

# Practice Concepts and Policy Analysis

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Kathleen Walsh Piercy, PhD, Editor

The Gerontologist  
Vol. 50, No. 3, 408–417  
doi:10.1093/geront/gnp138

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Advance Access publication on October 6, 2009

## Acceptability and Feasibility Results of a Strength-Based Skills Training Program for Dementia Caregiving Dyads

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**Purpose:** The current article provides an in-depth description of a dyadic intervention for individuals with dementia and their family caregivers. Using a strength-based approach, caregiving dyads received skills training across 5 key areas: (a) education regarding dementia and memory loss, (b) effective communication, (c) managing memory loss, (d) staying active, and (e) recognizing emotions and behaviors. Results of the acceptability and feasibility of the intervention protocols are also presented. **Design and Methods:** Caregiving dyads were randomly assigned to participate in the intervention. Participants in the treatment condition were asked to complete a series of evaluation questions after each intervention session and an overall evaluation of the program. Data were also collected from the intervention specialists who implemented the protocols. **Results:** Overall, the evaluation data indicated that the content and process of the intervention were viewed as highly acceptable and

feasible by both participants and intervention specialists. **Implications:** This article highlights the merit of using a strength-based approach for working with caregiving dyads with dementia and how a single intervention protocol can be used to address the goals of both care partners. Furthermore, the intervention program was found to be highly acceptable and feasible, which is an important aspect of developing dyadic protocols.

*Key Words:* Caregiving, Dementia, Intervention

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Older adults and their families coping with symptoms of mild-to-moderate dementia and memory loss face unique challenges in providing care and in managing the cognitive, functional, emotional, and behavioral symptoms. For caregivers (CGs), the stress of caregiving can increase symptoms of depression, health problems, and feelings of emotional strain and role captivity (Deimling & Bass, 1986; Schulz, Visintainer, & Williamson, 1990). For care receivers (CRs), dementia limits cognitive and functional capacities and can lead to a range of negative outcomes, such as reduced self-esteem and symptoms of depression and anxiety (Gurland, 1980). Because family CGs provide the vast majority of daily home care

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for persons with dementia (Anehensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995), it is imperative that interventions support their ability to continue providing care and effectively cope with their role as informal caregivers. Interventions supporting CRs' remaining skills are also important in maximizing their cognitive and functional abilities and addressing CRs' psychosocial issues.

Most interventions to date, however, have focused on CG interventions separately from CR interventions (for exception, see Teri, Logsdon, Uomoto, & McCurry, 1997; Whitlatch, Judge, Zarit, & Femia, 2006). Previously tested interventions for CGs typically focus on improving outcomes, such as depression, strain, and burden (Kennet, Burgio, & Schulz, 2000), by providing educational information and resources (Bass, Clark, Looman, McCarthy, & Eckert, 2003); skills training (Coon, Thompson, Steffen, Sorocco, & Gallagher-Thompson, 2003); and social support groups or counseling (Mittelman et al., 1993). Although varying in form, all these interventions share the common function of educating caregivers about dementia and memory loss and helping them develop skills for addressing specific caregiving issues, such as behavior management techniques, communication skills, and/or effective problem solving. Research has found consistent results in improving CG outcomes using educational skills training programs that focus on changing CGs' behavior, perceptions, and/or knowledge base (Burgio, Stevens, Guy, Roth, & Haley, 2003; Gitlin et al., 2003). Although these studies illustrate the benefits of CG training, they do not address CRs' psychosocial outcomes or include CRs as active participants in the intervention process.

Studies of CR interventions have primarily examined the efficacy of cognitive rehabilitation techniques to address cognitive and functional issues, including learning and memory processes (Brush & Camp, 1999; Clare et al., 2000), constructive (or positive) engagement (Judge, Camp, & Orsulic-Jeras, 2000), and performance on instrumental and personal activities of daily living (Josephsson, Backman, Borell, & Nygard, 1995; Zanetti et al., 2001). These existing interventions utilize a variety of techniques (i.e., cognitive task analysis, errorless learning, and spaced retrieval) that draw upon CRs' remaining cognitive abilities while circumventing losses in cognitive processing. Overall, these studies have found that with appropriate training and structure, persons with dementia can benefit from cognitive rehabilitation skills

training. Although positive results have been found, research has not investigated whether it is efficacious to train family CGs to implement these techniques in the home and whether this approach directly improves psychosocial outcomes for CRs.

An alternative and potentially more robust approach are programs targeted at the caregiving dyad that combine key elements from both CG and CR interventions. A dyadic intervention would provide both CGs and CRs with a core set of evidence-based skills and coping mechanisms for managing dementia by implementing a single protocol that flexibly addresses both care partners' care issues and needs. The current study examines the acceptability and feasibility of an innovative dyadic intervention, *Acquiring New Skills While Enhancing Remaining Strengths (ANSWERS)*. This intervention combines education and skills training (traditionally used with CGs) with cognitive rehabilitation skills training (traditionally used with CRs) for caregiving dyads with mild-to-moderate dementia. Effects of the *ANSWERS* intervention on psychosocial outcomes (e.g., depression, anxiety, and dyadic relationship strain) for CGs and CRs will be reported elsewhere.

### **Description of the *ANSWERS* Protocol**

The overall goal of the *ANSWERS* intervention was to provide both CGs and CRs with a core set of skills for managing and coping with the symptoms of mild-to-moderate dementia. Dyads received information and interactive skills training across five core areas: (a) education regarding dementia and memory loss, (b) effective communication, (c) managing memory, (d) staying active, and (e) recognizing emotions and behaviors. The *ANSWERS* protocol consisted of six 90-min curriculum-guided sessions between an intervention specialist, the primary family CG, and the CR.

The intervention was structured using a strength-based approach (Orsulic-Jeras, Shepard, & Britton, 2003; Yarry, Judge, & Orsulic-Jeras, in press) to present module-specific skills. In contrast to the traditional medical model, the strength-based approach emphasizes current possibilities and options and includes individuals undergoing treatment as active participants in their own wellness process. Sessions were organized by the following four principles: (a) presenting educational information and core skills, (b) modeling and practicing selected skills, (c) providing direction and feedback, and (d) problem-solving and answering questions.

Dyads, in consultation with the intervention specialist, selected a core set of skills to practice each session that addressed the dyad's specific care needs and issues. Each of the six intervention sessions built upon the previous session, allowing dyads to become more experienced and comfortable with each technique. This distinguishing feature of the protocol was important because it allowed dyads with diverse care needs (i.e., communication and stress) or characteristics (i.e., level of impairment and living arrangement) flexibility and time to select and practice skills. After each session, an action plan was used to list each chosen skill, along with how and when each skill would be practiced. Dyads were asked to keep the action plan in a prominent location and to document any difficulties they experienced when practicing skills. At the beginning of each session, the previous session's action plan was used to assess how each skill was implemented and discuss barriers encountered.

Intervention specialists ( $n = 4$ ) held at least a master's degree in a counseling-related field and had prior training and experience in implementing traditional counseling techniques that ranged from working with children and families to adults and older adults. For this project, intervention specialists received extensive training in the following areas: memory and cognitive processes, symptoms of dementia, implementing cognitive rehabilitation techniques, and working with CGs and CRs as a dyad. Intervention specialists received a total of 22 hr of initial training consisting of lecture, modeling, role playing, case examples, feedback, and discussion. To ensure fidelity to the protocols, intervention specialists received supervision and feedback when initially working with dyads. Ongoing monitoring of ANSWERS was accomplished through biweekly conference calls, which allowed for discussion of cases and review of protocols, including length and content of sessions, modifying techniques, and working with dyads.

### *Session 1: Introduction and Educational Information*

Session 1 focused on orienting dyads to the goals of the intervention as well as providing general educational information about dementia and memory loss. Unique to this program was a specific focus on which types of cognitive processes are most (e.g., short-term memory) and least (e.g., reading and long-term semantic memory) affected by dementia. This information was continually reinforced in

subsequent sessions by educating dyads about how intervention skills work to capitalize on cognitive strengths and compensate for cognitive decline.

Following the first session, dyads completed the strength-based inventory that assessed CGs' and CRs' current strengths and abilities across several areas, including life roles, social activities and interests, personality, and culture (Judge, Yarry, & Orsulic-Jeras, 2006). The purposes of the strength-based inventory were to facilitate discussion between CGs and CRs about the positive aspects of their care situation as well as to identify their individual and collective strengths. These strengths were further utilized and built upon in subsequent sessions (Yarry et al., in press).

### *Session 2: Effective Communication*

In Session 2, dyads learned about the ways in which dementia affects communication and how to implement effective communication skills for dealing with expressive and receptive language difficulties. Areas covered included anomia, repetitive question asking, and production difficulties. Examples of specific skills included (a) patience and acceptance, (b) asking questions, (c) reflecting, (d) personalizing, (e) compromising, (f) keep it short and simple, (g) rephrasing questions, (h) redirection with verbal and physical cues, (i) narrowing the choices using closed-ended questions, and (j) connecting with others using open-ended questions.

### *Session 3: Managing Memory*

Dyads learned how dementia affects short- and long-term memory and how to implement specific techniques and skills for managing the symptoms of memory loss. Managing memory skills work by exercising one's memory by practicing current abilities and/or using cues or "clues" in the environment. Example of specific skills included (a) giving hints; (b) using spaced retrieval for learning specific information; (c) using information in long-term memory and engaging in challenging activities; and (d) using a variety of external memory aids including calendars, signs and labels, and lists. External memory aids were custom made for participants to accurately reflect dyads' personal routines and care needs.

### *Session 4: Staying Active*

In Session 4, dyads learned how dementia affects both care partners' abilities to engage in physical,

mental, and social activities. Dyads were educated in using cognitive task analysis to simplify and structure activities while incorporating effective communication skills and managing memory techniques. Dyads discussed and prioritized activities important to them to stay active. Examples of staying active tasks ranged from completing instrumental and personal activities of daily living (e.g., laundry, cleaning, meal preparation, and showering) to hobbies and leisure activities (e.g., exercising, gardening, and reading). Additionally, dyads were provided with an activity notebook to use for mental and social engagement. The activity notebook contained a series of short stories and a variety of word games and puzzles designed to provide cognitive stimulation in the following areas: semantic long-term memory, attention, decision making, problem solving, reasoning, judgment, language, and math.

### *Session 5: Recognizing Emotions and Behaviors*

Dyads learned how dementia affects emotions and behaviors for both care partners. Areas covered included depression, anxiety, stress, emotional and behavioral outbursts, and changes in sleep and appetite. Examples of specific skills included (a) validation, (b) reframing, (c) reevaluating expectations, (d) giving yourself permission, (e) substituting behaviors and problem solving, (f) adjusting the environment, and (g) making time to relax. Dyads were also instructed on how to use and build upon prior skills learned (i.e., effective communication, managing memory, and staying active) to address difficult emotions and behaviors.

### *Session 6: Review and Wrap-Up*

Session 6 provided a final review of educational information and skills practiced over the course of the intervention. A final action plan was made that included a core set of skills, along with discussing how these skills could be used to address future care issues. Finally, dyads were provided with an information packet of community resources and educational pamphlets regarding dementia and memory loss.

## **Evaluation of the ANSWERS Protocol**

### *Participant Characteristics*

Participants were recruited over a 14-month period from 16 local social service agencies in Northeast Ohio. To be included in the study, dyads must

have been community dwelling and able to speak and read English. CGs were self-identified as the primary family CG, and CRs needed to have a diagnosis of dementia or memory loss and a Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975) score of 7 or higher.

Sixty-eight caregiving dyads were randomly assigned to participate in the intervention. Of these, 52 dyads completed the entire six-session protocol. Of the dyads who did not complete the protocol, seven dyads discontinued the study prior to the first session and nine dyads discontinued after the first, second, or third sessions. Chi-squared analyses and independent samples *t* tests were used to examine potential differences between dyads who completed the intervention protocol and dyads who did not. No significant differences were found between the two groups for age, gender, race, marital status, employment status of CGs, or CR's MMSE score. Attrition based on assigned intervention specialist ranged from 0% to 30%, with an average of 17%.

Demographic information for dyads completing the entire six-session intervention protocol is presented in Table 1. Of the dyads who completed the intervention protocols, approximately 75% of the CGs were women and approximately one third of CGs were employed part- or full-time. Likewise, most of the CRs were women and were older than CGs. A large majority of the dyads were Caucasian and lived in the same household. Approximately two thirds of the dyads were spousal relationships. Overall, CRs' MMSE scores indicated that they were experiencing mild-to-moderate symptoms of dementia. The majority of CRs had a reported diagnosis of Alzheimer's disease, and some had more than one dementia diagnosis. Intervention sessions primarily took place in participants' homes ( $n = 49$ ); however, several dyads preferred to meet at an assisted living facility ( $n = 1$ ) and at local adult day care centers ( $n = 2$ ).

### *Acceptability and Feasibility Data*

An important aspect of developing this dyadic intervention program was whether both care partners found the protocols acceptable and whether it was feasible to combine elements of traditional CG and lab-based CR intervention techniques into a single protocol implemented by dyads at home. Of particular interest was whether a single dyadic protocol could address the distinct needs of CGs and CRs and whether individuals with

Table 1. Sample Characteristics of Participants who Completed Study Protocols

Demographic characteristic	Caregivers ( <i>n</i> = 52)		Care receivers ( <i>n</i> = 52)	
	% or <i>M</i>	<i>SD</i>	% or <i>M</i>	<i>SD</i>
Age in years	66.4	12.73	78.9	8.66
Spouse of care partner	59.6%	—	59.6%	—
Live in same household	88.5%	—	88.5%	—
Women	73.1%	—	55.8%	—
White	90.4%	—	90.4%	—
College graduate	50.0%	—	25.0%	—
Married	84.6%	—	61.5%	—
Employed full- or part-time	32.7%	—	—	—
Retired	53.8%	—	—	—
Memory diagnosis				
Alzheimer's disease	—	—	68.3%	—
Dementia, any type	—	—	30.0%	—
Mild cognitive impairment	—	—	5.1%	—
Vascular dementia	—	—	7.7%	—
Other memory diagnosis	—	—	17.9%	—
Time 1 MMSE score (0–30)	—	—	22.8	5.39

Note: MMSE = Mini-Mental Status Examination.

memory loss or dementia could actively participate in the intervention program. Measures used to assess the acceptability and feasibility of the ANSWERS intervention included (a) the number of dyads who successfully completed the program, (b) CGs' and CRs' ratings of the session content and process, and (c) intervention specialists' ratings of the sessions.

*Number of Sessions Completed.*—The first measure of acceptability and feasibility of the ANSWERS program was whether participants were willing and able to complete the six-session protocol. Of the 68 dyads randomly assigned to participate in the intervention condition, 52 (76.5%) dyads completed the entire six-session protocol, indicating that the majority of dyads found the required time commitment feasible and session protocols acceptable. Sixteen (23.5%) dyads did not complete the study protocol. Reasons given included too busy (*n* = 3), no longer interested (*n* = 4), passively dropping out by not returning phone calls (*n* = 4), too anxiety provoking or confusing for CR (*n* = 3), CR hospitalized (*n* = 1), and no reason given (*n* = 1). Reviewing the reasons given by dyads for not completing the intervention, no distinct trends emerged that contributed to participant dropout. However, several of the reasons given highlight the importance of developing intervention programs that fit within dyads' busy schedules and are not overwhelming or difficult for either care partner.

*CGs' and CRs' Session Evaluation Ratings.*—Using a Likert scale (0 = *not at all*, 1 = *somewhat*, and 2 = *a great deal*), CGs and CRs were asked to complete a series of evaluation questions about the content and process of each session and the overall program. The evaluation data presented was collected from the 52 caregiving dyads who completed the entire six-session protocol and who were willing and able to complete evaluations. See Tables 2 and 3 for CG and CR evaluation data, respectively.

CGs indicated that the sessions and overall program were well equipped to address the challenges they faced (*M* = 1.54–1.86) and their care partners (*M* = 1.66–1.87). CGs believed that the information and strategies provided in the sessions and overall were very useful (*M* = 1.42–1.98), and the session materials were rated as highly useful and understandable (*M* = 1.86–1.96). Additionally, CGs rated the discussions that took place in each session as very helpful (*M* = 1.84–1.94) and indicated they would highly recommend the intervention program to other caregivers and individuals with memory loss (*M* = 1.91).

Across each of the sessions and the program as a whole (*M* = 1.37–1.70), CRs indicated the intervention identified the challenges they face. CRs also noted the sessions and the entire program provided useful information and strategies they could use for dealing with memory loss and dementia (*M* = 1.43–1.83). Similar to CGs' ratings, CRs indicated that all

Table 2. Means and Standard Deviations of Session Evaluation Data From Caregivers Participating in the Intervention (Ns = 47–51)

Question	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Overall
Did this session (program) identify the challenges you face when providing care for someone with memory problems?	1.54 (0.54)	1.78 (0.42)	1.78 (0.42)	1.76 (0.43)	1.85 (0.36)	1.82 (0.39)	1.86 (0.34)
Did this session (program) identify the challenges faced by the person with memory problems?	1.74 (0.49)	1.76 (0.43)	1.75 (0.44)	1.66 (0.48)	1.68 (0.52)	1.79 (0.41)	1.87 (0.32)
Did this session (program) provide useful information or strategies that could help you when providing care?	1.42 (0.54)	1.74 (0.44)	1.76 (0.43)	1.72 (0.50)	1.81 (0.39)	1.83 (0.43)	1.98 (0.15)
Did you feel the session (program) material was presented in a useful and understandable way?	1.94 (0.24)	1.88 (0.33)	1.94 (0.24)	1.86 (0.35)	1.94 (0.25)	1.96 (0.20)	1.91 (0.35)
Do you feel the discussion was useful in this session?	1.94 (0.24)	1.84 (0.37)	1.92 (0.27)	1.84 (0.37)	1.92 (0.28)	1.90 (0.31)	—
Overall, would you recommend this program to other individuals caring for someone with memory loss and their care partner?	—	—	—	—	—	—	1.91 (0.29)

the session materials and overall program materials were presented in a very useful and understandable manner ( $M = 1.69$ – $1.94$ ). Session discussions were also rated as extremely helpful ( $M = 1.68$ – $1.86$ ), and as a whole, CRs indicated that they would recommend the program to other individuals with memory loss and their caregivers ( $M = 1.93$ ). CGs and CRs were also asked the open-ended question: “What did you like most about this session/the entire program?” Selected responses are reported in Table 4.

*Intervention Specialists’ Session Evaluation Ratings.*—Using a Likert scale (0 = *not at all*, 1 = *somewhat*, and 2 = *a great deal*), intervention specialists evaluated the implementation of the intervention across several key areas, including whether the session addressed the educational needs and challenges encountered by dyads, CGs’ and CRs’ receptivity and engagement during sessions, and the extent to which CGs and CRs understood the information and material presented. This information, from a clinician’s perspective, was important in understanding how each care partner responded to and interacted with the intervention protocol. Intervention specialists also rated whether the session goals for presenting educational information and skills were addressed

and whether the educational needs of each dyad were met. Data from the intervention specialists’ session evaluations are presented in Tables 5.

Intervention specialists rated CGs and CRs quite differently in identifying the challenges they faced during each session and across the entire program. Comparing CG ratings ( $M = 1.24$ – $1.65$ ) with CR ratings ( $M = 0.75$ – $1.12$ ) indicated that CRs were not as actively involved as were CGs in communicating and discussing the challenges they faced. Across each of the sessions and the program as a whole, intervention specialists rated both CGs and CRs as being highly receptive and engaged ( $M = 1.85$ – $1.97$  and  $M = 1.89$ – $1.97$ ;  $M = 1.72$ – $1.81$  and  $M = 1.57$ – $1.68$ , respectively). Intervention specialists indicated that the session materials used in each session and overall were extremely well understood by CGs ( $M = 1.91$ – $2.00$ ) and, to a lesser extent, by CRs ( $M = 1.32$ – $1.61$ ).

## Discussion

The purpose of the current article was to describe the protocol of a newly developed dyadic intervention for individuals with dementia and their family caregivers and to report on the program’s acceptability and feasibility. Examining the

Table 3. Means and Standard Deviations of Session Evaluation Data From Care Receivers Participating in the Intervention (Ns = 32–42)

Question	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Overall
Did this session (program) identify the challenges you face when dealing with memory loss?	1.52 (0.63)	1.37 (0.55)	1.54 (0.56)	1.61 (0.49)	1.56 (0.50)	1.70 (0.47)	1.69 (0.47)
Did this session (program) provide useful information or strategies that could help you when dealing with memory loss?	1.44 (0.63)	1.43 (0.56)	1.69 (0.46)	1.75 (0.44)	1.83 (0.37)	1.79 (0.41)	1.76 (0.42)
Did you feel the session (program) material was presented in a useful and understandable way?	1.80 (0.46)	1.69 (0.47)	1.86 (0.35)	1.89 (0.32)	1.94 (0.21)	1.91 (0.29)	1.88 (0.32)
Do you feel the discussion was useful in this session?	1.68 (0.57)	1.68 (0.47)	1.75 (0.44)	1.82 (0.39)	1.86 (0.34)	1.85 (0.36)	—
Overall, would you recommend this program to other individuals with memory loss and their care partners?	—	—	—	—	—	—	1.93 (0.25)

acceptability and feasibility is essential to understanding whether educational skills training and cognitive rehabilitation skills training could be combined into a single protocol and whether both care partners could participate in and benefit from a dyadic approach.

The majority of caregiving dyads randomly assigned to participate in *ANSWERS* successfully completed the program, demonstrating that the six-session protocol fit within dyads' schedules and was not overwhelming or emotionally taxing for CGs or CRs. Additional features that were thought to lead to the success of *ANSWERS* include (a) implementing the program in dyads' homes, (b) scheduling sessions around dyads' preferences and schedules, and (c) providing dyads with easy-to-use materials (i.e., intervention manuals and activity notebook) and individualized external memory aids.

In evaluating *ANSWERS*, both care partners rated the session content and materials as extremely useful and indicated that they would highly recommend the program. Clinically, as rated by the intervention specialists, the *ANSWERS* program

was viewed as very acceptable and feasible to implement with caregiving dyads. Although intervention specialists rated CRs slightly lower than CGs in several areas (i.e., identifying challenges and understanding material), overall results demonstrated that individuals with memory loss were able to actively participate in the intervention, including the psychoeducational and discussion portions. Given the cognitive difficulties experienced by CRs in this sample, it is reasonable to expect that CRs were not as engaged as CGs. These results underscore the importance of developing intervention protocols and materials that can be easily understood and used by both care partners.

Overall, results from this study highlight how interventions designed for caregiving dyads are an acceptable and feasible way to implement treatment goals. With the appropriate external supports and intervention materials, CRs with MMSE scores as low as 7 and as high as 30 were able to actively participate in managing and coping with their symptoms. Furthermore, traditional lab-based techniques, such as spaced retrieval and cognitive

Table 4. Qualitative Comments on Session Evaluations From Caregivers and Care Receivers

Session	Care partner	Comment
1	CG	Information is clear and concise, identifies actual symptoms, and explains them. The ability to discuss problems and feelings and reach an understanding of the disease and how it is affecting us.
	CR	Understanding many thoughts and actions regarding memory loss. Very helpful—look forward to continued help. Use of layman’s terms.
2	CG	That I can use these skills on a day-to-day basis in everyday life. The opportunity to clarify communication skills and solve problems relating to communicating with each other. Giving (the CR) the opportunity to convey his feelings, which it has been difficult to do in the past.
	CR	Ideas on expressing myself more clearly. Discussing what I need or want.
3	CG	I like the specific techniques for remembering: lists, learning specific information technique. Examples presented and discussed will be very useful. Open discussion on the various methods that could be used to supplement short-term memory.
	CR	Discussion or suggestions that could make some activities more worthwhile and of interest! The question and answer session was very helpful in bringing things back to my memory. I remembered things that were happy to remember. I enjoyed it very much.
4	CG	Reviewing what is been useful so far, problem-solving difficulties and challenges we are facing in implementing strategies. Specific examples for improving communications. Provided a level playing field for patient and caregiver to express themselves openly.
	CR	The “give and take” discussions. Helping me reflex [ <i>sic</i> ] on strengths and weaknesses.
5	CG	A chance to think about what I do and think in relationship to mom’s dementia. It is good for me to get a clear understanding of my own behaviors and feelings. Everything. All the sessions have helped so much it is almost unbelievable. Our lives have become so much more stress free.
	CR	Conversation about possible “future needs” for me—especially being able to stay in my home for a long time with miscellaneous help, e.g., extra bathroom downstairs in basement level, etc. We had a long discussion on all the issues; taking time to express feelings and emotions.
6	CG	Helped us recap our strengths and what we need to focus on for continued improvement. The ability to have my concerns regarding the future answering concerns that may arise and how to problem solve in the future.
	CR	The fact that it is OK to express my feelings—no matter what they are and to know that it is OK and that I am still an OK person. Reminders—how to continue with what we have worked with over the past weeks.
Overall	CG	That the sessions were held in our home. The variety of skills and techniques addressed and learned. Specifically, the technique we figured out in session for getting mom’s meds taken regularly was awesome! The ability to process our feelings and to have a structured time to sit down and address those issues was invaluable. This program helped us focus on techniques to improve everyday living. Physical signs to track progress were very helpful and kept us on track. Biweekly reviews kept everything fresh and in focus!
	CR	I like the fact that is a very positive approach. When in the midst of an issue, the problem can seem insurmountable. This program looks ahead, providing practical and concrete solutions; tools that work. It makes me feel more in control, more at ease, knowing that the tools are there for our use. Taking the time to help me accept today. Learning about relaxing. Knowing I need to keep active.

task analysis, were effectively translated to fit into dyads’ real-world environments. These findings demonstrate the feasibility of training caregiving dyads on a core set of skills that can be used in their daily routines for managing and coping with the symptoms of dementia.

Although strength-based approaches have been used in prior research (Staudt, Howard, & Drake, 2001), this approach has not received extensive application or investigation with older adults or caregiving dyads. For this particular study, the use of a strength-based approach was thought to lead to the



Table 5. Means and Standard Deviations of Session Evaluation Data From Intervention Specialists (Ns = 31–47)

Question	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Overall
CG identified challenges	1.40 (0.58)	1.52 (0.55)	1.31 (0.71)	1.30 (0.59)	1.31 (0.58)	1.24 (0.74)	1.65 (0.54)
CR identified challenges	0.98 (0.75)	1.07 (0.75)	1.08 (0.72)	0.75 (0.76)	0.97 (0.81)	0.82 (0.76)	1.12 (0.64)
CG receptive	1.87 (0.34)	1.91 (0.30)	1.97 (0.16)	1.85 (0.36)	1.94 (0.23)	1.91 (0.29)	1.88 (0.33)
CR receptive	1.72 (0.54)	1.81 (0.45)	1.81 (0.46)	1.81 (0.40)	1.78 (0.48)	1.77 (0.50)	1.77 (0.50)
CG engaged	1.92 (0.28)	1.93 (0.26)	1.95 (0.23)	1.94 (0.25)	1.89 (0.32)	1.97 (0.17)	1.94 (0.24)
CR engaged	1.61 (0.58)	1.57 (0.59)	1.62 (0.55)	1.58 (0.50)	1.61 (0.55)	1.62 (0.60)	1.68 (0.53)
CG understood material	1.98 (0.15)	1.93 (0.26)	2.00 (0.00)	1.94 (0.24)	1.92 (0.28)	1.91 (0.29)	1.94 (0.24)
CR understood material	1.45 (0.60)	1.33 (0.65)	1.49 (0.69)	1.61 (0.50)	1.36 (0.68)	1.32 (0.64)	1.35 (0.65)

successful implementation of ANSWERS. As part of this, dyads received extensive educational information about how dementia affects both care partners across multiple areas (i.e., communication, staying active, emotions, and behaviors) and learned how to identify their individual and collective strengths. This knowledge base was then used to implement and modify intervention skills. Integral to this process was the ongoing training and monitoring of the intervention specialists who worked with dyads. A large portion of intervention specialists' training and subsequent time spent working with dyads centered on facilitating dialogue between CGs and CRs, assessing and building on dyad's strengths, tailoring skills, and addressing implementation barriers.

Results regarding the acceptability and feasibility of the ANSWERS program serve as a starting point for informing future research in developing and evaluating dyadic interventions. Forthcoming research should focus on developing other techniques that can be implemented to fit within a dyadic protocol and which skills are most effective in addressing CGs' and CRs' dementia-related symptoms. Research should also explore the extent to which individuals with severe symptoms of dementia could participate and potentially benefit from dyadic interventions. Finally, additional research is needed to refine and expand upon implementing a strength-based approach when working with caregiving dyads with dementia.

#### Funding

This research was supported by Grant NIRG-05-13032 from the Alzheimer's Association and Grant RO3AG026552 from the National Institute on Aging.

#### Acknowledgments

Information on the current study was presented at the 2007 and 2008 annual meetings of the Gerontological Society of America and at the 2009 American Society on Aging meeting.

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Received May 11, 2009

Accepted September 2, 2009

Decision Editor: Kathleen Walsh Piercy, PhD