LEISURE EDUCATION AND OLDER WOMEN'S PARTICIPATION IN LEISURE ACTIVITIES

BY

WENDY RAE STEWART

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ABSTRACT

Two studies were conducted to examine leisure education and older women's participation in leisure activities. The purpose of Study One was to determine the effects of a leisure education program on leisure participation in new, current, and re-engaged activities among older adults living alone in the community and receiving home care services. A single subject research design combining elements from the multiple probe and alternating treatments designs across subjects (ABC) was used in this study. Effects were assessed by introducing the leisure education intervention across subjects at different times. One subject received a one-hour leisure education program once a week (ten sessions over a period of 11 weeks). The second subject also received a one-hour leisure education program once a week (eight sessions over a period of ten weeks). Of the remaining two subjects in this study, one withdrew and another was eliminated, rendering it difficult to reliably and validly interpret the results. The leisure education program did not affect leisure participation in new, re-engaged, and current activities for the two participants that completed the leisure education intervention. However, social validity results suggested that the participants perceived the leisure education program to be a positive process worth recommending to others. As well there were noted changes in participation in and out-of-the home, as well as participation alone and with-others that requires further examination. Study Two was conducted following the withdrawal of two subjects. The purpose of study two was to identify issues related to leisure participation in the homes and communities of five older adult women. A qualitative interview

questionnaire was designed and employed. The participants completed an interview that lasted approximately one and a half hours. Findings suggest that participants in this study are generally interested in leisure and recreation; however, it was not a good time in their lives to be learning about community leisure and recreation resources, nor was it the ideal time for them to be exploring personal thoughts and feelings about recreation and leisure. Participants reported it was not a good time because they are widowed, they are no longer able to enjoy leisure activities, and they deserve the opportunity to rest and relax after working hard over a lifetime. It was not uncommon for participants to have misunderstandings about the concept of leisure. Health was frequently reported to be a barrier to leisure participation. Satisfaction was achieved from the limited activities that the participants could successfully do; however, dissatisfaction resulted from their inability to participate in preferred activities they did prior to facing health barriers and constraints. Traveling outside the home is an instrumental activity of daily living that seems to be related to leisure participation. Participants reported satisfaction with life, family relations, finances, housing, recreation, self-esteem, transportation, friendships, religious/spiritual fulfillment, and recreation.

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Table of Contents

LIST OF FIGURES

LIST OF TABLES

Chapter 1

Introduction

CHAPTER 1

INTRODUCTION

The effect of leisure education on older adults' participation in leisure activities is of interest to older adults, leisure practitioners, health care providers and researchers. Leisure education is a process which is individualized and contextualized; through this process an understanding of self and leisure is developed and skills necessary to participate in freely chosen leisure activities are identified and learned leading to a satisfying life (Bullock & Mahon, 2000). Leisure education may result in older adults acquiring new leisure pursuits, strengthening current involvements for longer periods of time, and as a result, lengthening periods of independence in their lives (Mahon & Searle, 1994).

Older Adults

In Canada and Manitoba, the older adult population is rising. Canadians aged 65 and over in 1998 represented 12% of the population in comparison to 8% in 1971 (Statistics Canada, 1999a). Predictions made by Statistics Canada suggest that this population will rise to 7 million or 18% of the population in 2021 (Statistics Canada). In Manitoba in 1998 the total senior population was 155,573 (14%) and is predicted to rise to 214, 500 by 2021 (Statistics Canada).

Seniors in Canada are not a homogeneous group and they have been differentiated by age, where they live, and whom they live with. Statistics Canada (1991) categorized older adults into the following groups: 65-74 (younger seniors), 75-84 (intermediate seniors), and 85 and older (older seniors). When appropriate in this study, these classifications will be referred to. Older seniors, people aged 85 and over, represented 400,000 or 10% of the Canadian senior population in 1998 and Statistics Canada (1999b) predict a rise to 1.6 million by 2041. The participants in this study were 87 and 86 years old.

Another trend in Canada is that the percentage of Canadians 65 and over living alone is growing. In 1996, 29% of Canada's older adults lived alone. This is an increase of 26% from 1981 and a 20% increase from 1971 (Statistics Canada, 1999c).

A majority of Canadians aged 65 and over reside in private households. In Canada, between 1981 and 1991 the percentage of the senior population living in institutions decreased from 8% to 6% (National Advisory Council on Aging, 1993a). By 1996, 93% of older adults aged 65+ lived in private households (Statistics Canada, 1999d). This suggests that a great proportion of the older adult population is living outside of institutions. Participants in this study lived alone in private residences.

Since older adults are living for longer periods of time in private residences in the community, there may be a need to provide assistance to maintain the highest level of independence possible within their home environments and communities. In 1987, 75% of older Canadians said they wanted to remain in their homes as long as possible to put off or avoid institutionalization, and of the 75% who responded, 20% said they would cash in their home equity to pay for home care in order to remain in their own homes (National Advisory Council on Aging, 1993b)

The number of home support workers and services to seniors in Canada has increased by approximately 50% in the last decade (National Advisory Council in Aging, 1993c). In 1991 there were 10,617 older adults recorded as clients receiving services from the Manitoba Health-Provincial Home Care Program (Centre on Aging, 1996). Services included nursing care, household chores, personal care assistance, therapy services, health counseling, and volunteer services.

Similar trends are being evidenced in both Canada and the United States. As American older adult populations grow and long-term-care services are available to individuals with severe impairment and disability, more people with substantial impairment will reside in the community (Rabin, 1989). In Canada in 1991, 84% of the older seniors had disabilities, 57% of the intermediate group had disabilities, and 37% of

the younger seniors had disabilities (Statistics Canada, 1997). As well, in 1995, 39% of all Canadian seniors living in private households reported some level of activity restriction as a result of some health condition. Older adults living in the community with disabilities and the inability to perform activities necessary to remain independent and maintain health can access home care services (Eustis, Kane, & Fischer, 1993). Chappell (1994) reported that functional disability tends to be a strong predictor of home care services for older adults. Hawkins, May & Rogers (1996) suggest that home healthcare services are an appropriate alternative for older adults with impairment that results in disablement, and that in-home healthcare is the one way that individuals believe will assist them in avoiding institutionalization, i.e., nursing home placement.

Types of activity restrictions may include a person's decreased ability to perform instrumental activities of daily living (IADL) thus requiring increased amounts of health support services. IADL are the activities that are complex and necessary to lead independent lives (Ham, 1989) and are often described as the management of household abilities (Verbrugge, 1990). IADL may include cooking, cleaning, telephoning, reading, writing, shopping, laundry, managing medications, using public transportation, walking outdoors, climbing stairs, outside work (gardening, snow shoveling), ability to perform paid employment, managing money, and traveling out of town (Kane & Kane, 1981). IADL participation is often related to leisure participation, i.e., telephoning to register for a class, cooking to socialize and entertain guests, managing money to be able to buy specific equipment, etc. At present, maximizing independence and delaying institutionalization are two goals being emphasized by health care systems (Wilhite, 1992). It is therefore necessary to identify interventions that will facilitate independence and community living, as well as reduce health care services and costs.

Leisure

It is important to examine the impact that leisure participation and leisure education interventions have on older adults who wish to continue to reside in their own

homes and remain independent. Although the definition of leisure is still debated, frequent mention is made to leisure being a state of mind (Neulinger, 1974; Iso-Ahola, 1980; Shamir, 1992). As a state of mind, a person perceives him/herself as having the freedom to choose what to do (Kelly, 1990; Shamir, 1992; Dattilo, 1994) and as having the "freedom from" or absence of coercion and interference (Mannell & Kleiber, 1997); the person perceives him/herself as having control over self and environment (Coleman & Iso-Ahola, 1993); the person perceives him/herself as being competent (Witt, Ellis, & Niles, 1984); the person is intrinsically motivated (Iso-Ahola, 1980; Shamir, 1992; Mannell & Kleiber, 1997); and the person has pleasurable experiences from activities freely chosen (Kelly, 1996; Mannell & Kleiber). If all these conditions are met, a person is likely to be having a leisure experience regardless of the type of activity he or she is performing.

Psychological benefits can be derived from leisure. Intrinsically motivated and self-determined leisure experiences may result in psychological benefits such as decreased feelings of helplessness, decreased feelings of being out of control and increased perceptions of self-efficacy (Iso-Ahola, 1982, 1983); development of self-concept (Smith & Mackie, 1999); and positive feelings associated with participation (Dattilo & Kleiber, 1993). Freedom to choose to participate in leisure has been shown to enhance coping skills (Coleman, 1993).

Facilitating leisure experiences for older adults may have positive outcomes. Life satisfaction and self-reported health are generally higher when older adults maintain participation in their favorite leisure activities (Searle, 1994). Older adults who are independent and maintain active lifestyles are less likely to require medical services (Stephens & Craig, 1990). Perceptions of personal control enhanced the psychological well being of older adults with mental retardation when participating in a physical activity program (Mactavish & Searle, 1992).

Leisure Education

Leisure education is viewed as a component of therapeutic recreation services (Bedini, 1990). Therapeutic recreation according to Bullock & Mahon (2000, p. 125):

> Is the purposive use of recreation/recreative experiences by qualified professionals to promote independent functioning and to enhance optimal health and well-being of people with illnesses and/or disabling conditions.

Leisure education, as a therapeutic recreation intervention, is thought to facilitate the ability to freely choose independent participation in meaningful leisure experiences (Dattilo, 1997) and this is accomplished through a process of teaching leisure related skills, values, and attitudes (Johnson, Bullock, & Ashton-Schaeffer (1997). According to Csikszentmihalyi (1997) leisure education is important for people of all ages:

> The popular assumption is that no skills are involved in enjoying free time, and that anybody can do it. Yet the evidence suggests the opposite: free time is more difficult to enjoy than work. Having leisure at one's disposal does not improve the quality of life unless one knows how to use it effectively, and it is by no means something that one learns automatically. (p. 65)

Through leisure education a person can learn to use their free time effectively and gain benefit from their leisure participation.

Leisure education interventions are delivered by a leisure educator, a therapeutic recreation specialist (TRS) trained in leisure education. One role of a leisure educator is to facilitate the development of leisure participation patterns that are self-initiated, self-chosen, intrinsically motivated, and pleasurable (Howe, 1989).

Researchers have demonstrated a variety of beneficial outcomes resulting from leisure education interventions. One such outcome is enhanced leisure participation (Anderson & Allen, 1985; Lanagan & Dattilo, 1989; Mahon, 1994; Mahon & Bullock, 1992). Searle & Jackson (1985) suggested that leisure education could also be a means to addressing barriers that limit leisure participation. Leisure education may enhance leisure

participation by identifying and addressing barriers and building skills to overcome such barriers. Boyd (1990) demonstrated that the lack of a large and balanced leisure repertoire can become an obstacle to leisure participation, and suggested that through leisure education, participants can explore a variety of leisure activities to expand their leisure repertoires. The number and variety of activities a person participates in during his/her leisure time constitutes a leisure repertoire (Searle & Brayley, 1993).

Another purpose of leisure education is to facilitate independent leisure functioning (Bullock & Howe, 1991). Leisure education increases leisure functioning by empowering individuals to express their preferences and make decisions (Boyd & James, 1990). Through leisure education, older adults can enhance their perception of independence and psychological well-being (Searle, Mahon, Iso-Ahola, Adam-Sdrolias, & van Dyck, 1995). Leisure education can facilitate leisure participation and thereby promote a sense of personal control and competence (Langer & Rodin, 1976; Rodin & Langer, 1977; Shary & Iso-Ahola, 1989; & Searle et al.).

Facilitating the perception of independence and psychological well-being of older adults through leisure education may have implications not only for increased leisure participation but also for the health and well-being of older adults. Very little is known empirically about the relationship of leisure and health. According to Deci & Ryan (1987) a greater sense of personal control positively correlates with good health and lower illness rates. Work by Coleman and Iso-Ahola (1993) hypothesized that social support gained through leisure experiences enhances health by buffering stress.

In a qualitative analysis, professionals involved in a Kentucky Homecare Program suggested that recreation is a necessary in-home service that influences the well-being and positive life experience of older adults (Wilhite, 1992). The older adults in this study were unable to complete at least seven instrumental activities of daily living (IADL) such as cooking, cleaning and housekeeping. To pass time, their main activity was watching television. The staff involved with this program believed that in-home recreation services

would help clients to live longer in their homes, in addition to adding quality of life to their later years. However, empirical data is unavailable to verify these beliefs. The concept of in-home leisure services for older adults requires further inquiry. The present study attempted to examine outcomes of a leisure education intervention delivered in the homes of older adults.

Unfortunately, very limited research is available regarding the impact leisure activities has on older adults with impairments or disabilities and their daily living in the community (Verbrugge, 1990). Upon reviewing the leisure education literature, it is evident that a variety of leisure education models have been developed (Zoerink & Lauener, 1991; Aguilar, 1987; Munson, 1988; Rancourt, 1991a, 1991b; Bedini, Bullock & Driscoll, 1993; Bullock & Howe, 1991) Very few, however, have been validated with an older adult population. Searle et al. (1995) validated the Community Reintegration Program (CRP) model developed by Bullock and Howe. This study attempted to extend the work of Searle et al.

Given that few validation studies have been completed, it is not surprising that very few research designs have been employed. The design used by Searle et al. (1995) was a field experiment. The research design used by Bullock and Howe (1991) was a case study. To date, one single subject design has been used with the CRP model (Dunn & Wilhite, 1997). Dunn & Wilhite's study examined the effects of the CRP model on leisure participation and the psychosocial well-being of older women living in their homes. Their results indicated that the intervention fostered an increase in leisure participation frequency and duration. The present investigation used a similar single subject design to examine the effects of leisure education on the leisure participation of older adults residing in the community.

Leisure participation is observable and can be measured (Dattilo and St. Peter, 1991). Participation can be observed by operationalizing frequency of participation. In

this study leisure participation was assessed by operationalizing the frequency of a person's participation in current, new, and/or re-engaged leisure activities.

Storey (1989) claimed that therapeutic recreation research has infrequently used social validation procedures. These procedures can be used to determine if leisure education goals, procedures, and outcomes are socially valued by participants and their significant others (Kazdin, 1982). As well, social validation procedures link research results to social context (Baer, Wolf, & Risley, 1968). This research study attempted to determine if participants valued leisure education.

In summary, research pertaining to older adults and leisure education is relatively limited. In particular, there has been little examination of relationships between leisure education and behavioral outcomes such as leisure participation. Single subject designs offer an opportunity to continuously observe and systematically collect data on participation before, during, and after a leisure education intervention (Zoerink & Lauener, 1991). However, few single subject designs have been used (Lanagan & Dattilo, 1989; Mahon, 1994; Mahon & Bullock, 1992; Dunn & Wilhite, 1997). Further research is necessary to examine the effect of leisure education on older adult leisure participation, and to determine if leisure education is socially valued by older adults.

STATEMENT OF THE PROBLEM

Interest for this study evolved from the desire to examine the impact leisure education has on the independent lifestyles of older adults, specifically, participation in leisure activities. The purpose of this study was to determine the effect of leisure education on older women's leisure participation. This study was reviewed by the Faculty of Physical Education and Recreation Studies Committee on Research Involving Human Subjects and received ethical approval (Appendix A).

RESEARCH QUESTIONS

1. Does leisure education increase participation in current leisure activities?
2. Does leisure education increase participation in new leisure activities?
3. Does leisure education increase participation in past leisure activities?
4. Is leisure education a socially valid process for older adults?

DELIMITATIONS

Participants in this study were screened with the Mini Mental Health State Examination and were expected to receive a minimum score of 24/30 (Folstein, Folstein, & McHugh, 1975). A score between 24 - 30 falls within a range that indicates no cognitive impairment (Tombaugh & McIntryre, 1992). A score within this range is suggested for a person to successfully complete a leisure education program.

LIMITATIONS OF STUDY

1. There was potential for attrition of the participants due to death, change in health status, or lack of interest in the study. If a subject cancelled a session as a result of illness, guests, commitments, appointments etc., the session was re-scheduled the following week. If a subject was ill, hospitalized and/or missed three consecutive sessions, the subject was no longer considered viable for the study.
2. The exclusion of the institutionalized elderly meant that the most frail were systematically left out of the sample.
3. Due to the number of subjects, the results are not generalizable to other older adults who are living in community residences in different regions of Canada.

OPERATIONAL DEFINITIONS

Older Adults

Older adults are defined as individuals 65 years old or older.

Community Residence/Dwelling

Community residence/dwelling was defined as living in the community.

Leisure

For the purposes of this study, leisure was defined by the investigator, as a subjective experience in which a person is intrinsically motivated, self-determined, and perceived him/herself as free and competent to choose and participate in activities resulting in pleasurable experiences.

Leisure Activity

Leisure activity was defined as any chosen activity engaged in during discretionary time (Kelly, 1990). Discretionary time is time judged or chosen for leisure: time beyond the time required for obligations of self-care, family, and work.

Leisure Participation

Leisure participation was defined as the total number of activities engaged in daily.

Discrete Categorization of Leisure Participation

Leisure participation was discretely categorized into current, re-engaged, and new categories. In order to determine the impact leisure education had on past, present, and future leisure participation, the following definitions were developed:

Current Leisure Activity

Current leisure activity was defined as any activity engaged in during the last twelve months.

New Leisure Activity

New leisure activity was defined as an activity that a person has never engaged in prior to this investigation.

Re-engaged Leisure Activity

Re-engaged leisure activity was defined as any activity that a person has previously been engaged in but has not engaged in during the last twelve months.

Social Validation

Social Validation is a process that measures the value of an intervention. This process helps determine if behavioral goals are significant, if procedures are appropriate, and if clients and society think the effects are important (Fawcett, 1991). In this investigation, older adults participating in the study completed a social validation questionnaire.

CHAPTER 2

REVIEW OF THE LITERATURE

The topics discussed in this literature review were briefly addressed in the introduction and are expanded upon in this chapter to provide the rationale for this investigation. Due to the limited amount of research on leisure education and older adult participation in leisure activities, literature was gathered from a variety of research areas: leisure, gerontology, health, and applied behavior analysis.

This review is separated into six sections. The first section addresses older adults and leisure time. The second section explains concepts of leisure. The third section reviews the relationship of leisure participation to older adults' health and quality of life. The fourth section examines leisure education conceptual frameworks, process and content, and interventions. The fifth section identifies implications for further leisure education research. The final section examines a variety of single subject designs that may be appropriately applied to leisure education research.

Older Adults and Leisure Time

The percentage of older adult populations is growing. Canadians aged 65 and over in 1998 constituted 12% of the population compared to 7% in 1911 (Statistics Canada, 1999a). In Manitoba in 1998, 14% of the total population was aged 65 and older (Statistics Canada). Possible explanations for the population growth of older adults are the declining death rates of the older adult population, increasing medical knowledge, declining infant mortality rates, and improving health status of older adults (Rabin, 1989).

Not only is the older adult population increasing in the province of Manitoba, and in Canada, but also this segment of the population has more time for leisure than any other portion of the population (Statistics Canada, 1997; Leitner & Leitner, 1985). Seniors in Canada have more free time and they also have many diversified leisure interests. Novak (1997) suggests that in Canada income, region, health, education, and

social status all shape the leisure choices of seniors and a common trend found in the research is that older adults partake in passive, media-related, socially satisfying, non-demanding, non-strenuous activities.

Leisure

Prior to further examining the leisure time of older adults, the term leisure must first be put into context. There are numerous definitions of leisure. In this study, leisure is defined as a subjective experience in which a person is intrinsically motivated, self-determined, and perceives him/herself as free and competent to participate in activities resulting in pleasurable experiences. In other words, "to leisure is to be freely engaged in an activity for its own sake" (Iso-Ahola, 1980, p. 9). This definition is satisfactory, however understanding the conceptualization is also important.

Leisure activity has been defined as any chosen activity engaged in during discretionary time (Kelly, 1990; Kelly 1996). Discretionary time is time judged or chosen for leisure; time beyond the time required for self-care, work, and family. To be defined a leisure activity, a person must perceive that he or she has the freedom to participate.

Dattilo & Murphy (1991) caution however, that participation in leisure activities, in the context of activity and time, is not the end result, they are the means to an end. The resulting state of mind or quality of the experience is the end or outcome (Kelly, 1990).

Leisure activity is directed or self-determined (Kelly, 1987; Coleman & Iso-Ahola, 1993). Self-determination is composed of two components: an attitude that results in people defining goals for themselves and their ability to initiate the achievement of those goals (Ward, 1988). In order to become self-determining, Ward insists that people must be able to make decisions, regardless of other people who do not agree with these decisions.

Another component of leisure experience is intrinsic motivation. People must be intrinsically motivated to experience leisure (Neulinger, 1974; Iso-Ahola, 1989; Shamir,

1992; Mannell & Kleiber, 1997). When intrinsically motivated, the activity is done for its own sake, not for external rewards.

In a leisure experience a person perceives him or herself as competent to participate. When a person's perception is that of a competent participation, he or she believes that involvement will result in reward and satisfaction, rather than failure (Witt, Ellis, & Niles, 1984). Increasing a person's sense of control and mastery is a main function and benefit of leisure (Coleman & Iso-Ahola, 1993).

Leisure Participation

Recreation participation is sometimes considered to be structured activities that allow individuals to practice and develop new skills and enjoy and express themselves (Peterson & Stumbo, 2000). While participating in recreation programs the individual is increasingly making decisions, self-regulating behaviors, and increasing his/her freedom to make choices. In this study, leisure participation refers to an individual's participation in current (during last 12 months), new (never engaged in before), and re-engaged (previously engaged in, but not in the last year) leisure activities.

Older adults have more time for leisure participation, however barriers to participation may exist. One barrier that may impede older adult participation is low perceived competence. Searle and Mahon (1991) found that older adults who perceived themselves as competent in leisure were more inclined to participate in community leisure opportunities. They also found that leisure education enhanced a sense of competence for older adults attending an adult day hospital program (Searle & Mahon, 1991, 1993). Leisure education may reduce participation barriers by increasing perceived competence.

A narrow leisure repertoire is a second possible barrier to leisure participation. The number of different activities a person engages in during his or her leisure is referred to as a leisure repertoire (Searle & Brayley, 1993). If the range of a person's leisure repertoire is limited, isolation and passivity may be the result (Howe-Murphy &

Charboneau, 1987). In contrast, an expansion of a leisure repertoire can result in higher levels of leisure participation and leisure satisfaction (Searle, Mactavish, & Brayley, 1993). Schleien, Tuckner, & Heyne (1985) suggested that a leisure repertoire suited to personal interests and desires could facilitate the constructive use of leisure time and increase social and motor skills necessary for independent daily living. Novak (1997) reported that people of all ages, including seniors could change and expand their repertoires and develop new interests.

There are benefits for older adults participating in leisure activities and there are also harmful effects from declining participation. Leisure participation has been identified as contributing to the life satisfaction (Riddick & Daniel, 1984; Kelly, Steinkamp, & Kelly, 1987) and the social integration of older adults (Kelly, Steinkamp, & Kelly). However, increasing health problems can result when participation in leisure activity decreases; in addition, there can be negative impacts on life satisfaction (Kelly, Steinkamp, & Kelly). It has also been demonstrated that the lack of opportunity to participate in leisure experiences can decrease the psychological well-being of a person (Decarlo, 1974). Having more leisure time does not imply that positive leisure experiences and benefits will occur. Intrinsically motivated and self-determined participation is required.

Leisure Education

Leisure education has been used as a therapeutic recreation intervention for the past few decades. Bullock & Mahon (2000, p. 125) describe leisure education as:

> an individualized and contextualized educational process through which a person develops an understanding of self and leisure and identifies and learns the cluster of skills necessary to participate in freely chosen activities which lead to an optimally satisfying life.

The leisure education process facilitates a person's self-determination in leisure and facilitates a collaborative relationship between the individual and the leisure educator (Bullock & Mahon).

Leisure education combines theory and experience for the purpose of learning about the value of leisure. Brightbill & Mobley (1977) suggested that older adults should be conditioned to believe that their societal worth is not dependent on how much money they earn in retirement. Through leisure education, the older adult may identify alternative activities to loneliness, anxiety, and boredom.

Leisure education interventions help people to self-initiate leisure participation during their discretionary time (Bender, Brannan, Verhoven, 1984, Schleien, Tuckner, & Heyne, 1985). Leisure education interventions may also have the potential to facilitate older adult leisure participation and as a result, enhance well-being (Mahon & Searle, 1994).

A brief examination of the conceptual frameworks of selected leisure education models will help illustrate the philosophical foundations for delivering leisure education interventions. The content of selected leisure education models will also be explored. Since the field of leisure education is relatively young, considerations for future models will be presented.

Leisure Education Conceptual Frameworks

There are important concepts that underlie leisure education (Bedini, 1990). Since the field of leisure education is relatively new, these concepts are still being researched and developed. These concepts or a conceptual framework drive the leisure education process (Searle et al., 1995). The conceptual framework provides the leisure educator with a philosophical understanding of the leisure education model being utilized. Historically, conceptual frameworks were not provided or elaborated upon. It appears, however, that researchers are now adding to or proposing conceptual frameworks to models previously developed.

Bullock & Howe (1991) highlighted a conceptual framework for a leisure education model called the Community Re-integration Program (CRP). This leisure education model was developed as a strategy for facilitating community re-integration through the use of therapeutic recreation for person's with disabilities. Wolfenberger's (1972) concept of normalization and his subsequent theory on social role valorization (Wolfenberger, 1983) form the basis of the CRP's conceptual framework.

Normalization theory suggests that physical integration, social integration, and acceptance are necessary for a person to be integrated into an environment (Wolfensberger, 1972). A person with a disability does not become integrated into mainstream society solely through physical integration. The person must also be socially integrated which includes social interaction and social acceptance. Making facilities and programs physically accessible is just the beginning to integration. The individual must also be provided with opportunities for appropriate interaction with other participants with and without disabilities. The result will be enhanced or positive attitudes that lead to acceptance of one another.

Through the introduction of social role valorization, Wolfensberger (1983) expanded upon the concept of valorization to suggest that both society and individuals with disabilities have a responsibility to defend "valued social role for individuals at risk of not being socially valued or accepted" (Wolfensberger, 1983, p. 234). Social interaction and social acceptance for person's with disabilities are vital for successful community re-integration.

Applying the principle of normalization to leisure education suggests that all people should be given the same rights, responsibilities, and opportunities to experience leisure. Participants must perceive that their participation in leisure has value and that others value their participation. Facilitating leisure participation in the community is not a luxury or a convenience; it is a necessity (Sylvester, 1989).

Searle et al. (1995) expanded upon Bullock & Howe's (1991) conceptual framework for the CRP model by adding self-determination and interdependence. Self-determination was presented as being closely tied to Bandura's social learning theory (as cited in Searle et al., 1995). This theory is based upon concepts of personal competency, which in turn, are based upon self-efficacy theory. Social learning theory and self-efficacy are thought to form the basis of self-determination (Weymeyer, 1992). According to Weymeyer (1992, p. 304), self-determination involves "autonomy (acting according to one's own priorities or principle), self-actualization (the full development of one's unique talents and potentials) and self-regulation (cognitive or self-controlled mediation of one's behavior)."

The work of Mahon (1994) helped facilitate our understanding of the relationship of self-determination and independent leisure participation, which now forms the conceptual framework for the CRP model. Mahon studied self-regulation or self-control strategies (the use of self-monitoring techniques) to determine if they facilitated self-determination skills such as independent leisure participation. Mahon's study found that self-determining behaviors could be facilitated within the context of leisure participation.

The concept of interdependence is about relationships and social integration (Condeluci, 1991). As a paradigm, it promotes acceptance and empowerment for all people, with or without disabilities. Problems that Condeluci identified as interfering with the development of interdependence is the limited supply of environmental supports for individuals, and the attitudes they possessed, not necessarily just their disabilities. The human service system was also identified as being problematic. The system, in this case, is the leisure educator. He or she must allow the participant to define personal problems and change the process to ensure it is participant controlled. Condeluci (1991, p. 121) referred to this process as a "paradigm shifting piece." To achieve interdependence, collaborative problem identification and problem solving must occur between the participant and the leisure educator.

It is imperative, according to Condeluci (1991) and Searle et al. (1995), that the participant has power and control over personal situations. Searle et al. concur that leisure educators must incorporate opportunity for participants to assume control throughout the leisure education process. Perceived leisure control and perceived leisure competence can be enhanced through leisure education and both are thought to be precursors to independent behavior such as leisure participation.

Empowerment is a concept closely linked to the concept of interdependence, implying that people take control of their lives (Condeluci, 1991). The concept of empowerment may be worthy of consideration for future leisure education conceptual frameworks. The concepts of interdependence and empowerment may help clarify the collaborative relationships between the participant and the leisure educator. First, the relationship of independence and dependence must be re-examined (Clark, 1989). The participant begins by searching for a balance between the need for assistance (dependence) and the need to self-determine (independence). The participant must then be empowered to decide what the appropriate balance will be. The outcome of this decision-making process is referred to as the "optimal level of interdependence" (Clark, 1989, p. 277). Collaboratively, the participant and the leisure educator facilitate the attainment of an optimal level of interdependence.

Bullock & Luken (1994) developed a leisure education model called Reintegration Through Recreation (RTR). It is a rehabilitation model with a conceptual framework that promotes a collaborative process, suggesting the participant must direct the process based upon his or her needs, interests, and goals. The RTR leisure education model is a community-based rehabilitation model for people with severe and persistent mental illnesses. The conceptual framework for this leisure education process includes self-determination, social role valorization, and a cognitive behavioral theoretical perspective. The first two concepts have been discussed previously, therefore only the last concept of their model will be discussed.

Meichenbaum (1986) suggests that a basic premise of cognitive behavior modification is that participants must gain an awareness of themselves in leisure, what they think about it, how they feel, and how they behave in order to change leisure experiences. The cognitive-behavioral perspective is based upon the following cognitive behavior modification principles: participants define their problems as they see them: participants learn to self-monitor their problems in order to increase personal awareness: participants develop and practice alternative coping skills relevant to their problems: participants evaluate progress and identify obstacles to further progress: and finally, participants modify their personal plan of action to promote progress. One unexplored question is whether cognitive behavior modification principles can be incorporated into leisure education conceptual frameworks for any or all populations, or if they are only appropriate for persons with severe and persistent mental illnesses. These concepts and/or conceptual frameworks are essential for the leisure education process.

Leisure Eduaction Process & Content

A leisure education intervention has both process and content (Csikszentmihalyi, 1997). The process should facilitate the development and enhancement of a person's leisure knowledge, interests, skills, abilities, and behaviors for lifetime participation (Howe-Murphy & Carboneau, 1987). More specifically, the process is how the content is presented to a client (Peterson & Gunn, 1984, Peterson & Stumbo, 2000). The conceptual frameworks discussed earlier suggest that the collaborative relationship will affect the process or delivery of the content. For the content to be effective, a normalized, self-determined, interdependent process, possibly using cognitive behavior modification principles should be facilitated.

A comprehensive leisure education model can facilitate the development of a person's leisure lifestyle through an educational process or any element of that process (Chinn & Joswiak, 1981). The components or units making up a leisure education process will be examined further. For the purposes of this thesis study, a single element will be

referred to as a content element. A content element "is what has to be done in the program [leisure education intervention] to achieve the intent of the enabling objectives" (Peterson & Gunn, 1984, p. 113). Enabling objectives are the leisure education intervention goals divided into behavioral units that are measurable and describe the participant's desired outcome (Dattilo & Murphy, 1991).

The content elements that are taught in an intervention should assist participants in examining and understanding their individual leisure participation patterns (Dattilo & Murphy, 1991). The selection of content elements is based upon needs identified collaboratively by the participant and the leisure educator.

It is necessary to clarify the breadth of possible content elements, since a variety of leisure education models exist and the number and type of content elements contained in models vary. Different combinations of content elements may be selected for use in different models. For example, one model may be composed of twelve content elements but only eight are completed since they were deemed relevant to the participant. He or she may already possess the skills or knowledge obtained in the other four content elements. As well, not all models use the same content elements. It is important that the efficacy of these content elements be determined so that it can be demonstrated that leisure educators are initiating "positive change in clients" (Bedini, 1990, p. 48).

Upon reviewing leisure education models it is apparent that a variety of content elements are included within models. Dattilo & Murphy's (1991) leisure education model includes the following content elements: leisure appreciation, awareness of self in leisure, self-determination in leisure, making decisions regarding leisure participation, knowledge and utilization of resources facilitating leisure, and social interaction. Chinn & Joswiak (1981) identified the following content elements: leisure awareness and self-awareness examination, social interaction skill development, and leisure activity skill identification. There are twelve content elements in the Bullock & Howe (1991) CRP model: activity identification, motivation for recreation participation, activity adaptations, alternate

substitute activities, goal setting, identification of resources, recreation skill development, coping with barriers, making recreation plans, selecting alternatives, people, personal and community resource identification, goal evaluation, and plan articulation. The Bullock and Luken (1994) model is composed of six content elements: leisure awareness, self-monitoring and behavior contracts, problem-solving and self-talk skills, activity mastery and planning skills, resources, and future planning.

It is evident from this list that the terminology for specific content elements is not consistent across models. Bullock and Mahon (1997) noted similar inconsistencies. Concepts may be similar or the same. However, it is difficult to know unless the author clearly delineates definitions for the elements. Confusion is also created when the concepts from a conceptual framework are used interchangeably as content elements, as in the case of self-determination in Dattilo & Murphy's (1991) model.

It would seem that clearly defining content elements is important for leisure educators. This would ensure that they are implemented appropriately and consistently with participants. For the profession of therapeutic recreation, it would ensure reliability across leisure education. Further research is needed in the area of content elements. Research is necessary to clarify content element definitions, terminology, applications, and their implications.

Leisure Education Interventions

Many different leisure education interventions have been used in practice and research. Persons with mental retardation have received considerable attention in the leisure education literature (Anderson & Allen, 1985; Lanagan & Dattilo, 1989; Mahon, 1994; Mahon & Bullock, 1992; Mahon & Bullock, 1993/94; and Bedini, Bullock, & Driscoll, 1993). Studies have also examined the effects of leisure education on persons with traumatic brain injury (Zoerink, 1988), women who abuse substances (Rancourt, 1991a; 1991b), behaviorally disordered youth offenders (Aguilar, 1987; Munson, 1988), and rehabilitation patients transferring from hospital to home (Bullock & Howe, 1991).

Leisure education has been described as relevant to older adults, yet very little research has actually been conducted on this population (Searle & Mahon, 1991, 1993; Searle et al., 1995; Mahon & Searle, 1994). A few of these studies will be examined to illustrate the findings of past leisure education research, and to gain insight for future leisure research.

Zoerink and Lauener (1991) examined the effects of a values clarification leisure education intervention on leisure attitudes, leisure satisfaction and perceptions of freedom in leisure with high school graduates with traumatic brain injury. Eight sessions consisted of identifying enjoyable recreation, choosing alternatives, public affirmation of an activity alternative, exploring past activities and patterns, examining benefits, removing barriers, and planning for the future. Their findings demonstrated support for psychological, educational, relaxation, and aesthetic dimensions of leisure satisfaction, although the findings were not statistically significant. The authors speculated that certain methodological problems were the cause. Recommendations regarding methodology improvement included the use of applied behavior analysis to assess behaviors before, during, and after a leisure education intervention rather than psychological indicators. As well, eight weekly group sessions were thought to be insufficient.

Aguilar (1987) conducted a study on delinquent adolescent attitudes toward recreation and delinquency. The intervention was called Leisure Education Program (LEP) and included the following components: leisure awareness, self-awareness, leisure skills, decision-making skills, and social interaction. The results of this pretest-posttest two-group design seemed to indicate that there were little difference in attitude towards recreation between the group that received the intervention and the control group that did not receive the leisure education intervention. They did report however that there were significant differences in attitudes toward delinquent activities. The control group demonstrated a higher positive attitude towards delinquent behavior than the leisure education group. Aguilar recommended that another approach to further examine the

relationship of leisure education and recreation is to consider the examination of behavioral changes such as participation rather than expressed attitude.

Munson (1988) conducted a study on the effects of leisure education versus physical activity or informal discussion on the self-esteem, leisure functioning, attitudes toward self, leisure, work, leisure participation, and satisfaction of delinquent adolescents. This study was an attempt to determine why Aguilar's (1987) experiment did not demonstrate significant outcome results. Munson's study used an intervention termed Leisure Education (LE) composed of topics on self-awareness, leisure-awareness, social interaction, resource awareness, and decision-making. A pretest-posttest control group design was used. Leisure education was not found to be any more effective than other methods used to enhance self-esteem and leisure functioning. In the analysis, it was recommended that ten sessions were insufficient to effect change. Munson also questioned whether the best components were selected to make up the intervention.

The Comprehensive Leisure Education Program (CLEP) was used in a exploratory study using qualitative or naturalistic research to examine the relationships of substance abuse, recreation and leisure for women who abuse substances, (Rancourt, 1991a, 1991b). The design was reported as being participant-observation research. The leisure education program was composed of the following components: self-awareness, recreation and leisure awareness, resource awareness, decision-making skills, social interaction skills, and recreation skills. CLEP also included a fitness program and was later expanded to include numerous other activities so that participants could apply their knowledge. Nine themes emerged from the data collected from open-ended structured and unstructured interviews, and written leisure education exercises and documents. The themes included motivation, barriers, self-esteem, locus of control, spirituality, mothering, playfulness, decision-making and benefits of participation.

The Wake Leisure Education Program was conceptualized, developed and implemented by project staff from the University of North Carolina (Bedini, Bullock, &

Driscoll, 1993). This particular program was designed for a public school system to determine if leisure education affected the transition of students with mental retardation from school to adult life. Quantitative and qualitative data were triangulated to determine the effect of leisure education on transition. A pretest and posttest were administered. A control group and experimental group were included in the design and subjects were randomly assigned. Additional instruments included a student survey, a parent questionnaire, and the Leisure Inventory Update. The qualitative component of the study included in-depth interviews for case studies. A ten unit leisure education curriculum was developed which included leisure awareness, self awareness in leisure, leisure opportunities, community resource awareness, barriers, personal resources and responsibility, planning, planning an outing, the outing, outing evaluation, future plans.

The results from the quantitative and qualitative data combined, indicated positive changes in behaviors and attitudes such as leisure awareness, activity initiation, participation and leisure appreciation. The results also suggested the importance of family support. However, there were no statistically significant results from the quantitative data. The following methodological problems were identified: attrition, loss of follow-up information, and a possible halo effect. To address them, single subject multiple baseline designs were recommended.

Bullock and Howe (1991) reported preliminary findings from a case study using the Community Reintegration Program (CRP) model that they developed. Bullock and Howe cited Wolfensberger's (1972; 1983) work on Normalization and Social Role Valorization as forming the conceptual framework for the CRP model. The model consists of twelve units: leisure awareness and activity identification, self-awareness of motivations for recreation participation, activity analysis, assessing adaptations and selecting alternative or substitute activities, goal setting, identifying personal, people, and community resources, activity skill development, coping with barriers, decision making,

and developing an action plan. The procedures for delivering the CRP intervention are outlined in chapter three.

The CRP model was delivered to persons with physical disabilities recently discharged from rehabilitation programs. A case study was conducted to examine the effectiveness of the CRP model on community reintegration. Quantitative and qualitative data was collected and triangulated for analysis. The instruments included internal record keeping forms, client forms, and peer evaluation forms. The findings highlighted two categories: (1) recreation participation and meaningful social interaction, and (2) initiative and positive affect toward the future. The subjects were thought to have improved behavioral functioning, adjusted to disabilities, and enhanced quality of life. The CRP model was described as being an effective intervention for community reintegration.

The studies described thus far provide a picture of the breadth of types of participants, dependent variables, and models that have been incorporated into leisure education research. The following studies examined leisure education with older adults. Searle and Mahon (1991, 1993) examined the effects of a leisure education intervention on the well-being of older adults attending an adult day hospital. Locus of control, perceived competence, and self-esteem were assessed. The intervention was developed from the Mundy and Odum (1979) model and work from the Ontario Ministry of Culture and Recreation (1978). The eight-week intervention was composed of the following components: leisure awareness, self-awareness, leisure skills, decision-making, social interaction, constraints, preferences, and action planning. This field experiment had an experimental and control group and pre-tests and post-tests were administered. The results of the study revealed that the leisure education intervention resulted in an increase in perceived leisure competence for older adults. Leisure education not only sustained perceived leisure competence over a term of three months, perceived leisure competence actually continued to increase after the study was completed (Searle & Mahon, 1993).

Searle et al. (1995) hypothesized that leisure education would increase a sense of control and competence, increase life satisfaction, and decrease leisure boredom among community residing older adults. The CRP model was used in this field experiment with an experimental (N=13) and control group (N=15) of older adults identified from the Canadian Aging Research Network needs study (N=1406 adults aged 65 and over). A few modifications were made to adapt the model for older adults. As well, the conceptual framework was expanded by Bullock & Howe in 1988 to include the concepts of self-determination and interdependence.

Results indicated that leisure education increased leisure control, leisure competence, life satisfaction, and reduced leisure boredom. Searle et al. concluded that leisure education did promote a sense of independence among older adults and recommended that further research on behavioral outcomes be conducted to test whether perceived independence results in behaviors demonstrating independent living. It would be of interest to test these findings by replicating the CRP model using a single subject design. Strong evidence for the efficacy of leisure education would be the result if it could be demonstrated that increased perceived independence, leisure competence and leisure control facilitate independent behaviors such as leisure participation.

Implication for Future Leisure Education Research

An examination of the leisure education literature reveals that many different types of independent and dependent variables have been tested with a variety of research designs. This review has been useful in identifying key issues that must be addressed to improve the attainment of significant results and/or empirical support for leisure education interventions being delivered to older adults.

Researchers have made recommendations to improve leisure education interventions. Bullock and Howe (1991) reported that past participants think it is necessary to go into the community during a leisure education intervention. Classroom learning is not as effective as actually experiencing community participation. Participants

must be actively planning, making decisions, and going into the community throughout the entire program (Searle & Mahon, 1993); on-site training and placement are necessary (Munson, 1988); and, combining leisure education and participation is effective (Rancourt, 1991a). Leisure educators must incorporate community participation into the process.

The CRP model is an attractive model to replicate in leisure education research. A review of the various content elements of different leisure education interventions revealed that the CRP is composed of the most frequently used content elements. They are: self awareness, leisure awareness, choosing alternatives, decision making, overcoming barriers, resource awareness, planning, and developing activity skills.

Many different dependent variables have been examined with leisure education interventions as the independent variable: leisure attitude (Zoerink & Lauener, 1991), self-esteem (Munson, 1988), community reintegration (Bullock & Howe, 1991), perceived competence (Searle & Mahon, 1991, 1993), and a sense of independence (Searle et al., 1995). Mahon and Searle (1994) recently suggested that acquiring new leisure pursuits and strengthening current involvements for longer periods of time may result in longer periods of independence for older adults. But the question remains, does leisure education promote independent leisure functioning as suggested by Bullock & Howe (1991), Schleien, Tuckner, & Heyne (1985), Chinn & Joswiak (1981), Lanagan & Dattilo (1989), Bedini, Bullock, & Driscoll (1993), and Anderson & Allen (1985)? Empirically validated research is required to assess older adult leisure participation (Mahon & Searle, 1994; Searle & Mahon, 1991, 1993; Searle et al., 1995).

The measurement of observable and measurable participation behaviors is recommended for further research by many authors (Dattilo & St. Peter, 1991; Mahon & Searle, 1994; Searle et al., 1995). To determine if leisure education facilitates independent leisure functioning, the following research question must be asked; does leisure education increase participation in either current, new, and/or re-engaged leisure

activities? To validate the process of leisure education, measurable and objective participation outcomes must be demonstrated.

Researchers have recommended that future studies use applied behavior analysis or single subject designs to examine leisure education intervention packages (Zoerink & Lauener, 1991; Bedini, Bullock, & Driscoll, 1993, Searle & Mahon, 1991, 1993; Searle et al., 1995). The identification of observable behavioral measures of participation may help to demonstrate the functional relationship between leisure education and leisure participation (Dattilo & St. Peter, 1991).

The use of single subject designs alone will not determine the existence of functional relationships between leisure education and leisure participation. Procedural reliability must also be demonstrated. Procedural reliability, which refers to the determination of whether the treatment agent has delivered the procedure as described (Gutkin, Holborn, Walker, & Anderson, in press), has received minimal attention in the leisure education literature (Mahon, 1994). Peterson, Holmer, and Wonderlich (1982) suggested that it would be difficult to conclude a "functional relationship" has been established between a dependent variable and the treatment if the independent variable is not adequately assessed. Procedural reliability checks must be conducted to ensure the integrity of the independent variable (Welch & Holborn, 1988). Procedural reliability checks will increase treatment effectiveness (Yeaton & Sechrest, 1992). Peterson et al. maintain that an inaccurately implemented treatment procedure such as a leisure education intervention may not be detected until a replication failure occurs. It is imperative that procedural reliability checks are made to decrease errors and to prevent replication failures. It is therefore necessary to determine if the Therapeutic Recreation Specialist (TRS) delivers the independent variable, leisure education, as designed in order to be able to conclude that the treatment was the source of change (Peterson et al., 1982). Leisure education replications are rare; therefore it is imperative that procedural reliability checks are made on the leisure education intervention to prevent replication errors. Single

subject designs will now be examined to determine their suitability for leisure education research.

Single Subject Designs

The terms single subject design, applied behavior analysis, time-series experiment, and intrasubject-replication design have been used to imply a research strategy developed to observe individual behavioral changes (Tawney & Gast, 1984). To be consistent, the term single subject design will be used. The single subject design researcher attempts to demonstrate a functional relationship between behavioral changes and an intervention. The functional relationship means that there is confidence through empirical evidence that the intervention caused the change and not some other variable (Tawney & Gast). Kazdin (1982, p.11) noted that, "because of the lawfulness of behavior and the clarity of the data from continuous frequency measures over time [single subject design], the effect of various procedures on performance could be seen directly."

Kratochwill (1978) wrote that Campbell and Stanley as the result of a need to conduct educational research with designs other than true experimental designs presented the introduction of time-series research in 1966. There was a need to "establish experimental control more reliably" (Kratochwill, 1978, p. 8). Two years later, the multiple baseline technique was published by Baer, Wolf, and Risley (1968). Ten years later, Kratochwill presented a table demonstrating that the multiple baseline design across subjects was a variation of time-series research. As a result of the research conducted, multiple baseline designs grew in popularity in the psychology literature. Even with the expansion of this type of research, the field of leisure education has to date, conducted relatively few single subject designs of any variation.

Multiple Baseline Designs

Multiple baseline designs are composed of several baselines across subjects, conditions, or behaviors (Kazdin, 1982). The baselines are staggered so that the implementation of interventions occurs at different times for each subject. After a baseline is established, a treatment variable is introduced to the first subject, and changes are recorded. When the data are stable, the treatment variable is applied to the second subject. At any point in which the intervention is applied to one subject and not the other subjects, comparison can be made between the treatment and no-treatment conditions. When a change occurs after an intervention is introduced to the first subject, comparisons of baselines are made. If the change occurs immediately after the intervention is introduced and not during baseline phases for the other subjects, a strong case can be made that the intervention created the change. Comparing the performance of subjects at the same points in time is critical to multiple baseline designs. The same applications are made to the second, third and fourth subjects. Three or more baselines are acceptable. Repeatedly demonstrating that changes in specific behaviors occur only when the intervention is applied, is convincing evidence that the intervention is responsible for the change.

In any investigation, the duration of phases are not specified in advance (Kazdin, 1982). The investigator must examine the data and decide if the information is clear enough to make predictions about future performance. Trends or variability in the baseline phase, or tentative, weak, or delayed effects during the intervention phase may require lengthening the phase. A few extra data points can often provide increased confidence that a trend is not occurring and enhances the evaluation of the intervention. The length of each phase is determined in part by the clarity of the data for one phase alone and in relation to other phases. Phases continue until data patterns are clear to the investigator. Stable data patterns, the absence of trend and variability in performance, dictate decisions to alter phases.

The baseline phase is the initial observation phase. According to Kazdin (1982), baselines are critical for describing current levels of performance and predicting future levels of performance. When baseline data is viewed as stable, the intervention is introduced. The intervention phase(s) are compared to the baseline phase(s). Detecting differences in the mean, level, latency, and trend of the data points between and/or within a phase is a common form of analysis in single subject research (Kazdin). This analysis is referred to as visual analysis. Visually analyzing the changes between baseline, intervention, and follow-up phases across subjects is how an investigator evaluates whether an intervention has changed a target behavior.

One criterion for conducting baseline observations is to establish current performance without influencing that performance. According to Sidman (1960), selecting a baseline which is not manipulated as an independent variable is "a critical step in the design of an experiment" (p. 317). The ideal baseline should have very little interference from other variables because interference will "reduce the sensitivity of the baseline to changes in the manipulated variables" (Sidman, 1960, p. 320).

Applied research is appropriate for the study of leisure education. Through the use of single subject designs, it is possible to show cause and affect relationships between interventions and client behavior (Dattilo, 1989). However, unique problems can arise. Direct observation as a method of assessing subjects in their natural environments can be difficult. It can be expensive and impractical to have a researcher observe subjects 24 hours a day. If a single subject study requires in-depth observations but they are difficult to obtain, investigators can use self-report as an assessment measure (Hersen & Barlow, 1976). When the subject is the only person with direct access to the event or activity, self-report may be necessary (Kazdin, 1982). Prior to subjects self-reporting or self-monitoring, they are provided with instructions on the frequency and methods of recording behavior by the researcher or practitioner. Precise descriptions of the behaviors are provided to enhance the reliability of recording. An individual subjectively defines

leisure experiences. An activity defined as leisure one day may be defined as work the next. An observer may have no way of reliably determining which activity was leisure by simple observation. Judgments regarding the definition of leisure activities are in the control of the subject and are likely to be more reliable by self-report.

Problems can occur when self-report assessments are conducted. Responding in socially desirable fashions and distorting one's account of actual performance may result (Kazdin, 1980). However, it is estimated that the occurrence of these problems are the same as reactive awareness (Sidman, 1960). Reactive awareness or distorting behavior occurs when one is aware of being observed

When self-report methods of assessment are used in single subject designs, baseline assessment may not be possible. A baseline is supposed to have little interference from variables that would desensitize the baseline to changes in the independent variable (Sidman, 1960). Self-reporting is a form of self-monitoring, and self-monitoring or self-observation is a reactive process and has the effect of an intervention (Hersen & Barlow, 1976). Mahon (1994) demonstrated that self-monitoring facilitated independent leisure initiation. If subjects monitor and record their behavior, the rates of their behavior may change regardless of the absence of the intervention. Self-report measures thus can have the effect of manipulating a dependent variable and therefore, cannot be used as a baseline. This does not mean that self-reports cannot be used with single subject designs; it simply means variations of single subject designs must be explored in an attempt to identify any problems associated with the omission of a true baseline.

Kazdin (1992) suggested that past literature has emphasized the use of complete single subject designs rather than design elements. However, design elements can be creatively used to assist in making good clinical decisions. Knowing that self-reports have a treatment effect in a single subject design, it may be necessary to exclude baseline observation data from the design. Excluding this element of the design eliminates

variability from "discoverable" and "controllable" causes (Sidman, 1960). It is therefore necessary to combine elements of different designs. When measuring the effects of two or more treatments, and unable to incorporate a baseline into the single subject design, it may be appropriate to use a multiple probe design (Sidman; Horner & Baer, 1978; Tawney & Gast, 1984) and/or the alternating treatment design (Barlow & Hersen, 1984).

Multiple Probe Designs

In situations where collecting baseline data is not possible without affecting the behaviors being observed, the multiple probe design can be useful. This design is a variation of a multiple baseline design and can be particularly advantageous when obtaining extended baselines are "unnecessary, reactive, or impractical" (Horner & Baer, 1978, p. 196). Sidman (1960) suggested that using probes to collect data could replace continuous direct observations

Baseline data are not collected continuously in the multiple probe design. Probe trials or probe sessions are operationalized by taking baseline assessment measures prior to an intervention (Tawney & Gast, 1984). Probe trials are taken periodically on the subject. Probe sessions are taken on several subjects over the same time period. In regards to internal validity, the probes must demonstrate that the target behavior changes only when the intervention is introduced. It is important to note that a minimum of three probes, preferably five, be conducted on each subject prior to the introduction of the intervention. Not all single subject designs require continuous data point baselines to draw conclusions about the effect of an independent variable on target behaviors. Conclusions can be drawn when probe data are collected.

The key difference between a multiple baseline design and a multiple probe design is the frequency of the probes or baseline data collections. Otherwise, design elements or criteria for these designs are the same. A multiple probe design was selected for this study because a true baseline could not be established by directly observing the subjects. To avoid the impracticalities of having an observer view the subjects on a 24-

hour basis, self-reporting took place. Direct observation by an observer may have acted as an intervention or independent variable, influencing subjects to change behaviors in response to being observed (reactance). Reactivity is the possibility of behavior changing because people realize they are being monitored (Kazdin, 1981). As well, leisure experiences are personally defined and an observer could not accurately determine when a subject was having a leisure experience. It was therefore important for the subject to personally record when a leisure experience occurred.

Tawney and Gast (1984, P. 272) recommend the following guidelines:

1. Pinpoint outcome objectives prior to initiating the study.
2. Collect probe data across each subject of the design prior to introduction of the independent variable.
3. Schedule a minimum of three consecutive days before introducing the intervention.
4. Apply the intervention to a new data series only when all data series show acceptable stability in level and trend.
5. Apply the intervention to a new data series only when criterion-level responding is demonstrated with the preceding data series.
6. Identify a minimum of three subjects.
7. Identify subjects that are similar, yet functionally independent from one another.
8. Collect continuous data on the behavior that is receiving the intervention.

Alternating Treatments Design

Direct comparisons of alternate intervention strategies cannot be made with multiple baseline or multiple probe designs (Tawney & Gast, 1984). Alternating treatment designs allow comparisons of two or more interventions and do not require a baseline condition before the introduction of an intervention (Barlow & Hayes, 1979). Other terms such as the multielement design (Ulman & Sulzer-Azaroff, 1975), multiple

schedule design (Hersen & Barlow, 1976), and simultaneous treatment design (Kazdin & Hartman, 1987) have been used to make reference to alternating treatments designs. Cooper, Heron, & Heward (1987) note however, that a number of studies have been termed simultaneous treatment designs and were in fact alternating treatments designs. Usually, the interventions of an alternating treatments design are alternated rapidly and counterbalanced session by session. In this design it is important that the subject be able to differentiate between two interventions. The intervention that is determined to be most effective is the intervention used in the final phase of the design.

A combination design composed of elements from an alternating treatment design, a multiple baseline design, and a multiple probe design can be used in an investigation when self-report assessment measures result in the elimination of baselines. Comparing two interventions, using elements of the alternating treatment design, may reduce the variability created by not having a baseline. Rather than describing current performance and predicting future performance from baseline data, descriptions and predictions could be compared to data from the first phase intervention. For example, the effects of a leisure education intervention (phase 2) can be compared to a self-report intervention (phase 1). This type of design would determine if the leisure education intervention had more, the same, or less of an effect than the self-report intervention.

It is unnecessary to randomly alternate the interventions (Tawney & Gast, 1984). After the implementation of a leisure education intervention, subjects will have acquired awareness, attitudes and skills to independently initiate leisure participation. An alternation would be unnecessary because the second self-report phase would be influenced by the skills attained in the first leisure education intervention. Therefore, it is only necessary to have one phase of each.

Incorporating elements of the multiple baseline design will enhance internal validity. Staggering the interventions across subjects, demonstrating an effect on the

dependent variable, and replicating this effect across subjects will demonstrate internal validity. Using probes will eliminate the problem of obtaining continuous data points.

Experimenting with variations of design or "analytic" elements is acceptable and often necessary (Cooper, Heron, & Heward, 1987). Wacker, McMahon, Steege, Berg, Sasso, & Melloy (1990) used a combination design incorporating a sequential alternating treatment design with multiple baselines and probes. Delgado & Lutzer (1988) conducted their research with a multiple probe design across cohorts (pairs of subjects), while Schuster, Gast, Wolery, & Guiltinan (1988) combined a multiple probe design across tasks with replications across subjects. Halle & Holt (1991) used a design called multielement probe design where they conducted baseline probes. Lalli, Pinter-Lalli, Mace, & Murphy (1991) used a multiple baseline design across groups referring to baseline, generalization, and follow-up probes. Sisson & Barret (1984) used an experimental design employing a multiple probe across different behaviors component, an alternating treatments analysis, and a final multiple baseline across behaviors design to evaluate two language-training procedures.

Single Subject Designs and Leisure Education Interventions

The leisure education intervention studies examined so far have included experimental designs, case studies, and exploratory participant-observer designs with a variety of different populations. Single subject designs have been recommended as alternate designs for leisure education research, and participation is thought to be an important dependent variable to study. It was evident however, that very few single subject designs have been utilized in the leisure education research, particularly with older adult populations (Dunn & Wilhite, 1997; Lanagan & Dattilo, 1989; Mahon, 1994; Mahon & Bullock, 1992). A brief review of these studies helps to illustrate the types of single subject design research studies conducted and found in the leisure education literature. Dunn & Wilhite's study is the only one of the four that included older adults. The other three studies examined adolescents and young adults with mental disabilities.

Lanagan and Dattilo (1989) combined a single subject research design (ABAB) with an experimental between-group design. In this study they attempted to determine what the effect of a leisure education program with authoritarian leadership versus democratic leadership had upon activity involvement. The leisure education program was made up of four content elements presented by Chinn & Joswiak (1981), the benefits of leisure, leisure barriers, leisure resources, and home-based hobbies and activities. The ABAB design failed to demonstrate a return to baseline in the third phase (participation was not decreased) which, from a clinical perspective is positive, and negative from a research perspective, (suggests that there may be intervening variables) (Kazdin, 1982). Another explanation why there was not a return to baseline might be that once a skill was learned, it was not easily extinguished. Since the third phase did not return to baseline, it is difficult to conclude the leisure education program independently changed the dependent variable. Regardless of the analysis, valuable information was gained from the extensive observations. Lanagan & Dattilo suggested that thirty-minute sessions were too short and that higher levels of involvement resulted if recreation participation occurred prior to the delivery of the leisure education intervention.

Mahon & Bullock (1992) and Mahon (1994) performed what Kazdin (1980) referred to as dismantling treatment strategies, or analyzing content elements of a treatment. These two studies looked at component parts of a leisure education process: decision-making using self-control techniques (Mahon & Bullock); and, decision-making and independent leisure participation using self-control techniques (Mahon). There is value in studying dismantling treatment strategies as well as package treatment strategies. Using a package treatment strategy simply means applying the entire package to the dependent variable (Kazdin). The CRP model is an example of a treatment package.

Mahon (1994) elected to study adolescents and young adults with a multiple-baseline across subjects design to examine the effect that self-control techniques had on the development of self-determination skills during leisure. The content elements of this

leisure education study in the Part A baseline included leisure awareness, leisure resources, and leisure communication skills. A decision-making model was introduced in the intervention phase. In Part B the baseline phase consisted of leisure action planning and self-monitoring. When baselines were stable, a self-monitoring intervention was introduced. Mahon's findings suggest that self-determining skills can be facilitated through leisure education. Decision-making instruction facilitated an increase in self-instructed leisure decision-making, and self-monitoring facilitated independent leisure initiation.

Mahon & Bullock (1992) chose to use an alternating treatment design to assess the impact that self-instruction training versus encouragement and verbal praise had on students talking themselves through a decision. Principles of cognitive behaviorism were used to determine the impact of decision-making instruction with self-control techniques versus instruction that only provided praise and encouragement. Leisure awareness training, considered to be part of Burt-Driscoll, Bullock, & Bedini (1991) and Mundy & Odums (1979) leisure education model's were used in this study with the following content elements: concepts of leisure, self-awareness in leisure, knowledge of leisure opportunities, leisure resources, and leisure barriers. All four subjects demonstrated an increased ability to self-instruct by the end of the study, providing initial support for teaching decision-making skills in leisure.

To determine the functional relationship between leisure education and leisure participation more single subject designs should be used. To date, one single subject design has been studied with the CRP model. This study was conducted by Dunn and Whilhite (1997). Dunn & Wilhite's study utilized a single subject multiple baseline research design across two older adult women residing in their own homes, and examined the effects of the CRP leisure education program on leisure participation and the psychosocial well-being. Their results indicated that the intervention fostered an increase

in leisure participation frequency and duration. The leisure education program did not affect measures of psychological well-being.

SUMMARY

Increased leisure time does not necessarily guarantee increased leisure participation or satisfying leisure experiences. Leisure participation may result in improved health and quality of life if the appropriate skills are possessed. Individuals may require assistance obtaining these skills. Leisure education is a process used to facilitate leisure awareness, skills and knowledge necessary to experience satisfying independent leisure functioning.

The conceptual framework of leisure education is built upon community independence and interdependence, self-determination and normalization. These concepts help illustrate how leisure education can facilitate perceived independence in older adults. Perceived independence can be evaluated for its effect on behavior by measuring behavioral outcomes such as leisure participation.

Past research suggests that single subject designs may be appropriate for the study of leisure education provided that procedural reliability checks are conducted. Researchers are also encouraged to replicate the use of leisure education models to determine the effectiveness of leisure education with older adults.

CHAPTER 3
METHODOLOGY

This methodology section is composed of two studies. Study One contains the following six sections: (1) Participants, (2) Design, (3) Dependent Variables (4) Instruments for Data Collection, (5) Independent Variable, (6) Procedures, (7) Reliability and Validity, and (8) Analysis. The second study evolved after two participants withdrew from the first study, rendering the design invalid. A minimum of three participants is required for a single subject design to be valid (Kazdin, 1981). Study Two is composed of five sections: (1) Research Questions, (2) Research Design and Instrument, (3) Participant Selection, (4) The Participants, and (5) Analysis.

STUDY ONE
PARTICIPANTS

The investigator established participation criteria, and Home Care case managers determined whether or not their clients met the criteria. Participants, for this study, met the following criteria: living independently in own home, isolated, inactive, perceived barriers to leisure participation, a desire to overcome barriers, a score of 24 or higher on the Mini-Mental Health State Examination (Folstein, Folstein, & McHugh, 1975), and 65 years of age or older. Two participants completed the study, while two other participants withdrew due to lack of interest, hospitalization and illness.

The two participants were recipients of a Provincial Home Care Program. Services accessed included meal preparation, personal hygiene, dressing, etc., a maximum of three times a week, which was considered to be a minimal level of support. Participant selection was determined through several discussions with Home Care staff and the older adults receiving Home Care services. The criteria, as outlined above was provided to case managers and they were requested to identify a list of potential

participants, and obtain verbal permission for the researcher to make telephone contact with the potential participants. Home Care staff provided names, addresses, and phone numbers.

In order to successfully participate in this study, as suggested by Tombaugh and McIntyre (1992), participants had to obtain a minimum score of 24/30 on the Folstein, Folstein, and McHugh (1975) Mini Mental Health State Examination scale (refer to Appendix B). This score indicated that the participants had the cognitive ability necessary to successfully complete a leisure education program. An appointment was made with the subjects by telephone to administer the test in person. If they met the minimum score of 24/30, they were introduced to the study and asked to sign a consent form.

A consent form was developed for the subjects to read and sign. This form ensured subjects that confidentiality would be maintained and that they could withdraw at any time. A contact name was provided so subjects could call and verify the legitimacy of the study. The consent form is located in Appendix C. For confidentiality purposes, fictitious names have been assigned to the participants.

After four participants agreed to partake in the study, two of the four subjects (A, B, C, D) withdrew. Subjects A and C participated in the study. Subject B completed the first visit (completed the MME and the Current and Past Leisure Activity Finder) and second visit (completed consent form and telephone checklist review) in phase A of the study. During phase B, the third visit, she received the leisure education manual, reviewed it, and then withdrew from the study. She reported that the study would obligate too much of her time and that she was satisfied with her leisure lifestyle. During Phase A, visit 1, of the design, Subject D completed the MME. On the second visit she completed the Current and Past Leisure Interest Finder, and the Telephone Checklist was explained and trained. Phase B was delayed due to Subject D being hospitalized in Phase A. It therefore became necessary to extend Phase A in order to obtain stable data points before moving to the next phase. Phase A is the baseline phase in which data from the

intervention phase will be compared through visual inspection. It is important then, that an accurate set of data points be obtained from Phase A for the comparison of phases to occur, and then be able to generate reliable findings. Phase B began during the third visit. During this visit, the first intervention session was delivered. However, Subject D had to be withdrawn from the study as she missed three consecutive leisure education sessions in phase B due to health problems, doctor appointments and hospitalization. New participants could not be added to the study because baseline data collection must occur at the same time for all subjects.

Alice

Alice (Subject A) was an 87-year-old woman living in a mid-western Canadian city. She was widowed, had completed grade 6, and was a homemaker. During her adult years Alice raised her two daughters and donated her free time to volunteer organizations.

At the time of the study, she was living in an apartment building for older adults. She had had two hip surgeries and walked with a walker due to an unsteady gait, although she often took risks walking without the walker in her apartment. The greatest health risk in her mind came from blackouts that she could have at any given time as a result of heart problems. Alice would rarely leave her apartment without the assistance of another person to help her take her medication (Nitro), if she needed it. She required an escort if she traveled on the public transportation system (Handi Transit) and as a result, had not accessed the system for over two years. She could only walk short distances and did not feel safe going out alone. Alice's trips out of the apartment consisted of shopping, medical appointments, and the occasional dinner at her daughter's home. Alice's daughter worked full-time and had a family of her own and would drive Alice on these excursions approximately once a week. Alice received Home Care services in the morning and the evening to dress and undress, and every two weeks she would receive assistance with household chores such as laundering and vacuuming. Alice would wash her kitchenette floor although she had assistance for this chore and it was difficult for her to kneel down.

However, she smiled and claimed that she "did a better job". She also took pride in washing her own dishes and occasionally baking cookies. She was not impressed that she was being encouraged to start receiving Meals on Wheels. It was costly and she felt confident she could prepare simple meals easily enough on her own.

Alice reported that she reads very little now as her eyes "go blurry" from reading. Current leisure participation at the time of the study consisted of watching television and walking in the hallway with Home Care attendants whom Alice had come to know very well. Occasionally, she would have dinner with her daughter's family.

Past leisure interests included going to church, playing piano, singing in a choir, gardening, bowling, curling, sewing, crocheting, and knitting clothing for her children and donating clothing to charities, playing cards (Bridge, Whist, Cribbage) and traveling.

Brenda

Brenda (Subject C) was an 86-year-old woman who had been widowed for less than a year at the time of the study. She had two daughters and was a homemaker after she married. Prior to marrying, Brenda enjoyed working as a teller at a bank, and had completed "Matriculation 1 & 2", a two-year university course.

At the time of the study, Brenda walked with a cane and continuously misplaced it within her apartment. As a result she had numerous canes hanging on chairs in her high-rise apartment. She reported having a visual impairment although she was an avid reader with the assistance of a large magnifying glass (newspapers, mail, magazines, letters). Brenda left her apartment almost daily to go to the bank and grocery store. Both were within walking distance of her apartment. She could not carry heavy bags and walk with a cane at the same time so she'd make daily trips to "pick up a few things". Brenda independently accessed Handi Transit in the winter and the public bus system in the summer. Members from her church would pick her up on Sundays to attend mass and occasionally take her out for lunch.

Brenda was notorious for talking on the phone to her daughters who lived in other provinces and writing letters to family members and friends. She claimed that she preferred solitary activities such as knitting, watching television, completing crossword games etc. because she did not have a partner to go out with. She did however, have a few friends in the apartment building with whom she would have coffee.

Past leisure interests included attending the ballet, symphony, orchestra, and theatre with her husband, gardening, traveling, playing table games, entertaining and socializing. As an adolescent she enjoyed figure skating (pairs), basketball, gymnastics, and swimming.

DESIGN

A single subject research design that combined elements from the multiple probe and alternating treatments designs across subjects (ABC) was used in this study. Characteristics of each of these designs were incorporated to reduce possible sources of variability. In-depth daily observation can result in obtaining reactive assessment data (Kazdin, 1982). As well, it is difficult for an independent observer to reliably determine which activities a subject subjectively classifies as leisure. Therefore, self-reports were used to measure participation behavior in leisure activities. Self-reporting involved recording personal leisure participation, which were identified in advance by the investigator on the Current & Past Leisure Activity Finder (see Appendix D). This assisted in determining which activities were new, current, or re-engaged activities. In this study, subjects were asked to record their daily participation in leisure activities, and to record whether or not this participation took place in or out of their homes and whether they participated alone or with others. The subjects in this investigation recorded their daily leisure participation in the Telephone Checklist form (see Appendix E). The Telephone Checklist data was then classified by the investigator into discrete categories and was graphed.

There are three phases in this design labeled A, B, and C (see Figure 3.1). Phase A is the self-report phase, phase B is the leisure education and self-report phase, and phase C is the follow-up, self-report phase. Phase C was considered different from Phase A because a true baseline could not be restored due to the nature of the intervention. It was assumed that after participating in a leisure education intervention, the participant would have new knowledge and a changed attitude towards leisure and self-reporting takes on the form of an intervention that affects the dependent variables, so Phase C cannot be considered a true baseline (Hersen & Barlow, 1976). Therefore, characteristics of the alternating treatments design were applied. Rather than comparing data from a baseline phase to other phases, comparisons of changes in data points across phases A and B of this design were made. Describing current performance and predicting future performance are based upon data from phase A. These comparisons demonstrate the effects leisure education and self-report interventions had upon leisure participation. The comparison of phases is characteristic of an alternating treatments design where phases are alternated repeatedly. Rather than repeated alternations, each intervention was implemented only once. This was possible because the interventions were staggered across four subjects. The B phases were staggered so that phase B interventions would occur at different times for each subject. This is characteristic of a multiple baseline design. The effect of the intervention on the dependent variable can be demonstrated when changes occur immediately after the intervention is introduced and these changes do not occur in phase A for the other subjects.

PHASE A

Phase A consisted of calling the subjects to obtain data on their daily leisure participation. The TRS endeavored to call each subject every second day for the first and second subjects in phase A. Due to extended A phases for the third and fourth subjects, intermittent probe trials were conducted once a week. Immediately preceding the introduction of phase B, subjects three and four received a total of five probes. These

probes were taken every second day. When the data points were stable in phase A. as determined by the investigator, phase B began.

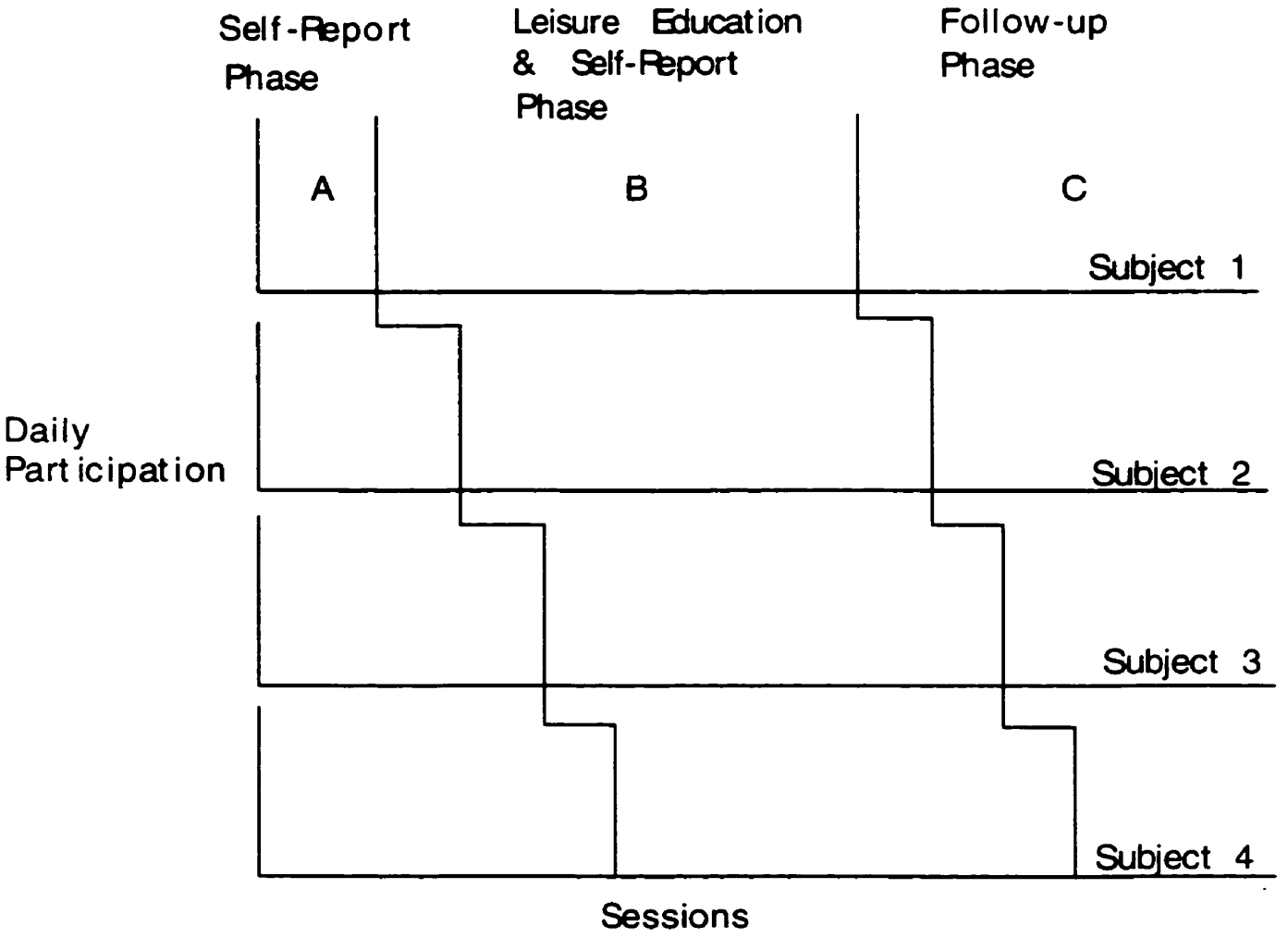

Figure 3.1. Multiple probe, alternating treatments design (ABC) across subjects.

PHASE B

The leisure education intervention (phase B) was conducted once a week in the subject's home and when applicable, in the community. Searle et al. (1995) averaged a total of 17 sessions per subject in their leisure education study. Some subjects required 2 or 3 sessions to complete a unit, while other subjects completed units in advance. This intervention was estimated to be completed over 17 weeks. Subjects continued to

complete daily telephone checklists and received calls from the TRS every second day throughout phase B. When phase B data were stable for the first subject, the second subject began phase B. The same schedule was set for the third and fourth subjects. If the phase B intervention was implemented and changes occurred immediately after the introduction of phase B, but not during phase A for the other subjects, a strong case could be made that the phase B intervention caused the change in leisure participation.

PHASE C

Once the intervention sessions were completed (phase B), one telephone call was made weekly to each subject for the duration of four weeks. Subjects continued to complete Telephone Checklists. They recorded leisure participation as they did in phases A and B. The TRS and the subject mutually set dates to call and collect the data. A follow-up interview took place two weeks after the last intervention session. At this time the social validity questionnaire was completed.

DEPENDENT VARIABLES

In this investigation, the dependent variable was Participation in Leisure Activities.

Leisure Participation

Leisure participation is defined as the total number of current, re-engaged, and new activities. These sub-sets were created to determine if changes occur in a person's type of leisure participation.

Current Leisure Activity

Current leisure activity is defined as any activity engaged in during the last twelve months. The subjects completed a list of current leisure activities as taken from the Current and Past Leisure Activity Finder at the first home visit.

Re-engaged Leisure Activity

Re-engaged leisure activity is defined as any activity that a person has previously participated in, but not during the last twelve months. A list of re-engaged activities was taken from the Current and Past Leisure Activity Finder.

New Leisure Activity

New leisure activity is defined as any activity that a person has not engaged in prior to this investigation. A list of new leisure activities was determined by examining the Current and Past Leisure Activities Finder for activities not listed. Activities not listed on the Finder but recorded on a subject's telephone checklist were considered new activities.

Location of Participation

The location of leisure participation is of interest when dealing with older adults' leisure participation, particularly when these subjects were identified as being isolated and inactive.

In-home

In home activities are any leisure activities, which took place in the subject's home.

Out-of-home

Out-of-home activities are any leisure activities, which took place outside of the subject's home. The facilities such as a games room in an apartment block are considered to be out-of-home.

Social Contact

The type of social contact associated with an older adult's leisure participation is important to know, especially since these subjects were identified as living alone, isolated, and inactive.

Alone

Any leisure activity participated in individually, i.e., going for a walk without interaction with others, is considered to be alone.

With others

Any leisure activity involving interaction with another person. A group activity is classified as being with others if interaction occurs.

The dependent variables for leisure participation were discretely categorized from the responses on the Telephone Checklist into the categories illustrated in Figure 3.2:

INSTRUMENTS

The following instruments were used in this investigation:

Mini Mental Health State Examination: The Mini Mental Health State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975) measures cognitive function and can be used by non-health professionals (Ham, 1989). To determine if the subjects have the cognitive ability to successfully participate in the leisure education program, a minimum score of 24 had to be achieved. Tombaugh and McIntyre (1992) suggested a classification system of cognitive impairment upon which this minimum score was determined. A range from 24-30/30 suggested no cognitive impairment, 18-23/30 suggested mild cognitive impairment, while 0-17/30 suggested severe cognitive impairment.

The developers of the MMSE suggested it had good reliability and validity. They reported a test-retest (24 - 28 hours, single examiner) Pearson coefficient of 0.887. Concurrent validity, as determined by correlation with the Wechsler Adult Intelligence Scale, was Pearson $r = 0.776$ ($p < 0.0001$) for the Verbal IQ and Pearson $r = 0.660$ ($p < 0.001$) for the Performance IQ. For reliability, a Pearson coefficient of 0.887 was reported. Concurrent validity was determined to be 0.776 ($p<0.0001$).

Current and Past Leisure Activity Finder: In order to generate a list of current and past leisure activities prior to phase A of the design, the subjects completed the Current and Past Leisure Activity Finder. The form was used as a guide to ask for and record leisure

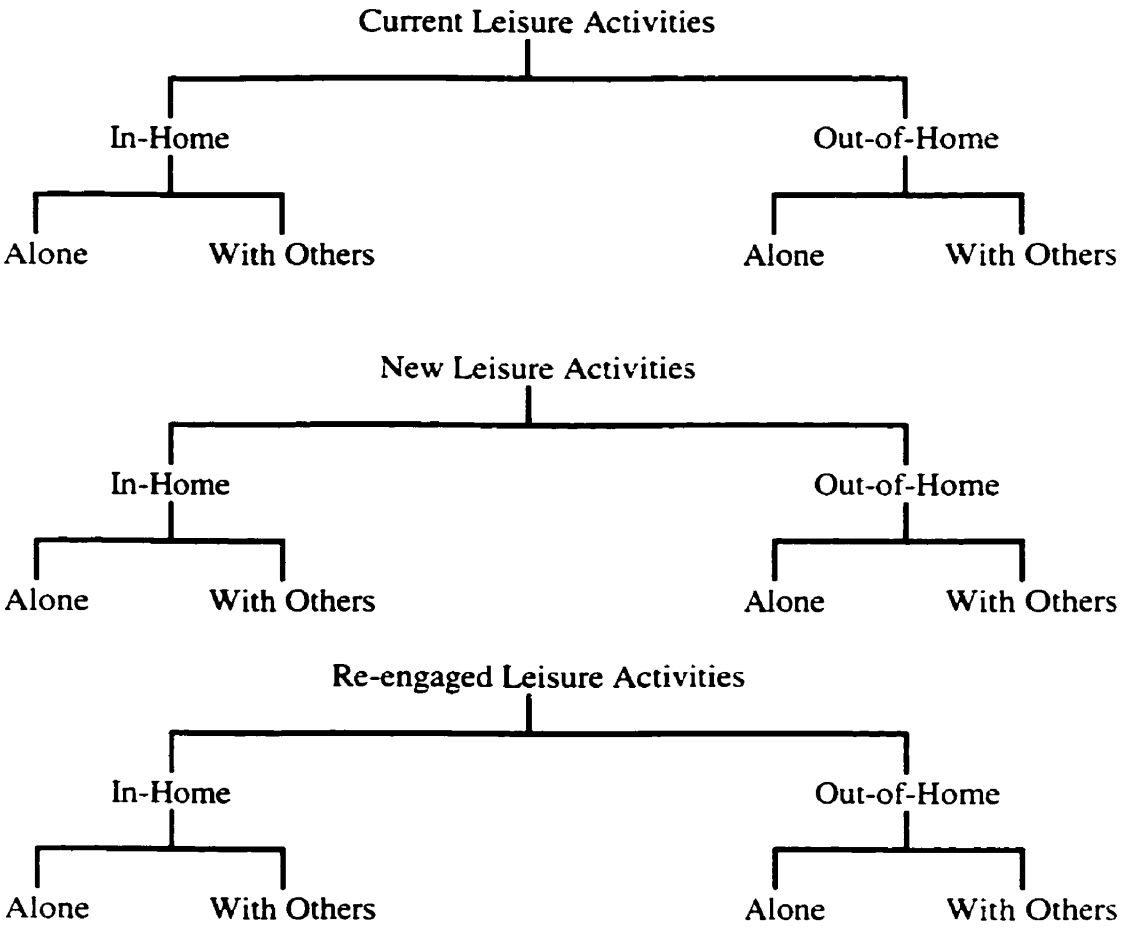

Figure 3.2. Discrete categorization of leisure participation into current, new, and re-engaged leisure activities.

participation information. From the activities listed on this form, the investigator was able to compare and discretely categorize responses from phases A, B, and C.

Telephone Checklist: The telephone checklist was developed so that the subjects could record their daily participation in leisure activities and easily relay this information to the TRS over the phone. Bishop, Jeanrenaud, and Lawson (1975) reported that recall data is accurate after comparing the use of time diary and recall questionnaires for surveying leisure activities. The activities identified on the Telephone Checklist were used by the

TRS to verify if subjects had participated in current, new, and/or re-engaged leisure activities. Subjects listed all the activities that they participated in and checked off which ones they completed in or out of the home, alone or with others.

Social Validity Questionnaire: A social validation questionnaire used by Searle et al. (1995) was minimally modified for this investigation. The subjects completed the questionnaire two weeks after the delivery of the leisure education intervention (Appendix F).

INDEPENDENT VARIABLE

Community Re-integration Program (CRP)

The leisure education intervention used in this investigation was a modified version of the Community Reintegration Program (CRP) developed by Bullock and Howe (1991). The CRP was created as a transitional therapeutic recreation program for clients leaving rehabilitation environments and re-entering their respective communities. The purpose of this model is to enhance the quality of life of individuals with disabilities through leisure education and enable them to independently function in their communities. By participating in the CRP, clients develop awareness, knowledge, and skills necessary to maximize independence in leisure, while acknowledging the physical, mental, emotional, and social benefits of participation in leisure activities.

Modifications were made to the CRP model by Searle et al (1995) to ensure its appropriateness for older adults. The CRP Participant Guide (Bullock & Morris, 1990) originally designed as a guide for self-study, was contextualized for older adults, resource lists were changed to incorporate local resources, and community participation was incorporated into the intervention. The above-mentioned modifications also apply to this investigation.

Researchers have identified other modifications to enhance leisure education interventions. Combining leisure education and participation is an effective modification

to leisure education interventions (Rancourt, 1991a; Searle et al., 1995). Bullock and Howe (1991a) reported that clients, after completing a leisure education intervention, recommended that community involvement be incorporated into the intervention as soon as possible. Participants must also be actively planning and making decisions throughout the entire intervention (Searle & Mahon, 1993). On-site training and placement are also necessary for learning (Munson, 1988). In this study, community participation was incorporated into the intervention where appropriate. Participants had the opportunity to plan, make decisions, and learn in the leisure environments of their choice.

The CRP model is composed of twelve units (content elements) and is to be delivered by a TRS. Originally, the CRP model was designed to be a self-instructional leisure education program. However, after discharge from hospital, clients participating in the CRP for the first time were not completing the manual. As a result, the TRS role was introduced to facilitate the completion of twelve units and attempt to involve family, friends, and community resources to enhance progress towards independent leisure functioning in the community. The TRS in this study worked with the client to establish goals and to facilitate the completion of the leisure education intervention, while incorporating the exploration of community, family and friend resources.

Although the CRP model is composed of twelve units or content elements, a participant must not necessarily complete all twelve content elements (Bullock & Mahon, 2000). A participant's leisure education program is developed to meet his or her stated needs and interests, within the context of his or her life and the community in which he or she resides or is returning to.

Each unit in the Searle et al. (1995) study combined various activities including discussion exercises, paper and pencil exercises, role-playing, and leisure activity participation. This study incorporated the same types of activities to enhance the learning process and develop on-going action plans. Dattilo and Murphy (1991) suggested that a leisure education intervention should include the following: title, purpose statement,

goals, behavioral objectives, content, and process. For the purposes of this investigation, the intervention outline, as presented by Dattilo and Murphy, was followed.

The title of the leisure education intervention is "Recreation-The Time of Your Life." The stated purpose was to facilitate the independent leisure functioning of four older adults. The goals of the intervention were to increase leisure awareness, skills, and knowledge related to increasing independent leisure participation. Behavioral units or objectives describe the measurable outcomes of the intervention. The content of the program describes what was actually done in each of the twelve units. The process refers to how the content was presented by the TRS. For the purposes of this leisure education intervention, the objectives, content and process developed by Bullock and Howe (1991) were utilized. They are as follows:

Unit 1: What you do for recreation. The goal was for the subject to demonstrate leisure self-awareness. The objectives of this unit were (1) to have the subject understand the CRP process and show intent to participate, (2) to discuss the benefits of recreation, i.e., physical and mental well being, and (3) to identify six personal recreation interests.

If family and friends were involved, the TRS explained to them and the subject how the program worked. The TRS provided the subject with a CRP Manual and reviewed program goals. The TRS encouraged and answered questions, and explained program benefits. Through discussions with the TRS, the subject learned about the benefits of recreation. The subject completed the Recreation Activity List in the manual and selected six activities most often participated in the past, or those that she was currently interested in.

Unit 2: Why you do what you do. The goal of unit 2 was for the subject to demonstrate awareness of personal reasons for leisure participation. The objective for the subject was (1) the identification and description of at least two benefits, reasons, and/or interests related to participation in specific recreation activities identified in Unit 1. Completing the Recreation Reasons sheet with the TRS did this. The subject was asked to identify

why she had participated in activities in the past or what attracted her to new activities she had identified as being of interest.

Unit 3: How it is done. The goal of unit 3 was for the subject to demonstrate knowledge of requirements to participate in preferred activities identified in unit 1. Based upon the subject's analysis of activities and identification of interests in Unit 1 and 2, the objective for the subject was (1) to identify physical, mental and social skills required for participating in her preferred activities. The TRS then explained that examining these skills facilitated the identification of current capabilities, as well as requirements, which may have been too challenging for the subject. The Activity Requirements form required the subject to do an activity analysis on the first activity listed on her Recreation Activity List. The subject was then encouraged to complete activity analyses on the remaining five activities on her list.

Unit 4: Can you do it? The goal of unit 4 was for the subject to demonstrate awareness of current leisure capabilities and limitations. The objectives of this unit were (1) to identify current physical, mental, and social capabilities required to participate in preferred leisure activities, (2) to identify physical, mental, and social limitations to preferred leisure activities, and (3) to identify and address denial of limitation by realistically assessing current capabilities. The subject assessed the implications of current and potential physical, social, and mental capabilities for participation in preferred activities. The subject identified her strengths, weaknesses, limitations, and capabilities through discussions relating to future recreation involvement. The subject then speculated upon her physical, social, and mental capabilities to perform preferred leisure activities in the short-term (0 - 6 months) and/or long-term (7 months or longer). The TRS attempted to be aware of and addressed issues of denial, and helped the subject to realistically assess current conditions.

Unit 5: Ways to make it happen. The goal of unit 5 was for the subject to indicate awareness of activity adaptations or equipment modifications required for leisure

participation. The objectives of this unit were (1) to understand the difference between activity adaptations and equipment modifications, (2) to determine if either activity adaptations or equipment modifications were necessary to facilitate leisure participation, and (3) to know where to acquire equipment modifications or how to make activity adaptations when necessary. Together, the TRS and subject reviewed the brief article entitled "Adaptations and Modifications" and discussed different types of activity adaptations and equipment modifications. The subject identified limitations that inhibited participation and wrote them down on the problem list. The subject then determined which activity adaptations or equipment modifications could be made or purchased to allow for satisfactory participation. The subject listed these changes on the form in the column next to the problem list. The TRS encouraged the subject to have an open mind about adaptations and to creatively develop adaptations on her own.

Unit 6: Barriers. The goal of unit 6 was for the subject to demonstrate awareness of leisure barriers. The objectives were (1) to identify physical, attitudinal, and/or resource barriers to leisure activities identified in unit 1, (2) to overcome physical, attitudinal, and/or resource barriers utilizing problem solving techniques, and (3) to demonstrate the ability to overcome barriers through actual leisure participation. The subject was expected to be able to name physical, attitudinal, and resource-related barriers inhibiting participation in the activities identified in unit 1. The subject then generated a list of barriers and possible solutions to overcome these barriers.

Community Participation: The goal for the subject was (1) to demonstrate the ability to overcome barriers or develop coping mechanisms to deal with barriers when confronted by them in a community activity. In order to demonstrate this ability, an activity was planned. The subject used the Recreation Activity Planning Sheet to anticipate barriers. The subject and TRS discussed the potential barriers prior to departure. Immediately following the activity, the subject and TRS reviewed the experience.

Unit 7: Making plans for your future recreation. The goal for unit 7 was for the subject to demonstrate awareness of leisure planning. The objective of this session was for the subject (1) to develop short-term (0 - 6 months) and long-term (7 months +) goals for activity participation. The subject and TRS discussed how this process helped to define directions, measure progress, and indicate when changes in plans were necessary. The TRS referred back to the role recreation had in contributing to a person's well-being and reiterated how important it is to set goals for recreation participation. The TRS allowed the subject to set her own goals and made it clear that goals could be revised at any time.

Unit 8: What else is there? The goal of unit 8 was for the subject to select alternate leisure activities if barriers could not be overcome, activity adaptations were not possible, or equipment modifications were unattainable. The objectives of this session were (1) to search for activities that had similar reasons or benefits to those leisure activities originally identified in unit 1, and (2) to select an alternate activity and apply units 3 - 7 to this activity.

The subject completed the Recreation Alternatives Worksheet by selecting a new activity that she could do, and by comparing reasons for participation in this activity to those identified in the Recreation Activity List. The subject completed an activity analysis on the skills, adaptations, and modifications needed for the newly identified activity. The TRS guided the subject through the acquisition of new skills in the activity when and if possible. The subject set short and long-term goals for this new activity using the front side of the Recreation Activity Planning Sheet.

Unit 9: Resources...People. The goal of unit 9 was for the subject to demonstrate awareness of those people who provide social support. In this unit the objective was for the subject (1) to identify specific people who could provide support (physical, emotional, and/or attitudinal) to facilitate leisure participation, and (2) to begin making assertive requests for help or aid when appropriate. The subject completed the People Resource

List and determined from whom she could expect to receive physical. emotional. and/or attitudinal support. The TRS let the subject know that this information was confidential and did not have to be shared with her support people. The TRS also explained that support may have changed since the onset of disability, and encouraged the subject to think of people who had never been a source of support. If deemed necessary or desired. the TRS referred the subject to an assertiveness training program. or facilitated the completion of the Being Assertive form to provide an understanding of the importance of being assertive and learning what being assertiveness really means.

Unit 10: Resources...Personal. The goal of unit 10 was for the subject to demonstrate awareness of personal recreation resources. The objective of this session was (1) to identify financial, transportation, community, and equipment resources available for leisure participation. The subject assessed personal resources using the Personal Resources section of the Recreation Activity Resources sheet. The TRS encouraged the subject to analyze personal resources required for preferred activities. If barriers arose. the TRS allowed the subject to think them out as much as possible.

Unit 11: Resources...Community. In unit eleven the goal for the subject was to demonstrate awareness of community resources. The objectives for this session for the subject were (1) to identify sources of leisure information available in the community. and (2) determine the name of two local organizations or agencies where activities of interest were offered, and (3) locate and participate in a recreation activity offered in a community agency or organization. The subject identified recreation information sources by viewing telephone books, newspapers, magazines, as well as any additional sources the participant might have been familiar with. The subject identified two agencies or organizations that offered activities in her long-term recreation plans.

Community Participation: (1) The subject demonstrated the ability to locate and use a recreation program/facility in the home or community. The subject contacted the appropriate agency or organization in the community to solicit information required for

participation, i.e., times, dates, types of programs, etc., and went to this facility to participate in an identified activity. After the subject's participation in the activity, the subject and TRS discussed and reviewed the experience.

Unit 12: Before You're Through With Us. The goal of unit 12 was for the subject to summarize leisure plans. In unit twelve, a meeting was arranged with the subject to (1) re-evaluate and/or revise goals and (2) articulate her plan for recreation participation. The TRS talked with the subject about her specific plans, summarized the subject's goals, and encouraged re-evaluation on a regular basis. The subject re-evaluated and/or revised goals with the TRS when desired. The subject explained how she intended to implement activity participation in the community. If applicable, the TRS reviewed the content elements of the program that were identified as being important to the individual but were not completed, and encouraged the subject to complete them independently. The TRS answered questions and expressed opinions when warranted.

PROCEDURES

Subject names, addresses, and phone numbers were collected from a Provincial Home Care Program. To ensure client confidentiality, the official name and location of the Home Care Program will not be listed. The investigator approached the Director of the Home Care Program and requested access to potential clients for the study. Permission was granted. Prior to contacting clients, Home Care case managers reviewed their client lists and recommended potential candidates that they believed would benefit from an education program. When the clients gave their consent, the case managers forwarded their names to the investigator. The investigator then contacted the clients to obtain verbal consent to participate in the study and set a date to meet to conduct cognitive testing.

The investigator administered the Mini Mental Health State Examination (Folstein, Folstein, & McHugh, 1975) two weeks prior to beginning phase A of the investigation. If participants received a score of 24 or higher, they were eligible to

participate in the study. The TRS made an initial telephone call to each subject to introduce her and the program, and to determine if the subjects were willing to participate in the study. Confidentiality was assured. A date was arranged for the first home visit. A second call was made one day prior to the visit to re-confirm desire to participate and re-confirm date and time of visit. Prior to the visit, the TRS initiated the assessment process by reviewing information provided by the Home Care program, i.e., name, address, telephone number, age, and, date of birth. After meeting the client, the assessment was completed. Progress notes were completed after each session to monitor the intervention.

First Visit

At the first visit, May 1995, the therapeutic recreation specialist (TRS) introduced the program and obtained written consent to participate, and asked subjects to complete the Current and Past Leisure Activities Finder. This form asked the subjects to indicate what activities they had participated in during the past year and activities participated in prior to the last twelve months.

Second Visit

A date and time for the second visit was set at the first visit. The TRS explained the purpose of the Telephone Checklist and demonstrated how it was to be completed on a daily basis. The subjects had an opportunity to practice completing the form. The list was designed to enhance the reliability of the data obtained from subjects regarding their participation in activities from the previous day. The list facilitated accurate recording of participation. The forms were picked up once a week and new forms were provided by the TRS

Phase A

The TRS called every second day for the first and second subjects in phase A to obtain participation information recorded on the Telephone Checklist. The TRS read from Telephone Script 1 (see Appendix G). The script was developed to reduce the effect speaking to the TRS might have had on each subject's responses. Due to extended A

phases for the third and fourth subjects, the TRS called them once a week using Telephone Script 2 (see Appendix H). Immediately preceding the introduction of phase B, subjects three and four received a total of five calls every second day. The TRS discretely categorized the responses for each subject.

Phase B

The leisure education intervention (phase B) was conducted by the TRS once a week in the subject's home and when applicable, in the community. The TRS provided the subjects with a manual titled "Recreation-The Time of Your Life." The manual had instructions and exercises for each unit that could be completed in advance or with the TRS. Subjects continued to complete daily telephone checklists and were supposed to receive calls from the TRS every second day throughout phase B. However, daily telephone calls were invasive, annoying, and not appreciated by the subjects. Daily telephone calls were halted. Subjects simply recorded their activities daily and the TRS reviewed them during each leisure education session.

Phase C

Once the sessions were completed, one telephone call was made weekly for the duration of four weeks. Subjects continued to complete Telephone Checklists. They recorded leisure participation as they did in phase A and B. The TRS and the subjects mutually set dates to call and collect the data. A follow-up interview took place two weeks after the unit twelve meeting. At this time, the social validity questionnaire was completed.

RELIABILITY AND VALIDITY

Interobserver Reliability (IOR)

Interobserver reliability (IOR), also called interobserver agreement, refers to the extent that two observers agree on a behavior being scored (Kazdin, 1982). IOR was checked in all phases of this design. The investigator and a trained observer measured interobserver reliability by discretely categorizing the dependent variables in this study. The Point By Point IOR method was used to measure percent agreement. Percent agreement is equal to the number of agreements divided by the number of agreements plus the number of disagreements and multiplied by 100 (Kazdin, 1982). Kazdin suggests that this is the most rigorous method of computing IOR.

$$\% \text{ Agreement} = \frac{\#\text{ of Agreements}}{\#\text{ of Agreements} + \#\text{ of Disagreements}}$$

For IOR training, the observer reviewed the Interobserver Reliability: Recorder's Criteria form that defined a leisure experience, and the dependent variables - current, re-engaged, and new leisure activities (see Appendix I). This form also explained how the recorder would review the subject's Current & Past Leisure Activity Finder and then determine whether the activities listed on each subject's Telephone Checklist were current, re-engaged, or new activities by comparing them to the activities on the Current & Past Leisure Activity Finder. This process is called discrete categorization.

The observer who was trained to measure procedural reliability for this study was a female, high school special education teacher. She teaches multi-graded students (grades 9 – 12) with learning disabilities. The qualifications of this observer included a M.Ed., B.Ed., B.A. Prior to training, she signed a confidentiality paper indicating that she

would keep in confidence, all information she was exposed to during the study (refer to Appendix J).

To discretely categorize the activities as current, re-engaged, or new activities, the observer had to understand that each person's leisure definition depended upon what that person perceived to be leisure. The observer was then instructed on how to classify specific activities and how to determine the frequency of activities. For instance, if a subject recorded two activities outside the home such as going to the bank and the grocery store, they were considered 2 separate activities. Two phone calls equaled two activities. Two activities that occurred at the same time constituted two activities, i.e., knitting and watching television.

A sample data set was used to categorize and compare data to that of the investigator. When there was 100% agreement, the observer was considered trained. She was then instructed to categorize 35% of the Telephone Checklist responses in each phase in the design on the Interobserver Reliability Categorization by trained Observer form (see Appendix K).

Procedural Reliability

Procedural reliability checks are necessary to ensure the integrity of a treatment or independent variable (Welch & Holborn, 1988). Treatment integrity refers to the intended delivery of a treatment. Standardizing procedures facilitates adherence to planned procedures and the assessment of procedural reliability. Adequately assessing and double-checking the independent variable can help to ensure sound conclusions about the functional relationship between the independent and dependent variable (Peterson et al.,

1982). If observations are not made on the independent variable, conclusions about the source of change may be called into question.

The TRS attempted to deliver the same leisure education objectives to all subjects. Procedural reliability data was collected by audio-taping all of the leisure education sessions in order to have a trained observer review 35% of the sessions to assess whether the objectives were delivered as planned. Objectives were outlined for each unit, and each unit had a total of 1 - 3 objectives. Agreement percentages were calculated using the Billingsley, White and Munson (1980, p. 234) formula:

$$\textbf{Procedural Reliability} = \frac{\text{TA} \times 100}{\text{TT}}$$

"TA" is the number of times the TRS presented all of the objectives in each unit of the intervention that was being observed. "TT" is the total number of times the TRS was supposed to present objectives as determined in each unit of the intervention.

The observer first read over a blank copy of the leisure education manual; and then read the Procedural Reliability: Recorder's Criteria form (Appendix L), which outlined the goals, objectives, content, and procedures for each unit of the manual. She also reviewed the Procedural Reliability Recording Sheet (see Appendix M). A sample objective and a written narrative were used to train the observer. The trainee then listened to a session and scored the objectives she believed to be delivered and then her scores were compared to that of the investigator. When 100% agreement was obtained between the investigator and the observer, the observer was trained.

The trained observer then listened to the sessions identified by the investigator and recorded an "X" on the list every time the TRS delivered the objective outlined for a

session. The observer was instructed to listen carefully as the objectives for the sessions were embedded within conversations and she would be required to decipher if the objective had been delivered as designed.

The investigator selected the units that were reviewed because it was deemed important to review as many objectives as possible from different units. Each participant had specific units and objectives individually developed based upon their assessments and information garnered during the intervention. Sometimes the exercises in a unit involved answering a question for 6 leisure activities. This may have made it extremely difficult for an observer to read through and even harder to decipher if an objective had been achieved. Therefore, units were not randomly selected.

The trained observer listened to four sessions per subject. For Participant 1, the trained observer reviewed sessions 1, 4, 5, and 9 by listening to the tapes. For Participant 2, sessions 2, 3, 7, and 10 were reviewed. However, sessions 3, 7, and 10 were not recorded due to equipment failure. These three sessions were delivered on the same day and on this particular day the tape recorder broke. Fortunately, the TRS recorded the subject's responses on a working copy of the leisure education manual and reviewed the session at the beginning of the next session. The review of the previous session was captured on tape. In order to review Brenda's sessions, the trained observer listened to the beginning of the next session's tape and read the researcher's notations in the a working copy of Brenda's leisure education manual.

Social Validation

Social validation is a mechanism used to validate the effectiveness of a treatment (Yeaton & Sechrest, 1992), and can be used to determine if the consumer of a service,

such as therapeutic recreation, values leisure education goals, procedures, and outcomes (Mahon & Bullock, 1993/1994). Social validation procedures are also important to applied research because they "tie research results to social context and help ensure that procedures and results are important and focused on socially relevant issues" (Storey, 1989, p. 29). Social validation questionnaires provide further validation since questionnaire results represent the therapeutic criterion (Risley, 1970; Wolfe, 1978).

Therapeutic recreation research has infrequently used social validation procedures according to Storey (1989). Mahon and Bullock (1993/1994) examined the social validity of a leisure education program for persons with mental disabilities and is one of the few to report social validity in therapeutic recreation. Searle et al. (1995) also used a social validity questionnaire. The questionnaire used by Searle et al. was minimally modified for this investigation.

Halle, Boyer, & Ashton-Shaeffer (1991) suggested using qualitative and quantitative methods to obtain consumer feedback. In doing so, desired and actual outcomes can be compared. Qualitative and quantitative data can be used to validate research through subjective evaluation and measures of consumer satisfaction. The social validation questionnaire developed by Searle et al. (1995) included open-ended questions (qualitative) on satisfaction, as well as Likert-type scale questions (quantitative).

The subjects in Study One completed the social validation questionnaire two weeks after the delivery of the leisure education intervention. A therapeutic recreation specialist who was unfamiliar with this particular study and the participants involved, delivered the social validity questionnaire and asked the participants for their responses. It was hoped that a person with no attachment to this study would reduce any risk of bias in

recording responses, as well as to encourage participants to be as honest as possible about the experience that they had throughout the intervention.

The participants were ensured that the data collected from the social validation scale would be kept confidential: the names of each participant are therefore unknown. The results from the questionnaires will be presented as being obtained from Participant 1 and 2. A Likert scale was used to indicate participant satisfaction, while comments were collected to represent the participant's subjective evaluation of the intervention. The Likert scale consisted of 4 responses: 1 – Not Important, 2 – Somewhat Important, 3 – Important, and 4 – Very Important.

ANALYSIS

Experimental and Therapeutic Criterion

This single subject design used experimental and therapeutic criterion to analyze and evaluate the data and draw conclusions about behavioral changes that occurred. Risley (1970) suggested that experimental and therapeutic criterion might be used to evaluate data in applied analysis. These criterion help determine if changes can be attributed to the leisure education intervention. The experimental criterion refers to the way data are analyzed to decide if an intervention effected change. In this study, visual inspection is the experimental criterion. The therapeutic criterion determines whether the effects of the intervention are important and if the intervention has any clinical significance. Sometimes an intervention can meet the experimental criterion and not have relevance for the client or make a difference in his or her life. Social validation can represent a therapeutic criterion and can be used to support the experimental criterion.

Visual Inspection

Visual inspection was conducted in order to draw conclusions about behavior change, i.e., the frequency of leisure participation before and after a leisure education intervention. In this study, data collected from A, B, & C phases were graphed, and visually inspected. The experimental criterion is achieved when leisure participation changes or shifts at each point the intervention is introduced across subjects. Phase A performance is used to measure change after the intervention is introduced.

Visual inspection is done by visually examining graphed data to judge the reliability of intervention effects (Parsonson & Baer, 1978). When using visual inspection as the analytical tool, the effects or change must be potent and obvious when looking at the graph (Baer, 1977). Visual detection is an "unrefined" and "insensitive criterion," meaning that changes occurring as a result of the independent variable will be obvious by looking at the data on the graph (Kazdin, 1982). Visual inspection was used to analyze the data on leisure participation. As well, mean lines were plotted for each phase of the design to assist with visual inspection of the criterion related to mean change.

Visual inspection using mean, level, trend and latency criteria for graphed data points is the primary method of analysis for the single subject design data in this investigation (Kazdin, 1982). The mean refers to the average rate of performance across phases. A mean line can be inserted to help illustrate changes in the average rate of performance across phases. Level refers to the change or shift of performance from the end of one phase to the beginning of the next phase. The level of performance is examined by looking at performance immediately after an intervention is introduced or withdrawn. Trend refers to systematic increases or decreases in the data over time. For

example, a horizontal line indicates there is no trend. Latency refers to the period of time between the delivery or withdrawal of an intervention and changes in performance. The sooner the change in performance, after the intervention has been delivered, the clearer the intervention effect becomes.

Comparative Pattern Analysis

Comparative pattern analysis (Patton, 1990) was used to analyze the open-ended responses on the social validation questionnaire. Comparative pattern analysis is a form of inductive analysis. Patterns, themes, and categories of analysis emerge from the data; they are not pre-determined. Patton presented two processes associated with comparative pattern analysis: convergence and divergence. Convergence refers to how things fit together, while divergence refers to drawing apart patterns or categories. Fitting information into categories begins by looking for "recurring regularities" in the data. Regularities can then be put into categories. The categories are then judged on the basis of two criteria: "internal homogeneity" and "external heterogeneity." Internally, the data in the category must hold together in some meaningful way. Externally, there must be distinct and clear differences between the categories. This, in a sense, becomes a classification system.

When many categories or systems are developed, it becomes necessary to prioritize them in accordance with salience, credibility, uniqueness, heuristic value, feasibility, special interests, and materiality of the classification schemes. The categories are then tested for completeness. Internally, the categories should be consistent and externally they should form a complete picture; the categories can be tested against the original problem or questions to determine if they are logically related. Divergence is

completed by extending known items of information, bridging different items, and surfacing new information that could fit and then, by trying to verify its existence. Closure can be assumed when sets of categories can no longer be formed or become redundant and clear regularities are formed and integrated.

Comparative pattern analysis contains elements of technical and creative components (Patton, 1990). The search for categories, themes, and patterns is guided by the research questions. The patterns should be easily understood and are considered to be qualitative findings, not theories or typologies. The patterns should answer the research questions, but they should also be practical and useful. Creativity is required to determine what information is significant and meaningful. The analyst must rely upon personal intelligence, experience, and judgment.

Descriptive Statistics

Descriptive statistics were reported for the results derived from the Likert-type scale questions on the social validation questionnaire.

STUDY TWO

METHODOLOGY

This methodology section consists of (1) Research Questions, (2) Research Design and Instrument (3) Participant Selection, (4) Subjects, and, (5) Analysis.

STATEMENT OF THE PROBLEM

A second study was deemed appropriate when two subjects withdrew from the single subject design in the first study. One subject withdrew and another was eliminated from Study One, rendering it difficult to draw valid conclusions from a single subject design that requires a minimum of three subjects. A questionnaire was therefore developed to further identify issues related to older women's leisure participation within a subject's home and community.

Miller & Crabtree (1994) suggest that a multimethod approach to clinical research could be valuable in a situation such as this one. The multimethod approach used in this study can be referred to as a sequential design in which the results of a study form the basis of another, i.e., describing key variables that lead to the development of a questionnaire. Study One resulted in the development of Study Two.

RESEARCH QUESTIONS

The purpose of the one time, in-depth interviews of five women aged 65+ was to further explore leisure/recreation participation patterns of older adults residing independently in community dwellings in an urban setting in Canada's mid-west. The following research questions were asked:

(1) Is leisure participation important to older adults residing in community dwellings?

(2) Does health affect the leisure participation of older adults residing in community dwellings?

(3) Are older adults residing in community dwellings satisfied with their leisure participation?

(4) Are IADL related to the leisure participation of older adults?

LIMITATIONS OF STUDY

1. The subjects were selected from a population of older adults receiving home care services in a mid-western Canadian city, and had been participants in a previous university study that was cancelled. They were selected because they had met the investigator and rapport had already been established. Therefore, the results might not be generalizable to other older adults who are living in community residences in different regions of Canada.
2. The exclusion of the institutionalized elderly meant that the most frail were systematically left out of the sample.

OPERATIONAL DEFINITIONS

Instrumental Activities of Daily Living (IADL)

Instrumental Activities of Daily Living (IADL) are complex activities needed to reside in a community residence (McDowell & Newell, 1987), and to lead an independent life (Ham, 1989). Examples of IADL are cooking, shopping, laundering, telephoning, reading, managing medications, using public transportation, managing money, and traveling (Kane & Kane, 1981).

Life Satisfaction

Life satisfaction was defined through the use of the following descriptive words that compose the Terrible/Delightful scale: health, finances, family relations, paid employment, friendships, housing, recreation activity, religion, self-esteem,

transportation, and life as a whole (Andrews & Withey, 1976; Michalos, 1980; Michalos, 1985). These descriptive words had phrases that described the meaning or context for the participants. They are as follows:

Health	The present state of your general, overall health (relatively free of common and chronic illness).
Finances	Your income and assets (including investments, property, etc.).
Family Relations	Kind of contact and frequency of contact you have with your family members. This includes personal contact, phone calls, and letters.
Paid Employment	Any work for wages, salaries or fees.
Housing	The present type, atmosphere and state of your home (apartment, house, farm, room, etc.).
Recreation Activity	Personal recreation activities you engage in for pure pleasure when you are not doing normal daily living chores or some type of work. This includes relaxing, reading, TV, regular get-togethers, church activities, arts and crafts, exercises, trips, etc.
Religion	Your spiritual fulfillment.
Self-esteem	How you feel about yourself; your sense of self-respect.
Transportation	Public and private transportation (including convenience, expense)

RESEARCH DESIGN AND INSTRUMENTS

The cornerstone of qualitative research is describing persons, places, and events according to Janesick (1994). The purpose is to better understand, extrapolate, and illuminate reasons, rather than to determine, predict, or generalize (Patton, 1990). It is up

to other researchers to question, and attempt to determine, predict, and generalize reasons through further research.

For this study, a qualitative interview questionnaire titled Leisure/Recreation Questionnaire was designed to identify issues related to leisure participation in the homes and communities of five women living in a mid-western Canadian city (see Appendix N). Miller & Crabtree (1994) suggest that when doing clinical research, a question is asked within a clinical context and then the method of study used must adjust to the question and the setting. Such was the case with this study.

"In-depth information from a small number of people can be very valuable, especially if the cases are information-rich" (Patton, 1990, p. 184). In-depth interviewing allows the researcher to be more open and intimate with the text, especially when little existing literature is available (Miller & Crabtree, 1994). Since this study's original intent was to examine leisure behavior of older adults, interviews were deemed appropriate. Crabtree & Miller (1992) suggest that semi-structured interviews can guide, concentrate and focus communication between an investigator and interviewee and the questions on the questionnaire exist to guide the interview. Therefore semi-structured interviews were conducted and guided by a questionnaire developed for Study Two.

The questionnaire used for the interviews was created from existing scales. However, the intent was not to examine scale scores, but to generate themes and patterns from the data. Some of the questions on the questionnaire were developed to gain an understanding of how these five participants valued their leisure activities, how they interpreted leisure experiences, and rated their satisfaction with current leisure/recreation. Questions inquired about the participant's desire to learn more about leisure and

recreation and the timeliness of leisure education at this point in their lives. Participants were asked what their favorite leisure activities were, whether they participate in them, and if so, where? Questionnaires regarding health and the relationship of health and leisure were included, as well as questions on the performance of instrumental activities of daily living (IADL) and life satisfaction.

The Terrible-Delightful Scale (Andrews & Whithey, 1976; Michalos, 1980; Michalos, 1985) was incorporated into the interview questionnaire in order to measure life satisfaction. It is thought that leisure participation is related to life satisfaction (Riddick & Daniel, 1984; Kelly, Steinkamp, & Kelly, 1987; Searle et al., 1995). Also, the lack of opportunity to participate in leisure activities can have the effect of decreasing psychological well-being (Decarlo, 1974) and thereby reduce a person's life satisfaction. Therefore, participants rated their own lives, as they were at the time of the interview, in terms of 12 descriptive words or phrases on a 7-point scale (terrible, very dissatisfying, dissatisfying, mixed, satisfying, very satisfying, delightful). This scale was modified by and utilized by the Adult Day Care Research Group (1995) and reported a Cronbach's Alpha for the 10 items to be 0.76.

The Social and Leisure Activities Outside of Adult Day Care scale also comprised part of the questionnaire and was previously utilized by the Adult Day Care Research Group (1995). This tool was designed to examine the social and leisure activity participation that took place outside of Adult Day Care programs. The five participants in Study Two were asked to indicate whether they were able to participate, the frequency of their participation (never, rarely, sometimes, often), and whether they did the activity

alone or with others. Response sheets were developed in large, bold print to clearly delineate responses to the questions.

Information and insights gained from Study One inspired the inclusion of Instrumental Activities of Daily Living (IADL) questions in the interview questionnaire. IADL are the activities that are complex and necessary to lead independent lives (Ham, 1989) and are often described as the management of household abilities (Verbrugge, 1990). IADL may include cooking, cleaning, telephoning, reading, writing, shopping, laundry, managing medications, using public transportation, walking outdoors, climbing stairs, outside work (gardening, snow shoveling), ability to perform paid employment, managing money, and traveling out of town (Kane & Kane, 1981). IADL participation is often related to leisure participation, i.e., telephoning to register for a class, cooking to socialize and entertain guests, managing money to be able to buy specific equipment, etc. Types of activity restrictions may include a person's decreased ability to perform IADLs, thus requiring increased amounts of health support services and possibly, decreased amounts of leisure participation. Therefore it was deemed important to include IADL questions into the questionnaire.

IADL questions were obtained and modified from a client interview questionnaire developed by the Adult Day Care Research Group (1995). Subjects were asked questions regarding the frequency and type of assistance required to shop, travel outside the home, handle personal finances, use the telephone, and perform household chores. Responses that the subjects were asked to select from included: none (no need, no need as someone else does, does not know how, physical inability); some; a lot; with help (who); without help; with device (what).

PARTICIPANT SELECTION

When conducting qualitative research there is always a trade off between "breadth" and "depth" when deciding upon the number of subjects in a study (Patton, 1990). Breadth refers to studying specific experiences for a larger number of people, while depth refers to studying a wider range of experiences with fewer people. Patton stated, "there are no rules for sample size in qualitative inquiry" (1990, p. 184). Sample size is dependent upon what the investigator wants to know, what his/her purpose of inquiry is, the credibility of the work, and the time and resources available. For the purposes of the second study, five one-time, in-person interviews were conducted.

The criteria for participation in the interviews remained the same as per the original study. A non-probability, convenience sample was selected from the original list of participants provided by a Provincial Home Care Program. The five women who participated in the interviews were all 65 years of age or older, experiencing social isolation, participating in few, if any, leisure/recreation activities, and were living alone in the community.

Four of the five participants in the interviews had been participants in another study at a large mid-western Canadian university that had been cancelled shortly after it began. Selecting participants from the larger study proved to be a wise decision. Establishing trust, rapport, and authentic communication patterns are important to capturing the nuance and meaning of each participant's life from his or her point of view (Denzin & Lincoln, 1994). Since the investigator of this study was the therapist delivering the intervention for the larger study that was cancelled, rapport had already been established and the participants were at ease with the interviewer. When they agreed to

participate by telephone, an appointment was made to complete an informed consent form (see Appendix O). As well, they were provided with information regarding the study and the researcher (see Appendix P). Permission was granted to audiotape the sessions. Confidentiality was assured.

THE PARTICIPANTS

The subjects in Study Two ranged in age from 71 to 82. Education levels ranged from grade nine to grade twelve. Two of the participants had taken a few secondary technical courses. The marital status of these women included a single woman, a married woman, a separated woman, and two widowed women. The following section provides a more in-depth look at the five participants and their health concerns. For the sake of their privacy, fictitious names were used. Each participant created a fictitious name and granted the investigator permission to print these names within this document. Their names are Edina, Dede, Eveline, Dotti, and Gerta.

Edina

Edina was 82 years old at the time of the interview, which took place in her home. Edina had been married for 14 years at the time of the interview. Her husband was admitted to a long-term care facility and she regularly took a taxi over to the facility to visit him. Edina completed grade 10 and went on to take a "commercial course" and then on to college. Her past occupation was a senior administrative position at a large university.

According to Edina, she has had surgery on both knees and the right knee is "fused straight". She also had surgery on both hips. In addition to having osteoarthritis, Edina has been taking medication for thyroid problems since she was 18 years old. Carpal tunnel problems in her right hand resulted in surgery.

Dede

Dede resided in her home with her pet dog at the age of 72. She was widowed for 6 1/2 years at the time of the interview, and had been married for 36 years. Dede had completed grade 9 in secondary school when younger. She left school due to a "fight, disagreement".

Dede was declared legally blind as a result of macular degeneration. Her spine was "crystallized" and she had no sense of touch in her hands and arms as a result of one blocked carotid artery and one diseased carotid artery. The lack of sensation in her hands and wrists, as a result of the carotid artery problems were complicated by carpal tunnel syndrome. These health issues, particularly the carotid arteries were considered to be life threatening and in 1989 her physician recommended she "take care of her affairs."

Dede smoked throughout the interview. She had a raspy, loud voice, and a screechy, rolling laugh. She could travel through her home with great ease and easily located items for display throughout the conversation.

Eveline

Eveline, at the age of 71, was living in her own home with her pet cat. Eveline had been married for 47 years. She was widowed for 1 year at the time of the interview. She completed grade 11 in high school.

Health concerns identified by Eveline included arthritis in her neck, spine, hips, and knees; diabetes; and, a knee replacement as a result of an injury acquired while participating in an aquatic exercise program for her arthritis.

For the past year, Eveline had been living in the house her and her husband had shared previously. She lived alone for ten years as a result of a marriage separation.

However, her husband became ill and she cared for him until his death and then she remained in the house. Eveline seemed to have a permanent furrowed brow and rarely smiled. She claimed she was worrying a lot.

Dotti

Dotti lived in her apartment alone and was 76 years old at the time of the study. She had been separated for 37 years. Dotti also mentioned that her daughter had died in July 1995, 7 months prior to our meeting. During her school years, she completed grade 10. When she worked, Dotti held two jobs and at the same time, raised 3 children. She worked during the day as a waitress in a restaurant and in the evening as a bartender in a lounge.

Health concerns identified by Dotti included: cataracts, cancer in the jaw, headaches, sinus problems, and a stroke 5 years prior (residual paralysis on left side). Dotti smoked heavily throughout the interview. She sat in her apartment facing the window keeping watch of any events that might occur during our conversation. The television was on the entire time we spoke. Dotti did not like responding to questions by choosing from a list of responses. The interviewer had to repeatedly ask for responses.

Gerta

Gerta was 75 years of age at the time of the study and normally resided in an apartment. At the time of the interview, Gerta had been hospitalized and welcomed the opportunity to complete the interview in her hospital room. She was single, had never been married, and had no children. Gerta had completed grade 11. Her secondary schooling included some courses in shorthand and typing. Her past occupation was in personnel service. Gerta explained that her health concerns included leg ulcers on both

legs, the sensation of "pins and needles" in her hand and fingers, diabetes, and poor circulation.

ANALYSIS

Comparative pattern analysis (Patton, 1990) was used to analyze the data collected from the follow-up interviews in Study Two. When analyzing data, it is important for the analyst to monitor and report on his/her own analytical processes and procedures to the fullest and truest extent possible (Patton, 1990). The analyst is expected to report what was done for the analysis as well as the results. During the readings and note taking and writing, it was difficult for the investigator not to examine personal experiences in relation to the conversations with these women. Visions of these women and memories of discussions during the interviews were evoked over and over again.

The analysis process began with the analyst re-reading the research questions in order to create an appropriate focus for examining data, a technique advised by Patton (1990). Hard copy field notes were kept in addition to tape recordings. The recordings were transcribed. Each transcribed interview was read twice and key issues thought to be the main focus of the interview were noted. Before reading transcripts of the interviews however, the analyst reviewed the subject's file that included consent and intake forms to re-acquaint herself with the subject. After the first reading, the analyst made brief notations on the left-hand side of the transcript. At this point the analyst re-read the field notes on the hard copy of the questionnaire to ensure all pieces of information were included in the process. During the second reading, further notations and clarifications were made to notes on the page. After the second reading was complete, themes and patterns that evolved from the interview were recorded. Quotations from the interview

were also documented to enlighten and support the analysis. The same process occurred for each interview.

The analyst then read through all five sets of responses and searched for commonalities, themes, and patterns that emerged between the five people. The themes were analyzed to determine if they were related to one another. If so, they were collapsed into larger themes and sub-themes. Patton (1990) insists that there is no right or wrong way to describe themes, patterns, or categories, only ways to explain what the data says.

Convergence and divergence occurred as I turned notes into phrases and sentences. It seemed natural to clump or converge similar or recurring ideas together. Divergence seemed to evolve. Often it was useful to give labels to recurring ideas. Concrete labels like "transportation" and "health" became evident very early. However, more abstract concepts like "dependence" and "perception" were more challenging to label.

Chapter 4
RESULTS

STUDY ONE

The results section for Study One is composed of (1) procedural reliability, (2) interobserver reliability, (3) visual inspection, (4) discrete categorization, and (5) social validation.

PROCEDURAL RELIABILITY

Table 4.1 illustrates procedural reliability scores that suggest the goals and the objectives for the independent variable (leisure education) were delivered as designed. There was 100% agreement between the trained observer and the investigator.

Table 4.1
Procedural Reliability Percentages for Alice and Brenda

Subject	%
Alice	100%
Brenda	100%

INTEROBSERVER RELIABILITY (IOR)

Table 4.2 illustrates percentages representing interobserver reliability agreements between the investigator and the trained observer. These percentages indicate that there were acceptable levels of agreement for the discrete categorization of the dependent variables (re-engaged, current, and new leisure activities) in this study. According to Kazdin (1982) a generally accepted estimate of agreement is .80 or 80%. However, the level of agreement is also dependent on the characteristics of the data and consistency of

the observers. In Phase A for Brenda, agreement reached 75%. It is believed that the trained observer and investigator were consistent with their observations and 75% is an acceptable level. The rationale for 75% being an acceptable level is discussed in the next chapter. All the other estimates of agreement exceed 80%.

Table 4.2

Interobserver Reliability (IOR) Percentages in Phases A, B, and C

Subject	Phase A	Phase B	Phase C
Alice	100%	100%	95%
Brenda	75%	86%	87%

VISUAL INSPECTION

Alice

In Phase A (see Figure 4.1), Alice recorded her leisure participation for a total of 11 days. She made 75 daily recordings in Phase B and 64 daily recordings in Phase C.

In this study the intervention alone failed to show or provide reliable effects in the intervention phase for Alice. The experimental criterion was not met in the leisure education phase; performance did not shift when the intervention was introduced.

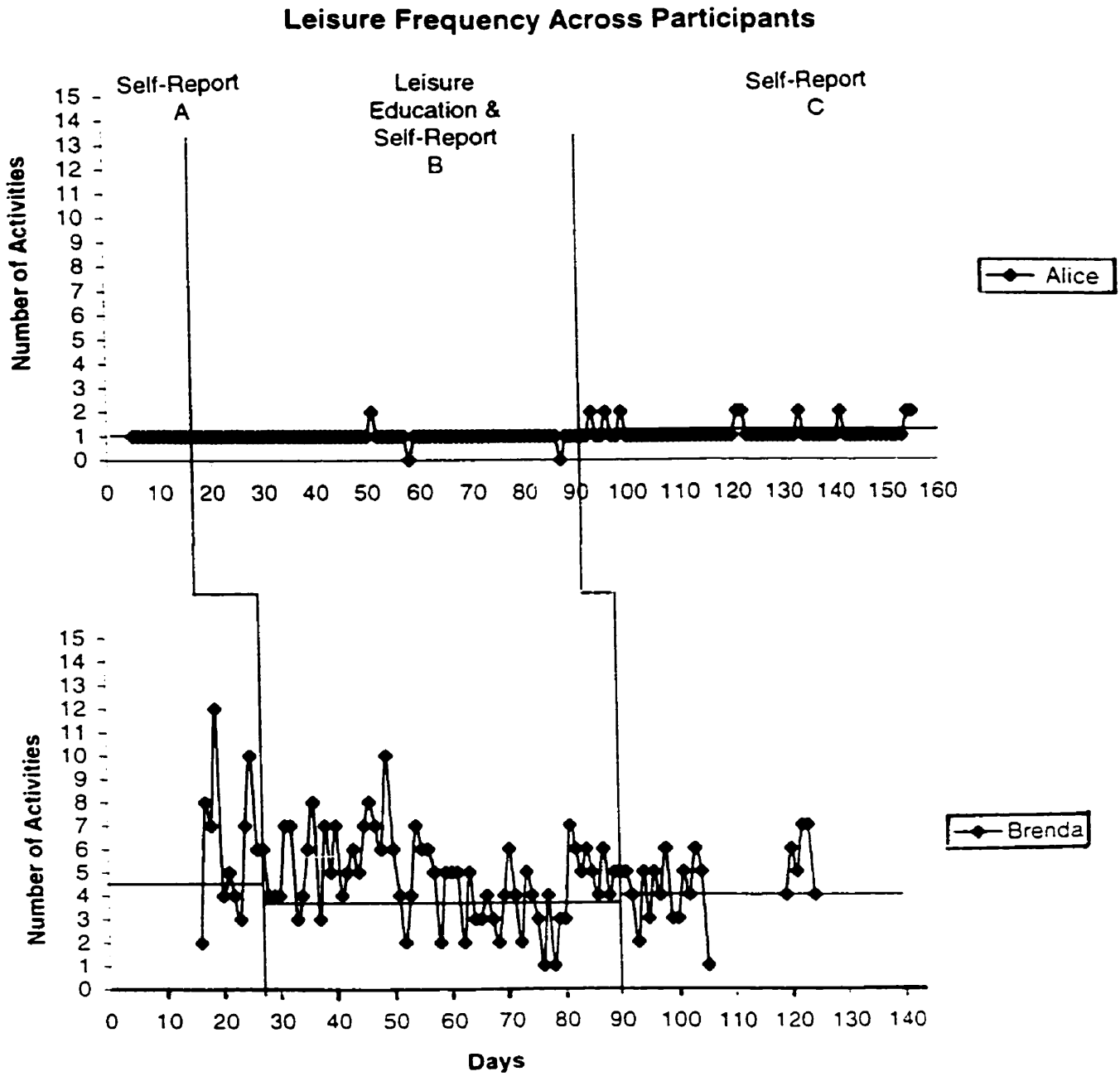

Figure 4.1. Multiple probe, alternating treatments design (ABC) illustrating leisure participation across participants.

Mean

There was no increase in leisure participation. The experimental criterion was not met. Calculated mean scores can be viewed in Table 4.3.

Table 4.3

Mean Scores for Alice in Phase A, B, and C

	Phase A	Phase B	Phase C
Mean	1	1	1.1

Level

There is no change in level from baseline to intervention phase. The experimental criterion was not met.

Trend

A horizontal line indicates no trend in phase A and phase B for Alice. The experimental criterion was not met.

Latency

The change from one activity to two activities in the intervention phase comes in the middle of the intervention, suggesting that extraneous factors may account for the change. The experimental criterion was not met.

Brenda

For Brenda, (refer to Figure 4.1) Phase A consisted of 11 daily recordings and was scheduled to begin the same day as Subject 1. However, Subject 2 became ill and was hospitalized at the time that she was to begin recording on the Telephone Checklist Form. At the time of the second scheduled visit Brenda called to cancel due to a water main

break in the building that she was residing. As a result, data for the first 14 days is unavailable. It would have been preferable to extend Brenda's Phase A to firmly establish a trend in the data. However, Brenda had become impatient with recording on the Telephone Checklist and called the TRS several times to enquire when the program would begin. The decision was therefore made to begin the intervention with the data obtained at that point in time. In Phase B, 62 days of recordings were made. In Phase C, 16 daily recordings were made. Brenda did not complete daily recordings for the following two weeks, however she did make daily recordings for the fifth week. The intervention failed to demonstrate that leisure education effected change in Brenda's leisure participation.

Mean

There was no increase in participation. The experimental criterion was not met. Mean scores were calculated and can be viewed in Table 4.4.

Table 4.4

Mean Scores for Brenda in Phase A, B, and C

	Phase A	Phase B	Phase C
Mean	4.6	3.9	4.1

Level

There is no obvious change in level across phases. The experimental criterion was not met.

Trend

There is no obvious change in trend across the phases. The experimental criterion was not met.

Latency

The experimental criterion was not met. There was no change in participation after the intervention was introduced.

DISCRETE CATEGORIZATION

Responses were classified into discrete categories by listing a number of behaviors and checking them off when they were performed (Kazdin, 1982). The investigator categorized the leisure activities listed on the subject's daily Telephone Checklist sheets by comparing the responses to the activities on the subject's Current and Past Leisure Activity Finder. The categories included current, re-engaged, and past leisure activities.

Alice's current, new, and re-engaged leisure activities are located in Table 4.5. In Phase A Alice participated in a total of 11 current activities. In Phase B Alice participated in a total of 73 current activities, and one re-engaged activity. In Phase C Alice participated in a total of 72 current activities, and two re-engaged activities. The apparent increase in current activities in Phase B is the result of increased days of data collection. For instance, in Phase A data was collected for a total of 11 days, whereas Phase B data was collected for a total of 75 days. In Phase C, 65 days of data were recorded.

Table 4.6 depicts Brenda's leisure participation. In Phase A Brenda participated in a total of 65 current activities and one new activity. In Phase B Brenda participated in a total of 275 activities, 19 re-engaged activities, and seven new activities. In Phase C

Table 4.5
Discrete categorization (current, re-engaged, new activities & percentages): Alice

Phase	Current	Re-engaged	New
A	11 (100%)	--	--
B	73 (99%)	1 (1%)	--
C	72 (97%)	2 (3%)	--

Brenda participated in a total of 92 current activities, three re-engaged activities, and two new activities.

When compared to that of Alice, Brenda participated in new leisure activities in every phase. She also participated in re-engaged activities in Phases B and C. Also note the frequency of current leisure participation. It initially appears as though current participation increased dramatically in Phase B, but it did not. The increased numbers of leisure activities are a result of a greater number of days in which data was collected. For instance recordings in Phase A were made over a period of 11 days. In Phase B, 65 daily recordings were made; and, in Phase C, 16 daily recordings were made.

Table 4.6
Discrete categorization (current, re-engaged, new activities & percentages): Brenda

Phase	Current	Re-engaged	New
A	65 (98%)	--	1 (2%)
B	275 (92%)	19 (6%)	7 (2%)
C	92 (95%)	3 (3%)	2 (2%)

When they completed their Telephone Checklist forms, the subjects were also required to indicate whether or not they performed their leisure activities in-home, out-of-home, with others, or without others. The information on the Telephone Checklists was then discretely categorized by the investigator by separating the current, re-engaged, and new activities into in-home alone, in-home with others, out-of-home alone, and out-of-home with others categories. Please refer to Table 4.7 and Table 4.8 to view the discrete

categorization of Alice and Brenda's leisure participation in and out of their homes, alone and with others. Percentages were calculated.

In Phase A current activities, Alice participated within her own home 27% of the time, while out-of-home activities represented 73% of her participation (refer to Table 4.7). When participating at home, she was always alone. When out of her home, she was always with another person. Alice did not participate in re-engaged or new activities in Phase A.

Her current activities in Phase A included walking outside with a health care aide or taking short car rides with her daughter, usually to her daughter's home for dinner. At home alone activities consisted of walking down the hallway of the apartment building.

In Phase B Alice's participation in current activities demonstrates a change in pattern. Now 62% of her current activities are participated in-home, and 38% are participated out-of-home. This is a reversal from Phase A. Also, in Phase A 100% of the in-home activities were performed alone. In Phase B, 58% are performed alone, but 42% are now performed with others.

In Phase B, Alice participated in the following current activities: walking alone in her home, walking with another person both, in her home and out of her home, and going over to her daughter's for supper. Alice re-engaged in one activity during Phase B. She played a game of Solitaire.

Table 4.7

Discrete categorization (activities in-home, out-of-home, alone, with others): Alice

	Phase A			Phase B			Phase C		
	Current	Re-engaged	New	Current	Re-engaged	New	Current	Re-engaged	New
In-home	3 (27%)	--	--	45 (62%)	--	--	27 (37%)	--	--
In-home-alone	3 (100%)	--	--	26 (58%)	--	--	23 (85%)	--	--
In-home with others	--	--	--	19 (42%)	--	--	4 (15%)	--	--
Out-of-home	8 (73%)	--	--	28 (38%)	1 (100%)	--	45 (63%)	2 (100%)	--
Out-of-home-alone	--	--	--	--	--	--	--	--	--
Out-of-home-with-others	8 (100%)	--	--	28 (100%)	1 (100%)	--	45 (100%)	2 (100%)	--

In Phase C, Alice's participation in current activities reverts back to similar percentages as evidenced in Phase A. In-home activities represent 37% of her current activities and 63% are out-of-home activities. However, she continues to perform

activities with others while in her home for 15% of the activities. The remaining 85% are performed alone.

In Phase C, the variety of Alice's current activities changed. She attended two parties. Alice had not attended a party during the study. However, she had attended parties earlier in the year and they were therefore considered to be current activities. She also participated in two re-engaged activities that included watching people play Whist and Penny Bingo. It was noted however, that Alice did not participate in any new activities.

Table 4.8 illustrates Brenda's leisure participation in current activities in Phase A. which primarily occurred at home, alone. However, she also participated in leisure activities out of her home alone and out of her home with others. In Phase A 74% of Brenda's current activities were in her home and 26 % were out of her home. Of the activities participated in her home, 90% of current activities were done alone. Brenda's activities outside the home were more evenly distributed, 59% were out-of-home, alone and 41% out-of-home with others.

Examples of current activities that Brenda participated in Phase A were talking on the phone, friends visiting, reading the newspaper, shopping, watching television, and knitting. The one new activity consisted of visiting with TRS delivering the leisure education intervention. Brenda considered this a leisure activity.

Table 4.8

Discrete categorization (activities in-home, out-of-home, alone, with others): Brenda

	Phase A			Phase B			Phase C		
	Current	Re-engaged	New	Current	Re-engaged	New	Current	Re-engaged	New
In-home	48 (74%)	--	1 (100%)	161(58%)	8 (100%)	6 (100%)	53 (58%)	2 (100%)	2 (100%)
In-home-alone	43 (90%)	--	--	143 (89%)	8 (100%)	--	41 (77%)	2 (100%)	--
In-home with others	5 (10%)	--	1 (100%)	18 (11%)	--	6 (100%)	12 (23%)	--	2 (100%)
Out-of-home	17 (26%)	--	--	114 (42%)	11(100%)	1 (100%)	39 (42%)	1 (100%)	--
Out-of-home-alone	10 (59%)	--	--	64 (56%)	4 (100%)	--	18 (46%)	--	--
Out-of-home-with-others	7 (41%)	--	--	50 (41%)	7 (100%)	1 (100%)	21 (54%)	2 (100%)	--

In Phase B the data suggests that a pattern changed within Brenda's current activities. Only 58% of Brenda's activities occurred in her home, whereas she increased participation in out-of-home activities to 42% in Phase B. Recall that in Phase A, Brenda participated in out-of-home activities 26% of the time. The distribution between activities in-home, alone and in-home with others remained relatively unchanged, as did the participation outside the home, alone, and with others. All of the re-engaged activities were performed in-home and alone. However, only 36% of her out-of-home activities were performed alone, while 64% were performed with others.

Current activities in Phase B remained unchanged. However, Brenda participated in 19 re-engaged activities that included taking a trip out of town to a museum, visiting with friends in a shopping center, taking a drive to a nursery with family members, picking raspberries, traveling, and sewing. Visits with the TRS during leisure education sessions continued to be perceived as new activities.

In Phase C, participation in current activities remained the same as in Phase B, 58% in-home and 42% out-of-home. A modest change occurred between in-home, alone and in-home with others. Activities in-home, alone decreased slightly to 77%, and activities in-home with others increased to 23%.

Activities performed in Phase C consisted of two new activities (visiting with the TRS), two re-engaged activities (sewing and visiting with friends outside the home), and 92 current activities that remained relatively constant through all three phases.

SOCIAL VALIDATION

Quantitative and qualitative data from the surveys completed by "Participant 1" and "Participant 2" was analyzed. The subjects have been labeled Participant 1 and Participant 2 throughout the social validity section in order to protect confidentiality. This was achieved by having an independent Therapeutic Recreation Specialist obtain the

responses to the social validity questionnaire so that the investigator did not influence the responses obtained from the participants. Descriptive statistics were examined and a comparative pattern analysis was conducted.

Descriptive statistics and comments

According to the quantitative and qualitative responses from the Social Validation Questionnaire, it seems that Participant 1 had a positive impression of the intervention. Quantitative responses ranged from one to five, one being unimportant and five being very important. On each of the five questions, she reported a ranking of "3" indicating the session was "important". Question one asked the participant if she believed it was important for her to participate in activities she enjoyed. She scored a "3" and responded, "Yes, for I don't like to sit back and watch others."

In reference to question two, which probed the importance of discussing what she did for fun and how important it was to her, Participant 1 scored a "3" and stated that she was "never too old to learn."

Question three enquired about the participant's perception of how important it was to do preferred activities; did she have the abilities to continue to do them; and were there things that prevented participation in these activities. Participant 1 scored a "3" and said "yes, in a way" it was important to me. "To talk about it is better than not talking." She was pleased to find out that she was not the only one to experience limitations to participation.

Question four probed the participant's perception of how important it was to plan and carry out plans for recreation. Participant 1 thought it was important to have someone

to talk to, and, she stated that she continues to participate "to a degree." "Some days I do it when I am able." She scored a "3" for this question.

Section three contained the remaining question regarding what happened to the participant as a result of this process, and would she recommend the process to family or friends. Participant 1 scored a "3" and stated, "It gave me more, urged me on to get mixed up in these fun things." She also stated "I'm sure lots would benefit" from this process.

Participant 2 responses ranged from "unimportant" to "somewhat important." Participant 2 scored a "2" for all of the questions, except question three, which she rated as a "1".

Participant 2 responded with a "2" for the first question. It is "somewhat important" for her to participate in recreation activities she enjoys. Her response to this question was, "when Wendy first contacted me, I was feeling low and felt I needed to get out." "Now I am doing enough things, and getting out better so I can do more."

Question two asked Participant 2 whether it was important to her to discuss what she did for fun and to explain why she did these activities. She rated the question with a "2" indicating they were "somewhat important" to her. However, her verbal response was "not honestly." "Felt wasting time on me." "All my time is leisure." "I told Wendy that I didn't learn that from her." "I don't honestly feel I learned something." I had learned it on my own...I have a friend who is making herself an invalid and I didn't want to be like that." I was motivated not to be." When asked if any part of the process helped her, Participant 2 said, "perhaps helped; sort of pointed out to me ... I'm lucky."

In response to question three, Participant 2 rated the sessions on problems, adaptations and modifications with a "1" indicating she thought they were "unimportant".

She stated, "perhaps [I] learned about physical things [I] use to enjoy." Then she stated that she had already known how to modify activities but supposed that she did "learn to figure out what [she] can't do and then [she'd] try something else."

She rated question four as being "somewhat important" as indicated by a score of "2", and stated that the leisure education "was what got me motivated, haven't had, might not have done it." Participant 2 indicated with a "2" that the outcomes of this process were "somewhat important" to her. When asked if her family supported her through this process, she stated that her daughter thought the process was "fine" and wants her mother to be more "involved with groups and the like." Participant 2 said she would recommend this program "to some people." She recommended people get involved in this process when they are without family or when a spouse has died.

Comparative Pattern Analysis: Themes from the Social Validation Questionnaires

Participants in Study One had positive impressions of the leisure education intervention. Participant 1 reported that "it gave me more, urged me on to get mixed up in these fun things". Participant 2 said, "I look at things a little better. Helpful for looking at things more, realizing I need to organize myself a little bit".

The participants determined that the most important part of the leisure education process was the companionship they received from the TRS when she came to their homes to deliver the intervention. Participant 1 stated, "Yes, it was important having someone to talk to". She made further statements like "good to have her visit", "miss someone calling", and "good conversation". Participant 2 stated that companionship was the most important experience; it was "high on the list".

Both Participants 1 and 2 believe that the TRS contributes to the process by being friendly, outgoing, and sincere. "Have to have [a] certain quality, be able to talk to people, [be] friendly, and be a little more outgoing," commented Participant 2. Participant 1 said the process "does take a certain type of teacher and teaching". It "does take a special type of person, if not sincere, don't deliver the same message".

The leisure education process is something that the participants would recommend to others. It is believed to be useful to people who are lonely, i.e., without family or recently widowed, as well as people that might require a little guidance or assistance finding resources. Participant 2 said she would recommend the program to others, "Yes, to some people" but, " not so much now as four or five years ago". They "can get into something and may not be so lonely and not get so set in their ways". Participant 2 recommended introducing leisure education to "those people without family or when spouse has died". Participant 1 also agreed that she'd recommend the program to others. "I'm sure lots would benefit. A lot not in a position to find these things themselves and may need a little guidance...to feel more involved, more important and more free."

The participants believed it was important for them to participate in activities they enjoyed. Participation in activities that are personally enjoyed may reduce boredom. Participant 2 explained, "for a time I felt why am I still living, but not now. I am not bored." Participant 1 claimed that recreation participation was "very definitely" important because she didn't like to "sit back and watch others" and that it would be a "dull world if [you] didn't have some outlet."

It is important to continue to participate in fun activities and become aware of the benefits that result from these activities, according to the participants. Participating in fun

activities may facilitate socializing and build confidence. "Perhaps I've learned to be more socially inclined," explained Participant 2. Comments from Participant 1 included "helped me, gave me more confidence to keep on" and provided "someone to talk to and tell about fun".

Leisure education sessions helped the participants assess abilities and limitations and identify alternative activities appropriate to ability levels. "Suppose I did learn to figure out what [I] can't do and then try something else". claimed Participant 2. "Learned I can't do physical things, but can do knitting, cards, find-a-word". "Sometimes feel I may be wasting my time but at 87 to heck with everyone else." Participant 1 said it "helped to have a clearer understanding of situation and how to handle it better".

The participants in this study did not receive much support from their family members with regards to planning and participating in leisure activities. The participants planned their activities independently, without the involvement of their families. Participant 1 said she didn't think her family knew what she was up to. "I have an independent life so I usually figure out to do things on my own. Family has their own lives and have busy lives". Participant 2 said, "Did on my own, nobody else".

Results from the Social Validation Questionnaire suggest that the participants had positive impressions of the leisure education program and they would recommend the program to others. It was important to them that they continue participating in activities they enjoy. The participants believe that the leisure education helped them assess their abilities and limitations and find new activities when needed. The most important component of the program was the companionship provided by the investigator. They believe TRS delivering the intervention is an important part of the process and can

influence the outcomes of the intervention. They planned activities independently of family members, and both were curious why they had been selected for the study.

STUDY TWO

RESULTS

Study Two consisted of participants completing a questionnaire that explored issues related to older adult leisure participation. These participants were living in their own homes and receiving home care assistance. The need for Study Two arose after two subjects were withdrawn and eliminated from Study One.

Major findings from the interviews conducted in Study Two will be found in this section. The first section examines whether leisure participation is important to the participants. The second section looks at whether the participants believe that health impacts their leisure participation. The third section explores if the participants are satisfied with their leisure participation. The fourth section explores the possibility of IADL participation being related to leisure participation. The fifth section examines the relationship between perceived ability to participate in certain leisure activities and actual levels of participation in certain leisure activities. The final section examines life satisfaction.

The Importance of Leisure

Several themes evolved from the analysis of the questionnaire regarding the importance of leisure. One theme suggested that leisure is important to a number of the participants in this study. Another theme seemed to indicate that some participants believe leisure is very unimportant. Additional themes included: the importance of leisure for mental and emotional health; the possession of a general interest in learning more

about leisure and recreation; current period of life is not a good time to be learning about recreation and leisure; disinterest in learning more about community recreation resources at this time; and, disinterest in further exploration of personal feelings and knowledge regarding leisure and recreation.

Leisure activity participation is important to three participants in the study. Leisure participation allows them to enjoy things they like to do, to avoid sitting around bored, to keep mentally alert, to keep busy, to help others, and to avoid perseverating on personal issues.

Gerta: Well because I'd like to do the things that I like to do. Well, because I like to have...I don't like to be sitting and doing nothing.

Edina: Because I think it keeps your mind active, it keeps you aware of what's going on in the world besides yourself.

Dotti: Very important. Oh, yes, I keep busy. I'm still working for United Way. Well, if I'm doing something that I'm helping, you know. I can't get out and do it now, so I do this in my home.

However, two participants reported that leisure was very unimportant to them. They perceived leisure as unimportant because they believed they had an abundance of what they called leisure time and were unable to do the leisure activities they wanted to because of physical limitations.

Dede: Because I can't really enjoy it anymore. I mean my whole life is made up of leisure now because of my handicaps. Like you know, my hands are practically useless now because of, you know, my condition. I can't see. I can't read.

Eveline is unsatisfied with the leisure time she has because she perceives physical limitations prevent her from participating in activities she enjoys. As a result, leisure is unimportant to her.

Eveline: Yes, unimportant because it's all I've got. I'd like something active, which I can't do anyways, so...

W: When you say that's all you've got, you mean leisure time is all you've got?

Eveline: Well, yes. That's the most I've got...time.

Leisure is important to health. Leisure participation was perceived to have a positive impact upon mental and emotional health if a person has the personality, attitude, and receptivity to the idea that leisure participation will positively impact health, and you are able to perform the activity.

Dede: Oh, I think it can have a positive impact on anybody's health if they could do it.

Gerta: Well because it gets you out of yourself. You don't have time to sit and think about yourself all the time. Keeps you occupied. Good for you.

Eveline was aware that leisure participation outside the home helped her avoid feeling depressed and increased her feelings of well-being.

Eveline: Well, actually I should say on your mental health.

W: Could you tell me a little bit more?

Eveline: Well, I feel so much better when I get out, you know. Right away I feel better, like a different person.

W: Like a different person than say, when you are at home?

Eveline: Uh huh.

W: Because you feel more active or...

Eveline: Not necessarily active, just more of a well-being feeling. My mental health is much better. Not depressed.

According to Edina, there is a relationship between leisure participation and a person's personality or belief that leisure has positive effects on health. If a person believes in the positive health benefits achieved through recreation participation, they will be able to access them.

Edina: It depends on your personality, I think. A lot of people nothing would help them. You know, they don't...

W: So, if you're receptive...

Edina: If you're receptive, I think it would be wonderful.

W: If you're receptive to it, then leisure could have a positive impact on your life?

Edina: I think so, because you know, if you're happy, you're a lot healthier than if you're not, aren't you.

Although participants believe leisure participation is important and that there are health benefits from participation in leisure, they only possess a general interest in learning more about leisure and recreation.

Gerta: Oh, more or less a general interest.

Edina: I think a general interest.

Dede: Just general I would think.

Dotti: Oh, I'm interested, but I don't go, you know...

At this time in their lives, participants report it is not a good time to learn more about leisure. Their explanations of this were entitlement to rest and relax after working

hard over a lifetime, inability to enjoy leisure activities anymore, uncertainty, lack of interest, or poor timing, i.e., better in earlier years when spouse was alive.

Dotti: I think at this time in my life you've got the right to sit and relax.

Edina couldn't explain why she wasn't interested in learning more about leisure at this time, even though she believed in learning at any age.

Edina: Probably not.

W: Probably not?

Edina: Although it's never bad to learn at any age, but I mean I don't know.

Dede was not interested in learning about things that she perceives she can no longer do or enjoy.

Dede: Not particularly.

W: O.K., why would that be?

Dede: Well, back to basics, because I can't really, literally enjoy anything anymore. There is not that much I can do, you know.

Eveline thought that she might have been more interested a year ago when her husband was still alive, but not at this time.

Eveline: No.

W: Any reason why not?

Eveline: I don't know...just not interested.

W: Do you think there would have been a better time that you might be interested in or have been interested in learning?

Eveline: Yes.

W: When do you think that would have been?

Eveline: Well, even in the past...like before my husband passed away.

Four participants did not want to know more about community leisure resources. They face many difficulties preparing to go into the community, i.e., it takes too much effort and they are not sure, when they get there, if they can participate, so they stop going. As well, they cannot go alone. As a result, they do not want to know what's available in the community.

Dede: No. Once again, I can't go out by myself.

Edina: Again, it would depend on how I could get there and how I could take part in things.

Preparing to go out requires a considerable amount of energy for Eveline. Therefore, it is often a barrier to going out.

Eveline: No, too much effort now a days.

W: By effort, what do you mean?

Eveline: Get ready and go.

W: Physically?

Eveline: Uh huh.

Since Dotti can't go out alone in the community, she was not interested in learning more about community services.

Dotti: Well, I can't do those things anymore. That's why I'm doing what I do.

W: What things can't you do anymore?

Dotti: I can't go alone.

Participants did not appear to want to take advantage of the opportunity to learn more about their feelings and knowledge of leisure and recreation because they were

content with their level of awareness of personal feelings and knowledge. they knew they can't do the recreation activities they want to do, or they simply were not interested.

Dotti was satisfied with her feelings and knowledge about leisure and recreation so she wasn't interested in learning more.

Dotti: No. I don't think so.

W: Why?

Dotti: I'm satisfied the way I am now.

Dede did not want to hear anymore about leisure because she had unsuccessfully attempted many activities in the past. She did not want to hear about things that she could not do.

Dede: No, because I would probably find out things I'd like to do that I know I couldn't do so...no, I wouldn't want to know anything because if I could do...I've tried numerous things, it just doesn't work.

Eveline did not elaborate on why she was not interested in learning about leisure feelings and knowledge.

Eveline: No.

W: Why not?

Eveline: Not interested.

Personal enjoyment, mental alertness, busyness, and focus on worldly issues are some of the reasons participants believe leisure and recreation are important. At the same time, perceptions that leisure is time void of pleasurable activities due to physical limitations influence some participants to think that leisure is very unimportant. Mental and emotional health benefits can be achieved from leisure participation if people believe

that leisure and recreation can facilitate health benefits. At present participants are generally interested in learning more about leisure, but are not committed to doing so at this time in their lives. They are not interested in learning more about community resources because they have faced numerous barriers to participation in the community and have, as a result, refrained from trying. Uncertainty, inability, lack of interest, and poor timing are reasons cited for not wanting to learn more at this time.

The Effects of Health on Leisure Participation

Health affects leisure participation. Health is the most important factor in the lives of participants. The participants rate their health as "fair" and explained that some of their health problems include mobility, vision, strength, balance and pain. Physical and mental limitations resulting from these health problems inhibit leisure participation.

A common theme for the participants was that health was most important at this stage of their lives.

Gerta: Getting well. That's the most important thing. Get these legs of mine well so I'd like to do a little bit of traveling if I can. Go see my brother and that. But I have to get these legs well first.

Eveline: Health

Having good health means doing things Edina likes to do, things that help her keep mentally and physically active.

Edina: Good health, probably.

W: Good health?

Edina: Still able to do things...wish I could do more things...I have other things I'd like to do, I'm not able to always. Stay active and have a good mind.

Participants rated their health as fair. These ratings are related to specific health concerns such as diabetes, sinus problems, headaches, lack of sleep, and arthritis.

Gerta: I would say my health is fair because I do have problems.

Dotti rates her health as fair because she has had difficulty sleeping and dealing with headaches for the past two months.

Dotti: Fair, I guess.

W: And why would you say fair?

Dotti: Because I haven't been feeling good since Christmas with this head.

W: Since Christmas?

Dotti: Haven't slept well.

W: And with this head you mean your sinuses?

Dotti: Yes.

Eveline rates her health as fair because she has arthritis and diabetes.

Eveline: I guess you would say fair.

W: Why would you say fair?

Eveline: Well, I have arthritis and diabetes.

Specific health problems such as mobility, vision, arm strength, and arthritis pain interfere with leisure participation outside the home. Participants face barriers to preparing or getting ready to go out, as well as walking, busing as a result of health problems.

Participants reported that health interferes with their ability to get ready or prepare for recreation participation. As a result of health problems, individuals face barriers such

as the inability to walk or get dressed independently or quickly. Gerta explained the impact health barriers have upon her attempts to prepare to go out.

Gerta: Well, my inability to walk for one thing. I can't walk by myself, you know. I can't even hang anything up in my closet.

Eveline reported that health problems such as pain from dressing and preparing to go out, make it challenging to make arrangements to go out to participate in leisure activities and as a result, she sometimes simply doesn't even try.

Eveline: Yes, because you're in pain all the time, eh.

W: Oh, O.K. Generally from the arthritis?

Eveline: Uh huh.

W: Oh, O.K. So that's sort of what slows you up, is that what you're saying?

Eveline: Yes, like you know, you get up in the morning, well it takes a long time and I never really get to go out until the late afternoon.

W: To what extent do your health problems stand in the way of doing leisure/recreation activities that you like?

Eveline: Well, all.

W: The preparation time?

Eveline: Right. Yes, you couldn't...a lot of things that I would like to do I can't do. You know, I would go bowling, stuff like that. There's always so much involved to get ready to do something...

W: So there's things?

Eveline: It's just too much trouble to be bothered doing it. It's not worth it.

Dotti stated that all of her health problems interfered with leisure participation. Her headaches, poor sleep, left-sided weakness due to a stroke made it difficult for her to perform leisure activities such as going for a leisurely walk alone.

Dotti: It has to be very slow. Once I get outside I'm not as steady as I am in the house for some reason.

W: Maybe you don't have enough things to hold onto like or...

Dotti: No, you have to be more careful. You can trip on the sidewalk if you don't lift your feet.

Edina has one knee fused and it does not bend. As a result she can't walk a block to a bus stop, nor can she walk up the steps on the bus. Therefore, mobility problems inhibit leisure participation outside her home.

Edina: No because I am not able to get out by myself. I have to have somebody around always to be with me because of my legs.

Dede attributes her inability to participate in leisure activities to health problems, which she refers to as "handicaps" such as blindness.

Dede: No because of my handicaps I can't do a lot of things I would like to do.

W: So, that stops you from...

Dede: Well, it stops me from going out and visiting. I can't go out by myself. I have to have somebody with me. Like I can't go shopping by myself because I can't read the prices...things like that.

Gerta explains how she is inhibited from going outside in the summer because her arms and hands continually feel like pins and needles and she doesn't have the strength to stop her wheelchair.

W: Are you able to go for a walk?

Gerta: No, not in this kind of weather I can't. And I don't think I'm going to be able to get out of my building in the summertime either because of that slanted thing at the front there, and I'm liable to go flying because there's nothing to hang on to.

W: Slant in floor, so would you...

Gerta: There's no rail.

W: There's no rail?

Gerta: Once you start down there you got no control. You grab the wheels on the side of your wheelchair, they won't stop it.

Health problems can impede a participant's ability to participate in leisure activities as well as interfere with their desire to pursue leisure activities, especially outside the home. While health is perceived to be most important at this time in their lives and they believe that leisure participation provides health benefits, health problems interfere with their ability to obtain those benefits through leisure participation.

Satisfaction with Leisure Participation

Participants are satisfied with past and current leisure participation. A level of acceptance and adjustment exists regarding the leisure participation a participant can and cannot do. Although participants admit there are many leisure activities they wish they could do, they are appreciative of the activities they can participate in.

Participants reported being satisfied with leisure participation during different stages of their lives, particularly in the past.

Dede: Yes, well when I used to go out bowling. Stuff like that. Up to and including contacting macular degeneration and before my ill health, I had a marvelous life. I was very active.

For Edina, satisfaction came from volunteering activities where she had a sense of belonging and could help others.

Edina: I think so...I did a lot for other people and that's how I got out...belonged to organizations and things...I'm a people person, I have to be doing things for other people and that's where I got a lot of my...

W: So you were satisfied?

Edina: Because I could teach other people how to do things.

Gerta found satisfaction in activities she performed and spoke of the accomplishments that continue to satisfy her like pictures and prizes she won for her participation.

Gerta: Yes, oh yes, I do. I've tried all kinds of things.

W: Can you tell me a little bit about...some of the things?

Gerta: Some of the things I...one thing I did do was curling when I was working. Even won a trophy. I used to bowl. I always went to church. I was in a choir. I've been in two choirs. Metropolitan Choir, put on a musical and I've got a picture of myself dancing. I was one of, I guess, eight dancers. I have a picture of that at home.

Although numerous barriers were reported as inhibiting leisure participation, participants did share that they were satisfied with the limited leisure activities they were involved in.

Satisfaction for Dede was provided by the personal challenge and skills she developed while playing cards with others.

Dede: I do have this one other activity that I play, cards.

W: Oh, well that's nice. What's the game called?

Dede: It's called 65. Which means you need 13 nickels and you can lose all 13. When I first started I was losing almost 13. Now I'm fighting back a bit. Now I might end up...oh sometimes I lose 30, but usually I fight back. Now I'm losing maybe 10 or 15 cents. That's not bad. But the enjoyment you get out of it...it's so nice to find that there is one thing I could still do. It really was.

While speaking about her volunteering for United Way, doing projects in her home, Dotti expressed her satisfaction. She is satisfied when she is busy and can help others.

Dotti: Oh yes, I keep busy, I'm still working for United Way.

W: What about United Way like what does that mean to you?

Dotti: Oh, I enjoy it. It's something I can do to help.

Eveline reported that her favorite leisure activity was Bingo. Participating in this activity gave her satisfaction by allowing her to see her friends.

Eveline: But I only have one.

W: You only have one activity. And what is it?

Eveline: That's every Tuesday, when I go uptown and go to Bingo. See friends there.

Eveline later reported how Bingo provided her with personal satisfaction. Getting out to go to Bingo made her feel better

Eveline: Well, I feel so much better when I get out, you know. Right away I feel better. Like a different person.

Edina also discussed her satisfaction with social visits from a couple from her church. This couple came into her home after driving her to and from church. She was very satisfied to have stimulating conversations.

Edina: Uh huh. Like this couple that take me to church now, he's a very interesting man and very interested in books and things...I could listen to him all day. Sometimes when they come, they will sit and talk for quite a while.

Gerta discussed her satisfaction from attending an Adult Day Care program. Getting out of her apartment gave her great satisfaction.

Gerta: The best part about it is just getting out. Getting out of my apartment, you know, for a day.

Some of the participants seem to have accepted and adjusted to leisure activities they can and cannot do. There are many activities participants would like to participate in

but can't. However, they have found activities that they can and do participate in to the best of their abilities.

Edina: I go to church. I take part in things that I can at church. I do a certain amount of cooking and if they are having something at the church, I always do my share. Things like that. Unfortunately, I can't do what I'd like to do because of my situation. I am willing to do whatever I can.

Dede: Wendy, I would love to be able to go out and do things. I would love to be able to volunteer for things, but you know, I'm more of a hindrance, you know, I drop things, I can't identify things, I can't identify people. I would love to be able to do it but I can't. I've accepted that a long time ago.

Dotti explains that there are many activities that she would like to do outside the home. However, she has accepted that she has certain mobility limitations, and as a result volunteers for United Way in her own home.

Dotti: Well, I can't do those things anymore. That's why I am doing what I do.

A common source of satisfaction among the participants' current leisure participation was the on-going playing of the television. It was common to conduct an interview at the same time that the television was on. It was not uncommon for the television to be playing all day long regardless of whether or not they were being watched or listened to. Participants indicated that listening to the television made it easier to deal with the silence or quietness in their homes where they live alone.

Dede: Oh, T.V. is on all the time. If nothing else, I listen to the weather information.

Edina: I have it on all day long, whether I listen or not. I put it on so that I know somebody's around the house. It's more to get somebody talking, then I don't feel like I'm so isolated.

Regardless of what else Gerta is going during the day, she is always aware of what is on the television.

W: So are you able to watch television?

Gerta: Oh yes.

W: And how often?

Gerta: All day.

Dotti has the television on all day to avoid the silence.

Dotti: I suppose so. It's awful quiet when you don't have anything on, you know.

W: Yes.

Dotti: Even if I'm not watching it.

Eveline has her television and radio on all day, every day.

W: I hear your T.V. going here.

Eveline: T.V. and radio.

W: How often?

Eveline: Often.

Participants are satisfied with past leisure participation. They wish they could participate in more activities then they currently are, but they are achieving satisfaction from the activities they are able to participate in. Current activities provide opportunity for personal challenge, increased skill level, accomplishment from helping others and

keeping busy, socializing, improving emotional well-being, and stimulating intellectual conversation.

The Relationship between IADL and Leisure Participation

Of the instrumental activities of daily living (IADL) examined in this study (shopping, traveling outside the home, handling finances, using the telephone, and doing household chores), travel outside the home seemed to be related to leisure participation. Home Care service providers assisted with IADL activities that the participants could not perform independently, i.e., vacuuming, laundering, cleaning bathrooms, and making beds. Participants reported that the interaction derived from the assistance received from Home Care staff was an important source of socializing and they fulfilled participant's needs for socializing.

Difficulties traveling outside the home greatly interfered with the participants' desire to take part in activities outside the home. Participants reported that transportation problems stopped them from going to church, Adult Day Care programs, visiting friends, etc. Travel outside the home was hindered by the lack of assistance provided by service providers, i.e., taxi drivers and by the lack of assistants available to help with travel outside the home.

It is sometimes necessary to have assistance from taxi drivers in order to enter and sit in a taxi. When taxi drivers are uncooperative, travel is difficult for Edina.

> **Edina**: It's very reasonable right now. It's only $1.75 each way, even if they raise it to $2.00 that's not too bad. But if you have to get help, what's the point, you know, and I have to have help. Then I have to sit in the front seat and then they argue about that. I have told them my doctor has written two letters to them, to the

transit company about it, and he just said, "I'm not writing anymore"...I tell them every time I phone, I have to have a front seat. I can't get in the back seat, you know. They give you a bad time about that.

It is important for Gerta to have assistance when traveling outside the home by taxi. She requires assistance entering the car. Her leg will not bend, thus she is restricted from sitting in the back seat of a car.

Gerta: Yes, have to sit in the front of the taxi. I can't sit in the back seat. My legs won't bend enough.

W: In the front seat? And do you do that?

Gerta: Oh, that's just the odd time.

W: You can do that by yourself?

Gerta: Well, the taxi driver, standing right there, if you need any help. I get them to put my leg in. My right leg's gotta be lifted because I can't lift it, not that high to get into a taxi.

The unavailability of another person to assist when traveling outside the home is also problematic and can result in the participant not traveling out of the home, or doing so infrequently.

Dotti: I can't go out alone.

Edina: No, because I am not able to get out myself. I have to have somebody around always to be with me because of my legs. But I enjoy people and I enjoy things and I wish I could do some of the things that I used to do and I can't do because I can't get out mostly, not because I haven't got the mind or the capability. It is just that I need help to get around because of my leg.

The participants required assistance performing certain IADL. Provincial Home Care staff provided the necessary assistance. Socialization occurs between the participants and the Home Care staff, and participants' needs for socializing are often filled by interactions with Home Care staff.

Edina: Oh yes, I've got two of the most wonderful people. They're really wonderful.

Gerta: Well, they are [an important source of socialization]...but I like people.

Dotti explained how well she got along with a Home Care worker and how these visits fulfilled her need for socialization.

Dotti: They are very nice. I get along good with them.

W: Do the visits from Home Care staff fulfill your need for socializing and visiting?

Dotti: Yes, we chat away while she works.

Eveline discussed her relationship with Home Care staff as being more than hired staff. The worker stays after her duties are completed and visits or waits in Eveline's home until her next appointment.

Eveline: Uh huh.

W: Yes.

Eveline: Very much so. Very nice girls.

W: You look forward to the visits?

Eveline: Yes, because she stays here for a while because she has one place to go after but not till around suppertime. So I said to her, just stay here instead of going home and back out again eh.

W: Oh, so that's nice...she stays and visits with you for a while.

Eveline: Yes, she sits and watches T.V. and I watch it in my bedroom, but you know... we talk while she's working too. She's an important part of my life.

IADLs are related to leisure participation, particularly travel outside the home. Difficulties with the ability to travel outside the home greatly affect participation. Participants require assistance traveling in taxis. They also require assistance traveling on sloped terrain and walking outside the home. The availability of people to assist them to attend activities such as church or Adult Day Care Programs can determine whether or not they will participate in these activities at all. Home Care service providers are an important source of socializing and help fulfill social needs.

Leisure Participation and Perceived Ability

The Social and Leisure Activities scale was utilized to explore participant's perceptions of ability to participate in leisure activities and actual participation levels. Results seem to suggest that participants in this study are involved in certain activities that they perceive they are able to, at varying levels, i.e., often, sometimes, and rarely. They do not participate in activities that they perceive they are unable to do.

Participants are able to, and often do participate in television watching, shopping with the help of others, and visiting with family and friends by phone.

W: Are you able to participate in watching TV?

Dede: Yes.

W: And how often?

Dede: I have the TV on most of the day.

W: O.K., so would you say sometimes, often...?

Dede: Often.

W: Often. And is that alone or with others or...?

Dede: It's usually alone, but you've got to realize I do it to catch the news. I watch all the news they give... The only way I know what's happening in the world.

Edina: Well, I did go shopping once a week, but I have a wheelchair usually, but once in a while I have to walk around that whole store and then I'm ready to tear somebody's head off...it's too hard on me. But I do go shopping, but I most of the time, I can get the automatic wheelchair...I guess often.

Dotti: Well, my one daughter phones me once a day from Steinbach. The other one phones me three or four times a day...often.

Participants are able to, and sometimes read, walk in the summer with the assistance of others, dine out with others, and visit with family and friends in person. Often, participation in these activities is limited to the availability of another person.

W: Are you able to read?

Gerta: Yup.

W: And how often?

Gerta: Well, whenever I am checking up on my mail.

W: O.K., so how would you classify that? Never, rarely, sometimes, often?

Gerta: Sometimes, I'd say.

W: Are you able to walk?

Dede: I can't remember the last time I went for a walk...Well, in the summertime I would probably go for a walk, Like I get Theresa to go out with me. A lady that works for me, but not in the winter.

W: O.K., so in the summer?

Dede: Just sometimes.

W: Are you able to participate in dining out? Going out for dinner?

Dotti: Oh yeah, the family take me out now and again.

W: So how often is now and again? Is that sometimes?

Dotti: Yes, sometimes.

Participants reported being able to participate in travel, cards, bingo, or games, arts and crafts, church, and movies, but rarely do so.

W: Are you able to travel?

Dede: With great difficulty. I've been known to go to Calgary a few times. It's no fun.

W: Is that right?

Dede: It's not really fun. You can't see...they bring you food and dump it on you and you don't know what's in there unless they tell you and flying is not one of my modes of transfer that I like. Like traveling by car. You know, I like to be able to step on, on the ground...That was kind of rare that year. Fortunately I don't have to travel anymore, I can get what I want here.

W: Are you able to play cards, bingo, games...?

Gerta: I've been playing them here [in hospital], but I have nobody to play with them at home.

W: O.K. What about...are you able to participate in arts and crafts?

Dotti: I am, I guess.

W: O.K. And how often do you participate in arts and crafts?

Dotti: I'm waiting to get my eyes fixed so that I can see to do it.

W: Are you able to participate in church?

Gerta: Well, I can't go to church, I can't go to church because of all the snow. Summertime I try to get there.

W: Oddtime?

Gerta: Rarely.

W: Are you able to participate in going to the theater, movies, or spectator sports?

Edina: I never get to go. Not spectator sports. Definitely, I could go to the theater or that if I were able to get to go. It's not that I couldn't participate. I can't participate in sports; that's for sure.

W: O.K. You are able to go to the movies. Spectator sports means watching the sport.

Edina: It depends. There is always a lot of stairs to climb usually in spectator sports. I wouldn't be able to go. Theaters are not so many steps usually, I don't think. I haven't been for so long, I've forgotten. I used to go all the time.

Participants are unable to do yardwork, walk outside in the winter, or partake in sports, particularly not at home.

W: Are you able to participate in outdoor yardwork?

Edina: No.

W: Are you able to participate in going for a walk?

Evelyn: No.

W: Are you able to participate in sports?

Gerta: No. Except I shouldn't say that. No, because downstairs [hospital day care program] I've been bowling and I've been carpet bowling and tic tac toe and things like that. I don't do it at home of course.

In many cases, participants in this study perceive themselves as having the ability to participate in certain activities, but participation is often inhibited by physical limitations, lack of partners, and limited transportation assistance. Participants did not perceive that they had the ability to do yardwork, walk outside in the winter, or do sport activities in the home.

Life Satisfaction

Findings from the Terrible – Delightful scale, designed to measure life satisfaction, suggest that participants were satisfied with friendships, spiritual fulfillment, family relations, housing, recreation, self-esteem, transportation, finances, and life as a whole. The reader will notice that responses to these questions are short and brief. This may have been the result of the type of responses requested, or it may have been the fact that they were the last questions on a very lengthy questionnaire and the participants were tired.

Participants indicated satisfaction with friendships.

Edina: Oh, I have...very satisfying I would say.

Eva discussed her satisfaction with friendships as follows:

Eva: Well, I have a small circle of friends and would say it's continual contact.

W: O.K., so out of all those categories, satisfying, very satisfying...

Eva: Yes, satisfied.

Satisfaction with religious/spiritual fulfillment was expressed.

Edina: Very good.

Dotti: Satisfying.

Dede: Well, I guess I'm satisfied. I believe in God and I believe in the right to pray whichever way you want. I don't go to church because it's just not convenient. You know, I'm satisfied with my two visits from my Minister every year

Gerta is satisfied with the religious/spiritual fulfillment she receives while at the hospital and while at home.

Gerta: Oh, while I'm in the hospital here, I've been going every Sunday. At home I can't get there.

W: So at home, how would you rate your...

Gerta: I listen to the T.V. I watch church on T.V. Start at 9:00 and go till 1:00, 1:30.

W: So, how would you classify...

Gerta: Very satisfying. I enjoy the different services.

Participants are satisfied with family relations.

Eveline: Satisfying

Gerta: Well, that's satisfying as well.

Dotti: Very satisfying. Delightful.

Housing is a source of satisfaction for the participants.

Dotti: I'm comfortable. I don't know what that goes under, satisfying.

Dede: Oh, very satisfying.

Edina: Well, it's as well as it can be...83 years...I think it's satisfying.

The participants in this study reported that they are satisfied with their recreation.

Eveline: Satisfied.

Dede: Very satisfied.

Edina: Satisfying.

The participants reported satisfaction with current levels of self-esteem.

Gerta: Satisfying.

Edina: Very good. I think I'm O.K.

Dede: Very satisfied.

The participants indicated their satisfaction with private and public transportation.

Eveline: I guess delightful.

Dede reported that she is satisfied with the private transportation she is able to access through friends and a hired driver.

Dede: Well, mostly private.

W: Mostly private and how would you classify it?

Dede: Well, I'm satisfied with the way it works out.

Gerta discussed her satisfaction with transportation services she pays for.

Gerta: I can't go public. I can't go on the bus anymore. And private, my friends don't come anymore. They're all the same age as me and they can't help me so I've got to get private transportation.

W: O.K., and how would you classify the transportation that you pay for?

Gerta: The one that I pay for has been good.

W: O.K., from this list...

Gerta: Satisfying.

Many of the participants reported satisfaction with their finances.

Eveline: Satisfying.

Dede: Very satisfying.

Edina: Satisfying, I would say. As satisfying as it could be.

Most participants were satisfied with life as a whole.

Edina: Satisfying.

Dotti: I feel it's satisfying. No complaints.

Dede: For my condition and the way I am, I would say very satisfied. I'm very lucky that I'm not stuck some place that I couldn't afford to be. You know, I'm happy that I can afford to be in my own home. You figure it out. I'm very satisfied.

Gerta, on the other hand, was less than satisfied with her life as a whole. She explained, in detail, some of the concerns that contributed to a mixed rating for satisfaction with her life as a whole.

Gerta: Well, there's a lot of things I can't do that I used to do, so I guess "mixed" would be the best.

W: Any other comments or...

Gerta: The older I get, the less I can do so that I...can't do anything about it. There's lots of things I'd like to do that I can't.

Most participants were satisfied with life as a whole. As well, they were satisfied with their friendships, religious/spiritual fulfillment, family relations, housing situations, recreation participation, self-esteem, transportation, and finances.

CHAPTER 5
DISCUSSION
Summary of Results

Included in this section is a summary of the results from the single subject design study and the interview study. The research questions for each study guide the format of this chapter. First there will be a discussion on the effect of leisure education on current, new, and re-engaged leisure participation and social validation. Then the themes that emerged from the analysis of the interviews will be discussed in the context of the research questions: (1) Is leisure participation important to older adults? (2) Is there a relationship between health and leisure participation for older adults? (3) Are older adults satisfied with their leisure participation? (4) Are IADL related to leisure participation? Then there will be a brief discussion on leisure participation and perceived ability, followed by discussions on life satisfaction, implications for practice and research, and limitations of this study. A summary and conclusion complete this section.

Leisure Education and Leisure Participation

Did leisure education increase participation in leisure activities for the two women in Study One? This question is answered with a no. Due to the attrition of two subjects, conclusions cannot be drawn from the single subject design. However, information can be gleaned from the process by examining the results from Alice and Brenda's interventions and the discrete categorization of their leisure participation.

Alice reported that she benefited from the leisure education program. She reported that the leisure education program increased her motivation and awareness of the benefits

of her participation in leisure activities. These findings support the work of Witt, Ellis, & Niles (1984) that facilitators can encourage the development of intrinsic motivation through leisure education. It is difficult to know however, if she would have followed through with participation if she had not participated in the leisure education intervention, but this conclusion cannot be drawn from the results of Study One. Performance did not change when the intervention was introduced.

Brenda was also able to identify benefits achieved from the leisure education process. She reported being more aware of the reasons why she participates in certain activities and during the intervention, Brenda reported she did all leisure activities with her husband in the past, and now is challenged to find leisure activities she could enjoy by herself. These insights seem to suggest that she has an increased awareness of her past leisure patterns and her current leisure needs, a positive outcome of leisure education. This result concurs with the work of Peterson & Gunn (1984); Peterson & Stumbo (2000) that states that leisure education facilitates awareness of self in leisure.

For the analysis of the single subject design, data was visually inspected, mean lines were inserted, and mean scores were calculated to illustrate changes from phase to phase for Alice and Brenda. In Phase A Alice participated in one activity per day. This activity was a walk down the hallway or out of the building to a garden with a home care staff member. On occasion, it would be a drive or dinner out with her daughter. In Phase B, similar results were seen.

Upon initial inspection, there appeared to be a slight increase in Alice's leisure participation in Phase C. This was identified through visual inspection and the insertion

of a mean line. Although this change did not meet the experimental criterion, there may be possible explanations to suggest the therapeutic criterion was met.

One speculation might be that leisure education had a delayed effect on leisure participation. Searle & Mahon (1998) witnessed a change in participation in the follow-up phase of a leisure education study. This study is noteworthy because the results did not demonstrate an immediate increase in leisure participation at the time of post-testing. Participation increased after the intervention had been delivered, evidenced through a follow-up study.

A second speculation might be the identification of small changes in participation with single subject designs. While visual inspection involves viewing the graphed data points for large and obvious change, sometimes small changes can be important and can be overlooked by visual inspection (Kazdin, 1982). This may have been the case with Alice in Phase B where her participation jumped from a consistent pattern of one activity per day to two activities in one day. One might argue that visually, it appears to indicate a change, specifically an increase in participation. The second activity performed by Alice was a re-engaged activity, a game of Solitaire that she had not played in two years. Also, recall, that Alice indicated through the Social Validity Questionnaire that the leisure education program increased her motivation to participate in leisure activities. It may be clinically significant to know that the leisure activities she participated in were card games. It may have been the result of available programs in the building she resides in. Alice was able to access programs being offered in the games room of her building in the fall, approximately the same time the follow-up data was being collected. These programs were unavailable during the summer months and could explain lower numbers in phases

A and B. Alice would not initiate participation with others, nor would she coordinate an activity. However, she would access programs if they were readily available to her in her building and if she was able to find another person to walk with her to the event. This result may have implications for the need of recreation participation programming in older adult housing, i.e., apartments, condos, etc.

For Brenda, neither the experimental or therapeutic criteria were met. The leisure education intervention did not increase leisure participation. By inspecting Figure 4.1 it is apparent that data points are missing for the first two weeks of Brenda's Phase A. The result is an unstable collection of data. Therefore, comparisons of data from phase to phase cannot accurately be made. Phase A began late due to a hospitalization and water main break in Brenda's home. It might also be important to note that Brenda was grieving the loss of her husband over the past year and was emerging from a depressive period. Another explanation might be Brenda's self-report of satisfaction with current leisure activities and that she was no longer searching for additional leisure activities. This is most likely the reason there is not an increase in participation after the intervention was introduced.

In hindsight, it may have been appropriate to discontinue the delivery of the intervention when Brenda reported that she was satisfied with current leisure activities. A more experienced TRS that specialized in leisure education might have terminated services at this point. Brenda's satisfaction with her leisure participation may have represented a therapeutic criterion, or clinical significance. However, the investigator was relatively inexperienced in clinical decision-making as it applied to the leisure education process at the time of the study. Although Brenda reported satisfaction with activities she was doing, she had not initiated participation in any of the activities she had listed on her

goal sheet so the intervention continued. From the perspective of the experimental criterion, analyzing the data, i.e., the activities on her goal sheet that she had not initiated participation in, would have suggested that an increase in participation had not yet occurred. The experimental criterion would therefore not have been met, so the intervention was continued.

It is worth noting that the IOR score for Brenda in Phase A was 75%. This result occurred because there were a sum total of four behaviors observed. The trained observer scored three out of four agreements with the investigator, which automatically represents 75% agreement. Although 80% is considered to be acceptable, this statistic was also considered acceptable.

An important component of this study was the discrete categorization of leisure participation. It provided an opportunity to explore the current, new, and/or re-engaged leisure participation of two women, as well as where they participated and whether it was alone or with others.

It was determined from the results of discrete categorization that Alice and Brenda experienced change to their leisure participation in current, re-engaged, and new activities. Alice participated in current activities in phase A while in phase B and C she participated in current and re-engaged activities. Alice's re-engaged activities were card playing. In phase A Brenda participated in current and new leisure activities, but in phases B and C she participated in current, re-engaged, and new leisure activities. Brenda had re-engaged in sewing and outings with others. These were activities she had not done in the past year. Brenda's new activities were the visits she received from the TRS.

It is worth noting that during the intervention phase, Alice participated in card playing, a re-engaged activity. It is also interesting to note that in the follow-up phase, two of the activities she attended were card games. As mentioned earlier, these findings seem to suggest that a therapeutic criterion was met. However, these results would not have been evident if leisure participation had not been discretely categorized.

A closer examination of the discrete categorization of current, re-engaged, and new leisure participation is required in future research. Are older adults interested in pursuing new activities? Are they interested in maintaining current participation in leisure activities of choice? Or, do they want to resume past activities they enjoyed? According to comments made in the second study, participants want to participate in past activities they cannot satisfactorily perform. Further research is required to explore the leisure participation of older women in current, re-engaged, and new activities.

By discretely categorizing leisure participation by location, it became evident that Brenda's leisure participation changed with regards to where the participation took place, i.e., in-home and out-of-home. In phase B, Brenda increased her participation out-of-the home. During phase A, the majority of her activities were performed in the home. It is difficult to determine if the outing that Brenda and the TRS took had any influence upon Brenda's increase in activities outside the home. However, a week following this outing, Brenda reported going out to a mall to shop and consequently made other trips on her own and with others. Further research is required to make these types of determinations.

Discrete categorization can also assist in determining whether a person participates alone or with others. Changes in Alice's leisure participation were found by discretely categorizing her participation as being performed alone or with others. For instance, Alice never participated alone in activities outside her home due to health concerns. She was always dependent on others to provide assistance. This information was derived from the discrete categorization of her leisure participation. This type of analysis raises additional issues surrounding leisure participation with others. Who can provide assistance with leisure participation, and what type of assistance can be provided to older adults for their leisure participation? Many questions have been raised by the information garnered from the discrete categorization of leisure participation.

Age categories, as they relate to older adult leisure participation, may be worthy of further study. The two participants in Study One were in the "older seniors" category and

according to Hawkins, May and Rogers (1996), older adults in the age range of 85+ have chronic conditions that lead to functional limitations and disability more frequently than older adults in the "young" and "intermediate senior" classifications. This would seem to suggest that future interventions for "older seniors" may need to vary from interventions being delivered to adults younger than 85+.

Xaverius (1998) conducted a literature review of interventions designed to engage older adults in social and leisure activities. She concluded, that, very little research on this topic has been conducted over the last 15 years and that there is a strong need to develop and measure strategies to increase the engagement of older adult leisure participation. This study was an attempt to increase leisure participation through involvement in a leisure education intervention. Xaverius is right, further research is necessary.

Social Validation

Leisure education is a socially valid process according to the participants in Study One. Both participants reported having positive impressions of the leisure education process and agreed that they would recommend it to others. The most important component of the leisure education intervention was the companionship provided by the investigator. Participant 1 and 2 indicated that the TRS delivering the leisure education intervention influenced the process by being friendly and out-going, and having the ability to communicate and teach. Both participants enjoyed the visits and having something to look forward to. One participant reported, "The sessions helped very much in that...because Wendy came on Monday and I had a visitor. After being married for 56 years, don't ever adjust to being alone." They believe the sessions helped them realize the importance of participating in activities they enjoy and helped them believe it is important to continue participating in fun activities. Learning to modify and adapt activities was also a valuable lesson.

An interesting outcome is evident from comparisons of the quantitative rankings and qualitative reports. Although Participant 1 and 2 reported satisfaction with the leisure

education process, one of the participants ranked her satisfaction as being "very unimportant" and "somewhat important." There appears to be a discrepancy between her quantitative and qualitative results and this might suggest that she did not value the leisure education process, but did not want to hurt the feelings of the TRS delivering the intervention.

The Importance of Leisure

Individuals that participated in the interviews reported that they were generally interested in learning more about the importance of leisure and recreation. However, they indicated they were not interested in learning more about community recreation services, nor were they interested in learning more about their feelings and knowledge in relation to leisure and recreation.

A lack of interest to learn about leisure feelings and knowledge might have been the result of not knowing what leisure education is and believing it was going to be work-like and difficult. When asked if this was a good time in her life to learn about recreation and leisure, Dotti replied, "I think at this time in my life you've got the right to sit and relax. I did enough with working two jobs and trying to bring up my children. I'm all pooped out. No, I'm not really, but I just want to relax." It may be important for future practitioners and researchers to re-phrase the title "leisure education" and thereby reduce the fear of having to "work" on leisure.

Participants did not want to learn more about community resources. Their lack of interest seemed to be the related to perceptions that health problems are barriers to leisure participation. They did not want to know that there were more things that they could not do at this point in their lives. It seemed that their perceived level of competence to perform leisure activities at home and in the community was low. Searle and Mahon (1991) reported that higher perceived competence might result in increased community participation. This may help explain why participants in the two studies were not regularly participating in community activities. They did not perceive they had the

competence to go out into the community, especially alone, to participate in leisure activities. The expression "I can't" was heard repeatedly throughout interviews.

Another consideration that might explain disinterest in learning about community resources might be the lack of awareness of available community resources and the appropriateness of these resources for older adults. One participant revealed her lack of awareness with the following statement, "I'm always willing to learn and there is not too much going on in our community, I don't think. We have a nice senior's center over here that I belong to but I haven't been able to go because there is no way to get there." Hawkins, May, & Rogers (1996) suggest that the challenge older adults and their caregivers face are finding out what is available and how to access it in their home communities.

Xaverius & Mathews (1999) have identified a possible solution to attracting participants to activities in the community such as senior centers. Using a variation of a multiple-baseline design with reversal, they attempted to determine the impact of public postings on participant attendance at two activity groups, creative writing and painting. The results suggested that members are likely to join the group during or in the weeks following the posting. They reported that it is an inexpensive way to attract community-dwelling older adults to engage in leisure activities. Since participants in Study Two indicated a disinterest in learning more about community recreation/leisure resources, and disinterest may be related to the lack of awareness of community resources and the fear of not being able to participate upon arrival, marketing and postings may be another strategy to increase awareness and desire to become more aware of community resources. Of course, mobility, transportation, and assistance issues will also have to be addressed.

This was not a good time for the interview participants to be learning about leisure and recreation. These individuals were between the ages of 71 and 82, "younger" to "intermediate seniors." It is interesting to note that the two participants in the single subject design that received the leisure education intervention reported moderate

satisfaction with the process of learning about leisure and recreation and they were in the "older seniors" category (85+). It would be interesting to know if age played a factor in the desire to learn more about leisure or the questions regarding learning about leisure on the questionnaire were vaguely written. It would be interesting to know when it might be a good time to learn more about leisure.

It was not uncommon for participants in both studies to have misunderstandings about the concept of leisure. People often tended to associate leisure with doing nothing. One person perceived her entire life to be leisure, which in essence meant guilt, selfishness, and the inability to do what she wanted to do. She put it this way, " My whole life is leisure. I feel it is a very selfish life I am leading...you're only thinking of yourself. I'm not busy. I feel guilty...I should be doing something."

Leisure education is a process that could facilitate an understanding of leisure, however, individuals have to be receptive to learning more about leisure and recreation. One of the participants in the single subject design suggested that people in her age range (older seniors) were already "set in their ways" and leisure education might be more effective when they were younger, and when their spouses were still alive.

The Effects of Health on Leisure Participation

Participants reported that their health was very important to them at this point in their lives and rated their health as being fair even after delineating numerous health problems and disabilities. These findings are similar to those reported by Hawkins, May and Rogers (1996), who also noted that American older adults report being in good health in spite of limitations to their activities. Initially, one might expect them to report poor health. However, Clarke, Marshall, Ryff, & Rosenthal (2000) also found that older adults subjectively rate their health positively even though they experience increased health problems and disability as they age. These findings come from a nationally representative study on the subjective well-being of Canadian seniors. Participants in Study Two seem to mirror findings of American and Canadian older adults: they rate their health as fair even though they have health problems and disabilities.

Almost every person interviewed reported health to be a barrier to participation in leisure activities. In Study One both subjects were over the age of 85 and also perceived their health problems to be barriers to their leisure participation. Statistics Canada (1991) reported that 8 out of 10 "older seniors" had disabilities, and that severe disabilities increased with age. Lefrancois, Leclerc, & Poulin (1998), while studying predictors of activity involvement among older adults, confirmed previous research that indicates that health status is one of the primary barriers to leisure participation for older adults. Further study of these health implications is required, particularly in relation to leisure education and leisure participation in the home and community.

It was abundantly clear through discussions with all participants that health problems, including disabilities, were perceived to be hindering leisure participation. However, there was a sense of reluctance to overcome some of these barriers. Physical health barriers were interfering with the participant's ability to dress and prepare for leisure activities outside the home to the extent that they did not bother to try. The

participants were well aware that leisure participation is good for mental and emotional health, but physical health problems continue to interfere with participation.

The impact of environmental barriers cannot be excluded from further research on the types of leisure participation preferred by older adults. Gerta could not descend down a ramp in a wheelchair because handrails were unavailable and her arms were not strong enough to stop the chair from flying away. Edina could not get down to the corner to catch a bus because of ice and snow on the sidewalk leading up to the bus stop, never mind the fact that she could not walk up the stairs on the bus. There are many, many variables that require further examination when it comes to the leisure participation and health of older adults.

Satisfaction with Leisure Participation

Participants indicated satisfaction with the activities they were able to participate in prior to health problems and resulting disabilities. They also indicated satisfaction with the few leisure activities they are now able to do. There seemed to be a level of acceptance and adjustment by some participants for the activities that they could no longer do, and some participants were able to replace old activities with different activities, but they still wanted to be able to do things they liked but could no longer do.

Lovell, Dattilo, and Jekubovich (1996) studied women who were aging with disabilities. A leisure education program was delivered to one group and the control group did not receive leisure education. One of the findings was a decrease in leisure repertoire due to reduced abilities resulting from disabilities. They suggested that practitioners should ensure they accurately assess current skills and interests with past skills and interests. By doing so, they will help integrate these skills and interests into a satisfactory leisure repertoire for the client. Participants in the Lovell et al. study reported a decrease in physical activities as a result of declining physical abilities and an increase in sedentary leisure participation. Participants in Study Two seemed to be conveying the same message. Gerta explains how disabilities have restricted her from preferred

activities, "I don't like to be sitting and doing nothing...You know, I like to crochet and I like to knit. I used to do a lot of sewing, I can't do that anymore; my fingers won't let me." Gerta's activities became increasingly more sedentary and her satisfaction decreased. Further research might examine the integration of past and current leisure skills that contribute to a satisfactory leisure repertoire for older adults aging with disabilities.

Are older adults actually satisfied with watching television? It may be prudent to further examine satisfaction levels with television watching. Wilhite (1992) studied older adults who were receiving in-home services and shared that participants reported television watching was one of their primary leisure activities. Godbey (1985) reported that approximately one quarter of television watching is "secondary" viewing, which means that television watching is done in combination with other activities. He further explained that people don't always spend more time doing very satisfying activities; often a great majority of time is spent doing less satisfying activities. These findings may help explain comments made by participants in Study Two. They repeatedly reported that they wanted to do activities they liked and were satisfied with, in the past. They did report levels of satisfaction with current activities, but not the levels of satisfaction they had achieved from past leisure preferences. Results from Study Two suggest that older adults have their television on nearly all day so to avoid the silence, suggesting a dislike for being alone, or possibly to avoid being lonely. Although the television was on, they frequently were not watching it or focusing their attention on it. Further study is required. Is the majority of older adults' television "secondary" viewing, is it a strategy for avoiding the silence they experience while living alone, or is it a coping mechanism for loneliness?

The Relationship of IADL and Leisure Participation

Travel outside the home appears to be related to leisure participation. From the perception of the participants, travel outside the home was the most significant barrier to their leisure participation in the community. Participants reported that travel was hindered by the lack of assistance or uncooperative nature of taxi drivers; taxi drivers' refusal to allow participants to sit in the front seat of the taxi; and, unavailable assistants or partners to travel with participants and assist with environmental barriers, i.e., sloped ramps, stairs, etc.

How can leisure education facilitate leisure participation for older adults when Canada's older adult population continues to age, and as they age, they acquire more and more severe disabilities and, continue to live in their own homes in the community? Similar trends and concerns are being seen in the United States. Gill, Williams, and Tinetti (1995) report that the primary goal for health care providers is to help older adults maintain function. Of the older adults aged 75+ that are non-disabled and living in the community, approximately 10% of them will lose independence in basic activities of daily living, i.e., bathing, dressing, and walking in the next year. These are issues that participants in both studies raised. They experienced difficulties walking, bathing, and dressing in preparation for leisure activities. It may be prudent to examine the relationship of leisure participation and Activities of Daily Living (ADL) and further explore the role of Instrumental Activities of Daily Living (IADL) and leisure participation for older adults residing in the community, especially in light of increasing disability as older adults age.

Hawkins, May, and Rogers (1996) indicated that approximately 45% of "older seniors" require assistance with basic activities whereas a much smaller percentage (9%) of older adults between the ages of 65 – 69 require this same type of assistance. As well, the need for assistance is related to the presence of physical limitations. As a result, there is a greater need for assistance as age increases. It would seem logical then, that these "older seniors" would also require more assistance for participation in leisure activities, as evidenced in Study Two with the levels of assistance required to travel outside the home. Further study might examine the amount and type of assistance that might be required to facilitate leisure participation for "older seniors."

Therapeutic Recreation Specialists must become familiar with the IADLs related to leisure participation and the types of assistance required to facilitate leisure participation, as well as the services offered by Home Care programs and services available to older adults. In May 2000 the National Advisory Council on Aging (NACA) set out parameters for a national home care program. The purpose is to ensure high quality services are delivered to seniors from coast to coast. Dunn & Wilhite (1997) recommended that TRSs become aware of the services offered by Home Care and determine how leisure education interventions could better serve home care clients. These services are not commonly delivered within home care services in Canada.

Traveling outside the home appears to be a significant instrumental activity of daily living related to leisure participation for older adults in this study. This issue requires further consideration.

Leisure Participation and Perceived Ability

Comments made by participants in this study seem to suggest that they perceive themselves as having abilities to participate in leisure activities. However, their levels of participation (somewhat, rarely, never) suggest that there may be barriers inhibiting participation even though they perceive they can participate. Some of the barriers identified were physical limitations and the lack of assistance to address difficulties resulting from physical limitations, transportation problems as a result of health limitations, and the lack of partners to participate with. These findings seem to confirm findings from a study by Lefrancois, Leclerc, and Poulin (1998) and Searle & Mahon (1997) that health status is a primary inhibitor to leisure participation for older adults.

Another consideration is the list of activities within the questionnaire. Although the activities listed on the questionnaire are thought to reflect the reported leisure activities of older adults (Adult Day Care Research Group, 1995), they may not have been the preferred or desired leisure activities of the participants in Study Two. As a result, they may not have had a strong desire to address and/ or overcome barriers inhibiting certain activities. Further study of preferred leisure activity may have been warranted.

Life Satisfaction

Several participants from Study Two were satisfied with life as a whole. It was interesting to note that participants indicated that they were satisfied with transportation when asked questions from the Terrible – Delightful scale, yet they were unsatisfied with components of transportation services, primarily assistance provided by the drivers as indicated earlier in the interviews. This may suggest satisfaction with the availability of services they might not otherwise have access to. Possibly, it means that dissatisfaction with the drivers is not a strong enough deterrent to stop them from using the service. The

satisfaction derived from activities in the community may be a greater motivation to overlook difficulties experienced with drivers.

The participants in this study lived alone and reported being satisfied with their housing arrangements. Novak (1997) suggests that more single people over the age of 65 will be living alone in the future and as a result, there may be an increased demand for suitable housing and transportation.

Participants indicated satisfaction with their financial situations. Participants reported satisfaction with family relations in response to the Terrible – Delightful questions in Study Two. However, participants in Study One reported that family members were not involved in the planning, nor were they involved in the actual participation of recreation activities with their loved ones on a regular basis. One participant reported that often, her contact with family members is not for recreation but for "important issues" such as doctor appointments and grocery shopping. She stated, "family members are extremely busy with their own lives and the lives of their children, in addition to caring for parents. Don't think family knew what I was up to. I have an independent life so I usually figure things on my own. Family has their own life and have busy lives."

Dunn & Wilhite (1997) suggested that increased family involvement in the leisure education process might facilitate a greater awareness of barriers that participants face when planning and implementing recreation activities. Also, family support might encourage and empower the participant. Future research might incorporate greater family involvement in the leisure education process. However, participants in Study One did not think that their families had the time to become involved in their leisure pursuits.

Caregiver burnout may be another inhibitor to family involvement. Caregiver burnout is "the physical, psychological, emotional, social, and financial problems that can be experienced by family members caring for impaired older adults" (George & Gwyther, 1986, p. 253). Trends among caregivers may also impact the time that is available to

assist older adults. Hawkins, May, and Rogers (1996) explain that factors such as lower fertility rates; higher rates of divorce, and increased female careers reduce their time to take on the role of caregiver. A possible solution might be leisure education for the caregivers (Carter, Nezey, & Foret, 1999).

Carter, Nezey, Wenzel, and Foret (1999) examined the role of a leisure education support group and its relationship to caregivers and care recipients. Leisure experiences derived from the leisure education process were thought to facilitate positive coping strategies, i.e., information seeking, problem-solving, and social support. These leisure experiences were also thought to help individuals overcome negative management strategies such as passivity and social isolation. Further study into caregiver burnout and family participation in leisure activity participation might be of interest to families and their aging parents, since care-giving will likely become more the responsibility of family and friends as the population ages (Carter et al.). Enhanced relationships between families and their aging parents may also help society avoid the development of intergenerational conflict, particularly as the number of senior's in Canada is growing (Novak, 1997). Recreation participation may facilitate these relationships.

IMPLICATIONS FOR PRACTICE

Practitioners require specific training on the delivery of leisure education models, in addition to training on how to implement specific content elements. This may include theoretical preparation in the classroom as well as training while on practicum. This training might also include training on clinical decision-making, i.e., selection of content elements, and the timing of initiation, continuation, and withdrawal of content elements.

In the single subject design, the participants were very interested in visiting with the investigator and looked forward to the companionship they received. This may be a need of "older seniors" that requires further study. The TRS could examine the possibility of facilitating socialization through the leisure education process, i.e., group sessions or socializing activities in the community. This may prove to be challenging if transportation is an issue.

There were other indications that changes might be required for the CRP when working with older adults. Unit four in the CRP manual involves an examination of problems with performing the requirements of chosen activities and unit five examined adaptations and modifications for leisure participation. This seemed to be overwhelming for the participants in the single subject design, particularly as they were endeavoring to remain independent in their own homes, and trying to avoid moves into institutions. They face the realities of their limitations and losses on a daily basis. It might be useful to focus on successful adaptations they have already made in response to health changes and transitions that affect leisure participation.

One participant in the Study Two reported that, when she was hospitalized, her leisure activity participation increased immensely because activities were available that she could attend. She did not face transportation barriers and the activities were well adapted to her capability levels. She loved the socializing that was facilitated through her participation. She demonstrated different participation levels from those reported while living at home. At home she was limited in her leisure activities. She primarily read and

watched television and was socially isolated. At the hospital she participated in bowling, carpet bowling, Tic Tac Toe, evening music programs, and she attended church. She reported that, when living at home, she could not arrange transportation for a one-hour church outing. As well, she did not have a companion for playing some of the games she did at the hospital. Not only did her participation levels increase when in the hospital adult day program, so did her desire to participate in leisure activities.

It may be worth exploring the facilitation of leisure participation in hospital programs and adult day care centers that provide transportation when conducting leisure education interventions with older adults. When fewer barriers exist to inhibit participation, "older seniors" may desire to and actually increase participation in activities of their choosing. This type of outing might be incorporated into leisure education interventions, particularly when participants are living alone at home. Otherwise, barriers perceived by the participants, such as environmental, health, and transportation barriers, will continue to limit participation for older adult populations.

IMPLICATIONS FOR FUTURE RESEARCH

Some of the implications for future research have already been discussed in the previous section. In addition, future studies could investigate the effectiveness and appropriateness of the CRP with different subgroups of older adults, i.e., younger seniors, intermediate seniors, and older seniors. It would be of interest to gauge whether or not content elements delivered to different age groups affect leisure participation in different ways. It may also be interesting to explore appropriate content elements based upon gender and health status.

A replication of this design would be recommended and it would have to include a stable set of probes throughout Phase A, prior to initiating the second phase. As well, the first phase for each individual must begin at the same time for each subject in order for the investigator to draw conclusions that the intervention effected change while using a multiple probe design.

Dunn & Wilhite (1997) suggest that researchers recognize the potential for attrition with an older adult population and include a larger sample size with single subject designs. Six to eight subjects might be appropriate. It would make for a lengthy period to deliver all the interventions but might accommodate the challenges faced by older adults, such as hospitalizations.

Searle et al. (1995) studied the effects of the CRP intervention on subjects with a mean age of 77.5 (intermediate senior). However, Dunn & Wilhite (1997) studied the impact the CRP had upon two individuals aged 77 (intermediate senior) and 94 (older senior). Both studies produced results suggesting that the CRP intervention was effecting change in leisure behavior. It seems that the content elements from the CRP for older adults may be appropriate for older adults in the "intermediate seniors" and one "older senior". It would be interesting to see further research that examined the effect of the CRP on "intermediate" vs. "older seniors."

LIMITATIONS OF THE STUDY

The most significant limitation to Study One was participant attrition. Two participants completed the study while two were dropped from the study, one for health concerns and the other one for time obligation considerations and satisfaction with current leisure lifestyle.

Limitations resulted from unstable data points in phase A of Brenda's data. Brenda's Phase A did not contain stable data points that are required to compare data points with the B and C phases of the design. This was the result of a hospitalization and a water main break in the building that she lived in. It would have been desirable to extend the phase, however, Brenda was growing impatient recording leisure participation data on a daily basis and not having interaction with the TRS. She had been planning a trip in the fall and was worried that the study would be extended and would interfere with her plans. Therefore the intervention phase was initiated prior to establishing a stable set of data points.

Recording daily leisure participation was subject to certain limitations. The subjects did not appreciate being telephoned on a daily basis to collect leisure participation data. Therefore, the investigator began collecting recording sheets and reviewing them with the subject on a weekly basis. This may have increased the opportunity for a subject to forget to record an activity on any given day and if she forgot to record data daily, she would have to rely on memory that may not have been as accurate as if the investigator had called daily to enquire.

Another limitation might have been inaccurate reports of participation due a misunderstanding of leisure definitions. It was up to the investigator to read through all the recordings and eliminate activities recorded that clearly were not leisure activities simply because they were performed during free time, i.e., washing the floor or doing laundry.

Limitations to Study Two may have been the length of the interview questionnaire and the types of responses required for certain questions. When the responses to questions were perceived to be cumbersome, responses became short and brief, with little explanation or reasoning for responses as was the case with questions from the Terrible – Delightful scale. It might be more prudent to shorten future questionnaires and probe more deeply into fewer topic areas.

Another limitation to Study Two may have been selection bias. The participants were familiar with the CRP leisure education program as a result of their involvement with a larger study where leisure education was the intervention of choice. Their beliefs and attitudes towards leisure and leisure education may have influenced their responses to questions in the interviews.

SUMMARY AND CONCLUSION

These studies have contributed to a limited body of knowledge with an older adult population. Often practitioners in the field of therapeutic recreation will say they know intuitively that their clientele (older adults) value and benefit from leisure education interventions. Further research is required to validate these intuitions and insights. While the single subject design in Study One failed to demonstrate generalizable results, the study provided the investigator with a greater awareness of how many different variables affect the leisure participation of older adults. Discretely categorizing the type of activity, the location the activity is performed at, and with whom the activity is performed proved to be an illuminating exercise.

The themes that emerged from the analysis of the interviews in Study Two seem to provide initial support for the perceptions that leisure participation is important to older adults. It is important to continue to participate in leisure activities but it is not important at this time in their lives to learn more about it and the resources for leisure and recreation in the community. Health affects leisure participation, often by inhibiting participation. These older adults are satisfied with current leisure participation although there are more things they would like to be doing but can't. Travel outside the home is an IADL that appears to be related to leisure participation As well, the older adults in this study are satisfied with their lives as a whole.

These themes are important indicators of areas worthy of further study. If leisure participation is important to older adults, then when is a good time to deliver leisure education interventions? When is a good time to learn about personal feelings and knowledge about leisure and when will it be appropriate to learn about community leisure and recreation services?

Leisure education is one intervention that might facilitate leisure participation by helping individuals overcome perceived environmental and health barriers. However it will have to be done in such a way that it does not overwhelm them, focusing on

capabilities rather than inabilities. Leisure education is also one way to facilitate acceptance and adjustment to present capabilities and the selection of alternate activities.

What are the implications for the leisure education process? Where will these interventions be delivered? Is the client's home appropriate? Is the recreation center appropriate? Is the nursing home appropriate? These are places where leisure education interventions are currently being delivered. Further study is required.

Who will pay for leisure education services? Home Care? The client? The community? Government? It will be important for the payers to understand and value the outcomes of leisure education before they will be willing to pay for such a service. Further research is required to demonstrate socially valued outcomes.

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APPENDICES

APPENDIX A
Ethics Approval

APPENDIX A

FACULTY OF PHYSICAL EDUCATION AND RECREATION STUDIES

COMMITTEE ON RESEARCH INVOLVING HUMAN SUBJECTS

TITLE OF PROPOSAL:

The effect of leisure education on older adult participation in leisure activities and instrumental activities of daily living.

PRINCIPAL INVESTIGATOR:

Ms. Wendy Chabi

SPONSORING AGENCY:

In partial fulfillment of the MSc Degree in Physical Education

The Committee on Research Involving Human Subjects (Faculty of Physical Education and Recreation Studies) has evaluated the above proposal according to the criteria of the University of Manitoba Committee on Research Involving Human Subjects and finds it to be:

X	
_____	acceptable
_____	not acceptable

under the approval category: __X__Approved; _____Renewal Approved; _____Approved in Principle; _____Tabled; _____Withdrawn; _____Denied

February 21, 1995

D W. Hrycaiko

Dr. D. W. Hrycaiko, Chair

Notes:

APPENDIX B

The Folstein Mini-Mental State Examination

APPENDIX B
The Folstein Mini-Mental State Examination

Maximum Score	Score	Orientation
5		(1) What is the year _____? season_____? date_____? day_____? month_____?
5		(2) Where are we: province_____? town_____? street_____? place_____? floor_____?
		Registration
3		(3) Name 3 objects (House, Tree, Car) 1 second to say each. Then ask subject all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____.
		Attention and Calculation
5		(4) Serial 7's. 1 point for each correct. Stop after 5 answers. 100-7=( ), 93-7=( ), 86-7=( ), 79-7=( ), 72-7=( ), 65-7=( ) Alternatively, spell "world" backwards.
		Recall
3		(5) Ask for 3 objects: House ( ), Tree ( ), Car ( ) 1 point for each.
		Language
9		(6) Name a pencil and watch (2 points). (7) Repeat the following "no ifs, ands or buts" (1 point). (8) Follow a 3 stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." (3 points).

(9) Read and obey the following: "Close your eyes" (1 point)
(10) Write a sentence. (1 point).
(11) Copy design. (1 point).

_____Total Score

APPENDIX C

Consent Form

APPENDIX C

Consent Form

At the bottom of the page my signature indicates that I want to take part in Wendy Chabi's study on:

"The effect of Leisure Education on older adult participation in leisure activities and daily living."

If you agree to participate in the study, you will be required to participate in a program for approximately 1 hour per week for a period of three to four months. You will also be required to fill out a questionnaire on three occasions.

I understand why this work is being conducted and I have had opportunity to ask questions. I know that taking part in this study is my own decision and I do not have to do anything I do not want to. I can withdraw at any time and nothing will happen. I am aware that anything I say in this program is confidential and when the study is written up, nobody will be aware that I was a participant. I give Wendy permission to tape record our sessions. I understand that I will be learning about leisure and I will make my own decisions as to what activities I wish to participate in. Wendy will tell me the results of the study when the study is complete.

Wendy Chabi: Graduate student in the Faculty of Physical Education and Recreation Studies at the University of Manitoba.
284-4275

Michael Mahon, PhD: Academic Advisor in the Faculty of Physical Education and Recreation Studies at the University of Manitoba
474-6131

Participant Signature_____ Date_____

Witness _____ Date_____

APPENDIX D

Current & Past Leisure Activity Finder

APPENDIX D

Current & Past Leisure Activity Finder

Please think about the activities that you participate in for leisure and recreation. These can be physical activities such as golfing, curling or going for walks, cultural activities such as going to concerts, or museums, activities that you engage in around the house like gardening, knitting, and cooking, or anything that you do for enjoyment.

Please list all of the leisure activities which you currently participate in. **Current** participation refers to any leisure activity you have participated in within the last year. List as many as you can remember.

_____

_____

_____

_____

_____

Please list all of the **past** leisure activities you have participated in, but not those activitites participated in within the last twelve months.

_____

_____

_____

_____

_____

APPENDIX E

Telephone Checklist

APPENDIX E

Telephone Checklist

In-home: In home activities are any leisure activities which take place in your home, including your yard.

Out-of-home: Out-of-home activities are any leisure activities which take place outside of your home. The facilities such as a games room in an apartment block are considered to be out-of-home.

Alone: Any leisure activity participated in individually, i.e., going for a walk without interaction with others, is considered to be alone.

With others: Any leisure activity involving interaction with another person. A group activity is classified as being with others, if interaction occurs.

Telephone Checklist

Please list the leisure activities which you have participated in today.	**Please check the appropriate columns.**			
	(In home)	(Out of home)	(Alone)	(With Others)

(If you require more space, please use the reverse)

APPENDIX F

Social Validity Questionnaire

APPENDIX F

Social Validity Questionnaire

Section 1

As we discussed on the phone, this is a short interview to provide some additional understanding to us about this process you have participated in over the course of the past several months. As with all of the data collected in this study, these responses will be kept confidential.

1. When we first contacted you, we indicated that we hoped that the program would help you participate in recreation activities you enjoy. Is this important to you? Please explain.

_____

_____

_____

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_____

_____

On a scale from 1 to 4, with 1 being not at all important and 4 being very important, how would you rate the importance of this goal?

Not Important	Somewhat Important	Important	Very Important
1	2	3	4

Section 2

During the last few months, you have been involved in a process designed to help you to participate in the activities you enjoy. I would like to ask you a few questions about that process.

2. During the first few sessions, you spent time discussing what you do for fun and why you do it. Was this important to you? Please explain. (**Probe instructions: Please attempt to get the respondent to explain whether they felt they learned anything through this part of the process, whether it helped them in any way, whether it proved useful in deciding later about what to do?**)

On a scale from 1 to 4, with 1 being not at all important and 4 being very important, how would you rate the importance of these sessions?

Not Important	Somewhat Important	Important	Very Important
1	2	3	4

3. Following the first few sessions, you explored how to do the activities you enjoy, whether you can still do them, what things, if any, prevent you from doing them, and how you can deal with things that get in your way of participating. Was this important to you? Please explain. **(Probe instructions: Please attempt to get the respondent to explain whether they felt they learned anything through this part of the process, whether it helped them in any way, whether it proved useful in deciding later about what to do and how to do it?)**

On a scale from 1 to 4, with 1 being not at all important and 4 being very important, how would you rate the importance of these sessions?

Not Important	Somewhat Important	Important	Very Important
1	2	3	4

4. During the last number of sessions, you made plans to participate in activities you enjoy and carried out these plans. Was this important to you? Please explain. **(Probe Instructions: Please attempt to get the respondent to explain whether they felt they learned anything through this part of the process, whether they continued their participation, whether they involved any member of their family or friends in these plans and activities, and did they feel that they met any new people through these activities?)**

On a scale from 1 to 4, with 1 being not at all important and 4 being very important, how would you rate the importance of these sessions?

Not Important	Somewhat Important	Important	Very Important
1	2	3	4

Section 3

I would like to ask you two final questions. (These questions are aimed at gaining an understanding of the respondent's perception of the outcomes from the study and the role the TRS played in effecting those outcomes.

5. Having completed this process over the past several months, describe for me what has happened to you as a result of this process? **(Probe Instructions: Please attempt to get the respondent to explain positive or negative outcomes they perceive from their experiences. Try to have them relate any outcomes to their family or friends. ALSO: Please attempt to get the respondent to explain what the specific benefits were, be sure to tie in family and friends into the discussion - that is, did their family support their increased activity, did family or friends participate with them, did benefits accrue to the family in terms of perceived higher levels of satisfaction with the way life is in general?)**

On a scale from 1 to 4, with 1 being not at all important and 4 being very important, how would you rate the importance of these sessions?

Not Important	Somewhat Important	Important	Very Important
1	2	3	4

6. Would you recommend this process to friends or other family members? If yes, what aspects of the experience were most important to you? **(Probe Instructions: Be sure to have them consider the contribution of the TRS to the outcomes.)**

_____

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APPENDIX G

Telephone Script

APPENDIX G
Telephone Script

Hello _____, it is Wendy calling. I am calling to find out what leisure activities you participated in yesterday and the day before. Did you record them on the telephone checklist? If yes, could you please read them to me starting with those activities you participated in two days ago and then yesterdays activities? If no, can you recall what activities you participated in and if so, please tell me what they are?

Thank you for your help. Have a nice day. Goodbye.

APPENDIX H

Telephone Script 2

APPENDIX H
Telephone Script 2

Hello _____, it is Wendy calling. I am calling to find out what leisure activities you participated in the last week. Did you record them on the telephone checklist? If yes, could you please read them to me starting with the first day of the week. If no, can you recall what activities you participated in and if so, please tell me what they are?

Thank you for your help. Have a nice day. Goodbye.

APPENDIX I

Interobserver Reliability: Recorder's Criteria

APPENDIX I

Interobserver Reliability: Recorder's Criteria

Leisure experiences are personally defined. It is not important if you agree that a certain activity is leisure or not. It is your responsibility to simply classify reported leisure activity as current, re-engaged, or new activity by comparing them to the activities listed on the Current & Past Leisure Activity Finder. To further assist you, leisure and leisure activity definitions have been provided.

Leisure

For the purposes of this paper, leisure was defined as a subjective experience in which a person is intrinsically motivated, self-determined, and perceives him/herself as free and competent to choose and participate in activities resulting in pleasurable experiences.

Leisure Activity

Leisure activity was defined as any chosen activity engaged in during discretionary time (Kelly, 1990). Discretionary time is time chosen for leisure: time beyond the time required for obligations of self-care, family, and work.

Current Leisure Activity

Current leisure activity is defined as any activity engaged in during the last twelve months. A list of current leisure activities were taken from the Current and Past Leisure Activity Finder which were completed by the subjects at the first home visit.

Re-engaged Leisure Activity

Re-engaged leisure activity is defined as any activity that a person has previously participated in, but not during the last twelve months. A list of re-engaged activities was taken from the Current and Past Leisure Activity Finder which was also completed by the subjects at the first home visit.

New Leisure Activity

New leisure activity is defined as any activity that a person has not engaged in prior to this investigation. A list of new leisure activities was determined by examining the Current and Past Leisure Activities Finder for activities not listed. Activities not listed on the Finder but recorded on a subject's telephone checklist were considered new activities.

You have been provided with a copy of the completed Current & Past Leisure Activity Finder for both subjects. This form will list all of the current leisure activities the subjects are participating in. You will be classifying leisure activities from three different phases of the study (A, B, & C) for each subject. Your task is to read the Telephone Checklist sheet and record how many current, re-engaged, and/or new leisure activities were recorded by the subject. You will be able to determine if the activities are current, re-engaged, and/or new by comparing the recordings to activities listed on the participant's Current & Past Leisure Activity Finder.

Please note the following criteria. If the subject recorded that she went out to the bank and to the grocery store in one day or one outing, these activities are considered two separate activities. Two phone calls equal 2 activities. Two activities that occur at thesame time are considered two activities.

When you see a line through responses, you are not to categorize this information. It may also be identified with an IADL label next to it. Please disregard these responses. They are not leisure activities.

APPENDIX J

Recorder Consent Form

APPENDIX J

Recorder Consent Form

At the bottom of the page my signature indicates that I agree to participate in Wendy Chabi's study on:

The effect of Leisure Education on older adult participation in leisure activity and daily living activities."

I understand that any information I hear or read is to be held confidential and I will not disclose information regarding the participants in this study.

Wendy has explained the training I will receive and I am clear as to my tasks (1) to classify leisure participation (old, new, and current leisure participation) and (2) to record the number of planned objectives delivered by the Therapeutic Recreation Specialist (TRS) in the leisure education interventions.

Should you have any questions regarding the study, please contact Dr. Michael Mahon or myself:

Wendy Chabi, B.R.S., B.A.	Graduate Studies in the Faculty of Physical Education & Recreation Studies at the University of Manitoba 306-668-2344
Michael Mahon, Ph.D.	Academic Advisor in the Health, Leisure, and Human Performance Research Institution Director/Faculty of Physical Education & Recreation Studies, Associate Dean at the University of Manitoba 204-474-8770

_____ _____

Name Signature

_____

Date

APPENDIX K

Interobserver Reliability Categorization by Trained Observer

APPENDIX K

Interobserver Reliability Categorization by Trained Observer

Date	Total # Leisure Activities	Current	Re-engaged	New

APPENDIX L

Procedural Reliability: Recorder's Criteria

APPENDIX L

Recorder's Criteria: Procedural Reliability

Familiarize yourself with the Leisure Education manual. You have been provided with a list of all the goals, objectives, content, and processes for each session. Please read them carefully. They are intended to provide you with an understanding of the information the subject received from the Therapeutic Recreation Specialist. Next, your task is to listen to specific session(s) and mark an X on the list each time the TRS delivered the objective outlined for a session. Units may extend into 2 or 3 sessions. In this case you will need to listen to all of these sessions. It is important that you mark an X only when the objective was delivered.

Please note that you will be listening to conversations that may stray off and on topic occasionally. It is your task to review the objective and sift through conversation to determine if the objective is met. The following is an example of an objective and the pursuing conversation:

Objective: **Identify 2 reasons for participating in a specific leisure activity**.

(Subject) I like to go bowling on Saturday afternoons with my three friends. It is the only day we can all get together. Sometimes I see one or two of them during the week, but we like to bowl on the weekend. (Therapist) Why do you like bowling? (Subject) I like to get a little exercise, I like the challenge, and I like to socialize with my friends. (Therapist) How are you challenged? (Subject) I always try to beat the score I had in the last game. I try to improve my shots.

APPENDIX M

Procedural Reliability Recording Sheet

APPENDIX M

Procedural Reliability Recording Sheet

Observer _____

Date _____

Subject _____

Please mark an X on the line to indicate that this objective was delivered in the session(s) you listened to on the tape.

Unit 1

Objective _____

Objective _____

Objective _____

Unit 2

Objective _____

Unit 3

Objective _____

Unit 4

Objective _____

Objective _____

Unit 5

Objective _____

Objective _____

Objective _____

Unit 6

Objective _____

Objective _____

Unit 7

Objective _____

Unit 8

Objective _____

Objective _____

Unit 9

Objective _____

Objective _____

Unit 10

Objective _____

Unit 11

Objective _____

Objective _____

Objective _____

Unit 12

Objective _____

Objective _____

APPENDIX N

Leisure/Recreation Questionnaire

APPENDIX N
LEISURE/RECREATION QUESTIONNAIRE

Name (Mr., Mrs., Ms., Miss):_____
Address:_____
_____
Date of Birth: _____
Interviewer:_____
Date of interview:_____
Time started:_____
Time Finished_____
# of calls to obtain interview: 1 2 3 4
# of visits to obtain interview: 1 2 3 4
_House _Apartment _Other_____

(1). What is you current marital status?

_Single/never married
_Married How long?_____
_Divorced/Separated How long?_____
_Widowed How long?_____
_Other_____

(2). What was the highest level of schooling or education you completed?

_No formal schooling
_Some Elementary
_Finished Elementary
_Some Secondary/highschool
_Finished Secondary/highschool
_Some College
_Finished College
_Some University
_Bachelor's Degree
_Master's Degree
_Ph.D
_Other: _____

(3). At this stage of your life, what is important to you? (Is it your relations with your family? Your Health? Your relations with your friends, etc.?)

(4). Do you feel that your leisure activity is an important part of your life? Yes_ No_ Please explain. (If necessary, give examples of leisure activities)

(5). What does leisure/recreation mean to you?

(6). On a scale of 1 to 5, with 5 being the highest, how important is leisure/recreation to you? Why?

Very Unimportant 1 2 3 4 5 Very Important

(7). If you were given the opportunity to learn more about your feelings and knowledge about leisure/recreation, would you take it? Yes_ No_ Why?

(8). If you were given the opportunity to learn more about how you might take advantage of leisure/recreation services in your community, would you take it? Yes_ No_ Why?

(9). What kind of information would you like to know about leisure/recreation or is it just a general interest?

(10). Is this a good time in your life to be learning about leisure/recreation? Yes_ No_ Why?

(11). Do you feel you had enough satisfaction from your leisure activities during different stages of your life? (e.g., during your adulthood, during child rearing years) **Yes _ No_ Why?** (If not at any stage, then ask, what would have given you greater satisfaction? What would you have liked to know or do?)

(12). Please tell me what your three most favorite leisure activities are now and how often you participate in them.

(13). Do you participate in these activities alone or with others; and if with others, with whom?

(14). Do these activities take place in your home or outside of the home; and if outside the home, where?

(15). I have some questions about specific activities that you may do. I will read you a list of leisure/recreation activities and ask you about each activity.

A) Are you now able to participate in the activity?
B) Do you participate in the activity? If so, how often?
C) Do you usually do the activity alone or with others? If with others, who?

At home	**(A)** 0 No 1 Yes	**(B)** 0 Never 1 Rarely 2 Sometimes 3 Often	**(C)** 1 Alone 2 With others 3 Alone & with others
Watching TV Who?_____	0 1	0 1 2 3	1 2 3
Reading Who?_____	0 1	0 1 2 3	1 2 3
Playing cards/ bingo/games Who?_____	0 1	0 1 2 3	1 2 3
Arts or crafts Who?_____	0 1	0 1 2 3	1 2 3
Going for a walk Who?_____	0 1	0 1 2 3	1 2 3
Outdoor yardwork Who?_____	0 1	0 1 2 3	1 2 3
Shopping Who?_____	0 1	0 1 2 3	1 2 3
Church or synagogue Who?_____	0 1	0 1 2 3	1 2 3
Church or related activities Who?_____	0 1	0 1 2 3	1 2 3

At home	(A)	(B)	(C)
	0 No 1 Yes	0 Never 1 Rarely 2 Sometimes 3 Often	1 Alone 2 With others 3 Alone & with others
Theatre, movies, spectator sports Who?_____	0 1	0 1 2 3	1 2 3
Dining out Who?_____	0 1	0 1 2 3	1 2 3
Visiting with family or friends in person Who?_____	0 1	0 1 2 3	1 2 3
Visiting with family or friends by phone Who?_____	0 1	0 1 2 3	1 2 3
Sports Who?_____	0 1	0 1 2 3	1 2 3
Travel Who?_____	0 1	0 1 2 3	1 2 3
Volunteer work Who?_____	0 1	0 1 2 3	1 2 3
Other (specify) Who?_____	0 1	0 1 2 3	1 2 3_____

Now I would like to ask you a few questions about your health.

(16). In general, would you say your health is:

_Excellent
_Good
_Fair
_Poor
_Bad

Why?

_____
_____
_____
_____
_____

(17). Do you have any health related problems? Yes_ No_ If yes, what is your/are your health problems?

_____
_____
_____
_____
_____

(18). To what extent do your health problems stand in the way of doing leisure/recreation activities you like?

_____
_____
_____
_____
_____

(19). Do you think leisure/recreation can have a positive impact on your health? Yes_ No_ Please explain.

_____
_____
_____
_____
_____

Now I would like to ask you a few questions about activities of daily living, things that we all need to do as a part of our daily lives. I would like to know if, <u>today</u>, you can do these activities without any help, or if you need some help to do them, or if you can't do them at all.

(20). How much shopping do you do (necessities like groceries, clothing, small purchases)?

_None:
- _No need
- _No need; someone else does
- _Does not know how
- _Physical inability

_Some
_A lot
_With help (Who)
_Without help
_With device (What)

(21). Do you travel outside the home? How? (Bus, drives car, taxi, walks)

_None:
- _No need
- _No need; someone else does
- _Does not know how
- _Physical inability

_Some
_A lot
_With help (Who)
_Without help
_With device (What)

(22). Do you handle your own finances? (collects and keeps track of income, writes checks, balances checkbook, pays bills, goes to bank)

_None:
- _No need
- _No need; someone else does
- _Does not know how
- _Physical inability

_Some
_A lot
_With help (Who)
_Without help
_With device (What)

(23). Do you use the telephone? (operates phone on own initiative, dials a few well known numbers, looks up numbers in the telephone book, answers telephone but does not dial, hears the telephone ring)

_None: _No need
_No need; someone else does
_Does not know how
_Physical inability
_Some
_A lot
_With help (Who)
_Without help
_With device (What)

(24). Do you do household chores? (does laundry in machine or by hand, performs light daily tasks such as dishwashing and dusting, performs heavy tasks such as vacuuming and window washing)

_None: _No need
_No need; someone else does
_Does not know how
_Physical inability
_Some
_A lot
_With help (Who)
_Without help
_With device (What)

(25). Are the visits you receive from Home Care staff an important source of social contact for you? Yes_ No_ Please explain.

(26). Do visits from Home Care staff fulfill your need for socializing/visiting? Yes_ No_ Please explain.

(27). Would you enjoy more social contact/visits? These visits could be from anyone you prefer, such as family, friends, or others. Yes_ No_ Please explain why. (If yes, ask person to specify who would be preferred visitors.

(28). Now I would like you to consider your life as it is right now. Here are a number of key words or phrases which people use to identify various areas of their lives. After I have read each key word or phrase, please consider how you would rate your own life, as it is right now, in terms of that descriptive word or phrase.

To assist you in giving your rating, I have designed a labeled scale which runs from "TERRIBLE" to "DELIGHTFUL" in several equal steps. Each of these steps has a corresponding number.

When you have picked the level from the scale that comes closest to describing how you feel about the particular area of your life, please tell me which label and number you have picked. For example, is your HEALTH "terrible", "very dissatisfying", "dissatisfying", and so on?

(Use the following scale for each question: Show card)

1. **Terrible**
2. **Very Dissatisfying**
3. **Dissatisfying**
4. **Mixed**
5. **Satisfying**
6. **Very Satisfying**

7. **Delightful**
8. **No Opinion** (not applicable, can't remember, no comment, etc.)
9. **Missing**

A) **Health** - The present state of your general, overall health (relatively free of common and chronic illnesses). ( )

B) **Finances** - Your income and assets (investments, property, etc.). ( )

C) **Family Relations** - Kind of contact and frequency of contact you have with your family members. This includes personal contact, phone calls, and letters. ( )

D) **Paid Employment** - Any work for wages, salaries or fees. ( )

1. **Terrible**
2. **Very Dissatisfying**
3. **Dissatisfying**
4. **Mixed**
5. **Satisfying**
6. **Very Satisfying**
7. **Delightful**
8. **No Opinion** (not applicable, can't remember, no comment, etc.)
9. **Missing**

E) **Friendships** - Kind of contact and frequency of contact you have with your friends. This includes personal contact, phone calls, and letters. ( )

F) **Housing** - The present type, atmosphere and state of your home (e.g., apartment, house, farm, room, etc.). ( )

G) **Recreation Activity** - Personal recreation activities you engage in for pure pleasure when you are not doing normal daily living chores or some type of work. This includes relaxing, reading, TV, regular get-togethers, church activities, arts and crafts, exercises, trips, etc. ( )

H) **Religion** - Your spiritual fulfillment. ( )

I) **Self-esteem** - How you feel about yourself; your sense of self-respect. ( )

J) **Transportation** - Public and private transportation (e.g., including convenience, expense). ( )

(29). Now, using the same scale, how do you feel about your life as a whole right now? Is life generally dissatisfying, satisfying, etc.? ( )

Thank you kindly for your answers. Your assistance with this project is greatly appreciated.

1. **Terrible**
2. **Very Dissatisfying**
3. **Dissatisfying**
4. **Mixed**
5. **Satisfying**
6. **Very Satisfying**
7. **Delightful**
8. **No Opinion**
9. **Missing**

(A)

No
Yes

(B)

Never
Rarely
Sometimes
Often

(C)

Alone
With others
Alone & with others

None: _No need
_No need; someone else does
_Do not know how
_Physical inability

Some
A lot
With help (Who)
Without help
With device (What)

APPENDIX O

Informed Consent Form

APPENDIX O
Informed Consent Form

LEISURE/RECREATION INTERVIEW

INVESTIGATOR:
Ms. Wendy Chabi
204-482-8770

I understand that I am participating in a project by Wendy Chabi, a graduate student at the University of Manitoba. I have been informed that my involvement consists of an in-person, one hour interview.

I understand that the purpose of the project is to learn about leisure/recreation activities of older adults in their respective homes and communities.

I give Wendy permission to tape record the interview.

I have the right to refuse to answer any question or questions that I may be asked and my participation is voluntary. I can stop the interview at any time.

I have been promised that all the information I provide is confidential and that no results will be released in any way that could identify me personally.

I understand that any concerns that I may have can be reported to Dr. D. W. Hrycaiko, Chair of the Committee on Research Ethics at the University of Manitoba.

Name:_____ Signature:_____
Date:_____

Interview's
Name:_____ Signature:_____

APPENDIX P

Investigator Information

APPENDIX P
Investigator Information

To whom it may concern:

I, Wendy Chabi, am a graduate student at the University of Manitoba. I am conducting interviews with individuals in order to gain a better understanding of leisure and recreation participation in the home and community.

The information that you provide is confidential and under no circumstances will your name be released to anyone. If there are questions you prefer not to answer, please do not feel obligated to answer them. Participating in the interview will have no effect on any services you are currently receiving.

Should you have any questions regarding the study, please contact Dr. Michael J. Mahon or myself:

Dr. Michael J. Mahon
Director, Health, Leisure, & Human Performance Research Institute
University of Manitoba
204-474-6131

Wendy Chabi, B.R.S., B.A.
Graduate Student
University of Manitoba
204-482-8770

Without your cooperation, this study would not be possible. Thank you.

Respectfully,

Wendy Chabi, B.R.S., B.A.