

## FAMILY CAREGIVERS: AN UNTAPPED TRAVEL MARKET

NANCY J. GLADWELL

LEANDRA A. BEDINI

ERIK T. BYRD

DAVID A. CARDENAS

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

*The purpose of this study was to investigate constraints to pleasure travel for family caregivers, specifically addressing constraints encountered from the industry's service provision providers. Data represented family caregivers' perceptions of physical, emotional, and social constraints that impact their leisure travel opportunities. Using a subset of data from a larger study that generated five constraints to leisure travel, this study focused only on the Service Provision factor that addressed physical and social accessibility of accommodations and services. Results showed that family caregivers not only missed their pleasure travel due to caregiving, but their travel-related decisions were shaped by their level of confidence in service provision. Recommendations address not only issues related to accessibility, but also ensuring that travel professionals are sensitive to unique travel needs of this travel market.*

Family caregivers are a hidden segment of the population that has the potential to become a viable pleasure travel target market. Unlike other target markets, such as "baby boomers," mature travelers, or even people with disabling conditions, family caregivers are unique and complex in their needs and constraints regarding travel. As a result, this population cannot be addressed by standard travel industry service provision approaches. Instead, the service provision industry needs to understand family caregivers in the context of their relationships to their care-recipients. Unfortunately, while recent research examines the market of baby boomers as well as mature adults (e.g., Administration on Aging, 2007; AARP, 2007; TIA, 2004), and travelers with disabilities, (e.g., Burnett & Bender-Baker, 2001; Daniels, Rodgers, & Wiggins, 2005; Mactavish, MacKay, Iwasaki, & Betteridge, 2007; Yan, McKercher, & Packer, 2004), there has been little research conducted to understand the constraints to pleasure travel for family caregivers.

Family caregivers can be seen as a niche travel market that is expected to expand greatly over the next several decades. According to the Administration on Aging (2007), the U. S. population that is 65 years and over will increase from 35

million in 2000 to 55 million in 2020. Similarly, the "85+" population is projected to increase from 4.2 million in 2000 to 7.3 million in 2020. As defined by the Family Caregiver Support Network, a family caregiver is "a spouse, adult child, other relative or friend who helps, cares for or is concerned about an older adult" (Interfaith Older Adult Programs, n.d., para.1). Many family caregivers fall within the age-range of the baby boomer population (individuals born between 1946 and 1964), which is becoming a large portion of mature adults with discretionary money and time. These data have strong implications for the travel industry's ability to meet the needs of the ever-growing travel market of family caregivers. These family members who care for their loved ones also seek travel opportunities. However, they often desire to travel with their care-recipient (their spouse or parent who has a disability), and subsequently are presenting new challenges to the travel industry.

Positive travel experiences are very important to one's quality of life. Unfortunately, studies have shown that people with mental and/or physical disabilities have limited involvement in leisure travel compared to non-disabled populations (e.g., Mactavish, MacKay, Iwasaki, & Betteridge, 2007; Yan, McKercher, &

Packer, 2004). Perhaps this is due, in part, to the lack of preparation and accommodations required for the caregiver to have quality experiences. In an analysis of the "tourism-driven" agencies, Stumbo and Pegg (2005) report that "despite national efforts to regulate accessibility, many individuals [with disabilities] find travel and tourism destinations to be unwelcoming" (p. 206). Burnett and Bender-Baker (2001) suggest that the travel industry has been slow to accommodate "different" capabilities among people with disabilities concluding that the "mobility-disabled" market "may be a profitable segment for the travel industry to target, if properly positioned" (p. 10).

The data about travelers with disabilities have direct implications for family caregivers as well, who are often the travel companion to individuals with disabilities. As the number of people with disabilities (50 million currently) in the US increases, the number of family caregivers can also be expected to grow quite rapidly as well. Recent estimates suggest that over 44 million people provide unpaid care for a family member or friend who is disabled, ill, or aged (National Alliance of Caregiving and The American Association of Retired Persons, 2004 [NAC/AARP]). Over half of these primary caregivers are 65 years of age or older.

Similar to other groups within this age cohort, caregivers report that pleasure travel (with or without their care-recipient) is an important leisure pursuit, but that they often desire travel with their care-recipient. For many, traveling with a loved one is a central focus of their meaningful leisure (e.g., Gladwell & Bedini, 2004). Caregivers report, however, that because of caregiving responsibilities, as well as innumerable unknowns regarding travel, they often chose to limit or give up this activity (e.g., Bedini & Gladwell, 2006; Chakrabarti, Kulhara, & Verma, 1993; Gladwell & Bedini, 2004; NAC/AARP, 2004). Additionally, Bedini and Gladwell (2006) examine the importance of "shared leisure" between caregivers and loved ones noting that caregivers would often abandon their travel when their travel companion (frequently their care-recipient) could no longer travel. Reducing or abandoning leisure travel can have physical and emotional consequences as well. Lindgren (1996) found that, in some cases, the inability to pursue travel triggers actual sorrow in caregivers and

care-recipients. Therefore, the loss of travel options is considered a significant enough consequence of caregiving that it is identified as an indicator of strain in the Caregiver Strain Index (Robinson, 1983). One such strain is the caregiver's consideration of their care-recipient's medical issues, which often makes travel prohibitive. Pleasure travel also becomes burdensome when facilities and services are not accommodating. Thus, the industry stands to lose both the individual with the disability as well as their caregiver.

## CONCEPTUAL FRAMEWORK

Understanding of the potential factors that may act as barriers to meeting the travel needs of both the caregiver and the care-recipient is necessary in order for the service provider to proactively attempt to reduce or eliminate such constraints. The conceptual framework for this study stems from the body of constraints literature that relates to leisure. While the purpose of this study is not to distinguish the types of constraints experienced by the respondents, it is important to understand the foundations of this conceptual framework. Constraints, which are considered to be more complex than barriers (Jackson & Scott, 1999), consistently have been presented in reference to the hierarchical model of Crawford, Jackson, and Godbey (1991). This model, which identifies three constraints categories (i.e., intrapersonal, interpersonal, and structural), serves as the basis for much of the leisure constraints research (e.g., Crawford & Godbey, 1987; Daniels, Rodgers, & Wiggins, 2005; Gladwell & Bedini, 2004; Henderson, Bedini, Shuler, & Hecht, 1995). This research typically defines intrapersonal constraints as internal factors that may interfere with leisure pursuits (e.g., worry, depression, stress). Interpersonal constraints result from interaction between people (e.g., marital, leisure companion, attitudes of others). Structural constraints involve factors outside of the individual (e.g., weather, finances, access).

With regard to travel, constraints also might be understood through Israeli's (2002) decision-making model. Here a visitor uses two methods, compensatory and non-compensatory, to evaluate a tourism service or attraction. Under the compensatory method of evaluation, undesirable attributes (e.g., stairs, complex layout, lack of sensitivity by staff) can be compensated for by higher levels of desirable attributes (e.g., elevators, directional signage, informed personnel).

Under the non-compensatory method, undesirable attributes cannot be compensated for by a higher level of another attribute. The attributes that are considered non-compensatory are discussed in the literature as barriers or constraints. Therefore, family caregivers who travel with their care-recipients who have disabilities have to use the non-compensatory method more than other travelers because access to specific attributes is necessary in order for them to enjoy their travel experiences (Burns & Graefe, 2007; Israeli, 2002).

In an examination of travel experiences of people with disabilities and their caregivers, Daniels, Rodgers, and Wiggins (2005) identify "travel companion constraint" and "travel companion negotiation" as interpersonal constraint themes (p. 924). These accounts reflect dependence of travelers with disabilities on travel companions (e.g., family caregivers), as well as the importance of a travel companion in overcoming constraints experienced in their travel pursuits. For many caregivers, they have to negotiate travel constraints for their companion with a disability. Therefore, constraints they encounter because of the actions or attitudes of the service provider affect both the traveler with a disability as well as the caregiver. While not all experiences of the subjects in the study are negative, the respondents note specific examples of conditions that restrict their travel experiences (e.g., cleaning crew leaving carts in hallways making it impossible for a wheelchair to pass). Similarly, in a study of only family caregivers, Gladwell and Bedini (2004) find similar experiences suggesting that service providers were "both 'good' and 'bad' in providing accessible services" (p. 690). The respondents note, however, that the attitude and perceive skill levels of some service providers posed a significant constraint. As an example, they note one respondent's comments on how the service providers can make her feel inferior, "as though you are a second-class citizen" (Gladwell & Bedini, 2004, p. 691). As these examples suggest, constraints caregivers face when traveling with their care-recipient are ongoing and interactive.

Goodall, Pottinger, Dixon, and Russell (2005) highlight some of the non-compensatory attributes using the example of historic sites. They indicate that certain constraints, such as access to the site's areas and facilities, cannot be overcome at historic sites; therefore, participants, and many times their caregivers, will decide not to visit the site, opting to choose another destination based solely on the absence of access. In

the case of caregivers, they could decide to visit the site, but at the cost of leaving their care-recipient behind. This scenario, in essence, limits the places that caregivers, as well as their care-recipients, can go and activities in which they can participate while on vacation (Goodall, Pottinger, Dixon, & Russell, 2005). Decisions, then, are made primarily with the care-recipient rather than the caregiver in mind, which compromises the travel experiences of the family caregivers. It is important to note that many of these constraints can be associated with either actual or perceived risks. Even if physical constraints can be negotiated, if either the family caregiver or the care-recipient perceives a high level of risk, they will not participate or travel (Yan, McKercher, & Packer, 2004). Therefore, the purpose of this study is to examine data taken from a larger study that addresses a variety of constraints to the pleasure travel of family caregivers. In particular, this study investigates the constraints that are due to interactions with the travel industry's service providers as encountered by family caregivers when traveling for pleasure.

## METHODS

Subjects were delimited to individuals who provided primary unpaid caregiving to an adult member of their family (e.g., spouse, parent, relative). These individuals were identified through the coordinators of the caregiver support groups from the 28 agencies listed in AARP's *Family Caregiving in North Carolina (2002) Directory*. To identify willing agencies, the researchers sent an email to a contact person for each of the 28 agencies listed asking if they were willing to help distribute survey packets to potential respondents through their caregiver support groups and related services. Nine agencies responded positively and subsequently four agencies were chosen that represented the four geographical regions of the state (mountains, piedmont, sandhills, and coastal). Each of these areas potentially offered a unique cultural perspective in terms of family caregivers (Bedini & Phoenix, 1999). The survey instrument was disseminated to a total of 870 potential participants who were identified by the four agencies.

The instrument was designed to solicit family caregivers' perceptions of physical, emotional, and social barriers that impact their leisure travel opportunities. The survey was comprised of a total of 82 items: 56 items about constraints and 26 demographic questions. Questions

on constraints were developed from quotes and phrases from interviews in an earlier study by Gladwell and Bedini (2004) that addressed family caregivers' constraints to leisure travel. These items addressed structural, intrapersonal, and interpersonal constraints (Crawford et al, 1991) and used a 4-point Likert scale with "4" representing "strongly agree" and "1" representing "strongly disagree." The 26 demographic profile items represented eight basic characteristics (e.g., age, sex, race, education, income); 12 specific questions dealt with the respondents' caregiving duties (e.g., hours and type of support, care-recipient's disability, level of assistance required by care-recipient), and six questions that addressed issues regarding traveling. These items were nominal or open ended.

As there was no comprehensive list of the caregivers who participated in the support groups identified in the *Family Caregiving in North Carolina (2002) Directory*, confidentiality of the subjects warranted the use of liaisons to contact and provide potential subjects with the survey packets. The researchers disseminated the 870 questionnaires requested by caregivers through the four liaisons who were administrators in the identified caregiver agencies. The liaisons distributed coded packets each of which included a cover letter, questionnaire, and self-addressed and stamped return envelope to these family caregivers through support group meetings or direct mailings. The potential respondents were asked to complete the questionnaire and then mail it back to the researchers directly. Reminder postcards were sent to the liaisons to distribute to their respective potential subjects two weeks after the initial mailing. A total of 105 usable surveys were returned for a response rate of 12.0%.

Data were analyzed using SPSS 14.5 for factor analysis, as well as independent t-tests, ANOVAs, and descriptive statistics. Independent t-tests and ANOVAs were run to determine if there were statistically significant differences for the Service Provision factor generated among relevant demographic profile variables.

## RESULTS

Initially, principle component factor analysis, with a varimax rotation and a cut-off Eigenvalue of 1.0, was conducted to determine constraints to leisure travel for family caregivers. To determine the internal consistency of the factors, Cronbach's alpha was used. Only items with a loading factor of  $\geq .40$  were used in

the interpretation of each factor. The 56 constraint items factored into five constraints/dimensions (Environment, Personal Experience, Financial, Shared Leisure, and Service Provision). It should be noted it was not necessary to delete any items due to being loaded on multiple factors.

The focus of this analysis is solely on the factor of *Service Provision*. The Service Provision factor comprised nine items that addressed the accessibility of facilities, accommodations, and services delivered by employees of travel related businesses. In addition, items that addressed lack of knowledge of travel opportunities, pace of guided vacations, inability to trust the knowledge and skills of people providing service, and unwillingness to stay at or visit accommodations that are not accessible were also components of the factor. The Cronbach's alpha for the Service Provision factor was .80.

The small sample size of 105 respondents raises the issue of appropriateness of sample for the factor analysis that was conducted. Tinsley and Tinsley (1987) stated that although factors generated from analysis of small samples are less generalizable than those from large samples, they found no empirical evidence to support the five to ten subjects to item ratio. In addition, Arrindell and van der Ende (1985), in their studies of stability of factors as a function of subjects-to-variables ratio, concluded that observations-to-variables ratio had no effect on factor stability. See Table 1 for items and specific factor loadings.

Descriptive analysis found that the demographic profile for this study was similar to previous studies conducted on

family caregivers (Bedini, & Phoenix 2004; Center for Disease Control, 2005; Scharlach, Gustavson, & Dal Santo, 2007). The average respondent (n=105) was female (85.4%), white (75.6%), and an average of 60 years old with a range of 32 to 87 years of age. Two-thirds (65.9%) of the respondents were married or partnered. Over a third of the respondents (36.0%) had a minimum of a four-year college degree, while 64.0% had less than a four-year degree. Only 29.5% of the respondents were employed full-time. Approximately one third of the respondents (34.6%) reported having to give up a job when they became caregivers. Fewer than half of the respondents (44.1%) indicated their household annual income was less than \$25,000, while 39.7% had an annual household income of \$25,000 to \$49,999, and 16.2% had incomes of \$50,000 or more. Roughly one quarter of the respondents (25.6%) cared for a spouse or partner, while 59.7% cared for a parent or parent-in-law. The average age of the care-recipients was 79 years old, with a range of 40 to 97 years of age. Roughly two thirds of the respondents (61.7%) lived with their care-recipients. The most common disability for the care-recipients was Alzheimer's disease or dementia (48.1%). Other disabling conditions included cerebrovascular accident, heart disease, Parkinson's disease, and cancer. The care-recipients' level of care ranged from level one (requires little assistance, 13.0%) to level four (requires constant assistance, 48.0%). Forty-eight percent of the respondents themselves provided care for their care-recipient more than 40 hours per week, while almost half (48.6%)

TABLE 1. Sample Items and Factor Loadings of Service Provision

Service Provision Factor (Cronbach's alpha = .80)	Factor Loadings
I would travel more if I knew more accessible services.	.713
I would travel more with my care-recipient if there were more accessible services.	.704
My care-recipient and I do not travel because of lack of accessible transportation.	.650
I do not travel with my care-recipient b/c I am worried that the accommodations are not accessible.	.591
I do not travel much because of lack of knowledge of travel opportunities.	.563
I would take my care-recipient on guided vacations if they moved at slower paces.	.507
Travel service providers lack the skills to meet the needs of my care-recipient.	.478
When I travel I do not enjoy myself because I am worried about the care-recipient care is receiving in my absence.	.451
I will not stay/visit accommodations that are not accessible when I travel with my care-recipient.	.379

received less than 10 hours of help/support each week.

With reference to their interest in leisure and pleasure travel, over 90% of the respondents stated that they had "some" to "great" interest in recreation and leisure travel. In addition, 49.3% stated that they had to give up travel because of their caregiving responsibilities. An additional 12% stated that they could pursue travel only if they took their care-recipients with them. Over one-third of the respondents (35%) stated that they engaged in no leisure travel at all with their care-recipient. Results from individual item mean scores ("4" representing "strongly agree" and "1" representing "strongly disagree") suggested that the responding caregivers greatly missed their travel (M=3.38). In addition, these respondents indicated that when they did travel with a care-recipient, their enjoyment was compromised. Results indicated that the respondents felt they did not have much freedom when they traveled with their care-recipients (M=3.33), often did not travel with their care-recipient because of the stress they encountered (M=2.93), and felt guilty if they were to travel without their care-recipient (M=2.89). Finally, results showed that caregiver respondents stated that they chose to stay closer to home when traveling with their care-recipients (M=3.06).

Caregiver respondents identified frustration from lack of energy to enjoy the trip for both the care-recipient (M=3.15), and for themselves (M=2.99). Specifically related to the travel industry, respondents noted that they would not stay at or visit accommodations that were not accessible when they travel with the care-recipient (M=3.04), they worried about care for the care-recipient when they traveled (M=2.99), and they would travel more if they had someone to care for their care-recipients (M=3.01).

Independent t-tests and ANOVAs were run to determine if there were statistically significant differences for the Service Provision factor and relevant demographic profile variables. The demographics that indicated differences with regard to service provision as a constraint to caregivers' leisure travel suggested that the problems identified spanned across various populations and conditions. As might be expected, results showed that service provision was a significant constraint to leisure travel for those respondents who had a household income of less than \$25,000 ( $p = .008$ ). Also, issues of service provision posed a substantial constraint to respondents whose care-recipients required constant care and assistance ( $p = .004$ ). Less

intuitive, however, was the result that indicated that "non-white" caregivers experienced greater constraints to their leisure travel regarding service provision than white respondents ( $p = .03$ ). There were no other significant differences between Service Provision factor and the remaining demographic variables.

## DISCUSSION

The results of this study indicated that service provided by travel industry employees is a significant constraint to leisure travel for family caregivers and thus, fits within the interpersonal constraints category of Crawford et al.'s constraints model (1991). Supported by the literature, the results also suggested that leisure travel is not only important to family caregivers, but that they miss the leisure travel they have given up due to their caregiving responsibilities. Results also showed, however, that there were several compromising issues in both traveling with a dependent care-recipient and in traveling without their loved one. With the projected growth in the number of baby boomers who not only will be entering the mature travel market over the next 10-20 years, but also potentially becoming family caregivers, it is important for the travel industry to begin to address the travel needs of this untapped market now.

Based on this study's results, there are two primary areas that must be addressed in order to capture this unique travel market: the accessibility of travel facilities and services and the training of travel personnel to interact with and meet the needs of family caregivers appropriately. Addressing both of these areas of concern can influence the marketing strategies used to reach the family caregivers market.

The challenges to service providers in terms of family caregivers include more than merely providing the Americans with Disabilities Act (ADA) mandated physically accessible facilities and services. In addition to providing physically accessible facilities and services, the results showed that much of the need lies in travel professionals being sensitive when providing services to meet the emotional and safety needs of family caregivers and their care-recipients.

Considering first the composition of the Service Provision factor, five of the nine items dealt specifically with physical and/or service accessibility issues. Since the average age of family caregivers was 60 years and that of the care-recipients was 79 years, travel service providers

should consider exceeding the minimal standards required by regulations and laws (e.g., ADA) in designing and renovating the physical accessibility of travel-related facilities and services. In situations where physical accessibility is not possible (i.e., historic site, rugged terrain), Goodall, Pottinger, Dixon, and Russell (2005) suggested exploring alternative methods to experience the site or activity intellectually. This could include the use of interpretation, video, virtual reality technology, and other forms of technology.

Perhaps one of the most important issues raised by these results is the strong indication that respondents choose to stay closer to home when traveling with their care-recipient (M = 3.06). This behavior likely is linked to the above insecurities about how physically accessible a travel venue is. In addition, the results pointed to worry and stress, as well as lack of energy for both the caregiver and the care-recipient, which in turn may restrict duration and distance to travel.

In addition, results of this study indicated that the Service Provision constraint was experienced more by respondents who had a household income of less than \$25,000. This segment of the caregiver market may be more likely to stay near home or suspend travel altogether. Additional costs required for their care-recipients as well as increased cost of air travel also may restrict their travel opportunities. Today's economic climate, coupled with the increased costs of necessary household expenses (e.g., prescription drugs, groceries, utility costs, etc.), also may serve as additional constraints. Under such circumstances, pleasure travel simply may not be a high priority.

Finally, results from this study indicated that specific elements of the travel experience had a significant contribution to the willingness of family caregivers to stay at or visit accommodations and or destinations. Challenges to the travel industry include improving the available knowledge of accessible and "disability sensitive" travel opportunities, consideration of the pace of guided vacations or outings, and establishing trust with the family caregiver market regarding the knowledge, skills, and sensitivity of the people providing travel services. Such actions by the travel industry may help alleviate the fear and lack of trust caregivers indicated having when traveling with their care-recipients. While the baby boomers and mature travel markets may have the time, desire, and financial resources to enjoy their travel over the next few decades, the fear and uncertainty

of travel with or without their care-recipient may have negative impacts on their personal travel decisions. Innovative solutions such as “assisted vacations” should be considered by the travel industry. Led by health care teams, one-week long programs of activities for caregivers (with and without care-recipient spouses) have been held in hotels or rehabilitation centers. Research on these “vacations” found that they have an immediate as well as long term ability to reduce physical complaints and symptoms of depression in spousal caregivers (Wilz & Fink-Heitz, 2008).

More significantly, however, other items in the Service Provision factor, “I would take my care-recipient on guided vacations if they moved at slower paces,” “travel service providers lack the skills to meet the needs of my care-recipient,” and “I do not travel much because of lack of knowledge of travel opportunities” address the skills of the service providers in terms of knowledge of these populations’ (people with disabilities and family caregivers) travel needs. Israeli (2002) further indicated that serving non-traditional populations does not come naturally to most people in the tourism and hospitality industry. This could be due the staff’s lack of knowledge regarding the travel needs of family caregivers who travel with people with disabilities or simply lack of familiarity with the population of people who have a disability. Mactavish et al. (2007) suggested that information accuracy and planning assistance are essential to accommodating families of individuals with disabilities. The lack of skills for the service providers is due to the service providers simply not knowing what information is important to this market (Daniels, Rodgers, & Wiggins 2005; McKercher, Packer, Yau, & Lam 2003). Some agencies are attempting to address these issues through appropriate trainings. For example, the American Byways Resource Center conducted a self-evaluation titled, *Accessibility Byways Training Initiative, 2009*. This is the exception rather than the rule, however, and much more needs to be done to address the issues identified here.

Perhaps most relevant, however, was the finding which indicated the importance of travel service personnel establishing trust with the family caregiver market regarding the service personnel’s knowledge, skills, and sensitivity to specific populations. Consistent with the category of intrapersonal constraints (Crawford et al., 1991), results showed that many of the family caregivers who responded felt as if they did not have much freedom and experienced stress

and worry when they travel with their care-recipient and thus tended to stay closer to home. If they traveled alone, many expressed feelings of guilt coupled with an indication of a desire to travel if someone were able to care for their care-recipient. These results emphasize that travel-related service providers need to work with family caregivers “to facilitate psychologically, as well as physically safe and comfortable environments within which caregivers and their recipients can pursue their leisure travel” (Bedini & Gladwell, 2006, p. 332).

In addition, tourism service providers must ensure that their staffs have relevant and appropriate training and information to meet many of the needs of people with disabilities and their caregivers. For example, hotels, airlines, and motor coach lines should consider the transportation needs of individuals who use a wheelchair or walker, not only with logistics such as a van lift, but also when establishing the actual distance, pace, and the length of time required to prepare for and complete an excursion. Such examples may have a direct impact on a caregiver’s decisions related to travel (e.g., where to go, what to do, or whether to travel or not). Ray and Ryder (2003, p. 68) stated:

Those hospitality and tourism operators who do attempt to attract the disabled need to know ‘what they are getting themselves in for’. As mentioned by Guzman (1999), extra time is often needed for each customer, and additional specialized equipment may have to be stocked. With the hearing-impaired community, interpreters would have to be hired, with maybe more than one sign language (in the case of multiple nationalities) needing interpretation.

Service providers need to consider innovative ways to market the presence of access, safety, and understanding to these potential visitors in all venues. Israeli (2002) suggested that evaluating a potential tourism site is comparable to the decision making process: “In decision-making terminology, a tourist (decision maker) has an objective of enjoying a tourist attraction; he or she evaluates sites (alternatives) that are characterized by factors (attributes) and selects the one that serves his or her objective in the best manner” (p. 101-102). Since family caregivers are often the decision makers for both their care-recipient and themselves, service providers need to provide comprehensive and accurate information to these potential customers about site accessibility, local health care providers, physical and mental requirements to participate in activities, and other non-

physical attributes that would be of interest. This information, as well as other traditional promotional information, should be easy for the caregiver and care-recipient to access and utilize. Including such information in marketing materials may influence caregivers’ travel decisions positively. For example, travel opportunities that provide trusted and qualified care or assistance for the care-recipient may aid in reducing these feelings of apprehension on the part of the family caregiver. This is particularly important since approximately 90 % of the respondents indicated they had interest in recreation/leisure travel. Similarly, for marketing, brochures can be developed in Braille, larger print, or in an audio format (Goodall, Pottinger, Dixon, & Russell 2005). Websites and electronic media can be developed to illustrate accessibility and amenities designed specifically for travelers with disabilities and their caregivers. In summary, provision of accessible travel facilities and services should be viewed as part of standard service delivery and not as an additional revenue source.

#### LIMITATIONS

This study was not without limitations, however. The first limitation of the current study was the lack of diversity in the sample. This group of respondents was predominantly white and female. This clearly over-represents the primary demographic attribute of sex and may have influenced the results to some degree. Female respondents constituted 85.4 % of this study, while according to the National Alliance for Caregiving and AARP (2004), women comprise 61% of all family caregivers in the United States. With regard to race, when compared to the National Alliance for Caregiving and AARP (2004) data, whites and African-Americans were slightly over represented, while Hispanics and Asians were underrepresented. The second limitation was the low response rate. A larger response rate would allow for greater generalization of the findings.

To confirm the results found here, there are several recommendations for future study. First, it is important to replicate this study with a larger and more representative sample. In fact, because family caregivers are often burdened with a lack of unobligated time, consideration should be given to using qualitative methods in order to obtain more in-depth information about these issues. In addition, since caregivers’ travel often includes their care-recipients, future research should focus on a better understanding of the physical, social, and

psychological needs of the care-recipient based upon their specific conditions and/or disease/s to aid travel providers in offering the travel facilities and services which could reduce or eliminate specific potential travel constraints. Research also should examine specific factors and constraints that may impact caregivers' decisions related to traveling for pleasure (e.g., whether to travel or not, where to travel, mode of transportation). Finally, while research has addressed the mature, disabled, and baby boomer travel markets individually, the family caregiver market (which represents a combination of these three individual markets) is a unique and quickly growing market that should not be ignored. With this said, research is needed to determine what type of travel information that could positively influence the caregiver's decision-making regarding traveling for pleasure.

## REFERENCES

- AARP (2002). *Family caregiving in North Carolina directory*. Retrieved October 8, 2008, from [www.aarp.org/statepages/pdf/NC\\_FmlyCrgvng.pdf](http://www.aarp.org/statepages/pdf/NC_FmlyCrgvng.pdf).
- AARP (2007, June). *The sky's the limit: Travel trends among the baby boom generation & beyond*. Retrieved April 20, 2008, from [http://www.aarp.org/research/reference/boomers/travel\\_trends.html](http://www.aarp.org/research/reference/boomers/travel_trends.html).
- Administration on Aging. A profile of older Americans: 2007. Available from <http://www.aoa.gov/PROF/Statistics/profile/2007/2.aspx>. Accessed March 6, 2008.
- Arrindell, W. A., & van der Ende, J. (1985). An empirical test of the utility of observations-to-variables ratio in factor and components analysis. *Applied Psychological Measurement*, 9, 165-178.
- Bedini, L. A. & Gladwell, N. J. (2006). Barriers to leisure travel of family caregivers: A preliminary examination. *Topics in Geriatric Rehabilitation*, 22(4), 322-333.
- Bedini, L. A. & Phoenix, T. L. (1999). Addressing leisure barriers for caregivers of older adults: A model leisure wellness program. *Therapeutic Recreation Journal*, 33, 222-240.
- Bedini, L.A., & Phoenix, T. L. (2004). Perceptions of leisure by family caregivers: A profile. *Therapeutic Recreation Journal*, 38, 366-381.
- Burnett, J. J., & Bender-Baker, H. (2001). Assessing the travel-related behaviors of the mobility-disabled consumer. *Journal of Travel Research*, 40, 4-11.
- Burns, R. C., & Graefe, A. R. (2007). Constraints to outdoor recreation: Exploring the effects of disabilities on perceptions and participation. *Journal of Leisure Research*, 39(1), 156-181.
- Centers for Disease Control and Prevention (CDC). (2005). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
- Chakrabarti, S., Kulhara, P., & Verma, S. K. (1993). The pattern of burden in families of neurotic patients. *Social Psychiatry and Psychiatric Epidemiology*, 28, 172-177.
- Crawford, D. W. & Godbey, G. (1987). Reconceptualizing barriers to family leisure. *Leisure Sciences*, 9(2), 119 - 127.
- Crawford, D. W., Jackson, E. L., & Godbey, G. (1991). A hierarchical model of leisure constraints. *Leisure Sciences*, 13(4), 309 - 320.
- Daniels, M. J., Rodgers, E. B. D., & Wiggins, B. P. (2005). "Travel Tales": An interpretive analysis of constraints and negotiations to pleasure travel as experienced by persons with physical disabilities. *Tourism Management*, 26, 919-930.
- Gladwell, N. J., & Bedini, L. A. (2004). In search of lost leisure: The impact of caregiving on leisure travel. *Tourism Management*, 25, 685-693.
- Goodall, B., Pottinger, G., Dixon, T., & Russell, H. (2005). Access to historic environments for tourists with disabilities: A compromise? *Tourism Review International*, 8, 177-179.
- Guzzman, R. (1999). Market for disabled travelers offers a mix of opportunities and challenges. *Wall Street Journal*, 28 April, F4.
- Henderson, K. A., Bedini, L. A., Hecht, L., & Shuler, R. (1995). Women with physical disabilities and the negotiation of leisure constraints. *Leisure Studies*, 14, 17-31.
- Interfaith Older Adult Programs. (n.d.). *Family caregiver support network*. Retrieved March 10, 2009 from <http://home.interfaithmilw.org/fcsn>
- Israeli, A. A. (2002). A preliminary investigation of the importance of site accessibility factors for disabled tourists. *Journal of Travel Research*, 41, 101-104.
- Jackson, E. L. & Scott, D. (1999). Constraints to leisure. In E. L. Jackson & T. L. Burton (Eds.), *Leisure studies: Prospects for the twenty-first century* (pp. 299-321). State College, PA: Venture.
- Lindgren, C. L. (1996). Chronic sorrow in persons with Parkinson's and their spouses. *Scholarly Inquiry for Nursing Practice*, 10(4), 351-370.
- Mactavish, J. B., MacKay, K. J., Iwasaki, Y., & Betteridge, D. (2007). Family caregivers of individuals with intellectual disabilities: Perspectives on life quality and the role of vacations. *Journal of Leisure Research*, 39(1), 127-155.
- McKercher, B., Packer, T., Yau, M. K., & Lam, P. (2003). Travel agents as facilitators or inhibitors of travel: Perceptions of people with disabilities. *Tourism Management*, 24, 465-474.
- National Alliance for Caregiving & American Association of Retired Persons. (2004). *Caregiving in the U.S.* Washington, DC: Author.
- National Scenic Byways Program (2009). *Universal Accessibility and Byways Training Development*. Retrieved February 25, 2010, from <http://bywaysonline.org/forums/viewtopic.do?topic=329>
- Ory, M. G., Hoffman, R. R., Yee, J. L., Tennstedt, S., & Schulz, R. (1999). Prevalence and impact of caregiving: A detailed comparison between dementia and non-dementia caregivers. *The Gerontologist*, 39(2), 177-185.
- Ray, N. M. & Ryder, M. E. (2003). "Eilities" tourism: An exploratory discussion of the travel needs and motivations of the mobility-disabled. *Tourism Management*, 24(1), 57-72.
- Robinson B. C. (1983). Validation of a caregiver strain index. *Journals of Gerontology*, 38, 344-348.
- Scharlach, A. E., Gustavson, K. & Dal Santo, T. S. (2007). Assistance received by employed caregivers and their care recipients: Who helps care recipients when caregivers work full time? *The Gerontologist*, 47(6), 752-762.
- Stumbo, N. J. & Pegg, S. (2005). Travelers and tourists with disabilities: A matter of priorities and loyalties. *Tourism Review International*, 8, 195-209.
- Tinsley, H.A., & Tinsley, D. J. (1987). Uses of factor analysis in counseling psychology research. *Journal of Counseling Development*, 34(4), 414-424.

- Travel Industry Association of America.  
Domestic research: Travel volume  
and trends, 2004 edition. Available at:  
<http://www.tia.org/Travel/tvt.asp>. Ac-  
cessed November 21, 2005.
- Wilz, G. & Fink-Heitz, M. (2008). Assisted  
vacations for men with dementia and  
their caregiving spouses: Evaluation  
of health-related effects. *The Geron-  
tologist*, 48(1), 115-120.
- Yan, M. K., McKercher, B., & Packer, T. L.  
(2004). Traveling with a disability:  
More than an access issue. *Annals of  
Tourism Research*, 31(4), 946-960.