

A Stress-Busting Program for Family Caregivers

Sharon L. Lewis, PhD RN FAAN • Denise Miner-Williams, PhD RN CHPN • Allen Novian, PhD LMFT LPC • Monica I. Escamilla, MS PsyD(c) • Paula H. Blackwell, MT ASCP • Jennifer Hale Kretzschmar, BBS • Lyda C. Arévalo-Flechas, PhD RN • Peter N. Bonner, MS



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Aging baby boomers, longer life spans, and rising levels of Alzheimer's disease and related dementias (ADRD) will result in a caregiver crisis in the near future. The ways in which caregivers deal with stresses related to caregiving will be critical to both their own well-being and their ability to care for others. The purpose of this article is to describe the Stress-Busting Program (SBP) for family caregivers and its effectiveness. The essential components of the SBP are education, stress management, problem solving, and support delivered in a group setting for 9 weeks. Results of the SBP indicate that throughout the program, caregivers experienced significant improvements in general health, vitality, social function, and mental health scores and decreases in anxiety, anger/hostility, depression, perceived stress, and caregiver burden. The SBP is a cost-effective health-promotion strategy for caregivers who have substantial ongoing stress.

Alzheimer's disease and related dementias (ADRD) currently affect more than 5 million Americans. Aging baby boomers, longer life spans, and rising levels of ADRD will result in a caregiver crisis as the number of people age 65 and older with ADRD is expected to reach an estimated 7.7 million in 2030. This is an increase of more than 50% above the number of people who are currently affected (Alzheimer's Association, 2008).

One out of eight people age 65 and older has ADRD, and nearly one of two people over age 85 has ADRD. To put this number in perspective, one in eight Americans has a family member with ADRD. ADRD is the seventh-leading cause of death overall and the fifth-leading cause of death for those older than the age of 65. Hispanics/Latin Americans and African Americans have a higher risk of developing ADRD than Whites (Alzheimer's Association, 2008).

Caregivers of Patients with ADRD

Family members are the primary source of care and support for people with ADRD. Seventy percent of people with ADRD live at home and are cared for by family and friends. Almost 10 million Americans care for a person with ADRD (Alzheimer's Association, 2008). These caregivers usually are middle-aged adult children or older spouses who sacrifice their own health to care for a loved one who is battling a debilitating disease.

One of the most compassionate and self-sacrificing things a person can do is care for a sick loved one. Caring for a family member with impaired mental and behavioral functioning presents the most stressful of caregiving situations (National Family Caregivers Association, 1999). Much of this stress relates to the many losses experienced during the course of caregiving.

These include losses of a relationship and intimacy that once were shared with the person who now requires care. As the illness progresses, there is the loss of the person the caregiver once knew. In addition, the care recipient's disruptive behavior and ever-increasing dependence is particularly stressful to caregivers.

Caregiving is an experience for which most people are not prepared, and the family caregiver often becomes the hidden victim of disease. Not only does the patient with the disease suffer; the caregiver also suffers. The psychological, social, and economic impacts of caregiving also can be overwhelming.

Caregiving Effects

ADRD destroys active productive lives and devastates families financially, emotionally, and socially. Family caregivers perform an incredibly valuable service for their relatives with dementia and the formal healthcare system, which was estimated at \$36.5 billion in 2007 (Anderson & McConnell, 2007). Caregivers provide care at a considerable cost to themselves both emotionally and physically. At the core of these emotional and physical costs is the stress associated with caregiving.

As family caregivers struggle to care for others, they endanger their own health. Caregivers are at risk for emotional, mental, and physical health problems that arise from complex caregiving situations and the strains of caring for family members with ADRD. The chief risk for institutionalization is not a decline in the health of care recipients, but instead a decline in the health of family caregivers themselves (National Alliance for Caregiving & Evercare, 2006). In addition to experiencing high rates of stress and depression, caregivers also have mortality rates that are 63% higher than noncaregiver controls (Schulz & Beach, 1999). The

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emotional, financial, and physical stresses of caregiving can have a deadly impact.

The ways in which caregivers deal with the stresses associated with caregiving are critical to their own well-being and their ability to provide care. If the health and well-being of caregivers are threatened, care recipients are in jeopardy. Increased acute care and institutionalization of care recipients are likely outcomes if the family caregiving system collapses. If the needs of family caregivers can be addressed, caregivers can more effectively look after care recipients and prevent hospitalization or placement in long-term care facilities. Both caregivers and the family members for whom they care ultimately will suffer if the needs of caregivers are not met.

Keeping family caregivers healthy and able to provide care is crucial to maintaining our nation's long-term healthcare system. With the aging of the population, this issue will only grow in importance in the coming decades. If caregivers remain healthy, the quality of life for care recipients will substantially improve.

History of the Stress-Busting Program (SBP)

In the process of working with family caregivers of patients with dementia, caregivers were asked by the authors, "What can we do to help?" A frequent response was "I cannot cope anymore...." Stress management was the top need identified by caregivers nationwide (Krach & Brooks, 1995; National Alliance for Caregiving & Evercare, 2006). This finding had important implications for the development of the SBP for Family Caregivers. The primary purpose of the SBP was to reach out to caregivers to teach them stress-management strategies and help them cope more effectively with stress related to caregiving.

Phase 1 of the SBP

Phase 1 of SBP, which began in 1996, involved working on an individual basis with spouses and adult children who were primary caregivers of patients with ADRD. The only intervention used was teaching simple relaxation strategies (such as relaxation breathing and guided imagery). The effectiveness of the intervention was monitored using self-report measures of quality of life.

The results indicated that relaxation therapy can be an effective intervention in decreasing perceived stress and depression and enhancing quality of life (Hale, Murphy, Blackwell, Bonner, & Lewis, 2003; Lewis, Clough, Hale, Blackwell, & Bonner, 2002; Lewis et al., 2002). Yet caregivers wanted more educational information on stress management, preferably received in

the setting of a small support group. This led to the development and implementation of Phase 2.

Phase 2 of the SBP

Phase 2 of SBP, which began in 2001, is a multi-component program for caregivers of patients with ADRD. The program involves psychoeducational support groups that meet with two facilitators for 1½ hours once a week for 9 consecutive weeks. During the 9-week program, participants discuss various topics related to caregiving and are taught specific stress-management techniques (Table 1). Caregivers are given a handbook, a relaxation/meditation CD, and a resource book for caregivers (Gray-Davidson, 1999). The 30-minute relaxation CD guides listeners in relaxation breathing, modified progressive muscle relaxation, and guided imagery. Caregivers are encouraged to use the CD every day. The material in the handbook is the primary resource used for education and is the focus for discussion of various topics. Caregivers are encouraged to actively participate in group discussions.

At each session, caregivers are taught various stress-management techniques (Table 1). Learning a variety of techniques enables caregivers to identify those that work best for them. Some techniques work better for certain situations. Relaxation is the key component of any stress-management program. There are many methods to manage stress as a biologic response, but the common pathway is relaxation.

SBP intervention outcomes were assessed on both short- and long-term bases using self-report measures of quality of life. The results of this phase are presented in this article.

Methods

Participants

A total of 209 ADRD caregivers (162 women and 47 men; 128 spousal caregivers, 78 adult children caregivers, 3 others) were studied. This convenience sample of caregivers was recruited from a large metropolitan area in south Texas. The demographic data of the sample are presented in Table 2.

The average age of spousal caregivers was 70.6 years, and 53.7 years for adult children caregivers. The average age of male caregivers was 69.0 years, and 61.8 years for female caregivers. There were 149 White (non-Hispanic) caregivers and 53 Hispanic/Latin-American caregivers (the majority of whom were Mexican Americans).

The Reisberg classification scale was used to assess the level of disability of the person with ADRD (Reisberg, 1988). In this scale, scores range from Stage 1 (*no cognitive decline or subjective complaint of memory deficit*) to Stage 7 (*very severe cognitive decline, late dementia*). In

Table 1. Content of Sessions and Stress-Management Techniques

| Session | Title and Content | Stress-Management Technique |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Introduction | Group Introductions and Guidelines Focus: Group introductions, purpose, and expectations of group. | |
| 1 | Stress and Relaxation—Part 1 Focus: Causes of stress, unique caregiver stressors, mind-body-spirit connections to stress. Given resource book <i>The Alzheimer's Sourcebook for Caregivers</i> by Freena Gray-Davidson. | Relaxation breathing and meditation |
| 2 | Stress and Relaxation—Part 2 Focus: Physical and emotional effects of stress, positive aspects of caregiving, relaxation response, creating a relaxation environment. Given meditation/relaxation CD that guides them in learning relaxation breathing, meditation, imagery, and muscle relaxation. | Progressive muscle relaxation and guided imagery |
| 3 | Reactions to Grief and Loss Focus: Grieving process and losses related to ADRD. Understanding the relationships among loss, grief, and depression. Identification of symptoms of depression and strategies for managing depression. | Art therapy |
| 4 | Coping Skills Focus: Self-assessment to assist caregivers to identify their coping strategies. Discussion of self- and environment-focused coping strategies. Use of humor as a stress reliever. Changing roles and relationships. | Aromatherapy |
| 5 | Challenging Behaviors Focus: Understanding and managing difficult and challenging behaviors commonly exhibited by people with ADRD. Strategies to manage these behaviors are discussed. Self-assessment assists caregivers to identify these behaviors and the effect they have on their lives. | Massage |
| 6 | Positive Thinking Focus: Changing the way one can think (cognitive restructuring) and ways to view situations in a more positive framework. Twisted thinking is discussed. | Journaling |
| 7 | Taking Care of Yourself: Healthy Living Focus: Integrating the strategies learned in earlier sessions to help develop a healthier lifestyle. Emphasis on incorporating good nutrition and exercise into daily routines, prevention of burnout, and good sleep habits. | Music therapy |
| 8 | Choosing a Path to Wellness Focus: Final integration of first seven sessions and applying them so that caregivers will be empowered to take care of themselves on a long-term basis. Caregivers create a plan for how to do this and focus on healthy living. | |

Note. ADRD = Alzheimer's disease and related dementia

the current study, the level of dementia ranged from 4 (*intact orientation and recognition of familiar people but moderate cognitive decline with some deficits in memory, concentration, knowledge of current events*) to 6A (*severe cognitive decline; can usually recognize familiar people, but may forget their names; impaired orientation to time and place; possible exhibition of personality and emotional changes*).

Procedure

All participants provided informed consent. The study was approved by the institutional review board at a university health science center and the research and development committee at a Veterans Affairs hospital in a city in the Southwest.

The intervention is described above as Phase 2 of the SBP. The effectiveness of the SBP was determined at the beginning (Time 1), middle of intervention at 4 weeks (Time 2), end of intervention at 9 weeks (Time 3), and follow-up session 2 months following completion

Table 2. Demographic Data

| Variable | Mean ± SEM |
|----------------------------------|--------------|
| Age | 52.77 ± 1.92 |
| Years of caregiving | 6.47 ± 1.02 |
| Marital status | Percentage |
| Single | 11.1% |
| Married | 81.3% |
| Divorced | 7.7% |
| Employment status | |
| Employed | 24.5% |
| Unemployed | 75.5% |
| Education level | |
| High school or less | 17.3% |
| Some college or technical school | 42.8% |
| College graduate | 39.9% |
| Living arrangement | |
| With parent/spouse | 74.5% |
| Not with parent/spouse | 25.5% |

Key Practice Points

1. The taxing responsibilities and stress of complex caregiving situations place family caregivers at risk for emotional, mental, and physical health problems that ultimately puts patients at increased likelihood of being placed in a long-term care facility.
2. To remain healthy and able to provide care, family caregivers need to learn techniques to cope with their stressors and stress.
3. Caregivers who participated in the Stress-Busting Program demonstrated significant improvement in their quality of life and well-being, decreased responsiveness to stressors, and reduced depression.
4. When family caregivers are reluctant to care for themselves or seek help, nurses are in the ideal position to identify stressed caregivers and help them get the support they need.

of the intervention (Time 4). Exit interviews using a semistructured format were conducted to assess the changes that occurred after the caregivers' participation in the SBP.

Questionnaires

Demographic Information

A demographic information form was used to obtain data about caregivers and care recipients. At the middle and end of the intervention, an updated demographic information form was used to obtain data about changes in diet or exercise, stressors, and illnesses.

Screen for Caregiver Burden

Caregiver burden is a major stressor for caregivers. The Screen for Caregiver Burden was used to identify distressing caregiver experiences (Vitaliano, Russo, Young, Becker, & Maiuro, 1991). The 25-item questionnaire provides scores for objective burden (number of potentially negative experiences) and subjective burden (appraised distress in response to the experiences). Vitaliano and colleagues demonstrated an internal consistency of 0.88–0.89. The test-reliability was 0.64–0.70. Criterion validity (differences in burden between caregivers and controls) was demonstrated using age- and gender-matched controls. Norms for caregivers and mean change scores for no-treatment groups are available (Vitaliano et al.). Using the current sample in this study, Cronbach's alpha was 0.89.

Quality of Life

The primary outcome of interest in this study was quality of life or a person's general well-being (Stewart & Ware, 1992). The critical attributes of this multidimensional concept are satisfaction with one's life; self-esteem; self-reliance; physical, mental, social, and emotional well-being; and the ability to function cognitively and socially (Stewart & King, 1994). In this study, quality of life for caregivers was determined using a variety of questionnaires that assess mental, social, and emotional health. These included the Perceived Stress Scale, the Short Form 36 Health Survey, the Symptom Questionnaire (SQ), and the Center for Epidemiologic Depression Scale (CES-D).

The Perceived Stress Scale designed by Cohen and colleagues is a 14-item questionnaire designed to measure the degree to which situations in one's life are appraised as stressful. The items are rated on a 5-point scale (0–4) with 0 = *never*, 1 = *almost never*, 2 = *sometimes*, 3 = *fairly often*, and 4 = *very often*. Items on the scale are designed to measure the degree to which subjects feel their lives are unpredictable, uncontrollable, and overwhelming. Cohen and colleagues demonstrated a coefficient alpha reliability of 0.84, 0.85, and 0.86. The test-retest stability was .85 in a 2-day retest and .55 in a 6-week retest (Cohen, Kamarck, & Mermelstein, 1983). The Cronbach's alpha in this study was 0.90.

The SF-36 Health Survey is a 36-item questionnaire that was developed during the Medical Outcomes Study (MOS; Ware, Snow, Kosinski, & Gandek, 1993). The SF-36 measures generic health concepts relevant across age groups. It provides a comprehensive, psychometrically sound, and efficient way to measure health from a person's point of view. The SF-36 was constructed to represent eight of the most important health concepts included in the MOS and other widely used health surveys. These include 1) physical functioning, 2) role limitations due to physical health problems, 3) bodily pain, 4) general health, 5) vitality (energy/fatigue), 6) social functioning, 7) role limitations due to emotional problems, and 8) mental health (psychological distress and psychological well-being). In addition to the 8-scale SF-36 profile, physical and mental component summary measures can be scored. The eight scales of the SF-36 are each constructed with a Likert scale rating.

The SQ is a questionnaire with brief, simple items that allows participants to describe how they feel by checking yes or no. It consists of 92 items, 68 of which indicate symptoms (symptom subscales), and 24 are antonyms for symptoms that indicate well-being (well-being subscales). Each scale can be subdivided into two main subscales (Table 3).

The SQ has an impressive record of reliability and validity and has been used in numerous studies (Fava

et al., 1983; Fava, Fava, Kellner, Serafini, & Mastrogiacomo, 1981; Kellner, 1971; Kellner, 1987; Kellner, Wiggins, & Pathak, 1986). The split half reliabilities of changes (the correlation of changes in the split halves of each scale) after 2 weeks in anxious and depressed outpatients with neurosis were anxiety 0.92, depression 0.94, somatic symptoms 0.86, and hostility 0.91. Test-retest reliability of depression in a study with anxious outpatients was 0.95 (Kellner, 1987). The SQ has criterion-related validity. It has been used in studies with patients with physical diseases and with psychiatric patients, and it has discriminated between groups of neurotics and normals. It is sensitive to changes in depression in normal people (Clough, 1991). In this study using the current sample, Cronbach's alpha results were anxiety 0.91, depression 0.88, somatic symptoms 0.90, and hostility 0.91.

The CES-D has been used widely in studies to assess symptoms of depression (Radloff, 1977). It is a 20-item, 4-point Likert scale ranging from *never* (0) to *most of the time* (3). It is used to assess overall levels of depression experienced in the past week. Possible scores range from 0–60, with higher scores indicating greater depressive symptomatology. It is suitable for use in general populations and has strong psychometric properties (Shaw, Vallis, & McCabe, 1985). It has been used with older adults (Himmelfarb & Murrell, 1983) as well as spouse caregivers (Pruchno, Kleban, Michaels, & Dempsey, 1990) and found to have excellent reliability and validity. In other studies, Cronbach's alpha was reported at 0.88 (Bergman-Evans, 1994; Kellner, 1987; Pruchno, Kleban, Michaels, & Dempsey). Cronbach's alpha was 0.89 in this study's sample.

Data Analysis

All questionnaire data were entered and scored in an Excel spreadsheet. Statistical Package for the Social Sciences (SPSS) was used for data analysis. Effectiveness of the SBP was assessed using repeated measures of analysis by comparing results before, midintervention, and after the SBP and at a 2-month follow-up period.

Results

Results of the SBP Intervention

Testing times were discussed above. Repeated measures analysis was used to analyze the results over the course of the study. The data are presented in line graphs. Statistically significant ($p < .05$) differences from baseline are indicated by asterisks. Over the course of the study, caregivers had significant decreases in perceived stress, depression, subjective caregiver burden, anxiety, and anger/hostility (Figure 1). In addition, they also had improvements in general health, vitality, social function, and mental health scores (Figure 2).

Table 3. Symptom Questionnaire Scales and Subscales

| Scale | Symptom Subscale | Well-Being Subscale |
|-----------------|--------------------------|---------------------|
| Depression | Depressive symptoms | Contented |
| Anxiety | Anxiety symptoms | Relaxed |
| Anger/Hostility | Anger/hostility symptoms | Friendly |
| Somatic | Somatic symptoms | Somatic well-being |

Based on analysis of quality-of-life measures from the beginning to the end of the intervention, improvement was shown by 97.4% of caregivers who participated in the study, with 61% showing improvement on all measures tested.

Caregivers' Evaluation of SBP

When caregivers who had completed the SBP were asked to identify the most helpful part of the program, the most common answer by a large margin was interaction with other caregivers and facilitators. The participants found that the help, advice, tips, and encouragement they received were most beneficial. In addition, the companionship of other caregivers led to a decrease in feelings of isolation (which many caregivers reported). Sharing their experiences in a group setting in which they felt comfortable and knowing that others were able to relate was invaluable to many caregivers.

When participants were asked to describe the changes they made as a result of the SBP and the changes they maintained after the SBP, the majority of respondents said they can now manage their stress more effectively. They reported regular use of the relaxation techniques they had learned, with the most commonly used technique being relaxation breathing. As a more general lifestyle change, most participants said they learned to take time for themselves. All participants reported making some life changes as a result of the SBP. Their descriptions frequently involved rather dramatic change, such as the following:

"I was at a very low point in my life. The program saved me from going into a deep depression...it saved my life."

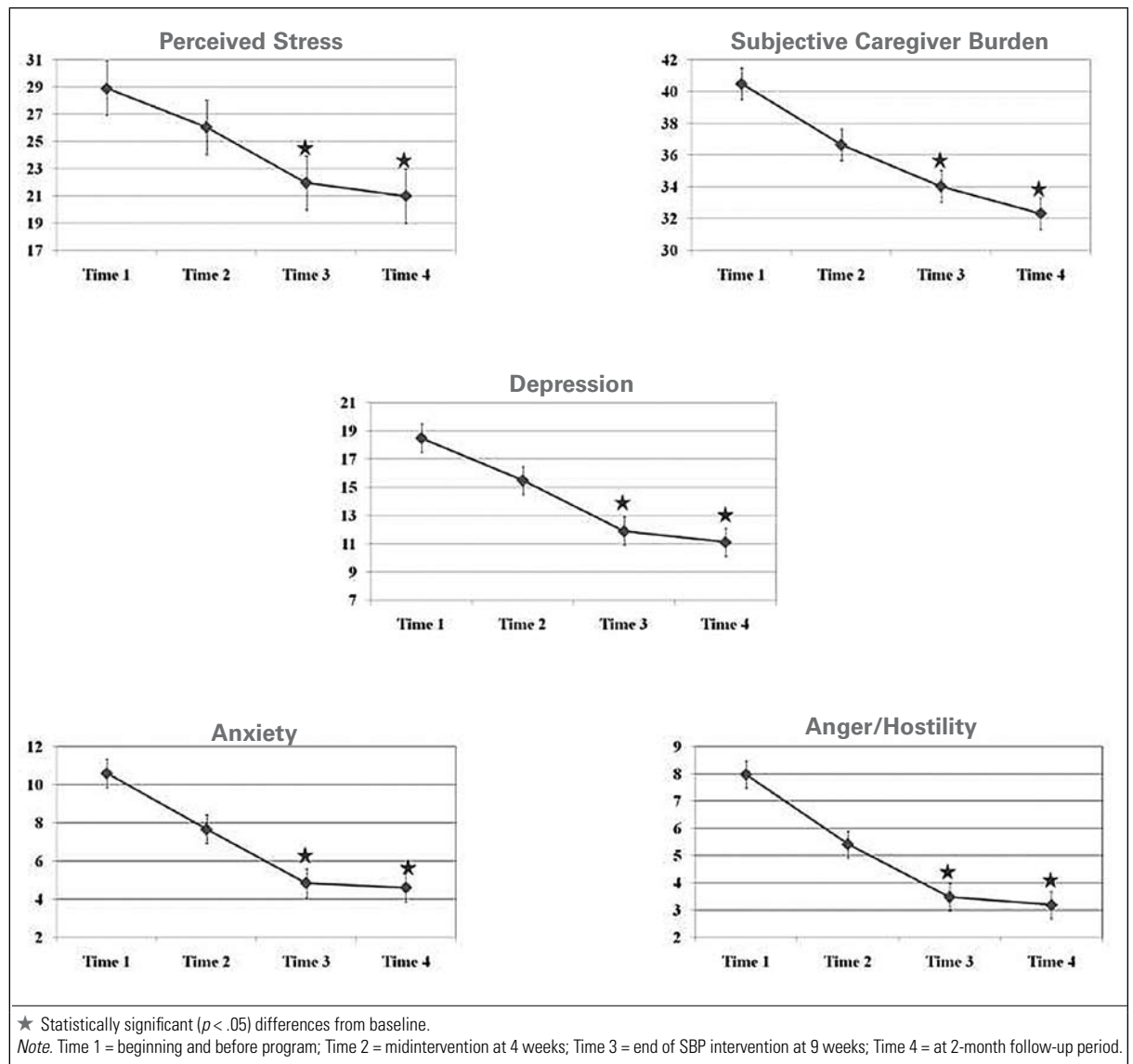
"The program was a turning point in my being able to cope."

"The descent into my husband's Alzheimer's accelerated for both of us. I thought my life had ended, that I would be nothing more than an empty shell forever. The Stress-Busting program gave me a safety net when I most needed it, and gave me the impetus to live richly."

Caregivers were asked the following question (response choices were on a Likert scale with a range from 1–5) at the beginning, middle, and end of the intervention: How well do you handle your caregiving

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Figure 1. Outcomes of Stress-Busting Program (SBP) for Family Caregivers



responsibilities? They reported significant improvement ($p < .02$) from the beginning (mean = 2.9) to the end of the study (mean = 3.7), indicating they subjectively felt they were more effectively coping as caregivers.

Phase 3 of the SBP

In Phase 3, the program was adapted for caregivers of patients with Parkinson's disease. An attempt to have a mixed group of caregivers who cared for both patients with ADRD and Parkinson's disease was not optimal because of the unique needs of each type of caregiver and the specific issues resulting from the disease process. Therefore, there was a separate group for each disease. The handbook section on challenging behaviors was revised to address the disease process and the materials changed to

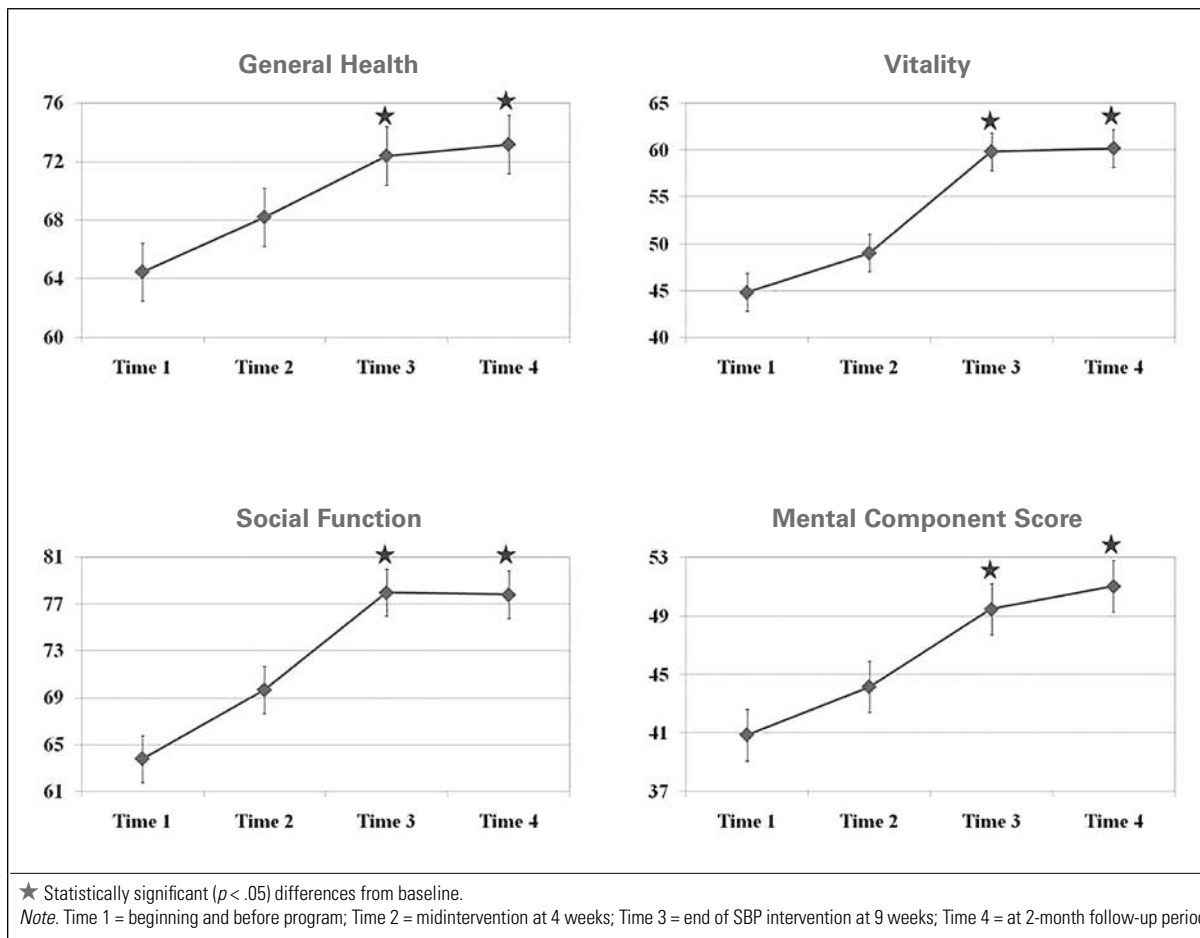
include examples that reflected Parkinson's disease symptoms.

Discussion

The overall goal of SBP was to teach caregivers to more effectively identify and deal with their stress, mobilize their resources, increase self-control, and improve personal quality of life. The essential components of the SBP were education, stress management, problem solving, and support. The results of this study indicate the multicomponent SBP for Family Caregivers has been highly beneficial for many caregivers by helping them cope more effectively with stress related to caregiving. Participation in the program also enhanced quality of life.

When caregivers talk about their health-related problems, stress seems to be the most pervasive

Figure 2. Outcomes of SBP for Family Caregivers



problem (Alzheimer’s Foundation of America, 2007; National Alliance for Caregiving & Evercare, 2006). Strong evidence suggests a causal link between stress and chronic conditions such as depression, cardiovascular disease, and acquired immunodeficiency syndrome (AIDS; Cohen, Janicki-Deverts, & Miller, 2007). Caregivers believe their stress takes a physical form in their health problems. Fifteen percent of caregivers report their health has become much worse, and 44% report their health has become moderately worse since taking on the caregiving role (National Alliance for Caregiving & Evercare).

Keeping family caregivers healthy and able to provide care is essential to maintaining our nation’s long-term healthcare system and, with the aging of the population, this issue will grow more important in the coming decades (Covinsky & Johnston, 2006). In many respects, a caregiver’s physical and mental health may be at the core of successful caregiving. If caregivers remain healthy, they can continue to provide care, and the quality of life for care recipients will substantially improve. Conversely, a caregiver’s failing health may result in the collapse of fragile support systems for care recipients. Although this study did not assess actual changes in physical health, perception of

physical functioning and role limitations attributable to physical health problems did improve (based on SF-36 scores).

Effective stress-management techniques have been shown to decrease physician and medication use, reduce hospital stays, and reduce mortality (Schneider, 1987). Caregiver interventions that result in significant improvements in stress and depression have public health significance because ultimately they will promote the health, well-being, and longevity of caregivers. Time invested in caregivers can save healthcare time and money.

Implications for Rehabilitation Nurses

The first step to helping family caregivers is to identify them. Caregivers must be identified by healthcare professionals, or they must identify themselves. Caregivers have been referred to as “hidden patients” because caregivers primarily have concern for their loved one and do not seek help for themselves. Consequently, caregivers experiencing stress must be identified and encouraged to get help. Nurses are key people in this process. The assessment of any patient needs to include an assessment of his or her primary caregiver.

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Listening attentively to caregivers as they speak about their experiences can provide clues to what their lives are like, and these clues should be explored. Assess these areas if possible:

1. Their level of stress and how well they are coping
2. How well they maintain their own nutrition, rest, and exercise
3. Level of social interaction versus isolation
4. Level of support from outside sources (e.g., family and friends)
5. How well they address their own healthcare needs (especially important for caregivers with chronic illnesses of their own)
6. Knowledge of community and Internet resources such as the Alzheimer's Association, local adult day care centers, and Web sites such as www.caregiver.org
7. Resources available for respite care (so someone can care for their loved one while they have time to themselves).

After an assessment is done, ask the family caregiver if he or she needs help. Find out the specific types of help they need. Caregivers often are reluctant to ask for help because they do not want to be a burden or they feel they may be rejected. It is important to be supportive and encourage caregivers. Many caregivers suffer in silence because they may not know how to ask for help or where to look for help, or they may not know that help is available for them.

Study Limitations

This sample consisted primarily of caregivers who were White and Hispanic/Latin American (primarily of Mexican-American descent). Further research is needed to include a more ethnically diverse sample.

Convenience sampling for a program such as this draws people who are open to receiving the information about the intervention. The results of this program may not be generalizable to all caregivers at all stages in caregiving. An inability to understand the significance of self-care and an unwillingness to invest in self-care are barriers that many caregivers must overcome before they can accept help and benefit from it (Murphy et al., 2007).

Another limitation was that the intervention was not exactly the same with each group. Although the basic topics were discussed with each group, variations among groups existed because the flow of the intervention was dictated by the needs of the group with the guidance of the facilitators. Although all groups contained elements of education and support, some groups tended to emphasize the group interaction and support element, while other groups focused more on didactic information. This flexibility also could be viewed as a strength of the intervention, however.

Conclusions

There is substantial need for more caregiver intervention in clinical practice as the growing number of older adults and the increased incidence of dementia result in more family members assuming caregiving roles. Meeting this challenge is critical to address the needs of caregivers and, in turn, the recipients for whom they care.

To remain healthy and continue to provide care, these family caregivers need to learn techniques to deal with their stressors. Stress-management programs for caregivers such as the SBP can support family caregivers and empower them to cope more effectively. The SBP serves as a model for such programs, as it has demonstrated outcomes of improved ability to cope with the stressors of caregiving. In addition, after completing this program, caregivers subjectively rate themselves with increased ability to care for their loved ones.

The next phase of research needs to address the process of shifting this program from the research setting into the community. The goal is to replicate the program in numerous sites in a self-sustaining manner while maintaining outcomes similar to those realized in the research setting.

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About the Authors

Sharon L. Lewis, PhD RN FAAN, is a professor at the School of Nursing and Medicine, University of Texas Health Science Center at San Antonio, and a clinical nurse scientist at South Texas Veterans Health Care System in San Antonio, TX. Address correspondence to her at lewissl@uthscsa.edu.

Denise Miner-Williams, PhD RN CHPN, is a geriatrics research fellow at the Geriatrics Research Education and Clinical Center South Texas Veterans Health Care System in San Antonio, and an assistant research professor at the School of Nursing, University of Texas Health Science Center at San Antonio in San Antonio, TX.

Allen Novian, PhD LMFT LPC, is a program coordinator at the School of Nursing, University of Texas Health Science Center at San Antonio in San Antonio, TX.

Monica I. Escamilla, MS PsyD(c), is a research assistant at the School of Nursing, University of Texas Health Science Center at San Antonio in San Antonio, TX.

Paula H. Blackwell, MT ASCP, is a senior research assistant at the School of Nursing, University of Texas Health Science Center at San Antonio in San Antonio, TX.

Jennifer Hale Kretzschmar, BBS, is senior research data management coordinator at the School of Nursing, University of Texas Health Science Center at San Antonio in San Antonio, TX.

Lyda C. Arévalo-Flechas, PhD RN, is a John A. Hartford Foundation Claire M. Fagin fellow and clinical assistant professor at the School of Nursing, University of Texas Health Science Center at San Antonio in San Antonio, TX.

Peter N. Bonner, MS, is a statistician at Data and Statistics, Inc., in Boerne, TX.

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