously active lifestyle included sailing, swimming, fishing, hiking, hunting and reading. He used to attend church on a regular basis but has not been there recently. He stated he was uncertain as to what recreation programs were available for him, although he was aware of many of the nearby facilities. R.C. appeared to have accepted his level of disability, and he was seeking some direction for the future leisure-related resources and programs, prior to being discharged from the study.

MP

There was also limited data collected on this participant due to re-admission to the hospital.

Health and Physical Appearance

M.P. was a 77 year old widowed female, admitted to hospital due to a fracture of her right femur. She was admitted to the intensive care unit in serious condition and later transferred to the Rehabilitation Unit into a semi-private room. Her other medical history included cancer of the cervix, arthritis in her hands, and a left below the knee amputation.

M.P. was short in stature and overweight. She moved about the hospital unit slowly in her wheelchair and her face presented the look of someone who was always in deep thought.

Shortly after her discharge from St. Paul's Hospital, she developed a sore on her right foot and was admitted to Mt. St. Joseph's Hospital. She was later admitted to a long-term care facility and became ineligible to continue participating in this study.

Early Background and Social Support

M.P. was a widow who lived alone in her East Vancouver house. She had two children and a sister. None of these relatives lived nearby and she did not appear to be in close contact with them. The investigator did observe a number of "get well" cards and flowers at her bedside in the hospital.

These were from her children, grandchildren, and a next door neighbour.

Participation in T.R.O.P.

She participated in one outreach session prior to her re-admission to hospital. During this visit, which took place in her kitchen, the investigator noticed her obvious lack of mobility within her home. She found it difficult to move around the kitchen and from one room to the next. She stated she now spent most of her time in the kitchen reading her magazines because she is afraid of falling and does not have the strength to move about too much. She appeared to enjoy the social nature of the first home visit. She was unable to be contacted to schedule the second visit due to her re-admission to hospital.

Work and Leisure History

She participated in several recreation programs while at St. Paul's Hospital. These included: bingo, pet visits, and attending live entertainment programs. Previously she enjoyed watching sports, reading, shopping, sewing, and used to go swimming. She also enjoyed watching her husband gardening and the company of her 12 year old dog which had died two years earlier.

Constraints to Leisure

M.P. was using a walker to mobilize inside her house, after being discharged from St. Paul's. She used a manual wheelchair when she left her house. M.P. had no apparent

financial concerns. M.P. had little knowledge of accessible facilities such as bingo halls or sports arenas. This was to be one focus area of T.R.O.P.

Research Questions One, Two, and Three

The key phrases from participants' responses which were related to research questions one through three are summarized and presented in Tables 1 and 2. These specific research questions were:

1. How did older adults describe the benefits of leisure?
2. How did older adults feel that they benefitted/did not benefit from T.R.O.P.?
3. What were the self-perceived facilitating factors which contributed towards enjoyment of leisure?

Benefits of Leisure

The most common response was that leisure provided them with a time to think or to collect their thoughts. T.R.O.P. gave participants additional opportunities to reflect upon their lives and their leisure. Another benefit was related to the element of "freedom". These benefits, as described by the participants, are consistent with the elements of enjoyment, relaxation and freedom of choice which are reported in the literature (Lee et al., 1994) and in the definition of leisure selected by the researcher (Datillo &

Murphy, 1991).

TABLE 1: Key phrases from participants' responses related to research questions one, two, and three

<u>Participants</u>			
Question Topic	TG	FB	VB
Benefits of Leisure	-provides time to think -allows you freedom to think clearly	-enjoyment -made me realize it might be better to be alive -keeps me interested in life and the world	-you can relax and collect your thoughts
Benefits of T.R.O.P.	-insight into what is available -specific resources for the disabled	-enjoyed being involved -became interested in certain things -got me thinking	-enjoyed the activities
Facilitating Factors	-aunt's help -being at home -being able to drive -thinking openly -enjoying people's company -not living a hermit's life	-being with my children -doing physical activities	-being around people -helping others

TABLE 2: Key phrases from participants' total responses related to research questions one, two, and three (continued)

Question Topic	Participants		
	JN	JR	PP
Benefits of Leisure	-time to think -gives you a chance to do what you want	-forget your troubles -gives you a social aspect	-sense of satisfaction
Benefits of T.R.O.P.	-found a chess partner -learned from the worksheets -made me interested in certain things	-made me more aware	-getting and having information explained -brightened the horizon -nice having a visitor
Facilitating Factors	-being able to get around -being able to watch sports -arguing with "the old lady"	-being with my relatives and friends	-working -being physically active (ballroom dancing)

PP's response to this question seemed inconsistent with previous discussions she had with the investigator. She referred to obtaining a "sense of satisfaction" as a benefit of leisure. During T.R.O.P. inpatient and outreach visits she mentioned that she enjoyed herself most when she was at work. Now due to her health, she felt frustrated with her recent lifestyle. This "inconsistency" could be an example of the increased trust the participant placed in the

s of involvement in T.R.O.P.

END OF Roll # 1

1 and 2, all the participants
c benefit of the T.R.O.P. program
ated multiple benefits. These
rom brief comments to more

benefits of T.R.O.P., as described by
participants included: "having a visitor" or increased
social contact, gaining insight into community recreation
opportunities, having an individual to direct questions
towards and answer questions, leading to an interest in
pursuing certain things. P.P. was specific in her
description of the benefits of T.R.O.P.:

It's great getting information from you. You've
explained a lot of things to me that I never knew
about...It's brightened the horizon. Because I'm
pretty well on my own. I lead a life like a hermit
really. It's kind of nice having a visitor.

These responses suggests that T.R.O.P. was able to
provide for a variety of participants' self-perceived needs
and that outreach leisure education can assist older adults
living in the community. The literature on other adult
populations has reached a similar conclusion (Clark &
Curran, 1994; Lyons et al., 1993).

The investigator did have some initial concerns

regarding the specific interview question "Has this program benefitted you in any way?" There was some fear, that the participants would have wanted to provide a pleasing response. It is difficult to ascertain whether such a "halo" effect occurred or not. The investigator could have assumed the participants' responses were more authentic if some had said "no" or "not much".

Facilitating Factors

What did participants perceive as contributing towards their leisure enjoyment? There was a strong emphasis on the importance of social support as a facilitating factor. Five of the six participants indicated their children, spouse, or friends were sources for social contact and support and contributed to their leisure enjoyment. Only one participant (PP) indicated having no relatives or friends nearby, although she did describe enjoying the company of her two friends who recently moved away. This finding contrasts the research of Ross (1991b.) who stated that there has been a decline in the families' ability to support their "elderly" members with varying health statuses due to geographic distance and the decline in multi-generational households. It would seem that the majority of the participants still "felt" their relatives were social supports, although these relatives did not usually live with them or within the same community. The two youngest participants FB and TG were very

close emotionally to their children. They both indicated they were involved in social groups within their community. All six of the participants expressed a desire for increased social contact. This need for increased social relations is consistent with the findings of other researchers (Freidland & McColl, 1992; Rubinstein, Lubben & Mintzer, 1994) and suggests that their family support was inadequate.

The hospital experience was perceived to be positive by a number of participants due in part, to the increased opportunities for socializing. For example VB stated she was not happy being alone all the time at her home, "I was very lonely, I cried a lot." Close relatives also described her as "socially isolated" prior to her hospitalization. However, these same relatives described her as "more positive, happier, in a better mood" when she was hospitalized. VB also became highly anxious as she approached her discharge date, stating she was not certain how she would manage when she returned to her home alone. She also said that she would miss everyone she met in the hospital.

It seems appropriate to state that the environment within St. Paul's Hospital provided temporary opportunities for patients to form short-term "friendships". In the two specific hospital units, where all the participants were patients, they were given a variety of structured and non-structured opportunities to engage in some form of

socialization. Prior to their admission to St. Paul's Hospital, many of the participants lacked such a variety of opportunities. After discharge from the hospital other participants mentioned they were "happy in the comfort of the hospital with company" (FB) and that they felt the loss of social opportunities. The effects of short-term increased social outlets, such as those provided in the hospital environment, needs further investigation.

The researcher also had some influence over the one participant's social isolation in the community and may have been a "temporary" facilitator towards enjoyment. For example, P.P. stated:

Let me put it this way Paul, I never get any visitors. I mean I don't see anybody else. It's kind of nice to have someone to come into your house and you can sit and talk to them...

The investigator found it surprising, that the only participant (JN) who lived with his spouse, also indicated a need for external socialization. This was also confirmed by his wife who requested the same. In this specific case it would appear at times that "social relations" were not necessarily "beneficial or supportive". Indeed, Coleman (1993) has stated they could be detrimental in some cases. The case of JN may well represent such a relationship.

Research Question 4: Leisure Interests

A summary of the participants interests is presented in Table 3. These interests were grouped into seven categories

comprised of six leisure experience domains and one additional category, labelled as "other" (Ballantyne, 1987; BC Rehabilitation Society, 1989). The domains were helpful in categorizing the various areas of interest. They were designed to determine the specific interests of the participants. The "other" category was formed from responses the participants provided in addition to the forced-choice items on the leisure interest worksheet.

The leisure interests table consisted of responses the participants provided primarily through their completion of the leisure interest worksheet, and any other responses which indicated additional interests throughout the duration of the study. VB identified the most (22) leisure interests. She was the only participant to indicate all the choices in both the "social" and "solitary" categories. This suggests she enjoys a variety of social interests but she also appreciates the opportunity "to relax and collect her thoughts" through these more solitary interests.

The lowest frequency of total expressed interests was indicated by JN. He selected only seven interests and did not indicate any in the social domain. This lack of social interests and the investigator's knowledge of his living situation, suggests that JN probably relies heavily on his wife for social support in addition to other assistance he requires from her for his daily care. This may account for some of the medical record entries which suggested JN was

unwilling to accept help from a home-making service and relied on his wife for most financial and care-giving matters.

The investigator was surprised to observe PP did not indicate any interests in the social and creative domains. This finding was inconsistent with data obtained during the two interviews and during outreach visits. During several outreach sessions PP stated she liked to write letters, cook for others, and that she belonged to a local seniors' centre. These interests were listed as choices on the worksheet, however PP did not select them.

Ballantyne (1987) stated that it was important for individuals to maintain a sense of balance within their leisure. He suggests they should participate in a variety of interests from each of the domains. Viewing the results of the Leisure Interests Worksheets, revealed that there were several participants in addition to PP, who did not indicate interests in at least one of the domains. FB did not indicate any intellectual interests. JN did not indicate any social interests although he wanted to find a chess partner and he recently had been to a community centre with his wife. JR did not indicate any physical or intellectual interests, although she later expressed a curiosity about swimming. The discrepancies in PP's, JN's, and JR's responses could be indicative of their increased understanding of what was being asked of them as

the program progressed. The Leisure Interests worksheet was administered in the very early stages of the program, while the participants were inpatients. As the program progressed, the participants may have become more familiar with leisure issues. There may have been an increased understanding and awareness on the participants' part. This suggests that utilizing a variety of data collection methods at the inpatient and outreach components provided more thorough and accurate results.

Table 3: Leisure Interests of Participants by Domain

Participants									
Domains/Leisure Interests	TG	FB	VB	JN	JR	PP	RC	MP	=
Social									
writing letters	x		x					x	3
social telephone calls	x		x					x	3
visiting friends/family	x	x	x		x				4
joining a group/club	x	x	x				x		4
caring for pet/animal		x	x					x	3
TOTAL	4	3	5	0	1	0	1	3	17
Physical									
exercise class/swimming	x	x	x						3
going for walks	x	x	x			x			4
gardening		x	x						2
practising relaxation				x		x			2
TOTAL	2	3	3	1	0	2	0	0	11
Solitary									
reading	x		x		x	x	x		5
listening to music	x		x		x	x			4
humming or whistling			x						1
being outdoors	x	x	x	x		x	x		6
daydreaming			x			x			2
TOTAL	3	1	5	1	2	4	2	0	18
Creative									
mechanics				x					1
crafts	x				x			x	3
painting/doodling		x	x		x				3
woodworking		x					x		2
cooking or eating		x	x					x	3
composing		x	x		x				3
planning parties	x								1
TOTAL	2	4	3	1	3	0	1	2	16
Intellectual									
visiting library/gallery	x								1
current events			x	x		x	x		4
discussions				x					1
hobbies/collecting	x		x					x	3
volunteering	x		x						2
TOTAL	3	0	3	2	0	1	1	1	11
Spectator									
watching TV or movies	x		x	x	x	x	x	x	7
bird watching			x					x	2
people watching	x				x	x	x		4
concerts/theatre	x	x	x		x	x			5
attending live sports	x		x			x	x	x	5
TOTAL	4	1	3	1	3	4	3	3	22
Others									
Chess				x					1
Entering contests						x			1
Crosswords/puzzles						x			1
Singing		x							1
Travelling						x			1
Bingo					x				1
Knitting					x				1
Baking						x			1
Skating	x								1
Bowling	x								1
TOTAL	2	1	0	1	2	4	0	0	10
GRAND TOTAL	20	13	22	7	11	15	8	9	

Research Question 5: Leisure Constraints

The following table (Table 4) presents the participants responses to the Leisure Challenges worksheet. The topic of "leisure constraints" has previously appeared in the literature under the headings of leisure barriers and leisure challenges (Ballantyne, 1987; Witt & Ellis, 1989). Only the participants self-perceived constraints appear in this table. Additional constraints to leisure, as perceived by the investigator or other staff familiar with the participants are presented in the participants' profiles.

The number of self-perceived constraints varied from a low of two constraints (TG, RC) to a high of 10 constraints (VB). The two participants who were diagnosed with depression (PP, VB) indicated the greatest number of perceived constraints. This finding provides support for the role which perceived freedom plays in self-determination. As Coleman (1993, p. 353) stated, individuals who perceive themselves to be constrained "will fail to exercise self-determination". Furthermore, persons who have a sense of self-determination and a related disposition towards an internal locus of control can "buffer" their health against life stress. In the cases of PP and VB depression may have been at least partially related to their perception of a lack of self-determination or a lack of perceived control.

Six out of the eight participants indicated five or less constraints. These frequencies may not reflect the potential impact these constraints had on the participants' leisure experiences.

The most frequently indicated perceived constraints affected four out of the eight participants. These constraints were: not having the physical skills, not knowing what programs or facilities were available, procrastinating or finding it difficult to start participating, and having no one to go with. The lack of knowledge constraint has been frequently reported in the literature (O'Neill & Reid, 1991; Searle & Mahon, 1993). Two participants mentioned they "did not have enough money to do what they wanted". The analysis conducted by Forbes, Hayward and Agwani (1991) found "low income" to be of greater impact on self-reported impairments of older adults. This did not appear to be the case in the majority of participants in this study. Many of their goals did not require additional finances and several of the participants who did have more "costly" goals appeared to have the available finances to pursue these goals (TG, PP).

The following three possible choices of constraints were not selected by any of the participants: "too many family obligations", "work is the main priority now", and "I don't have enough time". These could all be categorized as constraints related to other obligations or "lack of time" and suggest that participants were not experiencing a shortage of time due to other commitments. This finding was somewhat predictable given that all of the participants were retired and appeared to have few obligations related to their time.

The importance of discussing constraints to leisure

participation and aiming towards overcoming these constraints should be emphasized. However, there is a need to be conservative in goal planning for the health declining or unstable individual. Providing a form of continued follow-up, such as T.R.O.P., assisted participants in their clarification of leisure constraints and may lead to increase future successes related to their leisure experiences. "Staying current and addressing problems or barriers to participation" have improved success rates of other individuals requiring community supports due to disability (Clark and Curran, 1994, p. 31).

Table 4: Self-perceived Leisure Constraints
Participants

Constraints	T G	F B	V B	J N	J R	P P	R C	M P	=
I don't feel like doing anything						x		x	2
I rely on others for transport		x	x		x				3
I overcommit myself	x		x			x			3
I don't have enough money		x	x						2
I don't have the physical skills		x		x	x	x			4
I don't have the artistic skills			x	x		x			3
I am embarrassed about learning something new						x			1
I don't know what programs or facilities are available			x		x	x	x		4
I procrastinate			x	x	x			x	4
social situations are awkward			x			x	x		3
I have no one to go with	x		x		x	x			4
making decisions is difficult			x			x		x	3
others...									
- no bathing suit			x						1
- no chess partner				x					1
- I don't think leisure is important								x	1
Total Indicated Challenges:	2	3	10	4	5	9	2	4	

Research Question 6: Leisure and Life Satisfaction

This research question was asked in the concluding interview to establish the participants' perceptions of the relationship between leisure satisfaction and life satisfaction. It became apparent that several participants

had difficulty understanding the interview questions. This was not apparent in the pilot study as both of the pilot participants answered this question without hesitation.

Both PP and FB required this interview question to be reworded before they responded. The reworded questions included specific examples of the participants' leisure interests and satisfying experiences related to leisure. The participants' responses did not provide a definitive answer to the interview questions, but they suggested positive relationships between leisure satisfaction and life satisfaction. For example, FB stated:

I really don't think so. There probably, probably is...because the more I get involved with something ...I enjoy it better...I want to do it.

He previously stated:

going to the stroke club was the only thing that I enjoyed since coming out of the hospital...It made me realize that doing those things (attending club events) might (make it)... better to be alive.

For FB the stroke club provided social contacts with his peers who had also experienced a stroke. Additional statements from these two participants (PP, FB) were obtained from other interview questions and the investigator's field notes. These statements suggested that these two participants perceived a positive relationship between leisure satisfaction and life satisfaction although they had difficulty formulating their responses.

VB stated she was "very dissatisfied" with her life right now and attributes this to "not being able to go out and walk around the way I used to or do the kinds of things

I'm used to". This last statement suggests that VB is not satisfied with her life at least partially due to her dissatisfaction with her leisure.

The four additional participants perceived a definite positive relationship between leisure satisfaction and life satisfaction. A similar positive relationship has also been substantiated by the literature (Russell, 1987; Brown, Frankel & Fennell, 1991). Another participant stated her perception of the relationship between leisure satisfaction and life satisfaction, "They're almost one in the same. Because I don't have to worry about work or I can play basically 24 hours a day. That's my life and also my leisure" (TG).

The majority of the participants indicated their enjoyment of specific leisure interests from their past and their frustration due to not being capable of continuing these interests due to their change in health. However, Sainsbury and Bruce (1994, p. 35) have shown that seniors life satisfaction could still be improved in spite of poor or failing health.

Additional Factors

In addition to the results and discussions related to the specific research questions, additional results emerged from the data. This section reports and discusses these additional results.

Meaning of Leisure

The participants each viewed leisure slightly differently. Several participants discussed leisure as though it consisted primarily of activities. Yet others dwelled more on leisure as a "time to think" or to "relax and collect your thoughts". This conceptualization of leisure was somewhat consistent with the investigator's choice of a leisure definition. Leisure was defined as "a state of mind involving the perception of freedom to choose to participate in meaningful, enjoyable, or satisfying experiences" (Dattilo & Murphy, 1991, p. 3). Perhaps an even more flexible definition of leisure is needed. Lee et al. (1994) suggest that leisure is composed of many characteristics. There is no one concept which clearly defines leisure and one's interpretation of leisure experiences changes over time (Lee et al., 1994, p. 200).

One participant (PP) frequently mentioned her difficulty adjusting to retirement. Specifically she described problems relating to feeling non-productive because she was inactive and no longer working. These may be indicative of strong beliefs in the "work ethic" and her difficulty in accepting the aging process. The research findings of Lee et al. (1994) report an apparent association of the work ethic and feelings of guilt. Individuals who have mentioned the enjoyable times in their lives, as being their time at work, may have difficulty in enjoying themselves away from their work or tasks they perceive to be work.

Leisure Goals

The initial and final interviews frequently revealed, across all participants, their need to be mobile. "Being able to walk again or walk more" was a frequently cited goal of many participants and is consistent with the literature on older adults (O'Neill & Reid, 1991; Patterson & Carpenter, 1994). The investigator believed this goal was frequently realistic, given the participants' prognoses, and that they were able to describe how they would accomplish this. Also, being able to either better use the existing transit services such as the buses and accessible taxis or in one participant's case, their own vehicle were seen as common goals to be achieved.

The primarily individualized format of T.R.O.P. directed the investigator and the participant towards reaching mutually established goals, and when necessary revising these goals. Frequently the goals which participants indicated were related to overcoming leisure constraints. For example three participants indicated goals related to finding out what programs are available (VB, JR, PP) and these same participants identified "not knowing what program or facilities are available" as a constraint.

The success in attaining these goals or overcoming these constraints varied among participants, as was expected. Several of the participants in this study had degenerative conditions. For participants with degenerative conditions success in achieving leisure goals should be related to the achievement of slower rates of decline in

health (Flynn et al., 1993, p.268). Individuals differ in their adjustment process to illness and disability (Lyons et al., 1993). The different coping styles of the participants may have influenced their choice of goals and their success in attaining these goals.

Although the multidisciplinary approach used in the case study setting was not a focus of this study, evidence of the effectiveness of this approach emerged. The team approach enabled a variety of medical and patient concerns to be examined at the same time. While the team approach may only be used in specific areas of health care, it has particular value when working with the often complicated health issues of older adults. A "team" approach can also increase the coordination of efforts by ensuring that many of those involved in the patients' care are working together towards desired goals. In many of the participants cases these goals are related to adjustments in leisure behaviour. Other researchers have also found similar successes utilizing the multidisciplinary approach (McLennan, 1992).

Leisure Adjustment

Lyons et al. (1993, p. 254) defined leisure adjustment as "the modification of enjoyable, valued activities in responses to individual, social and/or economical changes". The participants' desire to change their behaviour varied from little or no expressed desire (JR, TG) to a high desire to change their leisure behaviour (PP, VB). The two male

participants (FB, JN) expressed only a slight desire to change their behaviour. JN expressed several leisure pursuits in which he may eventually become involved, however he was not interested in changing his behaviour at the present. JN stated when his leg gets better and he feels better, he will then consider these additional interests.

This particular factor (leisure adaptation) seemed to be the cause of great frustration for two of the participants (FB, PP). Both FB and PP discussed an interest in increasing their participation levels and wanting to return to a previous leisure pursuit. F.B. wanted to return to opera singing and painting. He had become involved in a stroke club after his second stroke which occurred close to two years ago. P.P. wanted to return to volunteering and going out to some shows. Both participants perceived they were physically unable to pursue these interests due to their physical limitations. F.B. had difficulty with speech and mobility, due to his stroke and P.P.'s persistent cough, decreased energy and decreased mobility made it difficult for her to pursue her interests. The investigator believed that FB's and PP's perceptions were realistic.

Health Status

It was apparent from the data, that the majority of the participants in this study were at a significantly high level of disability and had complicated medical problems. The participant profiles revealed diverse and multiple medical problems among the participants. The only individual

who had less complicated problems was TG. She had sustained a fractured leg due to a fall and had no other significant medical history or medical issues.

Two participants in particular, PP and FB had complex medical conditions. According to these participants' medical records and discussions the investigator had with other staff involved in these participants' care, FB had a medical prognosis which was somewhat uncertain and PP was likely to continue declining in her health. JN's health appeared to be slowly declining over the past 12 years. He required some assistance in managing the stump of his recently amputated leg and seemed dependant on his wife for assistance with dressing and with meal preparation.

Investigator-Participant Relationship

The relationship between the investigator and the participants changed as the study evolved. Many of the participants were initially reluctant to provide detailed responses to questions being asked by the investigator who was at least 25 years younger and relatively unfamiliar to them. The participants' experienced varying degrees of comfort with the investigator over the total course of T.R.O.P. For example VB, PP, and FB appeared to be sincere in their responses and trust in the investigator towards the completion of the initial outreach session. TG was consistently sincere and trusting from the first inpatient session to the completion of the program. She (TG) was also the youngest participant with the lowest number of health

problems. JN and JR were generally unwilling to fully let the investigator enter their world. Both JN and JR consistently provided brief, rather vague responses and did not appear genuinely interested in the T.R.O.P. process. The distant age gap between the researcher and the participants may have been a constraining factor in the evolution of the investigator-therapist relationship with JN and JR. This did not appear to be an issue with the other participants. The majority of the participants were prepared to offer more information to the investigator as they became more familiar with him. This may have been at least partially indicative of their increased trust in the investigator and their increased need for social opportunities as their time away from the hospital increased.

The investigator also became more confident and trusting of the majority of the participant responses (PP, VB, FB, TG) as time elapsed. He felt the outreach sessions provided him with a certain sense of privilege to be permitted to enter the personal living space of the participants.

CHAPTER FIVE

Conclusions and Recommendations

Conclusions

Leisure research on older adults has focused on activity participation and constraints to participation. Over a decade ago it was realized that the focus needed to be redirected towards the individual and not the activity (Tinsley & Tinsley, 1982). The subjective experience of leisure and the personal significance obtained through leisure matters more than the activities per se. For example, what appeared to matter the most to participants in this study was not a specific activity or number of activities. It was their need for social contact and support focused around friends and family which was most important.

Fulfilling social support needs is more difficult to achieve for some older adults who are now living alone and away from their friends or children. Significant life events such as the death of a spouse, retirement, and illness or declining health often present older adults with successive challenges to their leisure satisfaction and life satisfaction. As some participants have suggested (TG, VB, PP, and MP) the impact of such events are likely to be reduced, when there are friends and family available and capable of providing social support.

It appears that leisure research has largely excluded the study of older, community-dwelling adults, who have experienced recent health problems. The population statistics predict a continuing trend towards an increased number of

older adults, specifically to the Vancouver and Surrey communities (GVRD). These predictions suggest there will be an even greater need for community-based resources. Recreation practitioners need to be responsive to these changes, and they should be proactive and involved with clients in the change process. Closer working relations and coordination of efforts are needed between the community and institutional settings in health and recreation. Leisure has been recognized as contributing towards life satisfaction and as having health benefits. It would seem, that a more effective sharing of resources between health and leisure services is needed to better provide for an older population increasing in number and life expectancy.

"Older adults have lived long lives with a richness in experience that contributes to a high degree of individualism" (Hawkins & Mclean, 1993, p. 31). Such a statement should serve as a guideline to researchers and practitioners involved in the understanding of leisure experiences. The results of T.R.O.P. have indicated, these participants, who were all recently hospitalized older adults, were not a homogeneous group. For example, these older adults were diverse in their health, leisure interests, satisfactions, constraints and goals. It is probable that they also differed on many characteristics which were not focused upon in this research study. For example, more precise questions and observations might also be able to further explore areas such as: social class, education, gender, and culture.

Flexible approaches, such as those utilized in this

person-centred research program appeared to be effective in reviewing some of the rich experiences of these eight older adults. These experiences included their perceived benefits of leisure and T.R.O.P., facilitators of leisure, leisure interests, constraints to leisure, and their beliefs about the relationship between leisure and life satisfaction.

The relationship between leisure and life satisfaction has been predominately described in the literature as a positive one (Edginton, Jordan, DeGraaf, & Edginton, 1994). Some of the participants in this study also described the converse (VB, PP, FB) and viewed their dissatisfaction with their leisure as a contributing factor to areas of dissatisfaction in their life. Therefore leisure should not be depicted primarily as a positive experience.

T.R.O.P. and similar programs may not only have the potential to facilitate leisure enjoyment, but they may also have the potential to decrease leisure dissatisfaction and perhaps some aspects of specific participants' life dissatisfaction. There is a need for future studies to examine this new outlook on the leisure satisfaction and life satisfaction relationship.

Recommendations for Future Research

Leisure is a continuously evolving concept. This case-study approach assisted the researcher in conceptualizing "leisure" as it relates to eight recently hospitalized older adults. Initially, the investigator accepted Dattilo and Murphy's (1991) definition of leisure with a belief that such

a broad and subjective definition could be applicable to all populations. Now the investigator questions this choice of a definition. Such a definition meant that "leisure" was highly limited for many of these participants during the course of T.R.O.P. due primarily to their decreased physical status and lack of adjustment to these physical changes. "Freedom to choose to participate in meaningful, enjoyable, or satisfying experiences" becomes a very complicated concept. Most of the participants in this study were restricted by their multiple medical conditions. These "restrictions" imply a loss of freedom and therefore, by Dattilo and Murphy's definition, a loss of leisure opportunities.

It appears that researchers need to continuously reconsider their views towards leisure and their definitions of leisure based on new findings with different subjects. Leisure research and definitions should account for the experiences of older adults with declining health and who are susceptible to decreased leisure participation and to increased social isolation. Further investigation of the social benefits which outreach therapeutic recreation can provide is necessary. There is also a need to research the impact of social contact and social supports on older recently hospitalized adults further.

There is a need for additional research on the leisure experiences of community-dwelling older adults, who have experienced recent illness or declining health. At present there is little literature in this area, especially within the therapeutic recreation field. The literature which does exist

on older adults and leisure, frequently focuses on the healthy older adults in the community, or on those who are institutionalized. This is not surprising because recreation therapists have historically been employed by institutions such as long-term care facilities and hospitals. Hopefully, the research within the leisure and therapeutic recreation fields will be influenced by the changing direction of health care.

The results of this study have other implications for improvements in future research. Additional meaningful data could be obtained by selecting participants in the age category of 59-69 years of age. This particular study had an unintentional absence of participants in this specific age range.

An additional recommendation involves the increased utilization of a multidisciplinary team as an integral part of the investigation. Interviewing the members of the multidisciplinary team may have provided additional valuable information to the researcher. Additional information on how a multidisciplinary team approach could increase the coordination of inpatient and outreach health services.

There also remains a need for longitudinal studies which examine the subjective leisure experiences of older adults who have been recently ill. Such studies would provide data on the longterm effects which leisure education and outreach services can have on older adults after the passage of time.

Recommendations for Practitioners

Health System

There is a need for increased coordination and continuity of health-care services. This need has been consistently reported in the literature (Peat & Boyce, 1993, p. 282) and has also become evident through the results of this study. Several participants who were being discharged from the hospital were feeling a lack of continuity with their health-care (VB, JN, MP & FB) and on occasions did not know how to access specific resources. Related to this need for increased coordination would be the establishment of a more effective system for communicating the concerns of the older adults to the appropriate service, or to the individual involved in their care.

The planning for the future care of all British Columbians' health is presently under major revision. Many of the initial strategies outlined in this health reform should result in an increased community responsibility for health (BCRCHCC, 1991). The total health needs of recently hospitalized older adults should be given the priority and attention they appear to require. These include expressed needs related to increased social support. Health care boards will allocate resources to areas where they see the community need and the demand for resources. Therefore health and leisure practitioners should ensure that the needs of recently hospitalized older adults, who have not been aware of resources and opportunities available to them in the past, have the opportunity and the choice to express their needs to

health care decision-makers. These needs include the importance of providing outreach services for older adults.

Social Resources

There is a clearly defined need for increased social resources for older adults in our local population. The social needs of some older adults, especially those who are living alone, may require an increasing emphasis to be placed on improving their perceptions of leisure control, leisure competence, and intrinsic motivation. A shift will be required from the traditional therapeutic recreation roles in hospital and institutional-based services to more of a focus on developing community-based services which may need to address the issues of social networks and social supports. There will be a move away from hospital-based activity programs to meet the social needs of older adults with declining health like those described in this study. This transition will require the careful clarification of future roles for recreation therapists in light of existing community recreation programs and practitioners. Adequately addressing the social support concerns of older community-dwelling adults, will be dependent partially on the cooperation and coordination of hospital and community-based recreation practitioners. However, these resources may not be enough to establish what the older adult perceives to be "social support". The resources may act only to increase short-term social contact such as that which occurred while some participants were in the hospital.

Being hospitalized was not necessarily a "negative"

experience. This finding emerged from the comments given by several participants suggesting that researchers should not underestimate the social impact of hospitalization. Perhaps participation in T.R.O.P. provided an opportunity for reflections on their past, present, and future social experiences. Older adults living alone may have recognized the enjoyment they obtained from being surrounded by others, many of who were in a similar situation.

Restructuring and Coordinating Resources

Facilitating the involvement of older adults into future outreach programs will require a restructuring of existing health care services to support additional staffing in the community. A shifting from hospital based inpatient programs to community based outreach programs is consistent with the current health care plan and may be a reality in the near future (Core Services Report, 1994). Other researchers and practitioners in the therapeutic recreation field would like to see an emphasis from hospital to community-based therapy and rehabilitation (Condie, 1992, p. 11; MacDonald & Gallant, 1994). Health care service delivery is changing its focus from internal or inpatient forms of treating illness to more community-based services aimed at health promotion, wellness, and empowerment (Clark and Curran, 1993, p. 28). "Prevention and Public Health Services" are recognized as required services under the reformed provincial health care plan (Core Services Report, 1994). The targeting of specific services towards seniors' wellness and the recognition of these

services which need to be delivered from a variety of settings, including the home and recreation centres, is emphasized in the latest report from the British Columbia Ministry of Health (Core Services Report, 1994).

This study verifies the investigator's perception of the need for increased services to recently hospitalized elderly individuals residing in the community. The literature and direction of health care further supports this need. Furthermore, Lyons (1993, p. 257) advocates that recreation outreach services are a necessary function of rehabilitation services. As the need for these services frequently existed, almost without exception, prior to the individual's hospitalization, there are likely large numbers of elderly individuals in the community who could potentially benefit from similar outreach services.

In the Vancouver area there are numerous recreation and social programs available for the older adult. Unfortunately there is frequently little awareness of such programs by the older adult, and there is poor communication between various agencies involved in the delivery of these services (Core Services Report, 1994).

Conducting leisure education programs should be an essential component of a comprehensive therapeutic recreation service (Riddick & Keller, 1991, p. 170). The results and literature support the need for leisure education to focus on more person-centred approaches. There is a need to de-emphasize standard leisure assessment tools in favour of inviting the participants to talk about who they are and their

life experiences (Pedlar et al., 1994).

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LEISURE INTERESTS

What are my leisure interests, considering what activities I really enjoy, I am good at, or want to learn?

There are several components that contribute to a persons well-balanced leisure lifestyle and, these components are frequently met in ways we do not realize. The activities listed represent only a small sample of leisure possibilities and, everyone's interests will be different - for everyone is a unique individual.

Read the following list of leisure activities and check off those you would like to do...

SOCIAL...

- ☐ writing letters
- ☐ making social telephone calls
- ☐ visiting friends, family
- ☐ joining a social group or interest club
- ☐ caring for a pet or animal

CREATIVE...

- ☐ doing crafts, woodworking or mechanics
- ☐ doodling
- ☐ cooking or eating fancy food
- ☐ composing poetry, stories or music
- ☐ planning parties

PHYSICAL...

- ☐ joining an exercise class
- ☐ going for walks
- ☐ gardening
- ☐ refinishing furniture
- ☐ practising relaxation techniques

INTELLECTUAL...

- ☐ visiting libraries, museums or galleries
- ☐ keeping up on current events
- ☐ discussing controversial subjects
- ☐ hobby collecting
- ☐ volunteering

SOLITARY...

- ☐ reading
- ☐ listening to music
- ☐ humming or whistling
- ☐ sitting outdoors
- ☐ daydreaming

SPECTATOR...

- ☐ watching TV or movies
- ☐ bird watching
- ☐ people watching
- ☐ attending concerts/theatre
- ☐ attending live sporting events

OTHER...

Whether you think of leisure as an activity, time or state of mind, it is present in each of our lives. Depending on how you perceive and approach it, leisure can contribute to our feeling of satisfaction, hope, friendship and well-being. Therefore, we need to explore what leisure can be for each of us.

What are you looking for in your leisure experience?

Instructions: Read the following list and check off the items most important to you.

- | | |
|--|--|
| <input type="checkbox"/> to do something meaningful | <input type="checkbox"/> to challenge myself |
| <input type="checkbox"/> to contribute to my community | <input type="checkbox"/> to spend time with friends/family |
| <input type="checkbox"/> to feel peace | <input type="checkbox"/> to participate in a variety of activities |
| <input type="checkbox"/> to continue learning | <input type="checkbox"/> to have support from others |
| <input type="checkbox"/> to be physically active | <input type="checkbox"/> to feel committed to something |
| <input type="checkbox"/> to be creative/expressive | <input type="checkbox"/> to use, improve or develop my skills |
| <input type="checkbox"/> to relax or take it easy | <input type="checkbox"/> to have something to show for my efforts |
| <input type="checkbox"/> to be entertained | <input type="checkbox"/> to keep busy |
| <input type="checkbox"/> to be able to do what I want | <input type="checkbox"/> to organize and get things going |
| <input type="checkbox"/> to be spontaneous | <input type="checkbox"/> to learn more about myself |
| <input type="checkbox"/> to laugh and enjoy | <input type="checkbox"/> to develop friendships |
| <input type="checkbox"/> to help others | <input type="checkbox"/> to be competitive |
| <input type="checkbox"/> to improve my self-esteem | <input type="checkbox"/> to improve my health |

Others _____

CHALLENGES TO PARTICIPATION

What is preventing me from participating in the leisure activities that interest me?

Until these challenges are identified and explored, it will be very difficult for you to increase your satisfaction and enjoyment of leisure participation.

Read the following list and check off the items that affect your ability to participate.

- ☐ Often I don't feel like doing anything
- ☐ Too many family obligations
- ☐ Work is the main priority right now
- ☐ School is the main priority right now
- ☐ I rely on others for transportation
- ☐ I have a great deal of daily stress
- ☐ I have a bad habit of over-committing myself
- ☐ I don't have enough money to do what I want
- ☐ I am unemployed and I don't think leisure is possible under these circumstances
- ☐ I don't have the physical skills
- ☐ I don't have the artistic or creative skills
- ☐ I am embarrassed about learning something new
- ☐ I don't have enough time
- ☐ I don't know what programs or facilities are available
- ☐ I find it difficult to start, I procrastinate
- ☐ Social situations are awkward for me
- ☐ I have no one to go with
- ☐ Making decisions is difficult for me
- ☐ Following through on my intentions is difficult
- ☐ Others? _____

OVERCOMING CHALLENGES

Some of the challenges you identified are within your control to change. Select 3 challenges you think you can change and how you could reduce or overcome them.

CHALLENGE	POSITIVE STEPS TO OVERCOMING CHALLENGES
1.	
2.	
3.	

Adapted by BC Rehabilitation Society, from Ballantyne 1987, "Leisure Lifestyles..."

Appendix 2

Initial Interview Questions

1. How has your hospital stay been so far?
2. Where do you live? How long have you lived there?
Does anyone else live with you?
Where were you born?
3. Do you have any family? Where do they live?
4. Tell me some of the things you liked to do before entering the hospital or becoming ill?
5. Is there a community centre, a library, a church, or a park (or other recreational area) near where you live?
6. Were you happy with your lifestyle and free-time before you came into hospital?
7. Is there something you have not done, but would like to try/or find out more about ? Is there something you used to do some time ago and would like to do again?
8. What are you doing for your enjoyment while in the hospital?
9. What is (or what do you think will be...) the outcome of your surgery/hospitalization?
10. How do you see yourself functioning in 6 months from now? What will you be doing for your enjoyment then ?
11. Is there anything you'd like to ask questions about or find out more about ?

Concluding Interview Questions

- 1.a) Has this program benefitted you in any way? Have you learned anything about yourself through this program?
- b) What do you see as some of the benefits of leisure?
- 2.a) Do you find your participation in this program has changed your awareness of the importance of leisure?
- b) Has your attitude towards recreation/leisure changed recently? (If so, how would you say it has changed?)
3. How satisfied are you with your leisure? Has this changed recently?
4. Has your awareness of neighbourhood/community leisure resources changed? If so how has it changed?
5. Has your community participation in recreation or leisure changed recently?
6. In the next 12 months what do you see yourself doing for enjoyment/satisfaction?
7. What has helped you to enjoy your recreation/leisure?
What has helped you to enjoy your life?
8. If things could be a little different what would you like to see changed?
9. Would you say you are generally very satisfied with your life?
10. a) Generally speaking, would you say at the moment, you are satisfied with your life?
- b) Do you think there is any relationship between your satisfaction with your life in general and your satisfaction with your leisure?
11. How did the program make you feel towards yourself, your own leisure, and other people?
12. Were there any negative aspects to the program? Was there anything you would like to see done differently or improved?

Risks/Side Effects

There are no known or anticipated risks or side effects to participating in these sessions.

Benefits

Through participating in this study, you will receive services which may increase your awareness of the recreation resources in your community and obtain information and support in accessing those resources you choose. You will also have a clearer understanding of how you use your free time.

Participation in such a program may lead to an increased level of independence and the creation of new social circles in the community.

Monetary Compensation

There will be no monetary compensation. However, services will be provided free of charge.

Time Commitment

The total time required of you beyond that of treatment/leisure education is 3-4 hours.

Confidentiality

Any information resulting from this research study will be kept strictly confidential. Information reported for research purposes will identify you by a code number. You will not be identified by name. The results may be published in a professional journal and will be presented at the investigator's thesis defence. These will also be coded to protect your identity. If you have any questions or concerns at any time during this study, you may contact Paul Gallant at the numbers listed on page one.

I have read the above information and I have had an opportunity to ask questions to help me understand what my participation would involve. I freely consent to participate in the study and acknowledge receipt of a copy of the consent form.

Signature of Participant

Date

Signature of Witness