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The Savvy Caregiver Program: Developing and Testing a Transportable Dementia Family Caregiver Training Program

Kenneth W. Hepburn, PhD,¹ Marsha Lewis, PhD, RN,¹
Carey Wexler Sherman, MA,² and Jane Tornatore, PhD³

Purpose: This article reports on the development and field testing of the Savvy Caregiver Program, the transformation of a successful, academic-based caregiver psychoeducational program into a self-contained program that can be adopted in other locations. **Design and Methods:** Program development began with a prototype of a 12-hr course with the aims of introducing family caregivers to the caregiving role, providing them with the knowledge, skills, and attitudes needed to carry out that role, and alerting them to self-care issues. Results from initial field trials dictated a substantial revision of the workshop materials. The next version was field tested in multiple sites in southern rural Minnesota, Colorado, and Alaska. In this expanded testing, participants evaluated the program, and cross-group comparisons were conducted by use of well-established caregiver well-being scales. **Results:** Virtually all respondents reported increased skill, knowledge, and confidence, and all would recommend the program to others. A preintervention versus post-intervention analysis indicates that caregivers' reaction to the overall behavior of the persons for whom they provide care (i.e., "total reaction"), their self-

reported burden, and their beliefs about caregiving (emotional enmeshment) changed significantly in directions indicating better caregiver well-being.

Implications: Results suggest that it is feasible to translate a research-based caregiver intervention into a packaged program that can be adopted in other settings without the direct involvement of the program initiators.

Key Words: *Alzheimer's disease, Dissemination, Community intervention, Translational research*

Family members provide the bulk of community-based care for persons with dementia and often do so for long periods of time (National Alliance for Caregiving, 1997; Stone, Cafferata, & Sangl, 1987). This practice provides a substantial cost benefit to society (Arno, Levine, & Memmott, 1999; Max, Webber, & Fox, 1995), but it can exact a heavy toll on caregivers in the form of depression, social isolation, family stress, and other adverse outcomes (Alspaugh, Zarit, Stephens, Townsend, & Greene, 1999; Schulz & Beach, 1999; Schulz, O'Brien, Bookwala, & Fleissner, 1995).

The most frequently identified sources of caregiver burden and distress are issues associated with care receiver behavior and efforts to manage that behavior (Gaugler, Davey, Pearlin, & Zarit, 2000; George & Gwyther, 1986; Teri, 1997). Effectively dealing with these issues while maintaining one's own well-being is particularly challenging for family caregivers, given their close emotional ties to the care receiver, the changing nature of their relationship

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Address correspondence to Kenneth W. Hepburn, PhD, School of Nursing, 6-169 Weaver-Densford Hall, University of Minnesota, 308 Harvard St. SE, Minneapolis, MN 55455. E-mail: hepbu001@umn.edu

¹School of Nursing, University of Minnesota, Minneapolis.

²Department of Family Practice and Community Health, University of Minnesota, Minneapolis.

³Screen, Inc., 8017 1/2 8th Avenue S., Seattle, WA.

with the ill family member, and their need to take on new caregiving-related tasks for which they are typically unprepared.

Recent research suggests that caregivers can be trained to succeed in their new role with less detriment to themselves. In a National Institute for Nursing Research (NINR)-supported randomized controlled trial, we demonstrated that the Minnesota Family Workshop, a 14-hr psychoeducation program that drew on stress mediation theory (Lazarus & Folkman, 1984), was effective in reducing caregiver burden, depression, and reaction to behavior and in helping caregivers achieve a less emotionally enmeshed attitude (Hepburn, Tornatore, Center, & Ostwald, 2001; Ostwald, Hepburn, Caron, Burns, & Mantell, 1999). A number of other psychoeducational and counseling interventions have demonstrated benefits for caregiver well-being, delay of institutionalization of the care recipient, and even care recipient mortality (Brodaty, McGilchrist, Harris, & Peters, 1993; Buckwalter et al., 1999; Gallagher-Thompson & DeVries, 1994; Gendron, Poitras, Dastoor, & Perodeau, 1996; Mittelman, Ferris, Shulman, Steinberg, & Levin, 1996).

For large numbers of family caregivers to benefit from successful research-based training programs, the programs must be translatable to other locations and auspices. One might expect to see widespread translation efforts, given the anticipated increase in the number of persons with dementing disorders (Brookmeyer, Gray, & Kawas, 1998). However, reports of such efforts are notably absent from the literature.

In this article, we report on the development and testing of an innovative "practice-translation" project, the Savvy Caregiver Program (SCP). Modeled on the Minnesota Family Workshop (MFW), the SCP was designed to offer organizations a turn-key means of implementing our successful, academic-based caregiver psychoeducational program—without the direct involvement of the program initiators. We describe developing the SCP and field testing it with 140 caregivers in rural Minnesota; Denver, Colorado; and Anchorage, Alaska.

Challenges to Creating a Transportable Intervention

The original MFW program provided 7 weekly 2-hr training sessions to dementia caregivers and other family members. The sessions were designed and conducted by university faculty with disciplinary backgrounds in nursing, family therapy, education, and occupational therapy. A hallmark of the program was its emphasis on training caregivers for the unfamiliar work role into which they had been thrust. The program's curriculum was designed to help caregivers objectively appraise their situation (e.g., assess the progression of the disease in the care receiver and identify feasible caregiving goals) while

providing them with the knowledge, skills, and attitudes needed to mediate their stress situation and more effectively carry out the caregiving role they have assumed.

We recognized four major challenges in developing a transportable version of the MFW. The first was *translating expertise*. Teaching activities in the MFW curriculum drew on individual faculty knowledge and skills in the provision of tasks and exercises. The problem we faced was how to codify the teaching activities in a way that did not render them sterile and canned and yet did not require trainers and workshop leaders in other sites to have the same knowledge and skill set as the expert faculty. Moreover, because the program touches on sensitive issues, caregivers often sought additional information, causing segments to run longer than expected. In such circumstances, our faculty were able to draw on their well-developed sense of the program's content and pace to bring closure to the segment and to abridge future segments so as to fit all critical content into the session. Inherent in this problem was the recognition that providing individualized training to SCP workshop leaders would not be feasible.

The second challenge was in *transporting content*. The MFW information base, presented in talks and exercises by four faculty members, had not formally been written. Although these instructors used overheads, they did not have verbatim texts of their talks. MFW participants were given manuals that contained some of the materials covered in the talks, but these also were not comprehensive.

The third challenge was in *maintaining program integrity*. The MFW curriculum and order of presentation remained constant in the randomized trial. The final version had been refined over time in a series of previous field tests and beta versions. In developing the transportable SCP, we sought to preserve the program intact and particularly to ensure that the stress-mediation theoretical framework (Lazarus & Folkman, 1984) would be maintained. We also wanted to ensure that the workshop did not serve as a platform for any idiosyncratic permutations a local trainer might wish to use.

The fourth challenge was in *obtaining care recipient assessment*. During the MFW, a parallel activity program for care recipients offered the opportunity for an occupational therapist to assess the cognitive performance status of the care recipients, using a modified Allen scale (Allen, 1988; Burns, Mortimer, & Merchak, 1994). A key part of the learning activity in the MFW involved participants' viewing a videotape of their care recipient being assessed and then learning the results of the assessment from the occupational therapist. For the SCP, we needed to find a way to teach caregivers to estimate their care recipient's cognitive performance abilities, short of having potential SCP sites hire an occupational therapist to conduct such assessments.

Table 1. Caregiving Learning Objectives in the Savvy Caregiver Curriculum

Objective	Description
Acknowledge the disease	Understand and come to grips with the disease that is affecting the person. Recognize it is not personal—it is the disease and not the person that is causing difficulties.
Make the cognitive shift	Develop a strategic sense of what cognitive losses are occurring and how caregiver behavior has to adapt to these as they take place and progress.
Develop emotional tolerance	Recognize the central role of confusion in dementia and how it contributes to troubling behaviors (e.g., shadowing or repetitive questioning). Appreciate the care recipient's need for emotional stability in the face of confusion. Accept the caregiver's role of providing calm and stability.
Take control	Understand that dementia gradually erodes autonomy. Appreciate the social and emotional difficulties involved in taking control of another adult (thinking of the other as somehow not equal). Recognize the need to take control and be willing and able to do so.
Establish a realistic care goal	Accept that striving to ensure as good a quality of life as possible is the most realistic goal for caregiving. Recognize that rehabilitation, restoration, or retardation of disease progress are not feasible goals and let go of them, when applicable.
Gauge the care recipient's capabilities	Be able, using an occupational-therapy-based staging system, to estimate the care recipient's capacity for involvement in tasks and activities (kind, complexity, duration, etc.).
Design opportunities for satisfying occupation	Be able, based on the estimate of capability, to design tasks or activities in which the person can become engaged and which she or he will enjoy. Be able to communicate effectively with the person to promote and maintain involvement.
Become a sleuth	Adopt a problem-solving approach to caregiving, one that involves being able to stand back from the situation (emotionally), create hypotheses about causes of behavior, formulate and try out responses, observe and learn from results, and repeat the sequence as needed.

Development and Piloting of SCP Curriculum and Materials

In 1998, working with a staff member from the Metro Lakes chapter of the Alzheimer's Association of Minnesota, we developed a prototype version of the SCP, designed to overcome the challenges to transportability. The prototype was a 12-hr, self-contained dementia caregiver training program that could be offered in the community by governmental, educational, medical, or social service provider organizations and led by volunteer professionals from the sponsors. Table 1 outlines the key learning objectives of this SCP curriculum.

The prototype version of the SCP included the following materials.

Trainer's Manual

This manual orients the workshop facilitator to the SCP and helps him or her to conduct the program. The manual introduces the facilitator to the intent of the program, emphasizing the tone he or she should strive to maintain (training, in contrast to a support group). The manual specifies the order of talks and exercises in each of six 2-hr sessions. It provides specific learning objectives for each segment of each session, describes how the segment fits into the session and the overall program, and gives detailed directions for conducting each segment. The manual provides the slides and handouts the in-

structor needs for each segment of the program (also given to the participants). Finally, the manual specifies the "homework" the instructor should encourage participants to engage in after each session.

Caregiver's Manual

The caregiver's manual provides a written version of the material conveyed in the workshop. Initially, the manual was designed to follow along with the instructional sequence of the program, so the sections were divided by where the material fell in the curriculum. As we discuss in what follows, the structure of this manual changed in the field trial.

CD-ROM

In a separate project, a CD-ROM, *Alzheimer's Caregiving Strategies*, was developed at the Minneapolis Veterans Affairs Medical Center (Adelson, Burns, Hepburn, Maddux, & Smith, 1999). This CD-ROM involved faculty from the MFW and drew on its curriculum for content. Equally, it drew on material that was developed at the Minneapolis Geriatric Research, Education, and Clinical Center program. Although the content of the CD-ROM parallels that of the MFW and the SCP, of particular interest is the cognitive performance estimation procedure that is embedded in the program. Using video clips of persons with dementia who are being tested in the performance of

an everyday task (making toast), the CD-ROM introduces caregivers to the performance staging system we use and encourages them to estimate where their care recipient falls along the performance stages.

Once the prototype material had been developed, two of the authors (K. Hepburn and C. Sherman) led a workshop for five family caregivers, using the materials and following the scripts. The participating caregivers provided detailed and extensive commentary on the program itself and the materials used in it. This pilot resulted in a revision of the curriculum (primarily a reshuffling, but in some cases a revising or a deletion, of materials and segments). It also resulted in an expansion of both the caregiver's and the trainer's manuals.

Field Testing

Local Field Testing

The Metro Lakes chapter of the Alzheimer's Association recruited volunteers to serve as trainers for SCP workshops in their home organizations. These persons were from a variety of backgrounds such as public health nursing, social work, and therapeutic recreation. All had direct service experience with dementia patients and their caregivers. They received approximately 6 hr of training or orientation for the role to familiarize them with the pace and structure of the SCP, to show how certain exercises worked, and to illustrate the linkages between the trainer's and the caregiver's manuals.

From the spring through the fall of 1999, three of these volunteer trainers conducted a total of five SCP workshops throughout the metropolitan area of Minneapolis-St. Paul, Minnesota. The volunteers recruited participants for the workshops and found community locations in which to offer the workshops. We observed the trainers conducting three complete workshops and portions of two others, providing us with firsthand experience in seeing trainers who were not invested in the original program attempt to teach from the materials we provided. By agreement with the volunteers, we did not take part in these workshops but observed in silence. We kept notes on what worked and what did not work in the program, particularly assessing the extent to which (a) the trainers appropriately conveyed the intent and meaning of each segment; (b) which segments of the program were effective; (c) the segment achieved our intended or expected result; and (d) the content was (could be) presented in the time available.

At the end of each session and then again at the end of each of these programs, we asked program participants to complete evaluation forms. These forms sought the family caregivers' reactions to the individual segments within each session, to the teaching materials (slides and handouts), to the reading and homework assigned for the session, and, where

appropriate, to the segments of the CD-ROM assigned for the session. We also sought more general responses and judgments about the trainers' style and delivery and about the value of the segments, sessions, and the program as a whole.

The results of this initial field trial informed a substantial revision of the SCP materials. Overall, we tightened and removed elements from the curriculum program to sharpen the program's focus on caregiver role mastery. Acquiring the skills, knowledge, and attitudes important for success in the caregiver role became the central design feature of the program.

Because the trainers, typically, did not get through all of the material in the sessions, we eliminated content we determined to be less than central to the purpose of the program. For example, we eliminated an exercise that sought to have participants work through ways of improving family interaction related to caregiving. We retained this content in the manual and the homework assignments, but it was no longer an in-class exercise. We also eliminated or simplified some of the handout materials and slides. Although the caregiver's manual remained essentially intact, we added sections on communication and difficult behaviors and carried out minor revisions to simplify the language and remove jargon from the text.

We added text to the trainer's manual to better convey the intent of the segments and to provide fuller direction for their conduct. As a means of ensuring the inclusion of key material, we added directions for how much time training should spend on each segment in each session. Our observations reinforced the importance of using a specified amount of unstructured "debriefing time" at the beginning of each session to address issues and questions raised by the previous session or the homework and to review the results of experiential assignments.

Expanded Field Test

Next we initiated a field test of the SCP in settings outside the Twin Cities. One site, in southern Minnesota, provided linkages to a number of projects and agencies (including the regional Area Agency on Aging) with whose missions the SCP aligned. The second site, in Denver, Colorado, involved the Centura Health System Senior Clinic and the Rocky Mountain chapter of the Alzheimer's Association, both participants in a National Chronic Care Consortium/Alzheimer's Disease project seeking to implement a caregiver training program as part of the demonstration. The authors provided brief on-site training to the leadership of each site and have since provided problem-solving consultation by phone. The first implementation of this round of field testing of the SCP began in the fall of 2000. In the spring of 2001 we added a third field test site, the Alzheimer's Resource Center of Alaska in Anchorage. This site initiated programs without the

Table 2. Results of Participant Evaluation of the Savvy Caregiver Program

Evaluation Response Category	Strongly Agree (5)	Agree (4)	Total (4 + 5)
Overall response to SCP (%)			
More knowledgeable as a caregiver	86.4	11.4	97.8
Learned useful caregiving strategies	85.2	11.4	95.6
Feel more confident as a caregiver	68.2	27.3	95.5
Have more caregiving skills	75.0	19.3	94.3
Program content relevant to caregiving	72.7	18.2	90.9
Would recommend to other caregivers	95.5	4.5	100.0
Evaluation of SCP caregiver manual (%)			
Clear and easy to understand	75.0	19.3	94.3
Information relevant to caregiving	68.2	22.7	90.9
Information helps in caregiving	75.0	18.2	93.2
Information ties in with sessions	84.1	12.5	96.6
Expect to use manual in the future	68.2	22.7	90.9
Evaluation of workshop trainers (%)			
Information (talks or exercises) clear	86.4	9.1	95.5
Trainers presented clearly and well	85.2	11.4	96.6
Trainers encouraged discussion	92.0	6.8	98.8
Class time used effectively	78.4	15.9	94.3
Trainers made information relevant	88.5	10.3	98.8

Note: For all evaluation response categories, $N = 88$.

use of any face-to-face training; the program leader read through the materials and began programs after only a brief phone consultation with one of the authors (K. Hepburn).

This larger, three-site field trial was conducted in the framework of a quasi-experimental design, following review by the University of Minnesota Institutional Review Board. Each participating site recruited participants for SCPs in their area. Participants were informed that the organizations were taking part in a formative study of the program and were asked if they would consent to be part of the study. The organizations sent a list of these participants (and their signed consent forms) to our study center. We then sent participants a brief questionnaire, which we asked them to complete and return (using a stamped envelope we provided) prior to the beginning of the SCP at their site.

In addition to basic background questions about the caregiver and care recipient (e.g., age, gender, relationship to care recipient, living situation, education, and income), the questionnaire included five brief, well-established scales. First, the Revised Memory and Behavior Problem Checklist (Teri et al., 1992) includes a caregiver rating of the extent and severity of care recipient behaviors in four domains (memory, behavior, paranoia, and depression); it also includes a caregiver self-assessment of the extent to which she or he is bothered by each of these behaviors. Second, the Caregiver Burden Scale (Zarit, Orr, & Zarit, 1985) seeks to assess the extent to which various facets of caregiving are problematic for caregivers. Third, we used the Center for Epidemiologic Studies-Depression scale (Radloff, 1977) to measure one element of the emotional aspect of caregiving. Fourth, we used a Mastery scale (Pearlin,

Mullan, Semple, & Skaff, 1990) to record caregiver self-assessment of caregiving competence. Fifth and finally, we used the Beliefs About Caregiving Scale (Phillips, Rempusheski, & Morrison, 1989) to assess the emotional enmeshment of the caregiver. Approximately 3–4 months after the beginning of each program, we again mailed the same questionnaire to caregivers and asked them to complete and return it.

At the end of each SCP workshop, the site leaders distributed evaluation questionnaires that sought caregivers' ratings of the benefits of the program (e.g., improvements in knowledge, confidence, or attitude), their ratings of the effectiveness of the program and its materials, and their suggestions for ways to improve the program. Participants were asked to complete the evaluations and mail them back to the study center (using stamped envelopes we provided). We did no phone or mail follow-up to increase our survey response rate, so we report on considerably fewer participants than total entrants into the program. All data were coded and managed at our study center.

Expanded Field Test Results

Participant Demographics

In the year and a half of field trials held in Alaska, Colorado, and rural Minnesota, 22 separate SCP programs were offered at these sites by a wide variety of professionals—educators, nurses, social workers, recreational therapists, and even geriatricians. A total of 140 family caregivers took part; 40% were spouses of the care recipient, and 47% were adult children; 55% lived with the care recipient. Several paid caregivers (e.g., nursing assistants)

Table 3. *t*-Test Comparison of Caregiver Measures Taken Before and After Participation in the SCP

Measure ^a	Score		<i>p</i> Value	<i>n</i>
	Before	After		
Reaction to care recipient behavior (−)	8.56	7.29	.075	56
Reaction to care recipient paranoia (−)	4.62	3.65	.104	56
Reaction to care recipient depression (−)	9.71	7.47	.023	57
Total reaction (−)	31.02	26.12	.020	56
Zarit burden (−)	40.40	38.13	.047	63
CES–Depression scale (−)	16.33	15.10	.186	63
Master scale—caregiving competence (+)	2.48	2.47	.941	62
Beliefs about caregiving scale (+)	47.75	49.85	.003	60

Notes: Time after participation in the program was 3–4 months. SCP = Savvy Caregiver Program; CES = Center for Epidemiologic Studies.

^aThe plus or minus sign following each measure indicates the direction of change sought through the intervention, thus a decrease in the reaction to behavior score and an increase in the mastery score would both be good outcomes.

also took part, but their data were not included in the analyses reported here, nor were those of participants in the earlier Twin Cities prototype development groups (local field test participants). Participants in the larger field trial were relatively well educated (approximately 70% had more than a high school education) and affluent (modal household income was \$30,000–39,000). Almost all (95.7%) were non-Hispanic White.

Evaluation Findings

As the data in Table 2 indicate, participant response to the program, its materials, and the quality of the workshop trainers was very favorable. Virtually all respondents reported increased skill, knowledge, and confidence as a result of participation, and all would recommend the program to others in similar situations. The caregiver manual was also judged favorably. We note that, although they were still quite positive, the relevance items in Table 2 were scored lower than the other items, particularly in the “strongly agree” category. A closer examination of the data revealed that caregiving daughters tended to rate the program as slightly less relevant to them than did caregiving spouses.

Of particular importance, the participants reported a high degree of linkage and concordance between the text in the caregiver manual and the material presented by the trainers. This gives us reassurance that the trainers were faithful to the curriculum of the program, as specified in the trainer’s manual. Table 2 also provides caregivers’ reports on the effectiveness of the trainers and the training process. These results suggest that the program can be taught effectively by trainers from a wide variety of professional backgrounds.

Preintervention Versus Postintervention Findings

Table 3 reports on the results of a preintervention versus postintervention *t*-test analysis comparison of

caregivers on the small set of measures we used (taken prior to and 3–4 months after participation in the SCP). It is of note that on three important dimensions—caregivers’ reaction to the overall behavior of the persons for whom they provide care (i.e., “total reaction”), their self-reported burden, and their beliefs about caregiving (emotional enmeshment)—significant changes occurred in directions that indicate better caregiver well-being.

Discussion

The principal finding of this effort is that it is feasible to “translate” a research-based caregiver intervention into a packaged program that can be adopted in other settings. The experience of dissemination suggests that the SCP is flexible enough to be facilitated by a variety of leaders with different areas of expertise.

Results indicate that we met the four primary challenges we faced. Participant assessment of strong concordance between classroom activities and material in the caregiver manual indicates that the program is kept intact when other leaders implement it. The other evaluation data indicate that participation yields benefits that are similar to those found in the parent program. This encourages us to conclude that expertise was transported and program integrity was maintained. The participants’ evaluation of the caregiver manual leads us to conclude that the transportation of content was successful. Finally, when caregivers used the CD-ROM-based assessment of their care recipient’s performance stage, they judged it to be helpful and put the information to use. However, caregivers’ access to computers limited the utility of the CD-ROM, a situation we have sought to resolve (see the paragraphs that follow).

Thus far, we have learned three main lessons regarding implementation of the SCP. First, leaders have to be committed to the program and willing to lead within the parameters of a training paradigm. Given the SCP’s training emphasis, workshop leaders have to be willing to refer caregivers to other re-

sources to address their other needs (e.g., for information or support) and curtail impulses to transform the SCP into a counseling program.

Second, leaders have to prepare to lead the program. It takes time to read through both manuals and to understand the flow and timing of the curriculum. It does not work well to try to teach directly from the manual during the sessions. The manual can cue the leaders about the exercises and talks during the sessions, but leaders have to be in possession of the material beforehand. Most facilitators report that the first time through can be challenging but that they gain mastery through this experience.

Third, the SCP benefits from strong organizational support. Those leaders working in organizations in which aiding caregivers fits well and centrally with the mission found it easier to recruit caregivers and to offer the SCP as an integral part of their work. Thus, in Denver, where a natural linkage existed with a large clinical operation, the leaders found that caregivers were readily identified by clinicians and referred into the SCP.

Since our field testing, SCP has continued to evolve. Using feedback from the field trial trainers, we completely revised the caregiver's manual. The book was restructured so it could be read more as a stand-alone text. The language, reading level, and printing format were carefully examined; the resulting text is less complex, easier to read, visually less dense, and more reader friendly. Although the CD-ROM was well received, it was not used by everyone. Lack of equipment (a CD-ROM-equipped computer) or computer skills made it inaccessible to some participants. At the same time, we heard from trainers that a component of the training related to decision-making skills was difficult to teach. To remedy both problems, we produced a video that incorporates key elements of the CD-ROM (particularly the segment on care recipient assessment), provides a guided lecture on decision making by one of the authors (M. Lewis), and includes a segment illustrating the care recipient involvement strategies that SCP teaches. The new training video has helped to make the program even more portable.

Lastly, we found that a greater proportion of caregiving daughters took part in the SCP than in either of our NINR-supported trials. The evaluation responses suggest that we need to attend better to their situation, both in the curriculum and in the program materials. Thus, we are in the process of developing additional material for this caregiver group.

Several limitations of this report should be acknowledged. Approximately 37% of those taking part in the SCP trials did not provide follow-up data. Our examination of the nonrespondent demographic data does not suggest any differences between the two groups. The positive findings we are able to report stem from a within-group, preintervention versus postintervention analysis. A randomized trial of the SCP is currently underway in sites in Alaska,

Colorado, and Mississippi; this trial will provide a more rigorous test of SCP effectiveness.

Despite these limitations, the SCP has demonstrated that it can offer a wide range of organizations the opportunity to provide dementia caregivers with training from which the caregivers themselves claim to experience the same kinds of benefits as those demonstrated in the randomized trial of the MFW. The SCP offers organizations a turn-key means to add to the repertoire of assistance they can provide to this important and growing group of family caregivers.

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