

Dyadic Intervention for Family Caregivers and Care Receivers in Early-Stage Dementia

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Purpose: The Early Diagnosis Dyadic Intervention (EDDI) program provides a structured, time-limited protocol of one-on-one and dyadic counseling for family caregivers and care receivers who are in the early stages of dementia. The goals and procedures of EDDI are based on previous research suggesting that dyads would benefit from an intervention that increases the care receiver's active participation in his or her care plan, develops positive communication patterns between the caregiver and care receiver, increases knowledge and understanding about available services, and assists the dyad through the emotional turbulence of a diagnosis of Alzheimer's disease or other dementing condition.

Design and Methods: EDDI was developed in response to research and clinical findings that suggested that care dyads in the early stages of dementia and dementia care are able to engage in a dialogue about future preferences for care, and that this discussion could address some of the uncertainty and worry experienced by each member of the dyad. As part of a feasibility trial, 31 dyads participated in the EDDI program. Measures were obtained on the intervention's implementation, including the number of sessions attended, caregiver and care receiver ratings of treatment acceptability and effectiveness, and counselor ratings of treatment effectiveness. **Results:** Participant and counselor evaluations of the EDDI protocol indicated that the intervention was acceptable and satisfactory to the caregivers, care receivers, and counselors, and that the intervention's goals and objectives were achievable.

Implications: These findings indicate that individuals with early-stage dementia and their family caregivers

are able to participate in and benefit from a structured intervention that focuses on care planning for future needs.

Key Words: Alzheimer's disease, Counseling, Dementia intervention, Early diagnosis of dementia

Early-stage intervention research for family caregivers of individuals with dementia has typically focused on preparing caregivers to cope with later-stage problems such as behavior problems, activities of daily living care, family conflict (excluding the care receiver), depression, and burden (Hepburn, Tornatore, Center, & Ostwald, 2001; Mittelman, et al., 1995). For individuals with dementia, the most widely available early-stage programs have been support groups (Yale, 1995) designed to help participants deal with grief, reduce feelings of isolation, and increase knowledge about resources. Less consideration, however, has been paid to interventions that include both the caregiver and care receiver (see Clare, 2002 for an exception). Some explanations for this include the assumption that, compared with care receivers, family caregivers are more at risk for burden and distress, and thus need more support and attention, and the belief that care receivers are limited in their ability to participate actively in the intervention process. However, research on individuals in the early stages of dementia shows that they are often as fully aware as their caregivers about the meaning of their diagnoses, and they often have sufficient cognitive abilities to communicate choices and preferences (Whitlatch, Feinberg, & Tucke, 2005a, 2005b). Advances made in accurately diagnosing the early symptoms of dementia offer additional opportunities for interventions before the onset of significant stressors. Thus, an intervention that includes both members of the care dyad may represent an optimal approach in early-stage dementia.

These promising findings suggest that the period of early-stage diagnosis represents a critical time when both caregivers and care receivers can come to terms with the diagnosis and make plans for how they will

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arrange future care (Robinson, Clare, & Evans, 2005; Whitlatch & Feinberg, 2003). The innovation of the Early Diagnosis Dyadic Intervention (EDDI) program lies in its focus on the single dyad of care and its involvement of the care receiver and caregiver as active participants and decision makers. The rationale for the EDDI program comes from the emerging interest in decision making and care preferences in chronic illness, which has focused on three areas: (a) respect for the patients' autonomy within a medical model of health care decision making (e.g., advance directives; see High, 1988 and Wetle, Levkoff, Cwikel, & Rosen, 1988); (b) case examples of family dyads with physical, rather than cognitive, disorders (Walker & Allen, 1991); and (c) the views of family caregivers only (Smeglia & Deimling, 1997). The lessons learned from this research are threefold: care receivers are willing to take responsibility for treatment decisions; families benefit most when the caregivers' and care receivers' treatment goals and desires are mutually supported; and caregivers who can discuss goals and preferences with their relatives gain a better understanding of their care recipients and, as a result, feel better prepared and less burdened to make care decisions currently and in the future (Jacob, 1998).

For this article, we (a) describe the EDDI protocol; (b) report on the program's acceptability, feasibility, and usefulness; and (c) discuss future applications of the protocol. In subsequent articles, we will report on the intervention's effectiveness (e.g., regarding depression and well-being).

Description of the EDDI Protocol

The EDDI program uses the opportunity afforded by early diagnosis to help each dyad member express his or her preferences and concerns about the care situation and, similar to other dyadic approaches, strengthen the relationship bond (whether spousal or parent-child) through problem solving during joint sessions. The EDDI program views both members of the dyad as partners, rather than as a "giver" and "receiver" of care. However, distinct from other forms of couple's interventions, the EDDI program devotes considerable time to dementia-specific care issues, and it requires time for each care partner to meet separately with the counselor. The ultimate goal is for the dyad to work together to develop a mutual plan for coping with the disease over the long haul. This approach is likely to be reassuring to caregivers and care receivers in the present and to provide caregivers with a blueprint for how to approach difficult decisions in the future when the care receiver is no longer able to participate actively in the decision-making process.

The EDDI protocol (see Table 1) consists of nine sessions. The program's objectives are as follows: (a) to increase the understanding of care preferences and values of each dyad member; (b) to discuss and practice effective communication techniques; (c) to discuss discrepancies in care preferences and expectations; (d) to increase the dyad's knowledge about available services;

and (e) to explore the emotional significance and relationship issues brought on by the illness for both care partners.

To facilitate active participation and discussion between care partners, we designed intervention tools and materials to include simple language, minimize the cognitive load on care receivers' short-term memory and explicit processing, and capitalize on care receivers' remaining cognitive abilities, such as reading and long-term memory (Whitlatch & Feinberg, 2003; Whitlatch et al., 2005b; Zarit, Femia, Watson, Rice-Oeschger, & Kakos, 2004). These materials are available from the primary author (C. Whitlatch) and include caregiver- and care receiver-specific notebooks that discuss the content and goals of each session; session-specific carbonless-copy tools, worksheets, diagrams, and magnetic manipulation boards that serve as visual memory aids; and treatment protocols that include continual review and reinforcement of important concepts and skills. In addition, dyads completed a review sheet after each session that reinforced session objectives and evaluated the quality and usefulness of information presented during the session as well as homework to be completed before the next session.

We had the sessions held in the participants' homes so that the intervention could be accessible to all eligible participants, regardless of their mobility or ability to travel. Sessions were led by trained counselors with expertise in the area of dementia and who were familiar with the types of social services that are available both for early-stage and later-stage dyads. We randomly assigned one counselor to work with each dyad during the EDDI protocol. The intervention was highly structured and included standardized manuals, suggested prompts and probes, and intervention tools, materials, and exercises for each session, although the counselors were free to follow important digressions if they arose. For example, in one dyad in which the care receiver exhibited hoarding behavior, the counselor digressed to address the behavior and its impact on the dyad's relationship.

We had all sessions follow a similar format: The counselor would first meet with the dyad, and then the counselor would continue either with the individuals together in a "joint" session or meet separately with each care partner in "separate sessions." On the basis of our prior experience (Zarit et al., 2004), we designed individual sessions to address emotionally sensitive issues that participants might be uncomfortable or unwilling to discuss with their care partners and to prepare participants for productive joint sessions. This format gave care partners the opportunity to express their viewpoints and concerns and to work on strategies for expressing themselves during joint sessions. The counselor always ended the session with the dyad together, to summarize their interaction and preview the next session.

Session 1 is a joint session that provides dyads with information about Alzheimer's disease and other dementias, memory loss, the implications of diagnosis, and available resources. This session ensures that each dyad member has a basic understanding of the

Table 1. Early Diagnosis Dyadic Intervention Protocol

| Session No., OP | Session Name | Type and Time | Session Goals and Objectives | Session No., RP |
|-----------------------|-----------------------|----------------------|---|-----------------|
| 1 (<i>n</i> = 31) | Information (PLAN) | Joint; 90 min | Learn about changes expected with memory loss Learn about communication skills Learn about services that are available Discuss the importance of future planning | 1 |
| 2 (<i>n</i> = 27) | Care Values 1 | Separate; 90 min | Explore individual care values Begin process of planning for the needs of a person with memory loss Tool: Care Values Ladder worksheet | 2 |
| 3 (<i>n</i> = 24) | Care Values 2 | Joint; 60 min | Openly discuss care values Use communication skills in discussing care values Begin joint planning for the needs of a person with memory loss Tool: Care Values Ladder worksheet | 3 |
| 4 (<i>n</i> = 23) | Care Preferences 1 | Separate; 90 min | Discuss memory loss changes Discuss individual preferences for care: Formal and informal Think about the preferences of the other Discuss ways to share preferences with the other Tool: Care Preferences worksheet | 4 |
| 5 (<i>n</i> = 22) | Care Preferences 2 | Separate; 90 min | Continue work from last session Probe more into individual preferences Think of ways to share preferences with the other Tool: Care Preferences & Help Preferences worksheets | |
| 6 (<i>n</i> = 22) | Care Preferences 3 | Joint; 60 min | Talk together about consequences of memory loss Discuss similarities and differences in preferences Try to reach agreement or understanding of care preferences Tool: Care Preferences worksheet | 5 |
| 7 (<i>n</i> = 20) | Challenges 1 | Separate; 100 min | Review care preferences Examine sources of formal and informal help Identify barriers and solutions to getting help Tool: Barriers and Solutions worksheet | 6 |
| 8 (<i>n</i> = 20) | Challenges 2 | Joint; 90 min | Jointly discuss care preferences Jointly explore barriers and identify solutions Tool: Care Plan worksheet | |
| 9 (<i>n</i> = 20) | Final Review | Joint; 90 min | Review past discussions Identify unresolved issues Review where they can go to get the help they need Tool: Helpers worksheet | 7 |

Notes: *n* = the number of dyads who completed each session; OP = original protocol; RP = revised protocol, which also contains a pre-session; PLAN = Planning for Late Life Activities and Needs Project.

symptoms and progression of the disease and answers questions about the diagnosis and illness. Communication skills are also introduced and include the following: (a) keep it short and simple (KISS); (b) listen; (c) paraphrase; and (d) compromise. These communication skills and the information about the disease process are continually referred to in subsequent sessions.

In Sessions 2 and 3, the focus shifts to the assessment

of care values. In Session 2, the caregiver and care receiver meet separately with the counselor to discuss and prioritize the importance of nine care value categories (e.g., safety, money, and family stress; Whitlatch et al., 2005b). Caregivers rate how important they believe the care values are to the care receiver, and then they give their own ratings of the importance of each care value. Care receivers are asked to rate the im-

portance of each care value. A magnetic white board with magnetic strips that correspond to each care value is used to facilitate decision making when care values are compared and prioritized. The final prioritized list of care values is copied onto a carbonless-copy worksheet called the Care Values Ladder, which also serves as a visual aid and reference for future sessions. In Session 3, the caregiver and care receiver meet jointly to discuss and clarify the Care Value Ladder worksheets and work toward creating a shared worksheet. The worksheets of each member of the dyad are arranged side by side on the magnetic board, which enables the dyad to view and compare the similarities and differences in how each care partner prioritized his or her care values. To illustrate, a caregiver may have prioritized safety as the most important care value whereas the care receiver prioritized finances as more important for the making of future care decisions. Exploring and discussing these differences together enables the dyad to resolve or incorporate both perspectives into future care decisions. Throughout the session, the counselor facilitates the discussion by using suggested prompts and probes, moving the magnetic pieces around the board in response to the dyad's comments, and directing the dyad to construct a shared Care Values Ladder worksheet that encompasses both members' points of view.

Sessions 4 through 6 represent the essence of the intervention and build upon the previous' sessions discussions about care values. The goals are to explore and understand the discrepancies between the caregiver's and care receiver's care preferences, to examine where and how to find services or support that could be useful, and to discuss other topics that facilitate open communication between care partners. In Session 4 and Session 5, the caregiver and care receiver meet separately with the counselor to complete the Care Preferences worksheet, which contains three circles representing two informal and one formal service option for providing care (i.e., "myself-caregiver," "family-friends," and "formal service providers"). Using the magnetic manipulation board and 18 magnetic strips that correspond to specific care tasks (e.g., cooking, doing laundry, and dressing), dyad members place each care task in the circle representing their first choice of whom they would prefer to assist the care receiver. For example, a caregiver may indicate that he or she would prefer to help with most of the care tasks, leaving few tasks in the remaining two circles that represent "family-friends" and "formal service providers." The care receiver may prefer more help from formal service providers for personal care tasks, such as bathing, dressing, and toileting. For many dyads, seeing the caregiver circle filled with care tasks and the "family-friends" or "formal provider" circles sparse or empty brings about an understanding by both care partners of the need to pursue additional options for help. Session 6 is a joint session in which care partners discuss and explore how their similarities and differences could potentially affect future care decisions. The counselor discusses how full circles can lead to overload and helps the dyad explore alternate

care options. In a typical scenario, the majority of tasks are in the caregiver's circle and care partners discuss ways to decrease the number of tasks and responsibilities within the caregiver circle by utilizing help from family or friends and formal service providers. The process involved in Session 4 through Session 6 helps care partners reach an understanding of each other's perspectives and preferences rather than resolving all discrepancies.

In Sessions 7 and 8, the dyad discusses future challenges and barriers for utilizing help and possible solutions. In Session 7, the caregiver and care receiver meet separately with the counselor to review care preferences, discuss concerns from past sessions, and examine sources of formal and informal help. Each care partner completes the Barriers and Solutions worksheet, which documents potential barriers to getting help (e.g., financial or emotional barriers) and appropriate solutions for obtaining assistance. This leads to Session 8, in which the caregiver and care receiver work jointly to review each other's perceived barriers and then problem solve to find solutions for obtaining current and future help. Dyads complete the Care Plan worksheet, which lists specific care tasks (e.g., help getting to appointments), who will perform each task (e.g., daughter), and specific solutions for overcoming barriers (e.g., reminding the daughter a day in advance).

Session 9 provides a final review in which the dyad meets with the counselor for the last time to assess the progress made, identify unresolved issues, and review where they can go to get help. Caregivers and receivers work together with the counselor to complete the Helpers worksheet, which lists potential informal and formal helpers. The Helpers worksheet is a resource tool that can be easily accessed by dyads (e.g., attached to the refrigerator) when they need to arrange for assistance. The session concludes with a reflection on the dyad's progress and a review of the new skills they have acquired (i.e., effective communication, education about memory loss, the Helpers worksheet, and other resource or educational information).

Preliminary Evaluation of the EDDI Program

Sample Recruitment

Participants were recruited from the greater Cleveland area through a tiered approach. First, we informed social service and research organizations that serve individuals with dementia and their family caregivers about the project (which was referred to as "Project PLAN: Planning for Late Life Activities and Needs"), and we asked them to identify potential participants. Second, staff from these agencies sent initial letters that described the study. Third, research staff contacted these families to determine their eligibility and interest in participating. All participants who met the study's inclusion criteria were asked to participate.

The inclusion criteria were as follows: The caregiver had to have primary responsibility for the care receiver; both individuals had to live in the community, and they had to have a close kin or kin-type relationship. The

Table 2. Sociodemographic Characteristics of EDDI Participants ($n = 31$)

| Characteristic | Care giver | | | Care Receiver | | |
|---|---------------|-----------|------|---------------|-----------|----|
| | <i>M</i> | <i>SD</i> | % | <i>M</i> | <i>SD</i> | % |
| Age | 61.7 | 13.5 | | 78.9 | 9.2 | |
| Gender (female) | | | 77.4 | | | 65 |
| Relationship of CG to CR | | | | | | |
| Wife | | | 23 | | | |
| Husband | | | 16 | | | |
| Daughter | | | 42 | | | |
| Son | | | 0 | | | |
| Other | | | 19 | | | |
| Ethnicity or race | | | | | | |
| White | | | 64 | | | 64 |
| Non-White | | | 36 | | | 36 |
| Percent of CG and CR living together | | | 84 | | | |
| Education (years) | 14 | 2.3 | | 12.7 | 3.1 | |
| CG employed | | | 42 | | | |
| CR MMSE | | | | 23 | 3.9 | |
| Months since CG first noticed memory problems | 44 | 27.6 | | | | |
| Months since CG began assisting CR | 35 | 28.6 | | | | |
| Median income range (\$) | 20,000–29,999 | | | 10,000–10,999 | | |

Notes: EDDI = Early Diagnostic Dyadic Intervention; MMSE = Mini-Mental State Exam; CG = caregiver; CR = care receiver; *SD* = standard deviation.

care receiver was not required to have a formal diagnosis of dementia (one exception is subsequently described), but the care receiver did have to have symptoms consistent with an early-stage dementia or memory impairment (Alzheimer's disease, vascular dementia, etc). Care receivers who scored below 16 on the Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) were not eligible. Care recipients who scored 25 or higher on the exam (which may indicate normal aging; see Crum, Anthony, Bassett, & Folstein, 1993) also had to have a confirmed diagnosis consistent with dementia or memory impairment (e.g., mild cognitive impairment), including a thorough medical examination and neuropsychological testing. Although we used the MMSE score to determine care receiver eligibility, we used other factors regarding the care receiver's functioning to determine ability to participate; for example, some individuals with multiple chronic conditions were unable to participate because of the unpredictability and instability of their health and functioning.

Participant Characteristics

We originally recruited and enrolled 34 dyads in the EDDI program. Of these, 3 decided not to participate because of scheduling conflicts or the deteriorating health of one or both members. There were then 31 dyads enrolled in the program (see Table 2 for their sociodemographic characteristics). Of these 31 dyads, 22 (71%) completed six or more sessions and 20 completed all nine sessions. We considered these dyads to have received the full impact of the intervention ("completers"). The remaining 9 dyads attended fewer

than 5 sessions, and we did not consider them to have completed the intervention ("noncompleters"). EDDI sessions were delivered weekly or biweekly over an average period of 3 months (range 1.5 to 7.2 months). Comparing the completers with the noncompleters, we found only one statistically significant difference: Caregivers in the completer group were slightly older than those in the noncompleter group (65 years vs 54 years; $p < .05$). As a result of the relatively small sample size, the power to detect additional differences, including subgroup differences (such as kin subgroup differences), is limited.

Program Feasibility and Acceptability

Program feasibility answers the questions of whether the program's elements were successfully implemented and were acceptable to participants. Establishing these points is essential for understanding and interpreting future impact studies. We asked caregivers, care receivers, and counselors to complete evaluation forms after each session. The measures of feasibility and acceptability included (a) the number of sessions attended by the caregiver and care receiver and the amount of time spent in the EDDI program; (b) caregivers' and care receivers' ratings of treatment satisfaction to assess the acceptability of the intervention and ratings by caregivers of their counselor's effectiveness and enthusiasm; and (c) counselors' ratings of their own enthusiasm and effectiveness, and whether session goals were met.

Turning first to attendance, we find that the 31 dyads who enrolled in the EDDI program attended on average 6.93 sessions ($SD = 3.16$), spent an average of

72 minutes ($SD = 15.68$) in each session, and spent an average of 6.89 hours ($SD = 4.51$) total time in the sessions. Turning to the care partners' ratings of treatment acceptability, we find that data were available on 24 of the 31 dyads, who completed at least one of a possible nine session-evaluation forms (mean number of evaluations completed by caregivers and care receivers was 5.0 and 4.4, respectively). Caregivers answered eight items along a 7-point Likert scale, and care receivers answered four questions along a 3-point Likert scale. Items measured care partners' reactions to the intervention process such as quality and usefulness of the session material, quality of the session discussion, and whether session goals were met. Higher scores indicated higher levels of satisfaction with the session. In order to compare caregiver and care receiver ratings, we multiplied care recipients' responses by 2.3 and recoded them to be equivalent to the 7-point scaling used by the caregivers.

Caregiver ratings of treatment satisfaction across the nine sessions ranged from 6.01 to 6.45 out of a possible 7 points ($SD = 0.63$ – 0.80), whereas care receivers' transposed ratings of treatment satisfaction ranged from 6.62 to 7.00 ($SD = 0.00$ – 0.71). Overall, these ratings indicated that sessions were highly acceptable to both members of the dyad. Caregivers' ratings of counselor effectiveness and enthusiasm were also high, ranging from 6.25 to 6.88 ($SD = 0.35$ – 0.97). In qualitative comments, caregivers described counselors as having a warm and caring style, being able to get resistant care receivers to participate and engage fully in the sessions, and being highly knowledgeable about memory loss and appropriate services.

We asked the two EDDI counselors to rate (a) whether session goals were met; (b) the dyad's level of engagement and acceptance in the session; and (c) their own performance during the session. Counselors' ratings of whether session goals were met ranged from 4.67 to 5.71 out of a possible 7 points ($SD = 0.76$ – 1.00). Ratings for level of dyad's engagement and acceptability ranged from 4.56 to 5.25 ($SD = 0.73$ – 1.31), and the counselors' rating of their own level of enthusiasm and control of the sessions ranged from 5.21 to 5.59 ($SD = 0.59$ – 0.88). Although these ratings are slightly lower than the dyads' ratings, overall, these scores indicate that the counselors believed that session goals and the dyads' acceptability of the intervention process were consistently achieved throughout the EDDI intervention. In their qualitative comments, counselors noted it was first critical to build rapport and assume a nonjudgmental attitude with the dyad, and by the third session, the dyad was able to work more effectively together and with their counselor. Counselors also emphasized the importance of ensuring that both care partners felt listened to and part of the therapeutic process. This process was facilitated by the use of the intervention materials, notably the magnet board. Counselors indicated that, for care receivers, the process of the intervention (e.g., being listened to) was as important, if not more important, than adhering to the structured objectives of the session.

Discussion

We designed the EDDI program in response to the needs of early-stage families, on the basis of previous research suggesting that these families would benefit from a structured intervention that involved the person with dementia and dealt with care issues before the onset of significant stressors. In this feasibility and acceptability study, we found that dyads enrolled in the EDDI program successfully completed the full intervention and were highly satisfied. Likewise, counselors found the protocol useful and practical for early-stage dyads, the session length appropriate, and the research and intervention tools easy to use and helpful.

A number of factors may have contributed to the feasibility and acceptability of the intervention. First, sessions took place in participants' homes, which eliminated the barrier of travel to and from the program. One concern is that the home setting may present distractions to the dyad or counselor, although in our experience this was not the case. Another concern is that a home-based model may be cost prohibitive to many organizations that do not have staff available to travel to client's homes. However, it is not uncommon for social workers, counselors, and nurses within care-management agencies to make home visits. The EDDI program may be useful in these settings as well as in more traditional office or clinic settings. Second, the two counselors (i.e., a highly trained, experienced, and licensed social worker and counselor) received in-depth training about the EDDI protocol as well as ongoing supervision in the form of monthly face-to-face and telephone meetings. Their participation was critical to the successful implementation of the intervention and to establish a balanced and therapeutic relationship with the dyad. Counselors who would be most successful at achieving the goals and objectives of the EDDI program need to have a solid understanding of the needs and issues of older adults and individuals with dementia and memory loss, and they must be comfortable working with this population.

Throughout the intervention process, our research team encountered a variety of challenges that resulted in subsequent alterations of the protocol. First, some of our original tools, notably the Care Values Ladder worksheet, proved too challenging for people with memory impairment and required simplification (e.g., deleting the numbers, which distracted the care receivers). Similarly, some of the original domain names and related identifiers from the Care Values materials were too technical and also required simplification (e.g., replacing the word *autonomy* with *independence*). Furthermore, counselors found a significant overlap of materials in Sessions 4 and 5 and in Sessions 7 and 8. On the basis of their recommendation and acknowledgment that combining sessions would not result in a loss of content, we combined these two sets of sessions. This resulted in seven sessions, two fewer than the original protocol. In future applications, this may increase enrollment and completion rates. Finally, because only a few dyads completed the homework between sessions, we eliminated these materials.

Another modification is the addition of a pre-session

that would take place in the dyad's home before Session 1. In the present study, we enrolled dyads on the basis of the results of an initial telephone screening and an in-person interview conducted by a trained interviewer. The pre-session would serve three purposes: (a) to assess whether the intervention is appropriate for the dyad (i.e., whether the care receiver can actively participate or whether each has insight into the disease diagnosis), (b) to allow initially resistant dyads to try the initial session without committing to the full program, and (c) to gather information that would help tailor the intervention to the dyad's specific needs (e.g., demographic information, disease and diagnosis history, and types of help received currently). Information gathered would also include the care receivers' awareness of their diagnoses, terminology used to refer to the care receivers' memory problems, and areas of dyadic conflict or sensitivity. With this information, the EDDI counselors can begin to plan and modify the upcoming sessions on the basis of the dyads' existing care experiences.

A final consideration is the identification of dyads that would be best suited for the EDDI program. The dyad's larger family structure, organization, and dynamics were noted as important variables in understanding whether dyads were able to participate and engage fully in the intervention process. Counselors noted those dyads with multiple and competing demands or roles, and dyads in a continual state of crisis were less able to participate and engage in the EDDI program. A comparison of completers with non-completers revealed that dyads in which the caregiver was younger, and presumably a nonspouse (i.e., an adult child who might also have work obligations) were less likely to complete the full intervention. Counselors also noted that dyads with a "proactive" style were more fully engaged than those with a "reactive" style. Proactive dyads were better organized and able to focus on future care planning, whereas reactive dyads were more disorganized and focused on fulfilling basic and immediate needs (e.g., housing, child care, employment) rather than future needs. Further applications of the protocol might benefit from an assessment of these dyad-related characteristics (i.e., organizational level, proactive vs reactive status, extent of competing demands), which could help identify and target dyads that are best suited. Admittedly, this type of intervention does not appeal to all early-stage families.

With improved diagnostic procedures making it possible to detect Alzheimer's disease and other dementias reliably in the early stages, it is also possible to provide early intervention. The current study points to the feasibility and acceptability of an early-stage pro-

ocol that involves both the caregiver and the person with dementia in a one-on-one environment. Although the tested protocol was part of a study with a research focus, certain modifications as described herein would make it more feasible in real-world clinical settings. The potential impact and benefits of the EDDI program are also considerable, and an examination of program outcomes represents the next steps in advancing research on early-stage interventions.

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