Dementia Family Caregiver Training: Affecting Beliefs About Caregiving and Caregiver Outcomes

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OBJECTIVES: Family caregiving is an integral part of the care system for persons with dementing disorders, such as Alzheimer’s disease. This study tested role-training intervention as a way to help family caregivers appreciate and assume a more clinical belief set about caregiving and thereby ameliorate the adverse outcomes associated with caregiving.

DESIGN: Training effectiveness was tested in a trial in which family care receiver dyads were randomly assigned to training beginning immediately or were placed in a wait-list control group and assigned to receive training in 5 to 6 months, following completion of data collection.

SETTING: A community-based 14-hour training program provided in seven weekly 2-hour sessions. The training program curriculum was built on a stress and coping theory base. Recruitment and randomization were ongoing. Programs were begun every 2 months over a two and one-half year period for a total of 16 programs.

PARTICIPANTS: Community health and social service agencies referred primary caregivers and at least one other family member of community-dwelling persons with dementia to participate.

MEASUREMENTS: Data reported in this paper were gathered from each participating family at entry to the study and 5 months later. Standard measures of beliefs about caregiving, burden, depression, and reaction to care receiver behavior were administered to caregivers. A standard measure of mental status was administered to the person with dementia and standardized instruments were used to gather information from caregivers concerning care receivers’ behavior and abilities to perform activities of daily living (ADLs).

RESULTS: Data were analyzed from 94 caregiver/care receiver dyads with complete sets of data. Treatment and control caregivers and care receivers were similar at baseline, and care receivers in both groups declined similarly over the 5-month period. Significant within-group improvements occurred with treatment group caregivers on measures of beliefs about caregiving ($P = .044$) and reaction to behavior ($P = .001$). When outcomes were compared, treatment group caregivers were significantly different (in the expected direction) from those in the control group on measures of the stress mediator, beliefs ($P = .025$), and key outcomes, response to behavior ($P = .019$), depression ($P = .040$), and burden ($P = .051$). There was a significant positive association between the strengthened mediator, the caregivers’ having less-emotionally enmeshed beliefs about caregiving roles and responsibilities, and the outcome, namely improvements in burden ($P = .019$) and depression ($P = .007$).


Key words: dementia; family caregiver; role training; stress mediation

Managing major chronic conditions, such as dementia, relies largely on the ability of family members to assume, master, and maintain the caregiving role. Dependence on family caregivers will continue to grow in volume and importance because chronic disorders such as Alzheimer’s disease are growing in prevalence and cost of care.1–4 Family caregivers provide the great majority of home care for persons with dementia and other chronic diseases5–7 and do so for sustained periods of time.8 They also bear the majority of the costs of care, especially community care, either through out-of-pocket expenditures or the direct provision of care.8,9 Family caregivers, particularly those caring for demented relatives, pay an added
price: they provide care at the expense of their own physical and mental health, contending with added stresses in the family and risking social isolation.12–19

Attention to the importance of and jeopardy inherent in the dementia caregiving role has produced many efforts to understand the stresses on caregivers and to develop means of supporting them.20–22 A number of intervention programs, particularly those with multifaceted approaches that meld counseling, support, and some form of education, have reported positive results in efforts to support caregivers and reduce the adverse effects of caregiving.23–30 Several studies have also demonstrated an effect on prolonging the caregiving career and delaying institutionalization of care receivers.31–33 Reports in the clinical literature have proposed a number of ways physicians and other clinicians could be expected to be a major source of information and support for caregivers.1,34–37 Still, there is a notable gap in the help caregivers receive from physicians and other primary care providers in terms of clinicians’ willingness or ability to provide both timely diagnosis and management assistance throughout the course of the disease.38–43

This paper reports results from a caregiver intervention whose principal and predominant approach was to train caregivers for the unfamiliar work role into which they had been thrust. Most caregiver interventions have taken more of a treatment approach, suggesting, at least metaphorically, that caregiving is a comorbid condition of dementia. In contrast to a number of other interventions that include a training or education component,44–47 this program emphasized role acquisition rather than treatment as a method of ameliorating the stress and burden of caregiving. Through a randomized trial of a brief training program, the Minnesota Family Workshop (MFW), we sought to determine whether family caregivers would benefit from a program designed to provide them with the knowledge, skills, and caregiving outlook—that is, beliefs about the role and responsibility of the caregiver—they needed to understand and function effectively in that role. This article reports on a key hypothesis tested in the study: that, to the extent caregivers can frame their role as caregiver in more clinical, strategic terms (i.e., make explicit and clarify their beliefs about caregiving), they will demonstrate better outcomes on variables commonly studied in the caregiver literature such as burden and depression.

A previous paper discussed the impact of the caregiver training on burden and caregivers’ response to care receivers’ behavior.48 This paper looks specifically at caregivers’ beliefs; the program’s capacity for affecting those beliefs; and the relationships among beliefs, burden, depression, and other outcome variables.

METHODS

Sample

Caregivers entered the study as volunteers referred by a wide range of community organizations, including clinics, social agencies, and the Alzheimer’s Association. To be included in the study, the caregiver had to be a relative of the person with dementia, the family had to have been told by a physician that the care receiver had a dementing disorder (not necessarily Alzheimer’s), and the care receiver had to be living in a community setting (not necessarily with the caregiver, but not in a nursing home). A phone-administered screening established that the severity of the care receiver’s dementia had not progressed beyond the Functional assessment staging (FAST) 7b. stage.49 Because we considered the family to be a potential ally in caregiving, we required that at least one family member in addition to the primary caregiver take part in the workshop and data gathering.

Theory

The MFW training intervention was grounded in a stress and coping theory framework.30–33 In this construction, caregiving outcomes—caregivers’ response to their stress situation—might be mediated by caregivers’ appraisals of the situation. The appraisals include both caregivers’ objective understanding of the situation and their beliefs about their ability to manage the situation.

In keeping with this understanding, the MFW was aimed particularly at providing a training program built around the notion of caregiving as a role or describable job. The workshop emphasized that family members had now undergone (and were still undergoing) a process of role change and acquisition. Even as the disease was affecting their primary relationship with the care receiver (as a spouse, child, relative), they were taking on the work of a new role—caregiver—for which they had no training and may have had little understanding or appreciation. The training, therefore, focused particularly on seeking to reduce adverse stress outcomes (e.g., burden and depression) by developing or strengthening the knowledge, skills, and beliefs family members needed to perform well in the caregiving role. As caregivers, they needed information to enable them to carry out the tasks of this new role. They also needed beliefs about caregiving that would enable them to shift their perspective on their relationship with the care receiver. The training emphasized that they had to have some measure of clinical detachment to be able to carry out effectively the day-to-day tasks of the caregiving role. For example, we taught that they had to have enough emotional distance to be able to assess and analyze behavior and develop and implement strategies to manage the care receiver’s care.

Intervention

The MFW curriculum combined classroom instruction and exercises with assignments to read additional material and to put into practice principles and strategies taught in the workshop. Overall, we presented the training to the caregivers as being similar to that provided to a clinician—like a nurse or nurse’s aide—who would care for a person with dementia. The training included five main components:

1. Information Provision. Through presentations, readings, and a workshop environment that welcomed their questions, caregivers received information about the disease(s) they were encountering and the effect of these diseases on the care receiver’s abilities in daily life.
2. Concept Development. Caregivers were provided with a framework for understanding the progressive effect of dementing disorders on the care receivers’ cognitive functioning,44 which was assessed during
the workshop.\textsuperscript{55} They were guided to develop stage-
specific strategies for managing daily life and behav-
ior, a method demonstrated to be effective in other
settings.\textsuperscript{56,57} They were also encouraged to apply their
knowledge of these changes to the everyday strategies
they used to relate to the care receiver (e.g., in the ex-
pectations they held or the kinds of information they
provided to the person with dementia).
3. Role Clarification. The workshop emphasized that
while the caregiver’s role included assuring the care
receiver’s security and comfort and helping the care
receiver focus on doing things he or she enjoyed, it
did not include goals associated with rehabilitation
or retarding the course of the disease.
4. Belief Clarification. The workshop emphasized the
need to develop beliefs about caregiving, or a clinical
attitude, similar to those that nonrelative caregivers
learn to assume. First, they needed the ability to view
the caregiving situation with some distance and thereby
develop strategies for dealing with immediate and re-
curring caregiving situations. Second, they needed to
be more realistically concerned about the emotional
impact of their actions on the care receiver (to under-
stand, for example, that making decisions the care
receiver can no longer make will likely lower the
care receiver’s level of frustration and not damage
the care receiver’s self-esteem). Finally, they needed
to develop a strong belief in the need to care for their
own needs.
5. Mastery-Focused Coaching. Particularly in the final
sessions, caregivers’ reports on their efforts to put
what was taught into practice were treated like case
presentations in a clinical learning setting. The group
and faculty provided comment, critique, clarification,
and problem-solving suggestions to reinforce individ-
uals’ efforts, to lead them to ideas for improving their
practice of caregiving, and to strengthen their beliefs
in their own abilities.

Training was provided in group settings in weekly
2-hour sessions over the course of 7 weeks. Workshop fac-
culty was made up of a multidisciplinary team (nurse, edu-
cator, family therapist, occupational therapist). While care-
givers and other family members attended the training, a
daycare-like group was provided for care receivers. All ses-
sions were held at the Geriatric Research, Education, and
Clinical Center at the Minneapolis Department of Veter-
ans Affairs Medical Center.

Design
We used a random-assignment experimental design ap-
proved by the University of Minnesota’s Institutional Re-
view Board to study the workshop’s effects on caregivers.
The active phase of continuous recruitment lasted about
two and one-half years. During that time we offered 16
seven-session workshops at about 2-month intervals. Four
to seven primary family caregivers took part in every
workshop. The primary caregivers were required to bring
at least one other family member to the workshop, but
many caregivers involved more than one family member
(one primary caregiver was consistently accompanied by
eight other family members). Thus the size of the work-
shops varied considerably.

As each family was recruited and after informed con-
sent procedures were completed, the caregiver and other
family members completed self-administered questionnaires,
including a report on the care receiver’s behaviors and his or
her abilities to complete activities of daily living (ADLs). A
research staff member who did not take part in the training
met with the care receiver to assess mental status. At this
point, the family was randomly assigned (by computer pro-
gram) to either the treatment or control group. Those in the
treatment group were invited to participate in the next avail-
able workshop (within a few weeks of intake); those in the
control group were told they would be scheduled for work-
shop participation in 5 to 6 months time.

Caregivers completed the same self-administered ques-
tionnaires about 5 months after enrollment in the project (the
project researcher gathered mental status data on the care
receiver at this time). Those in the treatment group would have
completed the workshop approximately 3 months before
these data were collected. Control group caregivers did not
participate in the workshop until after these data were col-
lected.

Study Measures
Data on caregivers were gathered through self-adminis-
tered questionnaires. Data on the care receivers were gath-
ered through caregiver self-administered questionnaires
(for ADLs) and in-person interviews with the care receiv-
ers. We used a number of instruments whose properties
are well established. The mental status of the person with
dementia was determined through use of the Mini-Mental
State Examination (MMSE).\textsuperscript{58} The ADL level was deter-
mined through caregiver interview using the Lawton ADL
scale.\textsuperscript{59} The self-administered caregiver questionnaire sought
information on the frequency of the care receiver’s behav-
ioral difficulties—and on the caregiver’s reaction to these—
using the Revised Memory and Behavior Problem Check-
list.\textsuperscript{60} This 24-item Likert scale focuses on issues of memory
problems, disruptive behavior, and care receiver depression
(Chronbach’s $\alpha = 0.84$ for the frequency scale, 0.90 for the
reaction scale). The questionnaire also included the 20-item
Center for Epidemiologic Studies Depression scale (internal
consistency $\alpha = 0.92$)\textsuperscript{61} and the 22-item revised Zarit bur-
den scale (Chronbach’s $\alpha = 0.88$).\textsuperscript{62}

The Beliefs about Caregiving Scale (BACS) was used
to measure caregivers’ beliefs about their approach to and
duties within the caregiving role.\textsuperscript{63} This 28-question Likert-
type scaled instrument has two subscales: nurturing and
monitoring. The 12-item nurturing subscale focuses on the
caregiver’s belief that his or her role requires subordinat-
ing his or her own needs and interests to those of the care
receiver (typical items: “I have the responsibility of arrang-
ing my daily activities to accommodate my elder’s social
needs,” and “The transportation I provide must be accept-
able to my elder.”) Low scores on the nurturing subscale
denote a caregiver’s emotional enmeshment or overin-
volvement in the caregiving situation. The 16-item moni-
toring subscale relates more to the caregiver’s belief that
he or she must control the care receiver’s behavior (typical
items: “Laying down the law” to my elder is something I
must do.” and “I have the responsibility of confronting
my elder with his/her mistakes."). Low scores on the monitoring subscale point to caregiver rigidity. They reflect a caregiver’s beliefs about how the care receiver should behave, beliefs based more on social norms than on an appreciation of what the disease has done to the care receiver’s capacity for performing in a socially acceptable manner. Thus, low scores on the BACS subscales point to overinvolvement or lack of distance (a sense of inordinate responsibility or the need for a high degree of control in the situation). Moderate scores signal caregivers’ desires to provide high quality care to their family member, while realizing the disease is such that one person cannot provide all the care required. The standardized coefficient for reliability for the entire scale is 0.83; for the subscales, the α is 0.87 for nurturing and 0.86 for monitoring.

Analyses
Results reported in this paper use data collected on caregivers and care receivers at two points in time—at project entry (before randomization) and approximately 5 months later (for treatment group members, the latter point was about 3 months after completion of the workshop). The following analyses were performed using SPSS: T-tests were run to ascertain whether the control and treatment groups significantly differed on care receiver status or any of the dependent measures at entry and 5 months later, whether the control and treatment group care receivers differed significantly in the magnitude of decline from entry to the 5-month follow-up, and whether the dependent variable scores significantly changed over this 5-month period for the control group caregivers and for the treatment group caregivers.

One-way analyses of covariance (ANCOVAs) were performed to explore the relationship between participation in the educational programming and its effect on the key mediating and outcome variables. Caregivers’ beliefs (nurturing and monitoring), depression, burden, reported frequency of behavior problems, and reactions to behavior problems were examined at the 5-month follow-up point, controlling for project entry scores and care receivers’ initial ADL and MMSE scores.

Central to the concerns of the paper was an examination of a theorized association between changes in the stress mediator (beliefs) and changes in the stress outcomes (depression, burden, frequency of behaviors, and reaction to behavior). As a check on our model, we wanted to determine whether changes in caregivers’ beliefs (in the sought-for direction) by themselves contributed to improved outcomes. To this end, we conducted two separate sets of hierarchical linear regressions. One set, focused on the nurturing aspect of caregiver beliefs, examined, in four separate regressions, the association between nurturing and each of the four key outcome variables. Four comparable analyses were run on the second set, which focused on the monitoring aspect of belief. In each equation, we controlled for four variables in the first regression block (the baseline score for the outcome measure under examination, the care receiver’s baseline MMSE and ADL scores, and the caregiver’s experimental or control-group status). We included group status to account for the possibility that the intervention affected outcome scores in ways unrelated to caregiver belief. In the second regression block, we controlled for the initial and 5-month scores on the belief variable under scrutiny in that equation (nurturing or monitoring) to ascertain whether the belief variable contributed uniquely to the 5-month scores of the selected outcome variable.

RESULTS
A total of 117 caregiver/care receiver/other family sets were enrolled in the study, completed initial data gathering, and were randomized into the immediate intervention or wait-list arms of the study. As new subjects entered the study, they were randomly assigned to a study group. By chance, this randomization procedure produced an uneven distribution among the two study groups. In all, 72 caregivers were assigned to the immediate treatment condition while 45 were assigned to the wait-list control group. Although this imbalance affected the power of the study, it did not affect the baseline comparability of the two groups either on demographic variables (care receiver or caregiver age, gender, education, or income or whether care receiver lived with caregiver) or key study measures (care receiver MMSE, ADL, and problem behaviors or caregiver depression, burden, reaction to behavior, or beliefs about caregiving). Of the 117 caregiver participants, 23 did not provide data at the 5-month end point. Twelve of these were from the immediate treatment group and 11 were from the wait-list control group. Reasons for dropping out of the study were ascertained from 13 caregivers, all of whom reported the reason to be worsening care receiver condition (including nursing home placement) or other reasons exogenous to the study (e.g., transportation difficulties). Analysis of the dropouts versus completers revealed no significant differences between the groups; a more detailed comparison was reported in a previous paper. There was virtually no variation in workshop attendance. Almost all completing caregivers in the immediate treatment group attended all seven workshop sessions.

In general, the caregivers included in the study were younger (mean = 65 years, standard deviation (SD) = 13.56) than the care receivers (mean age = 77 years, SD = 8.43). The majority of caregivers were female (70.0%), while slightly over half of the care recipients were male (55.6%). All participants reported that they were Caucasian. Ninety-four percent of caregivers were either spouses (65.5%) or children (28.3%) of the person with dementia. The mean caregiver income was between $20,000 and $40,000. The mean level of caregiver education was some schooling after high school.

T-tests indicated no significant differences between either the treatment (n = 60) and control group (n = 34) caregivers or the treatment and control group care receivers at project entry for any variables used in the analyses. When examined for change in status over the 5-month period, care receivers in both groups had lower physical functioning and slightly lower cognitive functioning, but care receivers in the treatment and control groups did not significantly differ in their degree of decline over the 5 months (ADL: t = −0.36, P = .718; MMSE: t = 1.08, P = .282). Because the rate of deterioration did not differ between treatment and control groups, the amount of change in status was not controlled for in the ANCOVAs. Among
As Table 2 indicates, examination of the relationship between beliefs and outcomes confirms a positive association between developing more moderate beliefs about caregiving and experiencing improved outcomes. The results of the hierarchical linear regressions examining the relationship of caregiver BACS scores to the other 5-month dependent variable scores showed a significant relationship between beliefs and outcomes confirms a positive association between caregivers’ beliefs about caregiving and caregiver outcome. It also demonstrated the intervention’s ability to change beliefs and outcomes such as burden and depression. Treatment-group caregivers reported feeling less emotionally enmeshed in providing care for their care receivers and having less of a need to control their care receivers and their behaviors. These changes suggest a shift in beliefs that allows family members to think strategically about how to provide the best care for the care receiver. These shifts in beliefs about caregiving related significantly to better scores on two critical measures of caregiver outcome: depression and burden. These results are consistent with our theory-based expectations that caregivers, after being educated about the disease process and the implications for the functioning of the family member with dementia, will be more likely to realize the limitations of what they can do for their family member, will adjust the expectations by which they judge themselves, and will, consequently, experience less severe outcomes within the stress situation.

The study offers suggestions about three general areas of educational content, focus, and training emphasis that appear to have achieved the anticipated results in beliefs and outcomes among participating caregivers:

- **Instruction.** Caregivers appear to benefit from information provided in an ongoing manner. As caregivers learned more about the disease and how to man-

<table>
<thead>
<tr>
<th>Caregiver Outcomes Measures</th>
<th>Treatment Mean (SD)</th>
<th>Control Mean (SD)</th>
<th>F-Statistic* (df1)</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurturing</td>
<td>27.455 (6.951)</td>
<td>25.068 (6.371)</td>
<td>5.218 (1.79)</td>
<td>.025</td>
</tr>
<tr>
<td>Monitoring</td>
<td>61.385 (9.981)</td>
<td>58.283 (9.901)</td>
<td>1.753 (1.77)</td>
<td>.189</td>
</tr>
<tr>
<td>Behavior frequency</td>
<td>6.518 (5.442)</td>
<td>6.807 (4.393)</td>
<td>1.728 (1.80)</td>
<td>.192</td>
</tr>
<tr>
<td>Response to behavior</td>
<td>4.148 (4.358)</td>
<td>5.790 (4.366)</td>
<td>5.734 (1.80)</td>
<td>.019</td>
</tr>
<tr>
<td>Depression</td>
<td>11.994 (7.672)</td>
<td>16.086 (9.111)</td>
<td>4.375 (1.79)</td>
<td>.040</td>
</tr>
<tr>
<td>Burden</td>
<td>53.874 (12.403)</td>
<td>59.446 (5.575)</td>
<td>3.915 (1.78)</td>
<td>.051</td>
</tr>
</tbody>
</table>

*Different denominator degrees of freedom are due to missing values in the outcome variables.

MMSE = Mini-Mental State Examination; ADL = activity of daily living; SD = standard deviation.
age it, they found they had more questions. We fielded questions throughout the 7 weeks of the workshop and are confident that, had we continued to meet, we would have had to answer more detailed and more sophisticated questions. From our observation, an important form of instruction was the presentation of “how to” material for the caregiver—how to think about and manage the daily life and behavior of the care receiver.

- **Linkage.** Caregivers responded to specific information about services. This included information on salience (what a service did and how the caregiver and care receiver could benefit from it), access (whom to call), quality (who does the best job), and reasonable expectations (e.g., it may take a person a month to become accustomed to day care).

- **Coaching.** It is beneficial to coach caregivers to recognize their newly acquired role and to take on an outlook appropriate to the role (including a self-care perspective). As caregivers realized that the caregiving role was different from usual familial roles, they could think about their tasks and their own welfare in a different light. They became more analytic—more clinical—as caregivers, and they also seemed to accord greater weight and validity to the question of their own well-being.

Although the MFW employed a particular format—a classroom approach by a multidisciplinary faculty—we believe the content, focus, and emphasis can be used in a variety of ways. This study may be of particular significance to clinicians because it demonstrates that caregivers’ beliefs about their roles and responsibilities may ameliorate the burden and depression they experience from the stressful situation of providing care to a family member afflicted with a chronic illness such as Alzheimer’s disease. Helping caregivers let go of beliefs that are unrealistic and reinforcing beliefs about their abilities to engage in strate-

gic caregiving (e.g., planning with care receiver’s strengths and losses in mind and anticipating changes) are both possible and important. Skills are best learned when beliefs about caregiving are realistic. In short encounters, clinicians can be alert to caregivers’ beliefs about their role, reinforce healthy beliefs, and address unhealthy beliefs. Some of these beliefs may be deep-seated and may benefit by referral to other members of the team or other providers. Other studies have shown that even brief information provision in a clinical setting may be beneficial to family caregivers.65

The study had several limitations. The study sample was small and quite homogenous (in terms of ethnicity, income, and education), reflecting the upper mid-West community in which it was conducted. The sample included spouses, children, and other relatives as primary caregivers, and it included caregivers who resided with the care receivers (most) and others who did not. Such differences in relationship and residence may represent structural differences in caregiving that could alter the fundamental caregiving experience or confound interpretation of results.18,47,64 Additionally, caregivers in the study were help-seekers. They were all referred to the study through their own established relationships with clinical or other helping organizations. The effects of the intervention on caregivers who are not demonstrably help-seekers cannot be inferred from our results.

Another limitation of the study regards the length of time-to-follow-up measurement used in the study. We chose a 3-month postworkshop completion measurement timeframe because we believed it would give the caregivers time to apply—and experience the results of applying—the new beliefs, skills, and knowledge they gained from the workshop. Budget constraints precluded remeasuring further out in time, so we cannot comment on longer-term effects or the sustained (or degraded) effect of the intervention. We are also unable to report the extent to which treatment group caregivers actually acquired new knowledge or appropriate skills. Although caregivers’ reports of

<table>
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<tr>
<th>Caregiver Outcome Measures</th>
<th>Contribution of Monitoring</th>
<th>Contribution of Nurturing</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>F-Change</td>
<td>df1, df2</td>
</tr>
<tr>
<td>Behavior frequency</td>
<td>.272</td>
<td>2.73</td>
</tr>
<tr>
<td>Response to behavior</td>
<td>2.484</td>
<td>2.73</td>
</tr>
<tr>
<td>Depression</td>
<td>3.375</td>
<td>2.72</td>
</tr>
<tr>
<td>Burden</td>
<td>7.458</td>
<td>2.71</td>
</tr>
</tbody>
</table>

MMSE = Mini-Mental State Examination; ADL = activity of daily living.
their activities with care receivers—particularly in the later sessions of the workshop—provided substantial anecdotal evidence that they had done so, we did not have any objective measure of gains in either domain.

The intervention stood alone and was unconnected to physicians or care systems that provided primary and chronic care to the care receiver or caregiver. We had no way of integrating the workshop’s instruction with the work of clinicians or the clinical systems, nor did we know if our instruction was in concert or at odds with the care and instruction being provided. For example, we urged caregivers to avail themselves of adult daycare opportunities in the community, but we had no control over access to these programs and no way of knowing what caregivers’ physicians or care systems were advising them about daycare.

The instrument we used to measure BACS was not specifically validated only with caregivers of demented family members, and therefore should be interpreted with some care. The results also require cautious interpretation. Extreme shifts in beliefs on either subscale could point to areas of problematic behavior by caregivers (e.g., indifference or neglect). The changes reported in this study reflected shifts in the midrange of the scale, which seem more indicative of caregiver’s continued concern and involvement, as well as their movement to or acquisition of a more clinical framework of care.

The study raises a number of questions that merit future investigation. Our hypothesized correlation between BACS scores and reaction to behavior was not supported, although the result for monitoring ($P = .090$) is encouraging and deserves further study. The study did not demonstrate the predicted significant impact on care receiver behavior. Although the treatment caregiver reports of problem behaviors were lower at 5-month follow-up than reports from control-group caregivers, they did not achieve statistical significance. This also provides an encouraging basis for further investigation. Three broader questions should also be investigated: what augmentations might improve the workshop’s effect on caregivers’ reports of care receiver behaviors; what effect the workshop would have (particularly on longer-term outcomes, including health-care utilization) if it were structurally linked to a physician’s practice or a comprehensive care system for dementia; and how effective the workshop might be in more culturally and economically diverse groups of caregivers.

REFERENCES