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The Role of Unpaid Volunteers in a Group Caregiving Approach: Validation of the Share the Care™ Program

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ABSTRACT

Share The Care™ (STC) is a caregiving program that has been guiding people on how to pool their skills and resources to assist someone facing a health, aging, or medical crisis. The purpose of this research was to conduct a descriptive program evaluation to establish STC as an advanced program within the caregiver continuum that helps to alleviate caregiver burnout and isolation through the formation of an organized “caregiving family” for support. A sample of 134 participants completed an online questionnaire and 7 participated in follow-up phone interviews. The data collection was conducted in 2 phases, beginning with an online survey and followed by in-depth phone interviews of a sample of survey participants. The results of the study demonstrate that STC is successful in providing alternative caregiving strategies, helping to prevent isolation among adults living alone, easing burden among caregivers, and improving the overall well-being of those involved. A majority of caregivers (83%) reported a decreased sense of burden and 80% became more accepting of their family member’s challenge or diagnosis. STC is a replicable caregiving program that has been supported by evidence. Adapting this model could provide benefits to participants and communities.

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Caregiving; community-based care; share the care; volunteering

The world has begun to experience an unprecedented growth in the population of adults aged 60 and older. Current population projections from the United Nations indicate that the 60 and older population will make up 21.1% of the world’s populations in 2050, a 45% increase from 2013 (United Nations, 2013). The rate of growth among the older adult population is presenting considerable demand on the long term services and supports and health care systems, both nationally and abroad.

In light of these demographics, family caregiving has become an international priority. No nation is without family caregivers, who play an essential role in alleviating the demand and corresponding costs associated with the provision of

formal care. In the United States, there are an estimated 43.5 million adults providing unpaid care to another adult or child—60% of these are women and 40% men. The average age of these caregivers is approximately 50 years old (National Alliance for Caregiving & AARP, 2015). If caregivers were not available to provide care the costs to society would be significant. According to a 2011 report by AARP, the economic value associated with caregiving totaled \$450 billion in 2009.

Many caregivers often do not identify themselves as such; rather, they see themselves as maintaining the role of the spouse, child, or parent and view their caregiving tasks as an extension of this relationship. Therefore, they often fail to seek assistance from available resources when their caregiving tasks become too overwhelming. Family caregiving is many times associated with high levels of physical and emotional stress, financial difficulties, and an overall feeling of burden, all of which can jeopardize the ability to continue to provide care (Feinberg, Reinhard, Houser, & Choula, 2011). In addition, most caregivers are taking on the task of caregiving alone, with no help from unpaid or paid systems of care. According to the National Alliance for Caregiving and AARP (2015), only 32% of caregivers reported that they receive paid help from an outside source while one in three receives no help at all from either paid or unpaid sources.

There has been focus on the role of volunteers as a cost-effective strategy to assist along the caregiving continuum and fill gaps in the long term services and supports workforce. A theme of reciprocity emerges in much of the literature on volunteering, suggesting that civic engagement opportunities can also have a positive impact on those who partake in them. Formal volunteerism is a mutually beneficial activity, as it leads to increased quality of life for participants and enables them to positively contribute to society (Gottlieb & Gillespie, 2008; Morrow-Howell, 2010).

As a result of the high numbers of caregivers and the physical, emotional, and economic strain associated with caregiving tasks, caregiving is viewed by many as a public health priority (Center for Disease Control, 2016; Feinberg et al., 2011). The future demographic trends suggest that as the age structure of the population changes, there will be a need for even more caregivers, yet fewer will be available. Without the support from caregivers, there will be an overwhelming demand on the nation's health and long-term services and supports systems. Therefore, it is essential that innovative policies and programs continue to be established to support the current network of caregivers.

Purpose of the Study

This study examined the experiences of participants in a unique caregiving assistance program, entitled Share The Care™ (STC). The STC program uses groups of unpaid volunteers to provide caregiving assistance to persons in need. Through a descriptive evaluation, the research sought to determine

whether STC helps to alleviate some of the burden often placed on family members and if it successfully aids in reducing reliance on more formal programs and services.

To meet the study's objectives, the following research questions were addressed: (a) Is participation in STC associated with a reduced level of burden for the primary caregiver and/or other family members? (b) Is there an association between participation in STC and improved confidence in caregiving skills among group members? (c) Is there a relationship between the program's unique structure, emphasizing a shared group experience, and group members' satisfaction?

The STC Program

History

The STC program evolved when a group of women came together to help a mutual friend diagnosed with terminal cancer who had a limited network of family to assist with her care needs. The group provided a range of caregiving support for nearly 4 years, until she passed away. As a result of their experience, two of the original group members, one a coauthor of this article, documented their techniques into a book entitled, *Share the Care, How To Organize a Group to Care for Someone Who is Seriously Ill*, published by Fireside Books in 1995 (Capossela & Warnock, 2004). In 2003, ShareTheCaregiving, Inc. (STCG) was established; it was granted nonprofit status in 2004. The mission of STCG is to improve the quality of life of persons who are seriously ill, disabled, or experiencing the challenges of aging, and to reduce the stress, depression, isolation, and economic hardship often experienced by their family caregivers. STCG offers education on the STC program model, including an accredited training that is offered to health professionals and clergy—the individuals who may be in the best position to identify caregivers or care receivers who might benefit from the STC program.

The STC web site (www.sharethecare.org) contains information, videos, resources, group vignettes, and downloadable administrative forms. Currently, the main source of information on STC comes from STCG and its web site. Although there are no franchises, the STCG organization has documented STC groups in each of the 48 states and 13 countries since the book was published.

Intervention

To create a STC group, an initial meeting is required to work with the family or caregiver, if available, to determine who to invite to participate in the group and what kind of help is needed. Two individuals are established as the Leader and the

Coordinator for the purpose of organizing the first meeting. A list of potential group members is developed with the input of the care receiver. Group members may be friends or acquaintances of the care receiver or caregiver, or may be unknown to them and connected by another group member. If the STC group is established informally, volunteers are not typically vetted, as they are usually known to the caregiver. However, if an umbrella organization is administering a STC program, STCG highly recommends that any potential volunteers are screened by this umbrella organization prior to enlisting them.

At the first meeting, contact information is collected using an *individual data form*. Individuals will choose their level of commitment: to be a full-on member and Captain, or a *free floater* that only helps out occasionally. Group members work in teams of two as Captains of the Week. Among the first things the Captains must do is prioritize the family's needs and develop a formal emergency plan. Captains are also responsible for ensuring that the care recipient and caregiver needs are met through the assignment of specific caregiving tasks to group members. Group members are asked to rate themselves on individual jobs using the following system: *I'm terrific, I'm good, I'm fair, or Don't call on me*. After a week, a new team rotates in through a *rotating captains system* that is designed to prevent caregiver burnout among the group members and encourage teamwork.

A second meeting becomes necessary when there has been a dramatic change in the care recipient or another issue emerges that requires immediate attention. The group will meet to determine how to solve the problem or to readjust the level of care or support they are providing. The STC structure also emphasizes a closing meeting, which is necessary when the group must come to an end, usually because the care receiver is no longer in need of help, has moved, or has passed away. This final meeting offers group members closure by sharing and acknowledging each other and their experiences.

Methodology and Data Collection

Type of Design

The mixed-methods design of the study enabled the collection of rich qualitative information on the STC process and outcomes. Moreover, this approach was ideal due to the uniqueness of the STC program structure, as well as the lack of comparison group and inability to conduct pre- and post-tests. Data were collected after the groups had concluded and in two phases—once during the administration of survey data and once during the interview processes.

Sample

A nonprobability, self-selected sample of 134 participants participated in the online survey. The units of analysis in this study were identified as: (a) *care receiver*: the individual who received care from a STC group; (b) *group member*: the individual who was part of a STC group and provided caregiving assistance to a STC care recipient; and (c) *caregiver*: family members or friends who provided care assistance STC care receivers.

Prior to conducting outreach activities, an initial goal was established to recruit at least 100 participants for the online survey. Recruitment strategies were targeted toward STC participants who had completed their group involvement using e-mail list serves, web site advertising, and direct outreach to former STC groups. An electronic recruitment flyer was developed and included in the e-mail blast to the list serve. The same flyer was uploaded to the STC web site, sharethecare.org. A hyperlink was included on the web site that would take the participant directly to the appropriate survey based on how they identified—as a group member, caregiver, or care recipient. Participants were also able to download a .pdf file of the survey if they did not want to complete the survey online. A post office box was created for those individuals who chose to mail in their surveys. Upon initial release of the survey, the response rate was lower than expected. As a result, the STC President conducted direct outreach to several individuals and groups. This direct outreach led to a quick increase in survey responses. The study sample included 10 participants from countries outside of the United States, including Australia, Canada, United Kingdom, and Hong Kong. An internationally representative sample was chosen to demonstrate the global applicability of the STC program.

Data Collection

Phase one—Surveys

The online survey was conducted in May of 2014 via SurveyMonkey. The surveys were developed based on existing measures of caregiver burden and caregiver and volunteer satisfaction. Upon completion, the surveys were pilot-tested by a group of five key stakeholders who were familiar with the STC program. Revisions were made based on the comments and suggestions obtained in the pilot test reviews. There were three distinct surveys for each population group within the sample of participants. Each survey asked similar questions regarding demographics, the STC experience, and satisfaction with the overall experience. Satisfaction was conceptually defined as a sense of efficacy derived from the relationship with the care recipient and the team.

Phase two—Phone interviews

Phone interview questions were open-ended in design to gather further information and detail on participants' experience with STC. Approximately 50% of the respondents indicated interest in participating in an interview at the end of the survey. Interviews were conducted with 7 participants who were selected based the diversity of survey responses, as well as their availability and willingness to participate at the time of contact.

Data Analysis

Data from the surveys were analyzed using SPSS statistical software and reported using descriptive statistics. The survey also contained open-ended questions that required a narrative response, which were analyzed for any themes that emerged. The interviews were transcribed by the author and a content analysis process was used in the examination of the data. A two-stage process of manually coding this information was used to further reduce the identified topics and identify key themes and categories. During the initial stage of open coding, the data was intensely scrutinized for repeating patterns and commonalities, also making note of topics and categories that did not appear to be relevant to the study's research questions. Once open coding was completed, a focused coding process in which the data was intensely scrutinized again, but focusing more on the identified themes and categories that emerged during the course of open coding. Overarching themes and related subthemes were mapped to visually demonstrate overlapping relationships.

Protection of Rights of Participants

This research was approved by the University at Albany's Institutional Review Board and satisfied the conditions of human subject protection. To ensure the confidentiality of study participants, personal identifying information, such as name and actual address were not collected. If any participants provided this information, it was removed from all data and stored separately.

Findings

Quantitative Data

Demographics

Many of the demographic statistics, presented in [Table 1](#), aligned with those found in the literature relative to caregiving and volunteering. A majority of respondents (85%) were female. Approximately half of the group member

Table 1. Sample demographics.

Variable	United States (<i>n</i> = 124)			International (<i>n</i> = 10)		
	GM <i>n</i> = 54	CG <i>n</i> = 63	CR <i>n</i> = 7	GM <i>n</i> = 7	CG <i>n</i> = 2	CR <i>n</i> = 1
Gender						
Female	48	45	6	7	2	1
Male	5	14				
Age (years)						
18–29		1				
30–49	4	14	1	1		1
50–64	28	31	3	3	1	
65–79	22	13	3	3	1	
80–99		2				
Relationship Status						
Married	39	35	3	4	2	1
Widowed	6	12				
Divorced	4	7	1	3		
Single	5	7	3			
Race						
White/Caucasian	49	54	6	7	2	1
American Indian/Alaskan	1	2				
Asian or Pacific Islander	1	2				
Black or African American	1	1				
Hispanic or Latino	1	4				
Prefer not to answer	2	2				
Education						
Some High School	2					
High School Grad	3	3				
Some College	2	11	2			
Trade/Tech/Vocational	5	6				
College Grad	17	11	4	2	1	
Some Post Grad	2	8		1		
Post Grad Degree	23	22	1	4	1	1
Employment Status						
Full Time	19	22		1	1	
Part Time	10	10	1	3		1
Not Employed	4	4				
Retired	20	18	3	3	1	

*Note: GM = Group Member, CG = Caregiver, CR = Care Receiver; International participants represent the following countries: Canada, United Kingdom, Australia, and Hong Kong

and caregiver respondents were between the ages of 50 and 64. Most (64%) of the respondents were married. The respondents were racially homogenous, with 91% identifying as White/Caucasian. Based on the results, the respondents were well educated—80% of group members completed at least a college degree and 44% of these completed a postgraduate degree. Similarly, among caregivers, 69% completed at least a college degree and 37% of these completed a post-graduate degree. More respondents—an average of 63%—were employed part time, unemployed, or retired, rather than were employed. There was international representation among each group of survey respondents with 5 being from Australia, 2 from Canada, 1 from Hong Kong, and 1 from the United Kingdom.

Group details

The length of the STC group involvement varied depending on the level of need of the care recipient; however, almost half (48%) lasted for 1 or more years. During their involvement with the STC group, 76% of members reported contributing between 1 to 6 hr per week toward the group. Just over half of the respondents reported that their group was active within the last 5 years.

Approximately 75% of respondents were providing caregiving assistance to an individual with a serious or terminal illness, such as cancer, Amyotrophic Lateral Sclerosis, or Parkinson's disease. A majority of the remaining respondents were caring for an individual with a health-related aging issue such as Alzheimer's disease or dementia.

Survey participants were asked to respond to an open-ended question identifying how they became involved with STC. Most became involved in an STC group after being asked, either by the care recipient himself or another group member, or they may have gathered in response to a close friend being sick. Similarly, others became involved because they were referred to the program by a friend or a professional organization and volunteered to assist. Some became involved because of connections to faith-based communities; i.e., another church goer required assistance. Others formed a group for someone they knew after reading the STC book.

STC experience

There was consistency in the survey responses across the sample population. The following discussion of findings is organized according to these results and presented in [Table 2](#). Several themes emerged in the analysis of the caregiver and group member experience with STC. Socialization was a key component of the STC group for both group members and caregivers. Among group members, 93% felt that their STC experience increased their circle of friends. For caregivers, the availability of an STC group enabled them to increase or maintain levels of socialization, either by helping to increase their circle of friends, decreasing feelings of isolation, or increasing their social activities outside of their caregiving responsibilities.

For a majority (92%) of group members, having the ability to provide assistance in areas in which they had a level of expertise gave them a sense of comfort and helped to foster the promotion of innovative ideas and solutions within the group.

Self-awareness and self-worth were important factors of the STC experience. Most (88%) agreed that their participation in the group helped them to feel better about themselves, mostly because they were helping someone else. Moreover, the data revealed that for 72% of group members, participation in STC helped to increase their awareness of their own health and well-being.

Table 2. Share the care experience.

Variable	M	SD
Group member (<i>n</i> = 61)		
Socialization	3.31	.777
Flexibility and control	3.28	.951
Improved self-efficacy	3.22	1.06
Increased purpose	3.34	.965
Improved leadership skills	2.80	1.26
Increased health awareness	2.68	1.14
Caregiver (<i>n</i> = 65)		
Socialization	2.83	1.30
Balance	2.83	1.34
Decreased isolation	2.67	1.46
Wellbeing	3.07	1.28
Acceptance	2.89	1.14
Decreased burden	3.06	1.28
More time	2.42	1.48
Care receiver (<i>n</i> = 8)		
Socialization	2.38	1.60
Decreased isolation	4.0	.000
Acceptance	3.37	.518
Wellbeing	3.12	1.36
Less of a burden	3.0	1.31

Note. *M* = Mean, *SD* = Standard Deviation. 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree.

The group-member experience also contributed to a sense of purpose among group members. A majority (93%) of group members felt that what they contributed to the group made a difference to the care recipient's overall health and well-being.

The caregiver experience brought about several significant themes and feelings that are essential to a positive caregiving experience. In addition to socialization, themes related to flexibility, acceptance, and decreased feelings of burden emerged. Caregivers reported that the STC group helped them to use their time more productively and enabled them to spend more time with friends and family members outside of their caregiving responsibilities. A majority (83%) of caregivers felt a decreased sense of burden as a result of the STC group because their friend or family member was receiving additional help. Finally, most (80%) caregivers reported that the contributions of the STC group helped them to better accept the care receivers' challenge or diagnosis.

STC satisfaction

Table 3 demonstrates the high level of overall satisfaction reported by the study participants. An average of 90% of group members and caregivers were satisfied with both the helping experience and the care that was provided by the STC group. Approximately three-quarters of group members and caregivers reported being involved and supported in the group's decision making process. In regard to this feeling of support among the group, one group member stated the following:

You have no idea how important this is. I knew that I would never let my sick friend down because there was another person—maybe even more qualified than I was—backing me up—always! It removes the worry, the pressure. And it strengthens your confidence and resolve!

The availability of a supportive network of peers helps to alleviate anxieties among group members and assures a more confident caregiver.

The structure that is required to effectively run and maintain a STC group was also an essential piece that contributed to the overall benefit to the care receiver. One family member who was helping to care for her terminally ill mother commented, “There was absolutely no way we could have done this without the group—two teenaged girls could not have managed alone. The burden would have been on a friend if one had even agreed to step forward.”

Though many individuals have access to a network of family who can provide informal caregiving assistance if and when they need it, some individuals do not have a readily available support system. The aforementioned case involved a single parent mother with two teenaged daughters. She did not have access to family who could provide her with the care she needed. The structure of her STC enabled her to receive the care she required without putting unnecessary burden on her daughters.

Qualitative Data: Demographics

A total of seven interviews were conducted with six group members and one care recipient. There was one man interviewed and the rest were women. Five were between the ages of 65–79, one was between the ages of 50–64, and the care recipient was 91 years old. Five of the interviewees were married and two were single. Five interviewees were retired, one was employed part time, and one was employed full time. The geographic location of the interviewees varied and included the following states: California, Kansas, New York (New York City), Wisconsin, Maryland, and Washington. Attempts were made to contact 15 participants for a follow-up interview; however, some individuals did not answer the phone or did not return phone messages. Phone interviews were concluded when themes began to repeat in interviews and it was determined that a point of data saturation had been reached.

Table 3. Share the care satisfaction.

	Group Members		Caregivers		Care Receivers	
	M	SD	M	SD	M	SD
System was helpful	3.57	.894	3.11	1.32	3.88	.354
Felt Supported	3.36	.846	3.18	1.10	3.50	.535
Felt Involved	2.85	1.44	2.84	1.35	4.00	.000
Overall Satisfied	3.42	.855	3.32	1.13	3.88	.354

Note. M = Mean, SD = Standard Deviation. 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, 4 = Strongly Agree.

Most of the groups were established in response to a friend being diagnosed with a terminal illness. However, in one group the care recipient had a diagnosis of Kennedy's Disease (a rare motor neuromuscular disorder), in another the care recipients were recovering from a car accident. The care recipient was referred to the researchers by a group member from her care team. She was selected to be interviewed to demonstrate the applicability of the STC program in circumstances involving frail and isolated older adults.

Themes

Structure

One of the distinctive components of the STC program is its commitment to a specific programmatic structure. A repeated theme during the phone interviews was that adherence to this structure became very important to maintain cohesiveness. Members reported feeling a sense of security that the care receiver's needs were always being met. As one group member explained:

You're only saying yes to something you can actually do and it works for you to do, and if you can't do it, you say no. [And] there were enough people in your group it always got done, you know somebody could pick it up [and] so you're not carrying it.

The sharing of responsibility enables members to function effectively without carrying any additional burden as a result of their commitment and also contributes to the connection within the group. Clarity regarding tasks and assignments is essential and members need to be reminded of the scope of the group. They also need to be clear with themselves and the group, specifically about what their skills and limitations are.

Caregiver burden

A significant result of the STC groups among those interviewed was its impact on levels of burden among caregivers. In many instances, the caregivers may have been heavily burdened by the emotional and physical stress as a result of caregiving responsibilities. One caregiver commented, "Without our group, it would have been nearly impossible for me to continue employment while taking care of my sibling." In the study's sample, 41% of caregivers were employed full time and 18% were employed part time. The availability of the STC group enabled caregivers to better balance their caregiving responsibilities with other responsibilities.

The STC program tailors its structure to the needs of the care recipient and the caregiver. Because this is usually a new role for the caregiver, they may be unsure of their capacity, including strengths and weaknesses. The targeted support from the STC group helped to increase the confidence of the caregiver, as they felt assured that caregiving needs were always being met.

The STC program can also help to increase caregiver preparedness among group members. The survey data indicated that 72% of group members agreed that participation in the STC group expanded their leadership abilities, and another 72% agreed that STC increased their awareness about taking care of themselves—both of which can lead to improved caregiving preparedness and confidence.

Wellbeing

The information gleaned from the phone interviews indicated that STC is positively associated with the wellbeing of those who participate—including group members, caregivers, and care receivers. For group members, it gives them a sense of purpose and allows them to contribute to the wellbeing of others, which in turn increases their own wellbeing. For caregivers, it helps to ease their burden and increase their sense of security that caregiving tasks are being met. For care receivers, it provides them with a circle of positive support and enables them to stay at home for as long as possible with informal assistance in place. Regarding the provision of support to isolated older adults, the care recipient explained,

I think that's the best part, is that you can keep people in their own home instead of a nursing home or a burden on somebody else. I was just reading an article in the paper today about the trend as people are, they're living longer, they're having less children, so who's going to take care of the old people when they get old?

The reciprocal effects of the STC program were evident during the interview discussions. Several group members commented on the psychological impact of the STC system of care, explaining that they got far more out of their participation in the group, in terms of psychological benefits, than they put into it. These psychological benefits are consistent with the literature on volunteering and are important to acknowledge as they can impact the overall success and longevity of the STC groups.

Discussion

The mission of the STC program is to improve the quality of life of persons who are seriously ill, disabled, or experiencing the challenges of aging, and to reduce the stress, depression, isolation, and economic hardship often suffered by their family caregivers. The findings of this study suggest that the STC program may be positively associated with the following outcomes:

- (a) contributing to a reduced level of burden among caregivers;
- (b) supporting a care receiver's ability to stay at home with necessary supports, thereby decreasing the potential for reliance on more costly formal systems;

- (c) adding to or improving the well-being of participants by remaining focused on a distinct psychological structure; and
- (d) enhancing the caregiving skills of participants by preparing them for future caregiving situations.

The reduction in burden among involved caregivers is a significant finding of this research, both in terms of policy and practice. The development and provision of interventions that effectively identify the needs of caregivers and provide supportive services based on these needs will be most effective as the caregiving population continues to shrink. The distinct structure of STC enables the intervention to be tailored around the different needs of caregivers and care recipients. Thus, it provides a level of support that the caregiver is comfortable with, based on a person in environment philosophy—an important component of the social work profession.

The research findings also revealed that STC was effective in providing support to individuals without access to informal caregiving support through friends or neighbors. For instance, frail and isolated older adults could benefit from a structured STC program to provide socialization services, such as friendly visiting or transportation to medical appointments or community events. Addressing the issue of isolation and promoting socialization, especially among older adults living alone, is often pertinent in maintaining someone in their homes and communities.

The distinct arrangement of STC contributes to the overall wellbeing of participants, as it enables group member volunteers to provide only that with which they are comfortable, no matter the level or extent. This psychological structure supports the notion that even small contributions are vital to the group's success. This aligns with findings in the literature that volunteering is associated with a positive wellbeing, without regard to the number of hours spent volunteering, suggesting that even lower levels can contribute to a positive wellbeing (Morrow-Howell, 2010). Further, participation in STC promotes productivity among group member participants, which also leads to increased happiness and a stronger self-efficacy. There is a unique inter-relationship between aging, productivity, and health—in that they each contribute to the other (Butler, 2008). Similarly, the promotion of wellbeing through volunteer engagement can help to facilitate the role transitions of older adulthood.

The STC program has a history of anecdotal evidence of its successful use, both in the United States and abroad, and through this research study has established supportive evidence documenting its success. There is a strong capacity to put the program into practice due to the fact that it requires little to no cost to implement and administer. The program's built-in flexibility enables those adopting the intervention to tailor the components to the individual needs of the participants and the circumstances requiring the

establishment of the group. The global applicability of STC is demonstrated by the synonymous findings across the sample of United States and international participants.

Limitations of the Study

There are some potential limitations to the study design that should be taken into consideration in the discussion of findings. The study's nonexperimental design and purposive sample significantly limits the ability to generalize to other populations, or to assume causation in the results. However, the intention of the study was not to establish causal connections, but rather to suggest association among key variables by exploring the impact of an existing program on the participants involved.

The small sample size and overall lack of disparity yielded homogenous responses, which led to insignificant differences in comparisons between groups including gender, age, length of group, and so forth. This is a limitation that could be explored in further research. The sample lacked racial or economic diversity, making it difficult to associate the results with these populations, however the sample may be representative of the types of individuals that are attracted to or connected to this type of program.

It is also important to recognize the passage of time that may have occurred between STC group participation and data collection activities. For many study participants, several years may have passed since their involvement with STC, which could have impacted or influenced their memory of events or emotions related to their participation.

Implications for Further Research

The study's methodology was nonexperimental and qualitative in design, due to STC's unique structure and program model. Future research on similar caregiving interventions should consider an experimental design to improve generalization capacity and establish a defined evidence-base. Moreover, the use of a random sample might enable more diversity in the sample set. When critically considering the potential of large scale replicability of the STC program, the homogenous sample used in this study should be highlighted. The study's sample was mostly well educated White women of a higher socioeconomic status. Therefore, even though the program components are specific yet adaptable, there is not enough information to determine if the STC program would be scalable to more diverse communities with different cultural backgrounds and expectations. This is an important element that would require further research.

Summary and Conclusion

The population is undoubtedly aging at a significant rate. It is important to implement a proactive approach in addressing the impact that this demographic shift will have on social and economic systems, as well as family caregivers. Given that caregivers provide the majority of assistance to individuals in need of long-term services and supports, it is essential that policies and programs be developed that meet the needs of the current sector of caregivers and address the diminishing numbers of the future. This nonexperimental descriptive evaluation offers a foundation of supportive evidence that supports the STC program as a best-practice model in the field of caregiving and one that can be replicated in a cost-effective manner. The results of this study further indicate that STC is effective in addressing a number of different challenges, whether short or long in duration. Effective caregiving interventions should be multifaceted and utilize a person-in-environment perspective that meets the needs of caregivers and care receivers where they are at the time of accessing services. This research demonstrates that innovative, sustainable, and replicable programs such as STC that take advantage of the productivity and civic engagement behaviors of volunteers are a cost-effective strategy to address increasing demand and gaps in caregiving services and supports.

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