Pepperdine University

Graduate School of Education and Psychology

SELF-COMPASSION BASED STRESS MANAGEMENT WORKSHOP FOR FAMILY CAREGIVERS OF INDIVIDUALS WITH ALZHEIMER'S DISEASE

A clinical dissertation submitted in partial satisfaction

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This clinical dissertation, written by

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VITA

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ABSTRACT

Family caregivers to individuals with Alzheimer's disease (AD) encounter significant stressors that have the potential to lead to deleterious physical and mental health effects. Research demonstrates that caregivers who lack coping skills to address the stressors of caregiving may have a negative impact on the health and well-being of individuals with AD. While there is a large array of interventions for caregivers that address tangible needs and skills of caregivers, such as learning about local resources, communication strategies, learning about the AD disease process, and others, interventions to build caregivers' internal stress-resilience are less common. As such, the purpose of this research project was to develop a resilience-promoting, culturally adaptable group-based psychological workshop for family caregivers of individuals with AD, with a particular focus on the development of self-compassion in the context of AD caregiving stress. In order to inform the development and content of the intervention manual, a literature review was conducted on existing resources and findings pertaining to the needs and challenges faced by caregivers. The intervention manual was also informed by caregiver input collected via naturalistic observation on public online forum posts. Four licensed mental health professionals with specialties in geriatrics and/or mind–body interventions evaluated the group intervention manual and provided feedback on strengths and areas for improvement. Feedback from providers and the dissertation committee was incorporated into a section of recommendations for future development of the intervention.

Chapter 1: Introduction and Literature Review

Americans are living longer than previous generations thanks to advances in medicine and improvements in social and environmental living conditions. In the near future, America's geriatric population will continue to rise dramatically, making up 20% of the total population by 2030, an increase from 14% in 2012 (Ortman et al., 2014). As such, it is important to assess and address the health challenge needs and the well-being faced by this large subset of the population.

Alzheimer's disease (AD) is among the leading diseases affecting America's aging population, and is currently the sixth leading cause of death and the most common form of dementia in the United States (Alzheimer's Association, 2016). AD places a tremendous burden on the patient and their family, and particularly challenges the large number of individuals who become informal caretakers of people diagnosed with AD. This dissertation reviews relevant literature to inform the development of a workshop intervention, which specifically addresses the needs of caretakers working with individuals suffering from AD. In particular, the following literature review presents foundational information about AD and caretaker burden and stress, before offering further research to provide a rationale for the development of a self-compassion based workshop to address caregiver stress and promote caregiver well-being.

Alzheimer's Disease

Alzheimer's Disease Basics

AD is a neurodegenerative disease characterized by a decline in memory, language, problem solving, planning, judgment, and orientation, among other neuropsychological skills, which affects an individual's capacity to perform activities of daily living (ADLs). Hallmark features of the disease include deficits in memory, learning, and naming. Neurological damage in

the brain caused by the accumulation of beta-amyloid proteins is most common in the parietal-temporal regions, including the hippocampus and surrounding cortical structures. Tau proteins, also known as tau tangles, located inside of neurons, are another contributor to neurological damage that is believed to contribute to the symptoms of Alzheimer's. The ongoing impairment to the brain's neurons eventually leads to an inability to perform not only daily tasks, but also essential functions of the body such as conversing, walking, and swallowing. Neuropsychological decline is also accompanied by a variety of neuropsychiatric symptoms, such as apathy, agitation, depression, and irritability (Srikanth et al., 2005).

While the onset of AD typically occurs between 40 and 90 years of age, most individuals develop the disease after the age of 65, at which point every 5 years the risk of AD increases by a factor of two (Cummings, 2004). Once an individual acquires the disease, it reduces their life expectancy by half (Desai & Grossberg, 2005). Alzheimer's is the fifth leading cause of death for individuals over 65 and the sixth leading cause of death in the United States (Xu et al., 2016).

Alzheimer's Disease Prevalence

AD impacts 11% of the population, with an estimated 5.4 million cases in the United States. Approximately 96% of those cases are attributed to individuals age 65 or above; meaning that one in nine people over the age of 65 has the disease. Eighty-one percent of people who have AD are over 75 years old and approximately one third of individuals over 85 have AD (Hebert et al., 2013). Overall, the prevalence of AD rises exponentially with age, from 5% in 65- to 74-year-olds to almost 50% in people over 80 (Desai & Grossberg, 2005). Current estimates are that approximately 13.2 million people will be diagnosed with AD by 2050.

In addition, research shows AD and dementia are under diagnosed and underreported. Only half of those who may meet the criteria for AD are diagnosed by a physician (Boustani et

al., 2003; Bradford et al., 2009; Kotagal et al., 2015). Half of the people who have AD or another diagnosis of dementia in their medical records report not being informed (Barrett et al., 2006; Campbell et al., 2008; Zaleta et al., 2012).

Current research reveals women are at greater risk of developing AD than are men. Of the 5.2 million Americans age 65 and older with AD, 3.3 million are women. Thus, nearly two thirds of Americans with AD are female (Hebert et al., 2013; Hebert, Beckett, et al., 2001). One study showed 16% of women and 11% of men over the age of 71 had AD or other dementias. Several possible theories account for this disproportion, including the predominant idea that because women tend to live longer than men, and older age enhances the risk for Alzheimer's, women are at a greater risk of developing the disease (Chene et al., 2015; Hebert, Scherr, et al., 2001). Lifestyle and life experience may be protective factors for reducing the risk of dementia. Educational achievement is a protective factor for AD (Sando et al., 2008), which may be relevant given that women born in the first half of the 20th century likely experienced greater barriers to higher education.

Genetics may be another factor, as the APOE-e4 genotype associated with AD may have a stronger connection with Alzheimer's in women than men (Altmann et al., 2014). Other evidence supports the idea that there may be an interaction between the APOE-e4 genotype and estrogen (Yaffe et al., 2000).

The prevalence of AD differs between various ethnic and racial groups as well. Minority ethno-racial groups may receive a delayed diagnosis and inadequate treatment (Chin et al., 2011), as well as experience variability in incidence, mortality, participation in clinical trials, and care, such as medication, long-term support and services, and other interventions (Lines et al., 2014). Research indicates that while more non-Hispanic Whites are living with AD and other

dementias, some evidence suggests that older African Americans and Hispanics are more likely to actually have AD (Chin et al., 2011). Reasons for these disparities include racial biases inherent in cognitive screening tools, socioeconomic disparities, issues of trust between minority groups and the medical establishment, biological risk factors such as genetics and cardiovascular disease (Chin et al., 2011), and cultural differences, including a lack of culturally competent clinicians and discrimination (Lines et al., 2014).

Beyond challenges within the medical setting, individual barriers to treatment likely play a role in accuracy of the disease's prevalence. One self-reporting study revealed that out of the 11% of Americans age 45 and older who experienced increasing confusion or memory loss, only 24% had consulted a health care professional about their symptoms (Alzheimer's Association, 2016). Thus, it is important to note that even statistics on disease prevalence may underestimate the impact of AD on U.S. society and the possible burgeoning crisis regarding the need for care, given the imminent dramatic growth of the geriatric population.

Alzheimer's Disease Caregiving

The number of older individuals in the United States is increasing, suggesting an upsurge in chronic illnesses such as AD among the elderly, family involvement in caregiving will also continue to rise. In 2012, approximately 15.4 million Americans provided an estimated 17.5 billion hours of unpaid care work for people living with dementia (Thies & Bleiler, 2013).

Life expectancy after the diagnosis and onset of AD is, on average, 4 to 8 years, though some individuals may live as long as 20 years with AD (Brookmeyer et al., 2002; Larson et al., 2004). While the course of the disease may vary, it is estimated that a given individual with the disease spends approximately 40% of the duration of their state in the severe stage (Arrighi et al.,

2010). The long duration of AD is why an Alzheimer's patient requires significant assistance throughout the disease's course.

Caregiving for an individual with AD in earlier stages requires assistance in instrumental activities of daily living (IADLs), such as overseeing bills, transportation, shopping, managing medications, home organization, cooking, and aiding with behavior and mood management. As an individual with AD declines, assistance with ADLs becomes more prevalent, including dressing, going to the toilet, grooming, feeding, bathing, and general ambulation. While entering a professional medical caregiving facility is common, a significant amount of care is provided by unpaid, informal caregivers. It has been estimated that over 15 million Americans provide unpaid care for individuals with AD and other dementias (Alzheimer's Association, 2016) while only a small amount, approximately 8%, of individuals with dementia do not receive help from informal care providers (Kasper et al., 2015). Reasons for choosing to provide informal care to an individual with AD include the desire to keep a family member or close person in the home (65%), proximity to the person with dementia (48%), and the caregiver's perceived obligation as a spouse or partner (38%; Alzheimer's Association, 2016).

When analyzing who provides caregiving, a comprehensive study by the Alzheimer's Association (2016) reported that approximately one third of Alzheimer's and dementia caregivers in the United States are 65 or older, and over two thirds are married, live with a partner, or are in a long-term relationship. Approximately two thirds of caregivers and care recipients live together, and nearly a quarter of caregivers are responsible for both an aging parent and children under the age of 18 years. Over 40% of caregivers have a college degree, while 41% of caregivers have a household income of $50,000 per year or less. Approximately 44% of caregivers retain at least part-time employment.

Ethno-racial demographics reveal that more than two thirds of caregivers are non-Hispanic White, 10% are African American, 8% are Hispanic, and 5% are Asian American (Alzheimer's Association, 2016). However, some research exposes that the distribution of minority group caregivers varies between studies and is limited due to low inclusion rates of non-White caregivers. However, Hispanic and non-Hispanic African American caregivers experience a higher burden of caregiving and spend more hours per week providing care than do non-Hispanic White and Asian American caregivers (MetLife Mature Market Institute, 2006).

There appears to be a burden of caregiving that falls upon women, given that varying estimates state that women make up approximately two thirds of dementia caregivers (Alzheimer's Association, 2016; Richardson et al., 2013). Female caregivers spend more time providing care than do male caregivers; one estimate revealed that on average, daughters provide 102 hours of care per month whereas sons provide only 80 hours of care per month (Kasper et al., 2015). Wives provide informal care for their spouses more commonly than their husbands (Alzheimer's Association, 2016).

Alzheimer's Disease Caregiver Strain and Stress

Strains of Caregiving. Providing care for an individual with AD adds strain and stress to one's life. The caregiving experience causes a burden due to the more tangible limitations of one's time, a change of roles, interference with work, and finances. According to a review by the MetLife Study of Alzheimer's Disease (MetLife Mature Market Institute, 2006), AD caregivers provide an average of 47 hours of care each week. This amount of time would surely have an impact on an individual's capacity to fulfill their other roles and needs, whether personal, occupational, social, and/or self-care. Caregivers must also constantly learn to manage changes

in their patient's needs as the disease progresses, such as alterations in mood and personality, new behavioral disturbances, and the patient's ability to communicate.

Providing adequate care for an individual with AD comes with significant costs, which are taxing on society, families, and the caregiver. Previous estimates in the United States for the cost of care for an individual with AD, including medical and long-term care, as well as home care and lost caregiver productivity, was approximately $100 billion (Small et al., 1997). Later estimates stated that the cost per individual was roughly $18,408/patient per year for someone with mild AD; $30,096/patient per year for moderate AD; and $36,132/patient per year for severe AD (Leung et al., 2003). A separate and more recent study reported that the total average cost of services, including paid and unpaid care, was $77,337, of which $43,066 was attributed to family caregivers and $34,381 to paid services (MetLife Mature Market Institute, 2006).

The function of caregiving will impact the other roles and responsibilities in the caregiver's life. Approximately 10.6% of AD spousal caregivers reported leaving their job to provide care, and nearly all working family caregivers described changing their work schedule (MetLife Mature Market Institute, 2006). The compounded pressures of time and financial strain impact caregivers and their families and leave them at risk for greater levels of stress.

On average, AD and other dementia patient caregivers for provide care for more years than do other types of caregivers. Many continue to assist the care recipient even after they have been moved to an assisted living or nursing facility. Of care recipients residing in an assisted living community, 38% of family caregivers provided care for over 6 years (Kasper et al., 2015).

Risks to Caregiver. Providing care for an individual with AD has been associated with significant risks to the caregiver's health and well-being. Given that chronic stress is the most deleterious to health (McEwen & Stellar, 1993; Thoits, 2010), it is imperative to understand the

risks specific to caregivers. Existing research suggests that the physical health of a caregiver may be compromised when the caregiver becomes psychologically distressed (Pinquart & Sörensen, 2007; Schulz & Beach, 1999; Schulz & Martire, 2004). One study reported that stress rose 13.5% when caring for an individual with AD and that 32% of caregivers indicated their health became worse because of caregiver strain (MetLife Mature Market Institute, 2006). Emotional stress on caregivers has proven to be greater on women and significantly associated with older age, greater caregiving burden, and more functional impairment and behavioral symptoms in the patient (Jennings et al., 2015; Kim & Schulz, 2008). Greater levels of caregiver strain are also linked to worse outcomes for individuals with dementia, including higher rates of patient placement in nursing homes (Gaugler et al., 2009).

Stress experienced by the caregiver has the potential to negatively impact physiological well-being and physical health. Dementia caregivers are more likely to report poor and worsening health due to caretaking, as well as difficulty with health maintenance (Alzheimer's Association, 2016). Compared to non-caregivers, they have an increased risk of experiencing high levels of stress hormones (von Kanel et al., 2006), reduced immune function (Kiecolt-Glaser et al., 1991), developing cardiovascular disease (Mausbach et al., 2010; Vitaliano et al., 2002), and even mortality for caregivers under the highest levels of stress (Fredman et al., 2010; Schulz & Beach, 1999). Recent research has also demonstrated that elevated levels of perceived stress are associated with an increased 30% risk of amnestic mild cognitive impairment (Katz et al., 2016).

Negative mental health outcomes are also connected to AD and dementia caregiver stress, though caregiver mental health is often insufficiently addressed (Richardson et al., 2013). Fifty-nine percent of family caregivers of people with AD and other dementias rated their

emotional distress due to caregiving as high or very high (Alzheimer's Association, 2016). The stress experienced by AD caregivers put them at greater risk for worse mental health outcomes such as depression (Richardson et al., 2013), and higher stress levels are associated with increased depressive symptoms (Wimo et al., 2013). One study revealed one in seven dementia caregivers demonstrated symptoms associated with moderate to severe depression (Jennings et al., 2015), while another found that spouses caring for dementia patients were four times more likely to experience depression than were non-caregivers (Joling et al., 2010). Further research estimates that approximately 40% of family caregivers suffer from depression (Pinquart & Sörensen, 2003; Schulz & Martire, 2004), which may increase along with the severity of the patient's cognitive impairment. Low levels of self-efficacy for dementia caregiving have been correlated with higher levels of strain, more depressive symptoms, and lower self-rated health assessments (Jennings et al., 2015).

Caregiver Burden

Many definitions of caregiver burden can be found in the existing literature. Caregiver burden can be understood as a multidimensional construct that incorporates multiple types of caregiver struggles, including finances, physical capacities, psychological or emotional distress, and social well-being (Ankri et al., 2005). A simpler definition, though, is the "subjective assessment of stress and anxiety which may result from the perception that external caregiving demands exceed available resources" (Werner et al., 2012, p. 1836). Risk factors for caregiver burden include being female, being of advanced age, a decreased emotional state and poor physical health, caregiver depression, caregiver stigma, a poor current relationship with the care-recipient, low intrinsic motivation, high extrinsic motivation, decreased quality of life, the

number of hours spent providing care, low income, low self-efficacy, and coping mechanisms (Richardson et al., 2013).

Interventions for Caregivers

Interventions to address caregiver needs have been developed, many of which focus on teaching caregivers behavioral management strategies, enhancing caregiver social support, and providing respite (Jennings et al., 2015). A meta-analysis by Sörensen et al. (2002) revealed that such interventions are, on average, successful at alleviating burden, depression, and general subjective well-being. Their findings suggested interventions for caregivers may be more effective if they were to focus more on influencing the affective aspects of caregiving. Another meta-analysis of evidence-based caregiver interventions in geriatric psychiatry (Schulz et al., 2005) went further by suggesting caregiver interventions might benefit from shifting the focus away from physical and organizational challenges and toward less tangible sources of distress. In particular, they asserted that a previously unexamined factor that should be explored is the caregiver's perception of the patient's suffering, such as their psychological distress, physical discomfort, and pain, and the idea that little or nothing can be done about it. They proposed that this approach may provide an avenue that "get(s) at the heart of the caregiving experience" (Schulz et al., 2005, p. 1034).

Self-Compassion

About Self-Compassion

At the heart of centuries-old Buddhist philosophy is how to engage and alleviate human suffering (Hahn, 1998). Also found within ancient Buddhist teachings is the concept of self-compassion, though only appearing recently in psychological literature introduced by Neff (2003a, 2003b). In her work, she described the construct of self-compassion and provided

information about a self-reporting inventory that measures an individual's tendencies to be self-compassionate. She stated self-compassion involves being open to and moved by one's own suffering, experiencing feelings of caring and kindness toward oneself, exercising an understanding and non-judgmental attitude toward one's inadequacies and failures, and recognizing that one's personal experience is part of the common human experience (Neff, 2003b). As such, the construct of self-compassion consists of three primary features: self-kindness, common humanity, and mindfulness; converse features include self-judgment, isolation, and over-identification (Neff, 2003b).

Self-Compassion Based Intervention Research

Numerous researchers have explored the benefits of using self-compassion when confronting suffering, demonstrating that it has the capacity to promote positive mental health outcomes. A review of self-compassion conceptualizations, correlates, and interventions highlighted that greater self-compassion is associated with lower levels of depression and anxiety (Barnard & Curry, 2011). Numerous studies have also shown there are relations between self-compassion and positive psychological qualities such as happiness, optimism, wisdom, curiosity and exploration, personal initiative, and emotional intelligence (Heffernan et al., 2010; Hollis-Walker & Colosimo, 2011; Neff, Kirkpatrick, et al., 2007; Neff, Rude, et al., 2007). Self-compassion has also been demonstrated to moderate people's reactions to negative events (Leary et al., 2007), and training in self-compassion has been shown to increase self-compassion, mindfulness, life satisfaction, social connectedness, optimism, and self-efficacy (Breines & Chen, 2012; Neff & Germer, 2013; Neff, Kirkpatrick, et al., 2007). Finally, practicing self-compassion for even a brief period of time has been demonstrated to produce sustainable mental health changes (Shapira & Mongrain, 2010). Specifically, one pilot study showed a daily practice

of compassionate letter writing about distressing events experienced over the course of a week resulted in significant reductions in depression for up to 3 months as well as noteworthy increases in happiness for up to 6 months when compared to the control group (Shapira & Mongrain, 2010).

Self-Compassion and Mind-Body Interventions for Caregivers

As previously stated, demographic studies have shown the majority of caretakers for individuals with AD, as well as caretakers who experience greater caregiving burden, are aging female partners or daughters. Assessing whether or not the concept of self-compassion is an appropriate fit for the aging population is important. As such, Allen et al. (2012) examined the role of self-compassion on well-being as individuals age. Their findings revealed self-compassion was predictive of positive responses to aging, providing evidence for the encouragement of practicing self-compassion as a manner to improve well-being in older age.

There is a body of research (Cash et al., 2016; Franco et al., 2010; Innes et al., 2012; Jain et al., 2014; Lavretsky et al., 2013; McBee, 2003; Oken et al., 2010; Paller et al., 2015; Waelde et al., 2004; Whitebird et al., 2013) that demonstrates the utility and positive impact of mind–body or contemplative practices for stress alleviation, including studies applying meditation, mindfulness, and yogic-based psychosocial interventions for caregiver strain and burden. One investigation demonstrated the feasibility of the utilization of a modality called Central Meditation and Imagery Therapy for family caregivers of individuals with dementia, revealing it could reduce symptoms of anxiety, depression, and insomnia, as well as increase levels of mindfulness (Jain et al., 2014). Another study examined the effects of a brief daily yogic meditation ritual on mental health, cognitive functioning, and immune cell telomerase activity in family dementia caregivers with mild depressive symptoms (Lavretsky et al., 2013). Their

findings showed improvements across measures of mental health, cognitive function, psychological distress, and telomerase activity, which demonstrates the intervention's capacity to impact the biological stress response. It also established that a low-cost behavioral intervention has the capacity to positively affect a caregiver's coping abilities and quality of life.

Innes et al. (2012) investigated the effects of an 8-week meditation program consisting of two daily 11-minute meditation sessions on perceived stress, sleep, mood, and related outcomes in individuals with mild cognitive impairment or early-stage AD as well as their caregivers. Their findings revealed improvements in perceived stress, mood, sleep, retrospective memory function, and blood pressure. Franco et al. (2010) researched the effects of a mindfulness development program on the psychological discomfort and overload in primary family caregivers of AD patients, reporting a decrease in psychological distress and caregiver burden.

These studies present a mere glimpse of the deep body of research on the benefits of interventions using mind–body and contemplative practices to support caregivers. It is important to narrow the focus and examine the specific research on self-compassion related to caregiver stress and burden. While it falls under the umbrella of mind–body and contemplative practices, it is less-used construct, or at least one that is discussed less explicitly in current literature. Danucalov et al. (2013) investigated the effects of practicing yoga in combination with compassionate meditation on the quality of life, attention, vitality, and self-compassion of AD patients' family caregivers. The research data resulting from their 8-week intervention indicated improvement in all areas and provided evidence for the value of self-compassion for family caregivers of individuals with AD and other dementia.

Resilience and Stress Management

About Resilience

Resilience has been reviewed in various ways in the psychological literature. One manner of examination included an emphasis on trait resilience, comprising the ability to steer through, overcome, or bounce back from adversity (Block & Kremen, 1996; Windle et al., 2010). Bonanno (2004) argued that resilience is "the ability to maintain a stable equilibrium" (p. 20). More recent work has demonstrated positive emotions are a critical component of resilience (Tugade & Fredrickson, 2007; Tugade et al., 2004) wherein positive emotions are said to contribute to adaptive benefits in the coping process (Folkman & Moskowitz, 2000; Tugade et al., 2004). Further study of resilience has focused on the connection between psychological resilience and community and social resilience (Wiles et al., 2012). As part of a systematic review and analysis, Windle (2011) defined resilience as:

> The process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate the capacity to adapt and "bounce back" in the face of adversity. Across the life course, the experience of resilience will vary. (p. 163)

Bennett (2010) operationalized resilience with the following criteria: viewing one's current life positively, actively participating in life, returning to or maintaining a life that has meaning or satisfaction, being able to cope, and not feeling distressed. Zautra et al. (2010) provided a theoretical framework for resilience that encompassed many theoretical ideas of the construct, expressing that resilience includes three distinguishable and often overlapping components: *recovery*, or the return to baseline after a major stressor; *sustainability*, or the ability to progress

forward without disruption; and *growth*, or an enhanced adaptation beyond the original levels of functioning.

A meta-analysis (Lee et al., 2013) identified psychological factors associated with resilience, separating them into two broad categories. The first, risk factors, are associated with increased maladaptation and include depressive symptoms, severe anxiety-related impairments, and high stress levels. The other category includes protective or promotive factors, which enhance adaptation. This refers to life satisfaction, optimism, positive affect, self-efficacy, self-esteem, and social support. Their results implied that resilience could be part of a process that protects against anxiety, depression, posttraumatic stress disorder, and other psychiatric disorders. Further, they asserted that resilience is strongly associated with positive affect and optimism, which also positively correlate with self-efficacy and self-esteem. Additionally, they asserted that their results indicate that to improve resilience, a focus on increasing protective factors is more effective than reducing risk factors.

Resilience in Alzheimer's Disease Caregiving

Investigations of resilience in the lives of AD caregivers began to emerge in the late 1990s with an examination of the relationship between caregiver resilience and their coping skills (Garity, 1997). In a study of the relationship between stress level, learning style, resilience factors, and coping strategies among participants in 11 support groups, Garity's (1997) findings demonstrated caregivers with higher resilience were effective in employing coping mechanisms that focused on the positive aspects of caregiving. Other explorations of inferred resilience in AD caretaking reported protective factors connected to lower stress, including confidence in caregiving, problem solving skills, a strong sense of religion or spirituality, and social support (Garity, 2006). Later research explored the relationship between resilience and coping behaviors

and found caregivers who were considered more resilient had a greater ability to distance themselves from their caregiving role for intervals of time significant enough to participate in physical exercise, engage in hobbies, and experience periods of joy and laughter (Ross et al., 2003). Another study demonstrated the implications of high resilience in caregivers, finding a link between the decision to continue providing in-home care as opposed to placing the patient in a nursing home (Gaugler et al., 2007). An additional analysis revealed that as caregiver resilience increased, caregiver burden decreased (Scott, 2013). Finally, a study of family resilience linked social support, positive communication patterns, acceptance, optimism, family hardiness, family connectedness, and the effective management of symptoms as facilitators of the resilience process (Deist & Greeff, 2015).

Understanding the utility of resilience in caregivers is important. A systematic review of caregiver resilience of people with dementia found that higher levels of resilience were associated with lower rates of depression, better physical health, a lower sense of burden, lower stress levels, lower neuroticism, and greater perceived control (Dias et al., 2015). The findings also revealed social support was a moderating factor, relieving feelings of physical and mental overload caused by stress.

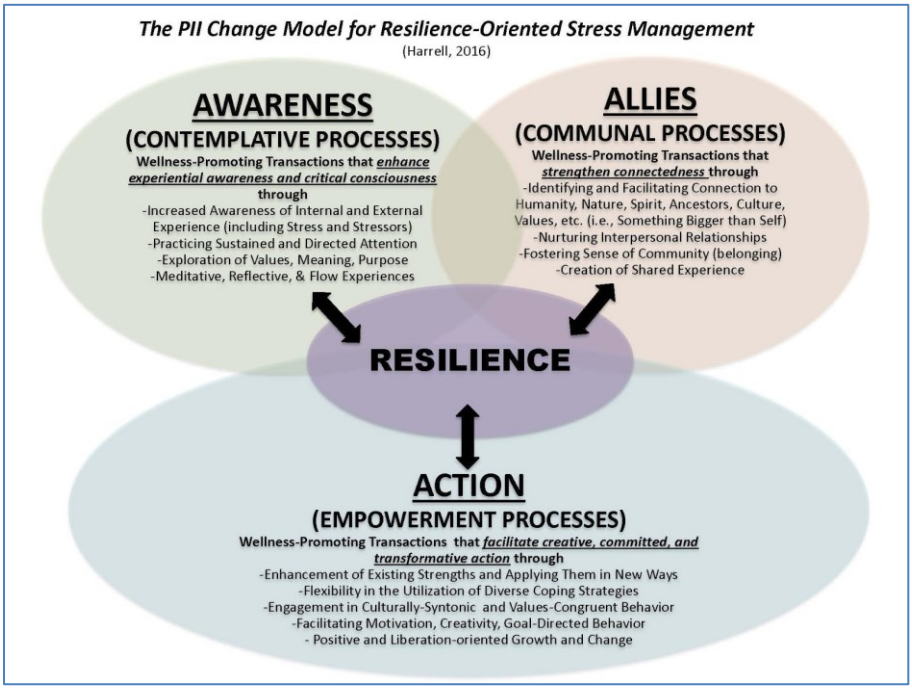
Harrell's Resilience and Reconnection Stress Management Group

Given that resilience is a concept that is sometimes seen as a protective mechanism that enables people to thrive in the face of adversity, improving resilience may be an important objective for treatment and prevention (Davydov et al., 2010), particularly in the context of chronic stress (Schetter & Dolbier, 2011). One model that targets this is the Resilience and Reconnection (R&R) stress management group intervention (Harrell, 2020). This group intervention is informed by a resilience-based, wellness-model approach to stress management.

The R&R group model is grounded in Person-Environment-and-Culture-Emergence (PEaCE) Theory (Harrell, 2015), which is an integrative approach to conceptualizing individual and collective wellness outcomes, including the transactional field of "Person-in-Culture-in-Context" (Harrell, 2015). The R&R approach emphasizes "cultivating, enhancing, and sustaining strengths and ways-of-being (positive adaptations) that promote culturally-syntonic stress resilience" (Harrell, 2020, p. 5). As such, this framework provides the capacity to address current stress management and important cultural and contextual factors, while also providing for prophylaxis to mitigate future stress and encourage greater well-being. This resilience-building intervention serves to mitigate stress by focusing on the amelioration of stress and increasing a sense of well-being, protection by way of building internal and external strengths and resources, and transformation by facilitating change and promoting one's ability to thrive (Harrell, 2020). Stress resilience is grounded in a model of change that uses contemplative, communal, and empowerment processes that serve as wellness-promoting transactions. The figures below demonstrate the model of change (see Figure 1) and the PEaCE-Based Stress and Resilience Framework (see Figure 2).

Figure 1

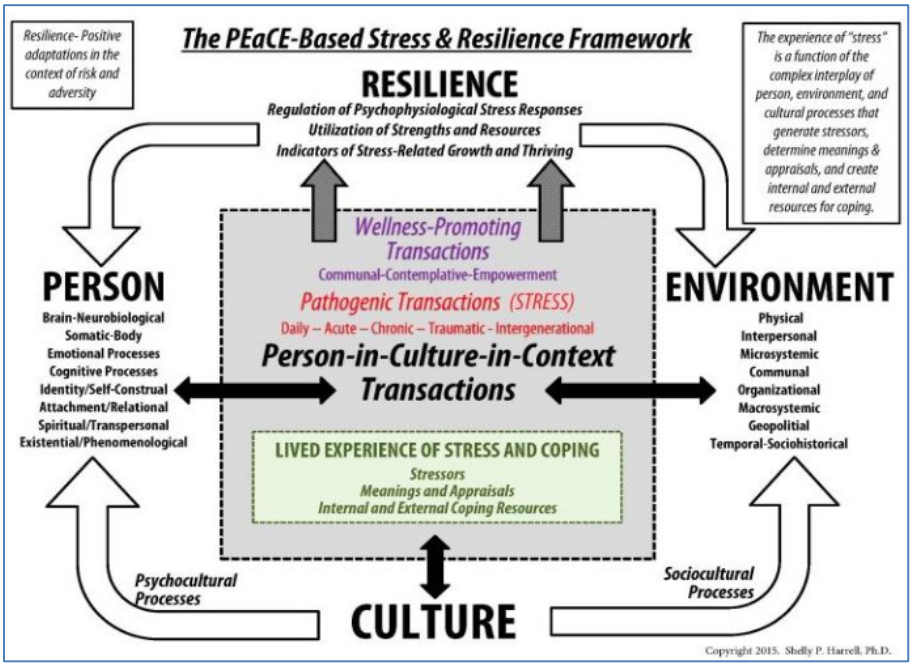
The PEaCE-Informed Interventions (PII) Change Model for Resilience-Oriented Stress Management



Note. From *Training Manual for the Resilience and Reconnection Stress Management Group*, by S. P. Harrell, 2020. Reprinted with permission from the author.

Figure 2

The PEaCE-Based Stress & Resilience Framework



Note. From "Culture, Wellness, and World 'PeaCE': An Introduction to Person-Environment-and-Culture-Emergence Theory," by S. P. Harrell, 2015, *Community Psychology in Global Perspective*, *1*(1), p. 27 (https://doi.org/10.1285/i24212113v1i1p16). Copyright 2015 by ESE Salento University Publishing. Reprinted with permission.

Summary and Rationale for Proposed Project

A review of existing literature showed family caregivers of individuals with AD experience significant stress due to the burden of their caretaking duties, financial preoccupation, changing personal and life roles, physical limitations, and sleep disturbances, among other issues (Alzheimer's Association, 2016; MetLife Mature Market Institute, 2006). These strains have been associated with significant risks to the caregiver's health and well-being, including physiological correlates of stress, such as increased stress hormones (von Kanel et al., 2006), reduced immune function (Kiecolt-Glaser et al., 1991), the development of cardiovascular

disease (Mausbach et al., 2010; Vitaliano et al., 2002), and increased mortality (Fredman et al., 2010; Schulz & Beach, 1999; Schulz et al., 2005), in addition to psychological implications such as depression (Jennings et al., 2015; Joling et al., 2010; Pinquart & Sörensen, 2003; Richardson et al., 2013; Wimo et al., 2013). Recommended interventions that address the affective needs of caregiving are recommended, specifically those that focus on the relatively under-examined concept of how a caregiver experiences their patient's suffering (Schulz et al., 2005; Sörensen et al., 2002). Several studies using self-compassion and similar contemplative practices of meditation, mindfulness, and yogic-based interventions to address caregiver stress and burden have demonstrated the capacity to positively impact coping mechanisms, quality of life, mood symptoms, perceived stress, and/or caregiver burden (Danucalov et al., 2013; Franco et al., 2010; Innes et al., 2012; Lavretsky et al., 2013; Waelde et al., 2004). The following project was designed to add to this body of literature by developing an intervention approach to caregiver stress. This resilience-based approach to stress management focuses on the application of self-compassion, providing caregivers with tangible tools to employ in an ongoing manner to ameliorate stress levels and enhance well-being.

Chapter 2: Methodology

In response to the ongoing demand to address the needs of family caregivers of individuals with AD, this dissertation study involved the development of a 1-day workshop for family caregivers of these individuals. This chapter describes the methodology used to create a 1-day, compassion-based stress management workshop for family caregivers of individuals with AD.

This study was conducted using a program development methodology with the main purpose of providing a workshop that will support the needs of family caregivers. The study's first phase included an extensive review of the existing literature, research studies, and stress management interventions using self-compassion or contemplative practices, which informed the creation of the 1-day stress management workshop. The second phase of the study involved obtaining information to inform the current literature about caregiver stress, burden, coping strategies, and self-compassion in the context of AD caregiving via the collection of public, personal online posts by caregivers. The third phase of the study integrated the data with the development of the workshop's Intervention Manual (IM). The fourth and final phase evaluated the workshop's curriculum by a panel consisting of four individuals: three mental health professionals with expertise in geriatrics, including working with family caregivers of individuals with AD, and one clinician with experience in mind–body contemplative practices.

This 1-day workshop includes the following components: psychoeducation, stress reduction strategies, skill-building exercises, prevention techniques, and resources for further learning and practice. The workshop draws upon primary components of Harrell's (2020) R&R stress management group intervention. While the R&R model is designed to be an ongoing, 90- to 120-minute, 12-session intervention focused on up to 25 optimal health and wellness themes

(OHWTs), self-compassion (or compassion in a broader sense) is among these themes. As such, this workshop's framework was formatted as an expanded full-day modification of Harrell's R&R individual session format, including (a) *Connection* (facilitating connection to the group goals and to other participant), (b) *Centering & Learning* (focused meditation and psychoeducation), (c) *Experiencing & Sharing* (movement, group activity, group sharing), (d) *Empowering and Committing* (skills training and planning), and (e) *Closing*.

The workshop is designed to enhance any or all aspects of the construction of self-compassion, including self-kindness, common humanity, and mindfulness. Given the overlapping areas of literature regarding caregiver burden and research demonstrating the utility of self-compassion, this workshop may also mitigate caregiver stress, strain, and burnout; increase coping mechanisms; and promote positive factors of wellness. Further, while the scope of outcomes for a 1-day workshop may be limited, the literature suggests the ongoing practice of self-compassion may have an impact in decreasing symptoms and behaviors related to depression, alleviating feelings of isolation, easing emotional strain and enhancing self-efficacy with regard to suffering, and increasing the caregiver's overall well-being.

Development of the Workshop's Curriculum

Phase One: Review of Existing Literature and Resources

The development of this 1-day workshop training focused largely on the use of an extensive literature review. Literature was gathered from a wide variety of sources, including internet databases such as Psych INFO, WorldCat, Article first, Wiley Online Library, EBSCOHOST databases, and PsycARTICLES, among others. In addition, further information was compiled from national organizations such as the American Psychological Association (APA) Div. 12-II – Society of Clinical Geropsychology, the American Psychological

Association (APA) Division 20 – Adult Development and Aging, Alzheimer's Association, Family Caregiver Alliance, National Alliance for Caregiving, Rosalynn Carter Institute for Caregiving, and self-compassion.org. The literature review focused primarily on the stress experiences of family caregivers of individuals with AD and mind–body based or contemplative interventions. More specifically, keyword searches included various combinations of the following terms: *Alzheimer's disease*, *dementia*, *aging*, *caregiver*, *stress*, *caregiver strain*, *caregiver burden*, *caregiver burnout*, *compassion fatigue*, *stress management*, *compassion*, *self-compassion*, *well-being*, *resilience*, *mind–body*, *contemplative practice*, *meditation*, *mindfulness*, and *yoga*.

An additional narrowed search was performed with a focus on compassion interventions among the aging population, and compassion, mind–body, or contemplative interventions for caregivers. Descriptive information was compiled pertaining to the strains of caregiving, effects of caregiver stress, caregiver strain interventions, and self-compassion based interventions. This comprehensive literature review was essential in providing supporting evidence for a self-compassion based intervention for caregivers.

Phase Two: Caregiver Input

In order to gain more potential information about the experience of stress, caregiver burden, well-being, adaptive coping responses, and self-compassion in the context of AD caregiving, qualitative information was collected from publicly-accessible online data posted by current and/or former caregivers. These data were composed of information on public internet pages from posts by individuals who self-identified as current or past informal caregivers of an individual with AD. The specific posts considered had a particular focus around stress as a result of caregiving. Data were collected via naturalistic observation with a focus on viewing and

collecting descriptive information provided by informal AD caregivers. This included, but was not limited to, websites such as online forums, chat groups, and comment sections focused on the topic(s) of AD, dementia, aging, caregivers, caregiver stress, caring for the caregiver, mindfulness and meditations for caregivers, and more. The researcher reviewed the posts' content to inform development of intervention's subject matter to ensure that it meets the needs of the target population. The review of public posts was for the sole purpose of a general needs assessment to develop the workshop intervention content. The information collected was then reviewed by the researcher, noting common themes regarding challenges faced by caregivers, as well as coping methods used that may relate to the workshop's main themes. This content aided in the development of the workshop intervention's curriculum.

Phase Three: Data Integration and Workshop Development

Upon the completion of extensive searches of existing literature and a thorough review of public online posts, the third phase focused on data integration and workshop development. This included synthesizing and organizing the information collected to inform the curriculum development for the 1-day workshop. The format and structure of this workshop's IM consist of text, visual aids, and handouts.

The curriculum structure is organized into the following sections: (a) *Introduction and Connection* – facilitating connection to the group's goals and to other participants; (b) *Centering and Learning* – focused meditation and psychoeducation; (c) *Experiencing and Sharing* – movement, group activity, and group sharing; (d) *Empowering and Committing* – skills training and planning; and (e) *Closing*.

Section 1: Introduction and Connection. Section 1 of the curriculum introduces the workshop's objectives and the rationale behind its development. It incorporates an overview of

the workshop and also addresses any questions. Herein, basic foundational information relevant to proposed attendees is provided, such as the workshop's premise and intent. As an ice-breaker, the workshop facilitator begins with introductions and a group activity in order to promote cohesion amongst participants.

This segment provides a check-in, or an opportunity for participants to explore and share their experiences of stressors. Attendees are invited to discuss their current methods of coping with stress. This sharing aims to further enhance a cohesive group environment for the participants.

Section 2: Centering and Learning. In section 2, the focus moves toward further exploring caregiver stress or burden and the concept and practices of self-compassion. This section begins with a focused or centering meditation. The facilitator leads the centering activity, which introduces the aspect of mindfulness and a state of focused attention and calm, followed by group sharing about this experience. Next, the workshop facilitator provides psychoeducation about basic definitions and factors that contribute to caregiver burden, as well as stress and its potential deleterious effects. This is followed by exercises intended to provide experiential understanding of self-compassion in caregiving, as well as a case vignette to highlight the possible use of self-compassion. These practices deepen the understanding of the multifaceted concept of self-compassion and provide an exploration of resilience and wellness promotion.

Section 3: Experiencing and Sharing. The third section begins with a mindfulness practice or movement exercise. Following, the group facilitator leads an interactive activity and group members are able to share their experiences and struggles related to the theme of caregiver burden and self-compassion. Finally, the group facilitator leads a caregiver breathing practice.

Section 4: Empowering and Committing. In this section, participants engage in an additional review and reflection on what they have learned. Caregivers are then introduced to ways in which they can continue to incorporate ongoing engagement of self-compassion, explore possible barriers, and make and share commitments to their future practices.

Section 5: Closing. The workshop's concluding segment consists of a final process of reflection as well as a consideration of the information provided. Resources are offered to participants for the further exploration of self-compassion experiences to aid them in their caregiving experience. The workshop ends with a final self-compassion exercise.

Phase Four: Workshop Evaluation

This closing phase included an evaluation of the workshop's curriculum by a panel of three individuals: two mental health professionals (clinicians and/or researchers) with expertise in geriatrics, including collaboration with family caregivers of individuals with AD, and one clinician/researcher with experience in mind–body contemplative practice interventions (see Appendix B: Evaluation of Curriculum Form). The focus of this form was on the applicability, cohesion of content, usefulness, and effectiveness of the workshop.

The following describes the inclusion criteria used to choose evaluators. Given that this workshop had two specific foci—caregivers for individuals with AD and self-compassion—participating expert evaluators were sought in those two primary areas.

Geriatric Mental Health Experts. Participating geriatric mental health professionals met the following criteria: (a) a licensed psychologist, LCSW, MFT, LMHC, or equivalent; (b) a minimum of 5 years of clinical and/or research experience with the geriatric population; and (c) had a general understanding of the stressors experienced by caregivers of individuals with AD and/or other dementias.

Mind–Body or Contemplative Practice Experts. Participating mental health professionals with experience in the mind–body or contemplative practices met the following criteria for inclusion: (a) a practicing licensed psychologist, LCSW, MFT, LMHC, or equivalent; and (b) had a minimum of 5 years of experience leading and/or researching mind–body or contemplative practices. For this second inclusion requirement, search and recruitment criteria attempted to target an individual with clinical and/or research experience specific to self-compassion, then secondarily to compassion. However, given the specificity of the practice and limitation of its scope among active licensed mental health clinicians, general mind–body or contemplative practice experience was accepted.

Recruitment Strategies and Procedures. Inclusion criteria, as previously discussed, guided the targeting and recruitment of expert evaluators for this 1-day workshop. Prior to contacting potential participants, approval from the Institutional Review Board (IRB) was obtained (see Appendix C: IRB Approval Notice). Mental health professionals were located through professional contacts, organizations, and special interest groups (e.g., Massachusetts Psychological Association, Institute for Meditation and Psychotherapy, Association for Contextual Behavioral Science – Aging Special Interest Group, Association for Contextual Behavioral Science – Compassion Special Interest Group, etc.). Internet searches were employed as well (e.g., revisions of university faculty listings, authors working on related research investigations, LinkedIn profiles, Psychology Today, etc.). The author sent an email to selected individuals or to listservs to describe the workshop and its rationale (see Appendix D: Evaluator Recruitment Email Script and Appendix E: Evaluator Recruitment – Email to Listservs and/or Professional Groups) and to invite these professionals to participate. Another script was

developed for a social media posting (see Appendix F: Evaluator Recruitment – Social Media Post), but was not used in the end.

Six professionals with interest in participating were then sent a brief questionnaire to assess their eligibility based on the aforementioned inclusion criteria (see Appendix G: Evaluator Eligibility Form). All individuals confirmed as suitable and potential evaluators were then sent an email (see Appendix H: Qualified Evaluator Email) along with three items: (a) informed consent (see Appendix I: Evaluator Consent Form), (b) the workshop curriculum, and (c) evaluation criteria for the curriculum (see Appendix B: Evaluation of Curriculum Form) via email (their preferred method of communication). The consent form incorporated an overview of the workshop's nature and purpose, the author's affiliation, the associated risks and benefits of participating in the process, and issues surrounding privacy and confidentiality. Had any interested participants not met the criteria, they would have been sent an email informing them that they were not eligible to participate at this time (see Appendix J: Unqualified Potential Evaluator Email); however, all interested participants met the criteria and were included.

Each expert evaluator was given 2 weeks to review and assess the curriculum. It was estimated that the review would take approximately 1 hour. At this point in the project, the researcher would email the evaluator to discuss the evaluation's status if it was not returned within 2 weeks and provide the evaluator with any further information or answer any additional questions regarding the study. If, at any point, an evaluator elected to discontinue participation, the researcher would thank the evaluator for their time and request that they delete or dispose of any study materials, including the workshop curriculum. Two participants elected not to complete the evaluation and were thanked for their consideration. Four participants reviewed the IM and completed the Evaluation of Curriculum Form.

As compensation for their time, each individual who completed an evaluation received the following: (a) a $20 gift card to an online store of their choice (store must allow purchases by gift card), and (b) an anonymous $20 donation to an AD non-profit organization of their choice.

Questionnaire and Data Collection. An evaluation questionnaire was developed to assess the content and quality of the group IM by obtaining data from practitioners regarding their feedback on the design, content, organization, efficacy, strengths, limitations, and suggestions for improvement (see Appendix B: Evaluation of Curriculum Form). The questionnaire included a total of 13 questions, consisting of eight items scored on a Likert scale and five open-ended questions. This was done to facilitate a broad range of feedback from practitioners with regard to AD caregivers and their needs within the context of a group intervention. The Likert scale items were rated from 1 to 5, with 1 indicating a *strongly disagree* response and 5 representing a *strongly agree* endorsement. The eight Likert scale items consisted the following statements: item one, The curriculum is thorough and provides adequate information regarding the stressors that are unique to family caregivers of individuals diagnosed with Alzheimer's disease; item two, The curriculum is thorough and provides adequate information on appropriate mind–body/contemplative interventions effective in work with caregivers of individuals diagnosed with Alzheimer's disease; item three, The curriculum is easy to read and understand; item four, The curriculum is well organized; item five, The curriculum provides practical coping strategies that can assist mental health clinicians when working to reduce stress in clients who are caregivers of individuals diagnosed with Alzheimer's disease; item six, The curriculum directly addresses the stated purpose of the workshop; item seven, The learning activities in the curriculum seem appropriate and sufficient for a one-day workshop; and item eight, This is a program that will be helpful for family caregivers of individuals with AD.

The remaining five open-ended questions included asking the evaluators for feedback on the strengths and weaknesses of the IM, eliciting suggestions for additional stress-reduction/management interventions appropriate for AD family caregivers, and any other considerations or comments for improving the IM. Data collection included emailing a copy of the group IM and an evaluation questionnaire to each evaluator.

Chapter 3: Results

This chapter provides an overview of the curriculum development and content used in the *Self-Compassion Workshop for Alzheimer's Disease Family Caregivers* group IM, as well as a summary of the evaluation process. Initially, a brief synopsis of the data collection process via a review of past and current literature is presented. Then, the structure and content of the *Self-Compassion Workshop For Alzheimer's Disease Family Caregivers* group IM (see Appendix K – Intervention Manual) are discussed. Finally, the evaluators' feedback is examined.

Overview of the Intervention Manual Development

Literature Review Table

The preliminary phase of the study entailed an extensive literature review with regard to stress and coping strategies, resilience, needs, and challenges of AD caregivers, caregiver burden, mind–body interventions for caregivers and/or aging populations, compassion, and self-compassion. Findings (see Appendix A: Literature Review Table) informed the initial structure and content of the group intervention.

Caregiver Input

A second phase further informed the curriculum development by collecting data via public posts online from individuals who self-identified as current or past informal caregivers of an individual with AD. In total, 37 caregiver comments were collected from seven different online communication forums. Of the 37 caregivers, 36 were determined to be likely female-presenting by a review of their names and current normative gender characteristics presented in their photos, while one individual who posted appeared to be male-presenting. Caregiver postings were reviewed and collected by focusing on the use of keywords often associated with caregiver burden, such as stress, overwhelm, alone, health, depression, anxiety, struggle,

hopeless, grief, guilt, exhaustion, and anger, among others. Overall, these comments had a stronger negative emotional valence and described several challenging experiences related to caregiving. Also explored were the topics of compassion and self-compassion. Notably, no caregiver comments relating to self-compassion were found. The few posts that included the word "compassion" were primarily focused on statements regarding a lack of compassion or other symptoms of compassion fatigue. Finally, themes of mind–body practices related to this workshop, such as meditation, mindfulness, yoga, relaxation, and self-care were explored. Table 1 provides multiple examples of each type of post.

Table 1

Online Caregiver Comments

Topic	Comments
Caregiver burden	*Comment 1.* "IDK how much longer I can do this work 55 hrs [*sic*], come home get treated like crap by my wife when I try to help her and then things get out of hand, I hate my life, I hate this damn disease and what it's doing to us, I would rather be dead if God would just take me home, this disease is making both of us ugly. she yells I'm tired, I yell back sometimes, this is destroying my family and me [*sic*]." *Comment 2.* "I am so stressed from applying for Medicaid for my Mom [*sic*] I know why caregivers die before their loved ones. They just seem to put up impossible hurdles, they want paperwork I don't have, my stress level was already high and some of it I've had to send in twice. Why don't they teach us in high school to keep every damn invoice and lease our parent ever will have in a society that wants us to go paperless? It feels like we're being punished, not helped."

Topic	Comments
Compassion	*Comment 1.* "I'm having a complete breakdown. I cannot breathe. My chest feels tight. I'm shaking. I have no love or compassion or kindness left in my heart right now. I don't even feel ashamed. I don't have anger. I don't have shame. I have nothing. Nothing. Oh my God. I have to get over myself so that I can continue to care for her. But at this e1act [*sic*] moment, I wish for escape . . . She's not doing it on purpose. She's fragile and she's scared and she's horrified by what's happening to her. I understand that. But God forgive me I have zero compassion left. I don't care what she's feeling. I don't care that she's not doing it on purpose. It's killing me. It's just killing me. Oh my God I hate this damn disease."
	Comment 2. "I have learned how to deal with most issues (such as bathing) but her newest is giving me anxiety and I can't find [a] solution. She does not want to keep her pull-up and continually tears it on the sides so that I have to replace it even though it is clean. I can't afford to go constantly replace them and not [*sic*] I get angry and yell at her. Then I feel guilty because I know she doesn't do it on purpose. I'm not an angry person and I hate feeling like this but I find it hard to be compassionate at these times. Any suggestion will be appreciated."
	Comment 3. "Why do we lose our compassion? All I did was ask my LO to change clothes because she has been in the same clothes for 2 weeks turned into a yelling match, I feel defeated [*sic*]."
	Comment 4. "I'm new to the group and my LO is in stage 5. Where do you find your patience and compassion in dealing with them? I get so angry at her forgetting and doing unnecessary things to 'help.' I'm angry at myself for not having a caregiver personally. Is this typical?"
Mind–body intervention	*Comment 1.* "I've been learning more about mindfulness and I have to say that carrying [*sic*] for someone with this disease really requires one to live one day at a time. If I think about what the future may or may not hold it really upsets me. So I will take it a day at a time knowing that the help I need will be there when and if I need it."
	Comment 2. "Take care of yourself. It won't be easy and you'll feel selfish. But the adage, 'you can't pour from an empty cup' is so, so true. Find one thing you can do for yourself each week (at least). Yoga, kickbo1ing [*sic*], reading a silly book, anything. I've become big on meditation and I'm still garbage at it (and don't do it regularly) but I've learned that mindfulness is a HUGE thing. It really is helpful when I'm able to take some time to focus on one single thing. I know it sounds impossible. But you will not, YOU WILL NOT be helpful if you can't help yourself."

Topic	Comments
	Comment 3. "I am so grateful for my yoga and meditation practice as they have provided me with patience and presence. With this disease all we have is the present moment. So I will be patient and understanding and remember she doesn't know what I said 5 minutes ago, what happened yesterday or maybe even who I am. But I will gently remind her. I will play with her and not blame her or find fault with her. I will not reason with her. I will not argue with her. I will not say 'remember.' I will allow her to be just as she is and love her through this."

Integration of Data and Intervention Manual Content

The literature review and empirical base for a resilience-oriented, self-compassion approach provided support for the creation of the *Self-Compassion Workshop For Alzheimer's Disease Family Caregivers* group IM. The specific themes and content of the 1-day group intervention were supported by both empirical studies and caregivers' personal expressions of challenges in order to identify the needs of AD family caregivers, as well as the strategies and resources recognized as most beneficial to the caregiver population.

The group IM was designed to be led by facilitators with the following criteria: (a) personal practice, plus training and experience leading self-compassion and mindfulness activities; (b) a trained mental health clinician or applied researcher; (c) experience with the geriatric community and/or caregiver support; and (d) training, interest, and/or scholarship in diversity. Given the specificity of these multiple criteria, this workshop is strongly encouraged to be co-facilitated.

The *Self-Compassion Workshop For Alzheimer's Disease Family Caregivers* group IM (see Appendix K – Intervention Manual) is 90 pages in length. Overall, it includes considerations for cultivating resilience through self-compassion, cultural adaptation, and a facilitator outline for the 1-day workshop. The group IM begins with a brief introduction of the rationale and aim to address stress and cultivate resilience among family caregivers, followed by an overview and

vision of the curriculum. It then provides suggestions for the identification and recruitment of group members, facilitator recommendations, workshop implementation guidelines, group preparation suggestions, and finally, several cultural and clinical considerations. Next, the IM outlines a one-page table for the workshop, followed by the workshop curriculum, with detailed step-by-step instructions for each activity. The concluding pages of the IM include appendices for the facilitator's use (e.g., a sample recruitment flyer and a list of Hyperarousal/Hypoarousal symptoms), and 18 handouts to support the intervention. These handouts incorporate a range of worksheets for use during the workshop, such as session overview templates, psychoeducational materials, scripts that participants can retain for their future personal use, and a resource list for caregivers.

Description of the Intervention. This workshop was developed as a 1-day workshop. Its format considers the needs and abilities of caregivers to obtain access to supplemental caregiving. While all caregivers are in unique situations, this 1-day model is designed so caregivers may be able to find short-term support. With that in mind, it is highly recommended that this workshop be implemented in partnership with an all-day adult care center, which can, on that day, supplement the participants' caregiving responsibilities. If a participant's AD patient is not able or willing to attend an all-day care center, the hope is that the caregiver can find alternative support for the day (as opposed to going to a weekly group meeting over multiple days in order to deliver this curriculum).

Additional formats for this curriculum were considered (e.g., weekly 1.5-hour sessions, an online format) but were ruled out due to possible time/travel constraints and technological limitations faced by the target audience (i.e., typically older adults). However, these formats may

be a viable option for future workshop development in specific communities, particularly in order to serve individuals who are geographically limited.

This curriculum is designed to last approximately 6 hours and 35 minutes, including about 85 minutes of breaks, for a total of 5 hours and 10 minutes of direct engagement in the curriculum's activities. As noted in Table 2, each activity is listed with approximate time durations, and the IM prompts facilitators to adjust timing according to their groups. The IM provides several recommendations for facilitators to prepare caregivers for group participation and to arrange the group according to individual caregivers and AD patients' needs.

Integration of Resilience and Reconnection and Self-Compassion. As its foundation, the workshop IM uses the framework of the R&R stress management group (Harrell, 2020) intervention. The group intervention is informed by a positive psychology orientation and is designed to be culturally-adaptive and enhance positive outcomes such as resilience and well-being (Harrell, 2020). It fosters resilience through the enhancement of individualized expressions of various qualities of resilience and develops coping skills that facilitate a positive adaptation to stress. While the R&R curriculum targets 21 resilience qualities amidst its multi-session group format, this IM focuses on one specific resilience factor: compassion. The emphasis is further narrowed to self-compassion due to ongoing research that demonstrates the positive correlation between self-compassion and resilience.

The R&R intervention uses the three essential pillars of resilience processes, known as the triadic change model. They include (a) contemplative processes (awareness – "what am I experiencing?), (b) communal processes (allies –"what/who will I connect with?"), and (c) empowerment processes (action – "what choices will I make?"; Harrell, 2020). The scaffolding of activities in this curriculum was developed considering the three R&R essential pillars of

resilience as well as the three facets of self-compassion: mindfulness, common humanity, and self-kindness.

Table 2 provides a visual reference and overview of the workshop, including sections, estimated activity times, the name and type of each activity, a brief description of activities and accompanying handouts, the elements of self-compassion (mindfulness, common humanity, and self-kindness) and/or the triadic change model (awareness, allies, and action), and the particular workshop component to which they relate.

Table 2

Workshop Outline

Section	Section Theme		Min	Time	Name / Content	Type	General Description	***Handout Name***	***Self Compassion Components*** *(Mindfulness, Common Humanity, Self-Kindness)*	***Triadic Change Model Components*** *(Awareness, Allies, Action)*	*Psychoeducation*	*Experiential*	*Dyad/Triad Share*	*Group Share*
SECTION 1	Introduction & Connection	1.1	5	9:00-9:05	Group leader welcome, self introductions & group rules	Welcome & Introductions	Group Leader intro + welcome		*Common Humanity*					
		1.2	25	9:05-9:30	Participant Intros/Ice Breaker - My Caregiver Name	Group Exercise	Group Exercise 1: Naming Ceremony + caregiving role, 1-2 little things they do to 'fill their cup' (that can be done daily/regularly)	*Handout 1: Centering Breaths; Handout 2: Naming Ceremony*		*Allies*		***x***		***x***
		1.3	10	9:30-9:40	Overview of Session + Safety	Psychoeducation	Basic Rationale for group, Provide participants with a schedule for day, Introduce safety and taking care of self (trauma-informed)	*Handout 3: Group Overview; Appendix B: Signs of Hyperarousal*			***s***	***x***		***x***
		1.4	10	9:40-9:50	Participant Stressors	Group Exercise (Dyad optional)	Group Exercise 2: collaboration to list stressors [on board]		*Common Humanity*	*Awareness, Allies*	***x***	***s***		***s***
		1.5	10	9:50-10:00	Participant Coping Used	Group Exercise (Dyad optional)	Group Exercise 3: collaboration to list attempts to alleviate stressors (demonstrates how hard they're trying!) [on board]		*Common Humanity*	*Awareness, Allies*	***x***	***s***		***s***
SECTION 2	Centering & Learning	2.1	15	10:00-10:15	Centering Meditation + Participant Reflections	Practice + Dyad Share	Practice 1: R&R Meditative Moment; then participants share in dyads what their experience was like, what they noticed during exercise, etc.	*Handout 4: Meditative Moments*	*Mindfulness*	*Awareness*		***s***	***x***	
		2.2	10	10:15-10:25	Effects of Caregiver Stress	Psychoeducation	Group leader shares definitions and brief research for caregiver stress impacts for participant learning	*Handout 5: Caregiver Stress Impacts*	*Common Humanity*	*Allies, Awareness*	***x***			
		2.3	10	10:25-10:35	Self-Compassion Intro	Psychoeducation	Basic definitions of Self-Compassion, How it Helps, Tips for Practice, including Backdraft	*Handout 6: Self-Compassion: What is it, How it Helps, Tips for Practice*			***x***			
		2.4	20	10:35-10:55	Learning Compassion - What Would You Say To A Friend?	Group Practice	Group Exercise 4 - Caregiver burden based example prompts read by group leader & group members provide compassionate responses	*Handout 7: Learning Compassion - What Would You Say To A Friend?*	*Common humanity, Kindness*	*Allies*	*x*	*x*	*x*	*x*
			15	10:55-11:10	(brief break)	(brief break)								
		2.5	10	11:10-11:20	Caring Body Connections	Individual Practice	Practice 2: Caring Body Connections	*Handout 8: Caring Body Connections*	*Mindfulness, Self-kindness*	*Awareness, Action*		*x*		
		2.6	20	11:20-11:40	Self-Compassion Break	Individual Practice	Practice 3: Self Compassion Break for personal caregiving experience; then journal & offering of participation for group share of the experience	*Handout 9: Self Compassion Break, Handout 10: Reflection on Self Compassion Break*	*Mindfulness, Common Humanity, Self-Kindness*	*Awareness, Action, Allies*		*x*		
		2.7*	30	11:40-12:10	Real Stories* (*optional; can omit for time, ability, or other reasons)	Dyad/Triad/Group Exercise	Group Exercise 5: Members get in groups of 2-3 and use case vignettes; first vignette is a caregiver who uses self-compassion in the context of caregiver stress, second is an example of not utilizing self-compassion. Then re-join whole group to discuss the vignettes.	*Handout 11: Case Vignettes*	*Common Humanity*	*Allies, Awareness*	*x*		*x*	*x*
			60	12:10-1:10	(longer break - 60 min)	(longer break - 60 min)								
SECTION 3	Experiencing & Sharing	3.1	5	1:10-1:15	R&R Meditative Moment or Mindful Movement	Experiential	Group facilitator leads another Centering Meditation; alternatively, may lead brief mind-body movement practice	*Handout 4: R&R Meditative Moments*				x		
		3.2	35	1:15-1:50	Burdens in a Box	Group Exercise	Group Exercise 6: Participants list one of their caregiver burdens on small pieces of paper (1-3 each depending on group size) and place in a box. Then burdens are selected from box and possible self-compassionate responses are devised, then shared with the group.	*Handout 12: Burdens in a Box Exercise*	*Common Humanity, Self-Kindness*	*Awareness, Allies, Action*		*x*	*(x)*	*x*
		3.3	20	1:50-2:10	Caregiver Breathing	Individual Practice	Practice 3 - Take One, Give One breathing (or imagery) + Group Share	*Handout 13: Caregiver Breathing*	*Mindfulness*	*Awareness*				**x**
SECTION 4	Empowering & Committing	4.1*	20	2:10-2:40	Learning Review* (*optional; can omit for time, ability, or other reasons)	Review & Reflections	Participants fill out review worksheet individually, then share in partners	*Handout 14: Learning Review*		*Awareness*			*x*	
		4.2	15	2:40-2:55	Action Plan Journaling	Individual Practice + Dyad	Listing top 3-5 responses or practices learned in session today, then set SMART goal for Action Plan; share with a peer	*Handout 15: Self-Compassion Action Plan*		*Action*			*x*	
		4.3*	15	2:55-3:10	Barriers Brainstorm*	Group Exercise	Group exercise 7: brainstorming barriers to utilizing self-compassion in daily caregiver experience + How to respond with resilient self-compassion to barriers [on board]			*Awareness, Action*				*x*
			10	3:10-3:20	(brief break)	(brief break)								
SECTION 5	Closing	5.1	10	3:20-3:30	Participant Evaluation	Evaluations	Participants fill out individual evaluations	*Handout 16: Participant Evaluation*						
		5.2	10	3:30-3:40	Resource Review + Q&A	Resource review + Q&A	Group leader provides and reviews resources for self-compassion practices and support (online + local)	*Handout 17: Resources*			*x*			
		5.3	5	3:40-3:45	Loving Kindness Meditation & Closing	Individual Practice	Practice 5 - Loving Kindness Meditation	*Handout 18: Loving Kindness Meditation*		*Awareness, Allies*		*x*		*x*

Overview of Evaluators' Feedback

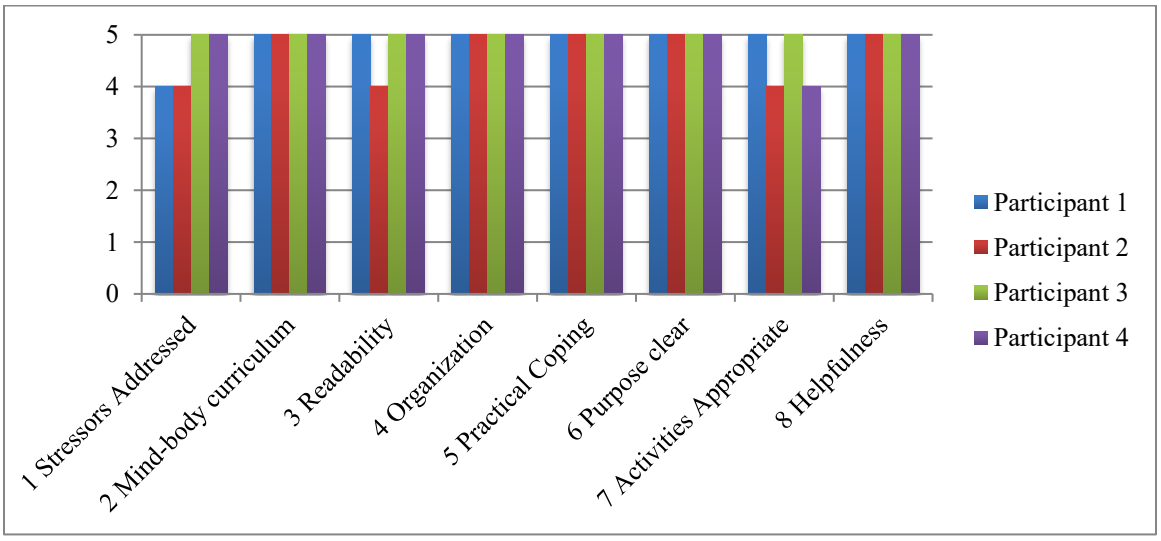
Upon the four evaluators' completion of the Evaluation Questionnaire, the researcher reviewed the feedback provided, particularly the qualitative responses to open-ended questions, in order to create a list of improvements applicable to the IM. An examination of completed questionnaires highlighted the strengths, limitations, and areas for enhancement. The list of revisions focuses on improving the IM's content and quality to facilitate its ease of use by practitioners, and is included in the discussion section.

Summary of Results

A scale of 1 to 5, wherein 1 was designated as *Strongly Disagree* and 5 as *Strongly Agree*, was used to evaluate the quality of the IM. Overall, the average response of all four evaluators to the Likert scale items found on the Evaluation of Curriculum Form was 4.83. The average response of Evaluator One for all items was 4.88, Evaluator Two's average was 4.63, Evaluator Three's average was 5.0, and Evaluator Four's ratings averaged 4.88. Figure 3 presents each evaluator's ratings for all eight Likert scale items.

Figure 3

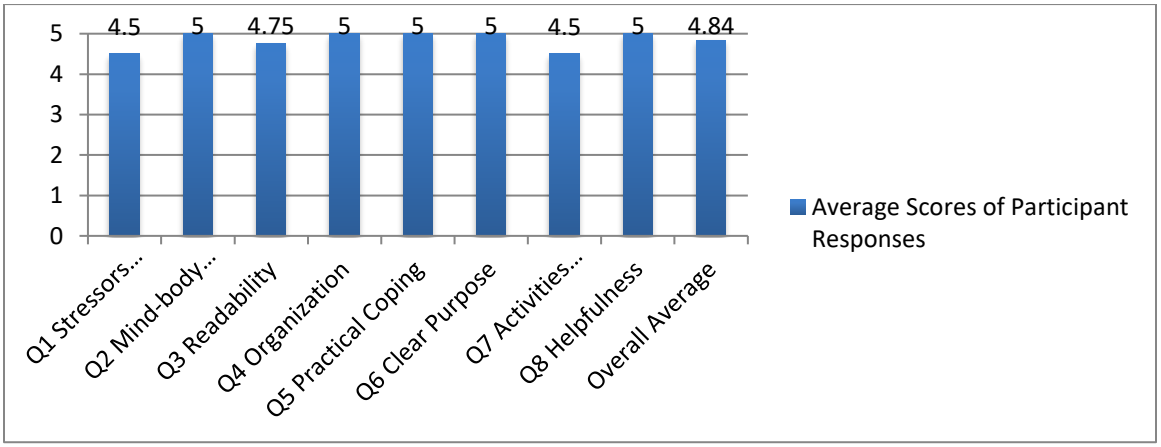
Evaluators' Responses to Eight Likert Scale Items



In general, the four evaluators agreed in their assessment of the group IM. The average of participant responses to item one, "The curriculum is thorough and provides adequate information regarding the stressors that are unique to family caregivers of individuals diagnosed with Alzheimer's disease," was 4.50. For item two, "The curriculum is thorough and provides adequate information on appropriate mind–body/contemplative interventions effective in work with caregivers of individuals diagnosed with Alzheimer's disease," the average response was 5.00. Item three, "The curriculum is easy to read and understand," received an average of 4.75. A 5.00 average was given for items four, five, and six: "The curriculum is well organized," "The curriculum provides practical coping strategies that can assist mental health clinicians when working to reduce stress in clients who are caregivers of individuals diagnosed with Alzheimer's disease," and "The curriculum directly addresses the stated purpose of the workshop." Regarding item seven, "The learning activities in the curriculum seem appropriate and sufficient for a one-day workshop," the average response was 4.50. Finally, item eight's average answer for "This is a program that will be helpful for family caregivers of individuals with Alzheimer's disease" was 5.00. Figure 4 presents the average rating for each of the eight Likert scale items.

Figure 4

Average of Evaluators' Responses to Eight Likert Scale Items



The evaluators observed numerous strengths of the group IM, most notably the curriculum's experientially-based learning and accessibility to caregivers who may be new to the practices of mindfulness and self-compassion. Comments in regard to this included:

> This will be a new set of tools that they will be able to add to their coping toolbox. It combines useful information with social interaction/social support and new skills that they can immediately put to use in their daily lives.
>
> I thought this program was well organized and provided a strong variety of activities and exercises for nurturing self-compassion. I specifically found the materials and phrasing of educational resources to be easy to understand for caregivers. Due to these strengths, participants would not need a foundational understanding or knowledge base to participate or understand the concepts presented.

The third evaluator echoed this idea, stating, "It is very experientially based, includes repetition of mindfulness practices, and appears to be designed with the idea of modifying to fit the backgrounds of participants."

The curriculum was also noted to be highly interactive. Comments included, "One of the biggest strengths of the curriculum is that it is very interactive. This will likely be very helpful in getting participants comfortable in interacting with their peers and helping them to feel more engaged in the workshop," and "It combines useful information with social interaction/social support and new skills that they can immediately put to use in their daily lives." Attention to monitoring safety and being trauma-informed were also considered to be strong points of the curriculum.

The evaluators also provided useful feedback and suggestions for improving the group IM. One evaluator noted the novelty, ambiguity, and possibility of it being "new-agey" for a

cohort of older adults. This emphasizes the importance of facilitators' ability to read their audience and use common, everyday language when describing activities to ensure resonance with the group members. Another evaluator expressed concern regarding the intensity of the 1-day workshop and ability for this age cohort to be present for the long duration.

The questionnaire included additional open-ended questions to elicit further recommendations with regard to appropriate interventions or other suggestions for enhancing the group IM. One evaluator provided the recommendation of incorporating post-workshop participant check-ins in order to increase the maintenance of gains and assess participants' ability to incorporate learnings from the workshop into their lives. This evaluator also presented the idea of providing space at the beginning of the workshop for participants and facilitators to share their hopes and fears for the workshop, as well as perceptions of mindfulness. Final suggestions from this evaluator included dividing workshop participants into pairs or teams for post-intervention check-ins with one another, and using technology to support ongoing caregiver well-being, such as providing recommendations for mindfulness and/or stress reduction apps. Another evaluator suggested the incorporation of problem solving, assertiveness skills, and social support networks into the curriculum, while the third evaluator suggested providing more physical movement activities for participants. Final recommendations for facilitators included a suggestion to ensure facilitator awareness of older adults' general cognitive abilities, particularly in the context of stress, disrupted sleep, anxiety, and depression, as well as the need for simple and succinct language. Tables 3 through 7 present the evaluators' responses to the open-ended questions included in the Evaluation Questionnaire.

Table 3

Evaluators' Responses to Item 9

Question	Evaluator comments
What do you consider to be the strengths of the curriculum?	P1. One of the biggest strengths of the curriculum is that it is very interactive. This will likely be very helpful in getting participants comfortable in interacting with their peers and helping them to feel more engaged in the workshop. I'm guessing that most of the caregivers have never participated in mindfulness-type activities before, so this will be a new set of tools that they will be able to add to their coping toolbox. It combines useful information with social interaction/social support and new skills that they can immediately put to use in their daily lives. P2. Overall, I thought this program was well organized and provided a strong variety of activities and exercises for nurturing self-compassion. I specifically found the materials and phrasing of educational resources to be easy to understand for caregivers. Due to these strengths, participants would not need a foundational understanding/knowledge base to participate or understand the concepts presented. This inclusiveness is extremely important when working with stressed caregivers. I thought offering time, education, and space for trauma-informed information, as well as the special attention given to the importance of monitoring safety within the curriculum was valuable. I also thought the ratio of education, exercises, and acknowledgement of personal experiences was balanced well. P3. It is very experientially-based, includes repetition of mindfulness practice, and appears to be designed with the idea of modifying to fir [*sic*] the backgrounds of participants. P4. Very complete. I appreciate the triad in change model which enlarges perspective. One day is realistic and practical and giving people handouts is a good take away to maintain the learnings of the workshop. Instructions to facilitator are clear.

Table 4

Evaluators' Responses to Item 10

Question	Evaluator comments
What do you consider to be the weaknesses of the curriculum?	P1. The novelty of the information taught about mindfulness might initially be a hurdle. Mindfulness, by its very nature, is a rather ambiguous concept, and for those older adults who don't have a history of interacting with mental health providers or talking about mental health, it might seem a little "new-agey." Consequently, leaders will need to be skilled at reading their audience and using more common, everyday language do [*sic*] describe some of the activities depending on whether it seems like the words are resonating with group members. P2. I wouldn't frame my feedback in terms of weaknesses. I strongly feel that this curriculum was very well done. After completion of my review, I felt that including check-ins with previous participants from the workshop may be a point of consideration. Recent literature suggests greater maintenance of learned skills from workshops/groups is achieved through supportive outreach by facilitators and/or fellow group members. This could allow for assessing how the caregivers have been doing post-workshop on integrating the skills/knowledge in their daily lives. It could help to address questions/barriers that may have developed once the caregivers have returned to their normal routines. The ability to add support or address concerns may lead to greater action planning on the part of the caregiver for better integration or utilization of self-compassion. This could look like a follow-up call in 2, 4, or 6 weeks from the facilitators or possibly including options for group members to buddy up and provide support to each other in predetermined time intervals (optional for the members). Choosing the latter could also increase peer support connection which is known to aide in stress reduction for caregivers as well. P3. It appears to be a very full day and I wonder about participants to be fully present for that duration. P4. It is a lot of material presented in a short time. Much to digest and integrate.

Table 5

Evaluators' Responses to Item 11

Question	Evaluator comments
What are some suggestions of additional stress-reduction/management interventions that are appropriate for caregivers of individuals diagnosed with Alzheimer's disease?	P1. Movement, anything that gets them moving (for those that are able).
	P2. My suggestion would be to incorporate the power of technology. Caregivers for individuals with Alzheimer's disease often have less personal time or ability to participate in activities outside the home. The use of technology for stress reduction can be effective at continuing the work with limited resources. For instance, there are many reviewed and free stress and mindfulness apps that involve short activities that are doable in small time frames and can be used in any setting. Inclusion of verified apps as part of the materials may help with reinforcing utilization of the exercises.
	P3. Problem solving, assertiveness skills, utilization of social support.
	P4. Easy access to resources, perhaps encouragement of shared contact information so participants can continue supporting each other

Table 6

Evaluators' Responses to Item 12

Question	Evaluator comments
Please provide any other suggestions for improving this workshop.	P1. The only other comment I have would be for the leaders to know their audience and make sure that their language and approach is responsive to those in attendance. Keeping in mind what we know about the cognitive abilities of older adults, especially when stress, anxiety, disrupted sleep, etc., are involved, means that instructions should be simple, straight forward, and to the point. For the most part, I think the sample instructions in the IM do that, but many mental health providers have a tendency to like the sounds of their own voice, thus adding lots of redundant or unnecessary commentary. The more the leaders stick to the script and avoid adding extra explanations, the better it will likely be for participants. Just something to make sure that leaders are mindful of from the beginning. P2. In the introduction section of the workshop it may be worth considering adding space for group discussion of the participant's and facilitator's hopes and fears about engaging in this workshop. Identifying the hopes could open space for participants to begin this workshop with awareness of what they might need as caregivers, which may invest them more into the series. Identifying the fears could help the facilitators understand the participants' framework of these concepts before starting the workshop, which may be used to dispel misconceptions. Perceptions of mindfulness, attention to self-needs, and values implicit in each participant's caregiver identity is shaped by cultural factors – referenced in the ADDRESSING framework noted in the materials – which may allow for deeper discussion of these intersecting values for better active engagement throughout the workshop. P3. It looks great. I think the program evaluation is useful in obtaining real-world feedback. P4. Offer downloads of meditations and exercises to access at home and reinforce workshop learnings.

Table 7

Evaluators' Responses to Item 13

Question	Evaluator comments
additional comments	P1. (no comments)
	P2. I thought this workshop was well put together and an area that is very needed within caregiver support – especially for caregivers of individuals with Alzheimer's dementia.
	P3. N/A
	P4. Excellent. Thoughtful. Comprehensive.

Chapter 4: Discussion

Overview

The purpose of this dissertation project was to develop a resilience-building self-compassion based stress management IM for AD family caregivers. The development of this IM was first informed through a comprehensive review of existing literature related to the needs and challenges faced by AD family caregivers, with a particular focus on mind–body interventions given the lack of self-compassion based interventions for this subset of the population. The IM was also informed by a second phase wherein the researcher used online data collection of AD family caregivers' public postings with attention to caregiver stress and burnout, as well as an exploration of coping mechanisms with a focus on the use of mind–body based strategies. Upon completion of the IM, four professional reviewers—all licensed mental health clinicians with expertise in geriatric mental health, AD, and/or mind–body interventions such as mindfulness, yoga, or self-compassion—evaluated the IM. Information was gathered via an evaluation questionnaire regarding the workshop's strengths, limitations, and areas for improvement. Implications of the findings and future directions for improving the IM are presented in this chapter.

Feedback From Expert Evaluators

Strengths of the Intervention Manual

The evaluators identified multiple strengths of the group IM. The primary strengths included (a) the intervention is well organized and provides a variety of activities and exercises; (b) the intervention is experientially-based in order to increase novel learning and engagement; (c) phrasing in the intervention is modified to meet the level of caregivers; (d) suggestions for modifications are provided in order to be congruent with the unique population of the group; (e)

being trauma-informed, in both educating the group and the implementation of activities; and (f) handouts that provide access for ongoing learning.

Limitations of the Intervention Manual

The evaluators also noted some limitations of the group IM. Two evaluators shared a similar critique, expressing that the full extent of the activities to carry out in 1 day might present difficulty in facilitating so much material. Also mentioned was that the intervention's length may conflict with older participants' limited ability to remain attentive and learn for such a duration of time. Another limitation involved the possible novelty and ambiguity of the mindfulness concept as well as the consideration that some of the older participants may lack interaction with mental health providers. As part of this comment, the evaluator expressed the importance of the facilitators' ability to use simple language, remain consistent with the IM's instructions, and stay cognizant of participants' responses.

Suggestions and Areas for Improvement of the Intervention Manual

The evaluators provided several suggestions for additional stress reduction/management interventions for AD caregivers that may benefit the curriculum, as well as some possible areas of improvement for the group intervention. One suggestion included adding a segment for participants and facilitators to express their hopes and fears about the workshop and/or about mindfulness itself in order to help frame the session and dispel any misconceptions. Two evaluators suggested harnessing the use of technology, particularly for those caregivers who may experience limited resources, by providing downloadable material for ongoing practice, as well as suggestions for free websites and apps for stress reduction and mindfulness. Another evaluator proposed increasing physical movement, while a third evaluator named problem solving and assertiveness skills as other effective interventions for AD caregivers. A final, valuable

suggestion included the idea of post-intervention participant follow-up by facilitators, and/or providing the option for participant caregivers to share contact information with an established follow-up plan in order to increase social support.

After considering the feedback received from the expert mental health clinician evaluators, the following modifications for a future version of the Facilitator IM were identified as ways to strengthen the intervention.

Discussion of Hopes and Fears. In the group intervention's introductory activity, invite participants and facilitators to share their hopes and fears in order to give participants a voice earlier in the session. This will also allow facilitators to tailor the intervention to the needs of the group as well as express their own concerns, which serves to establish common humanity among participant caregivers and the group leader.

Reinforcing Learning With Technology. Numerous options exist for using technology to reinforce the concepts learned in the workshop. They may include (a) recording audios of the facilitators discussing practices for participants' individual use after the workshop. The facilitator's familiar voice will help connect participants back to the session; (b) adding suggestions for web-based audio recordings for the ongoing practice and learning of self-compassion; and (c) providing recommendations for phone app-based recordings and educational materials for stress-reduction, mindfulness, and self-compassion.

Optional Ongoing Social Connection and Support. Facilitate a manner in which group members can engage with one another after/outside of the group, dividing interested participants in groups of two or three (in case one individual becomes unreachable or later chooses not to participate) and provide advice for follow-up using their shared pre-selected method of communication (e.g., phone, email, text message).

Post-Intervention Check-Ins. Establish several follow-up outreaches to participants via their preferred method of communication (e.g., phone call, email, text message) to remind the caregivers to use their new learnings, help with problem solving around challenges, and answer any ongoing questions that arise.

Additional Workshop Formats. Modify the curriculum to create additional options for the implementation of this syllabus, including (a) an online version for those who have the technological capacity and capability but cannot attend the workshop in person; and (b) a multi-session format with shortened meeting times, such as dividing the curriculum into five 1.5-hour sessions.

In addition to these recommendations, it may be beneficial to include some kind of measurements or metrics for the intervention's implementation. This could provide evidence for the intervention's degree of effectiveness and identify areas of further development. The use of a measurement tool may also serve as an informational clinical tool for participants, increasing awareness of their areas of growth, and possibly serve to bolster feelings of self-efficacy and resilience as well as to reinforce and motivate learning. One such measurement tool is the Self-Compassion Scale (SCS) or Self-Compassion Scale-Short Form (SCS-SF; Neff, 2003a), which could be implemented prior to or at the beginning of the intervention, as well as at different intervals after the intervention. This may be paired with facilitator led post-intervention check-ins as well.

Conclusion and Potential Contributions of this Study

Self-Compassion Workshop for Alzheimer's Disease Family Caregivers was developed to address the great needs of informal caregivers of individuals with AD. They often experience chronic stress, and many reach caregiver burnout, whether for brief moments or entirely. The

stress of this experience not only takes a toll on caregivers' psychological and physical well-being, but caregiver burnout is also implicated in poorer outcomes for the individual with AD. While many interventions exist to provide caregivers with a basic understanding of AD, what to expect in caregiving, caregiving problem solving, and often offer links to AD resources both locally and worldwide, fewer interventions address the development of caregiver resilience by exploring the challenging internal processes they experience. This IM was developed to help caregivers in developing a new skill set to address their many and varied experiences of stress, difficulty, and suffering experienced in their caregiving role. To further inform the intervention's development, public online postings by AD family caregivers were used. Four mental health clinicians specializing in geriatric mental health and/or mind–body interventions evaluated the IM to enhance its feasibility. All feedback was reviewed and incorporated into the IM or indicated for its future development.

This study potentially contributes a valuable resource for a large population of individuals who are underserved in current society due not only to age and health stigma, but resultant limitations to resources due to the AD caregiving experience itself. The great emotional and physical burden of caregiving frequently limits caregivers' lives to the walls of their home for years and diminishes the time a caregiver may otherwise spend taking care of themselves or enjoying moments of their own precious lives. It is the hope that this intervention can help family caregivers build resilience through self-compassion, calling upon their newfound ways of responding to the many difficulties they face in times of stress and difficulty. With this new ability, caregivers may experience moments of feeling less alone in their struggles, greater kindness and care for themselves, and a healthier adaptation to stress, potentially leading to

better psychological and physical health outcomes for both the caregivers themselves as well as their family member with AD.

Further, by providing access to a group intervention such as *Self-Compassion Workshop For Alzheimer's Disease Family Caregivers*, the researcher hopes mental health providers will feel empowered to use and implement an expert-informed intervention and increase the use of evidence-based practices to enhance the well-being of their unique and diverse patients and community. It is hoped that this intervention will continue to be developed and applied over time to many diverse populations with the primary goal of alleviating even a moment of suffering in the challenging experiences of caregiving individuals.

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APPENDIX A

Literature Review Table

Summary Table of Selected Literature

	Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
1	Alizadeh, S., Khanahmadi, S., Vedadhir, A., & Barjasteh, S.	2018	The Relationship Between Resilience with Self-Compassion, Social Support and Sense of Belonging in Women with Breast Cancer	Breast cancer, resilience, self-compassion, social support, sense of belonging	Article	Research study	Descriptive-analytical cross-sectional study	150 patients with breast cancer were collected by convenience sampling using Demographic characteristics; most aged 41-49, mostly married. Measures: questionnaire, Connor-Davidson resilience scale, Self-Compassion Scale (SCS) and the Multidimensional Scale of Perceived Social Support in Urmia, Iran	This international study demonstrated a positive correlation between self-compassion, social support, sense of belonging, and resilience and suggests ongoing interventional programs to increase resilience in this population.
2	Arimitsu, K., Hitokoto, H., Kind, S., & Hofmann, S. G.	2019	Differences in Compassion, Well-being, and Social Anxiety Between Japan and the USA	Culture. Compassion. Affect. Well-being. Social anxiety. Taijin kyofusho	Article	Research study	DESIGN: series of hierarchical regression analyses to examine whether culture and compassion for the self and others predicted positive and negative affect, subjective well-being, and/or	Two online surveys: one in Japan and one in the USA. US participants were 258 adults (59% female; M age = 37.25, SD = 13.69), who were born and had lived more than ten years in the USA and	Through a web-based survey of Japanese and American adults, we found that self-compassion was related to positive and negative affect, social anxiety disorder and TKS symptoms, and wellbeing in both countries. Compassion for others was found to be associated

Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
						social anxiety. MEASURES: Self-Compassion Scale (SCS), Differential Positive Emotions Scale (DPE), Social Anxiety Questionnaire, Taijin Kyofusho The TKS Scale (TKSS), Positive and Negative Affect Schedule (PANAS), Satisfaction With Life Scale (SWLS), INTERVENTION: n/a	were native English speakers. Japanese participants were 247 adults (55% female; M age = 36.50, SD = 8.33), who were born and had lived more than ten years in Japan and were native Japanese speakers. In terms of race/ethnicity, the American sample was mostly White/Caucasian (83%), followed by African American (6%), Hispanic (5%), Asian (2%), Native American (0.4%), and others (3.1%); the Japanese sample was all Asian (100%).	with increased positive affect and decreased TKS symptoms across both cultures. Simple slope tests revealed that self-compassion had a stronger relation with positive affect among US adults than their Japanese counterparts, whereas compassion for others was related to interdependent happiness only in Japan. These findings suggest that the link between compassion, well-being, and psychopathology might be universal, although the effects of the two types of compassion have different patterns between the two cultures.

	Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
3	Baker, D. A., Caswell, H. L., & Eccles, F. J.	2019	Self-Compassion and Depression, Anxiety, and Resilience in Adults With Epilepsy	Epilepsy Self-compassion Depression Anxiety Resilience	Article	Research study	DESIGN: quantitative cross-sectional survey design, the aim of the present study was to examine the extent to which self-compassion predicted depression, anxiety, and resilience when controlling for demographic and illness-related variables. MEASURES: The Liverpool Seizure Severity Scale 2.0 (LSSS), Self Compassion Scale (SCS), Hospital Anxiety and Depression Scale (HADS), The Brief Resilience Scale (BRS), INTERVENTION: n/a	Online recruitment of individuals in the UK over 18 years who self identify as having epilepsy; English speaking. 327 participants consented to take part in the study. Of these, 305 were recruited online and 22 from epilepsy clinics, 59 incomplete surveys were excluded, resulting in 270 surveys utilized for data analysis.	Self-compassion significantly predicted lower depression and anxiety and higher resilience when other significant socio-demographic and illness-related variables had been taken into account.
4	Chui, H., Hay, E. L., & Diehl, M.	2012	Personal Risk and Resilience Factors in the Context of Daily Stress	resilience, stress, chronic stress, adults,	Chapter	Theoretical	Review of empirical literature	n/a	This chapter explores the role of personal risk and resilience factors in adults of all ages as they cope with stressors in everyday

Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
			aging, research,					lives. It reviews prior theories researchers should focus on daily stress and coping as opposed to major life events or chronic stress, with the underlying proposition that daily stressor coping is more pivotal in understanding longer-term well-being and adaptation. The chapter reviews existing empirical literature on personal risk and resilience factors in the context of daily stressors. The chapter argues that research should focus on when and under what condition age is associated with greater vulnerability to daily stress as well as when and under what conditions age is associated with greater resilience to daily stress. It notes the embeddedness of systemological factors (structural, individual, situational) that influence stress reactivity and stress recovery.

	Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
5	Coon, D.	2012	Resilience and Family Caregiving	family caregiving, dementia, resilience, aging	Chapter	Review of literature	n/a	n/a	Explores family caregiving for people with dementia and reviews the literature on resilience in caregivers, identifying framework for ongoing research, practitioners, and policy makers for the ongoing development, evaluation, and dissemination of caregiver interventions in a resilience framework. Provides recommendations for mixed-methods and prospective longitudinal designs, application of theoretical frameworks, and examination of interventions that target both mental and physical health outcomes and serve diverse populations.
6	Cosley, B. J., McCoy, S. K., Saslow, L. R., & Epel, E. S.	2010	Is Compassion for Others Stress Buffering? Consequences of Compassion and Social Support for Physiological Reactivity to	Compassion, Stress reactivity Social support, Psychophysiology	Article	Research study	Participants completed online battery of questionnaires prior to experiment: compassion subscale of dispositional positive emotion	59 Participants, women, community sample of San Francisco, CA residents. All participants were healthy European–American women (Age: M = 27.89, SD = 6.74). no	Participants completed an online assessment of compassion prior to intervention, then experienced a social stress task in front of either two supportive or neutral evaluators, while their blood pressure, cortisol, high frequency heart rate

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		Stress				scales. Procedures included cardiovascular monitoring (ECG, ICG), social stress task, and social support manipulation; MEASURES: arterial blood pressure, cortisol, HF-HRV, manipulation check, ancillary measures of defensiveness, cynicism, pessimism, negative affect, global self-esteem, self-efficacy, loneliness, perceived support, social power.	prior history of smoking, or medication use known to influence hormonal and cardiovascular measures. $100 compensation	variability (HF-HRV), and liking for the evaluators were monitored. "Participants' compassion for others interacted with social support condition to buffer their physiological reactivity to stress. When provided with social support during the task, higher trait compassion was associated with lower blood pressure reactivity, lower cortisol reactivity, and higher HF-HRV reactivity. Higher compassion was associated with greater liking for the supportive evaluators. These relationships were not observed for participants in the neutral condition, regardless of their trait compassion." KEY FINDING: Compassion for others may increase the ability to receive social support, which may lead to more adaptive profiles of stress reactivity, particularly in women given that the study was only in women.

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7	Danucalov, M. A. D., Kozasa, E. H., Ribas, K. T., Galduróz, J. C. F., Garcia, M. C., Verreschi, T. N., Oliveria, K. C., Romani de Oliveira, L., & Leite, J. R.	2013	Yoga and Compassion Meditation Program Improve Quality of Life and Self-Compassion in Family Caregivers of Alzheimer's Disease Patients: A Randomized Controlled Trial	Alzheimer's disease, attention, caregiver, meditation, quality of life, self-compassion, vitality, yoga	Article	Research study	DESIGN: experimental - randomized control. MEASURES: WHOQOL-BREF, Subjective Vitality Scales Mindfulness Attention Scale, Self Compassion Scale; blinded assessors, pre and post measurements. INTERVENTION: 8-week program, 3 sessions per week, 1hr15min per session (one in person, 2 at home via dvd); 25min yoga asana, 12m30s mindfulness meditation, 12m30s compassion meditation	Recruitment: Sao Paolo, Brazil radio and newspapers advertisements and Alzheimer's Association of Brazil. 53 family caregivers were selected, 46 volunteer individuals completed all phases of the study. They were randomized into two groups: 25 family caregivers (22 women and 3 men) composed the yoga and compassion meditation program (YCMP) group, and 21 family care- givers (19 women and 2 men) composed the control group (CG).	Results: The yoga and compassion meditation program (YCMP) group showed statistically significant improvements ($P < 0.05$) on quality of life, attention, vitality and self-compassion scores as compared with the control group, which showed no statistical significant differences at the post-intervention time-point. Conclusions: Findings of the present study suggest that an 8-week yoga and compassion meditation program can improve the quality of life, vitality, attention, and self-compassion of family caregivers of Alzheimer's disease patients.
8	Delaney, M. C.	2018	Caring for the Caregivers: Evaluation of the Effect of an Eight-Week	caregivers, mindful self-compassion, MSC, compassion	Article	Research study	Design: observational mixed research pilot study that adopted an	13 female nurses in Ireland	Objective: Given research that suggests that self-compassion interventions may provide protective factors and enhance

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		Pilot Mindful Self-Compassion (MSC) Training Program on Nurses' Compassion Fatigue and Resilience	fatigue			evaluation design framework. Measures: Neff 26-item Self-compassion scale, The Freiburg Mindfulness inventory, ProQOL Version 5 Professional Quality of Life Scale: Compassion Satisfaction and Fatigue Version, Connor-Davidson Resilience Scale 25 item (CD-RISC 25),		resilience, this pilot study examined the effect of an eight-week Mindful Self-Compassion (MSC) training intervention on nurses' compassion fatigue and resilience, as well as participants' personal experience of the effect of the training. Findings: The Pre- to Post- scores of secondary trauma and burnout declined significantly and were negatively associated with self-compassion (r = -.62, p = .02) (r = -.55, p = .05) and mindfulness (r = -.54, p = .05). (r = -.60, p = .03), respectively. Resilience and compassion satisfaction scores increased.

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9	Diest, M., & Greef, A. P.	2015	Resilience in Families Caring for a Family Member Diagnosed with Dementia	resilience factors, Alzheimer's disease, family caregiving, dementia	Article	Research study	mixed methods. Measures: Family Attachment Changeability Index 8 (FACI8), Family Crisis Oriented Personal Evaluation Scales (F-COPES), Family Hardiness Index (FHI), Family Problem Solving and Communication (FPSC) Index, Family Time and Routine Index (FTRI), Relative and Friend Support Index (RFS), Social Support Index (SSI),	44 spouse caregivers of individuals with dementia in Western Cape, South Africa; 24 (55%) were Colored, 19 (43%) were White, and one (2%) was Black. female (n¼29; 66%). (''Colored'' refers to a racial category derived from apartheid classification, that was still used in the latest South African census. ''Colored'' celebrates diversity and an inclusive, hybrid history.) Ages 43-90 (mean=71.6; SD=9.3); dementia patients ages 50-90 (mean=74.0; SD¼9.5). Language: English (n=25; 57%), Afrikaans (n=18; 41%) and Xhosa	Findings: social support, positive communication patterns, acceptance, optimism, family hardiness, family connectedness, and the effective management of symptoms facilitated the resilience process in these families.

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							(n=1; 2%). monthly household income of the families (n=43) was as follows: 7 (16%) earned between $100 and $200, 16 (37%) between $200 and $500, 7 (16%) between $500 and $1,000, and 13 (30%) earned more than $1,000 per month. Families were economically slightly better off than families in the Western Cape province.	

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10	Fuertes, M. C., Aranda, G., Rezola, N., Erramuzpe, A., Palacios, C., & Ibañez, B.	2019	Long-Term Effects of a Mindfulness and Self-Compassion Program with Primary Healthcare Professionals	Mindfulness. Self-compassion. Burnout. Stress. Primary Healthcare	Article	Research study	MEASURES: questionnaires were completed to measure the levels of mindfulness (FFMQ), Self-compassion (SCS), perceived stress (PSQ) and burnout (MBI) after 8 weeks, 2.5hr sessions, then followed up 2 years later	41 healthcare professionals in Spain, 83% women	Results: This study explores the effectiveness of mindfulness and self-compassion-based interventions on emotional fatigue and stress in healthcare workers, and explored persistent effect of intervention 2 years post. Mean scores in mindfulness, self-compassion, and perceived stress significantly improved after intervention and in the long term without observing differences in the level of burnout. Participants who maintained a meditation practice demonstrated greater long-term improvement in self-compassion.

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11	Germer, C. K., & Neff, K. D.	2013	Self-Compassion in Clinical Practice	self-compassion; mindfulness; compassion; difficult emotions; psychotherapy; meditation	Article	Conceptual	n/a	n/a; explores use of SC in clinical population	Provides foundational information on self-compassion (SC) and its use in the context of painful experiences. Reviews the Mindful Self-Compassion (MSC) training program and its key meditations and practices (e.g., loving-kindness, affectionate breathing) as well as informal practices for use in daily life (e.g., soothing touch, self-compassionate letter writing).
12	Gilbert, P., & Proctor, S.	2006	Compassionate Mind Training for People With High Shame and Self-Criticism: Overview and Pilot Study of a Group Therapy Approach	Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach	Article	Research study	MEASURES: The Hospital Anxiety and Depression Scale (HADS), Weekly Diary Measuring Self-Attacking and Self-Soothing, The Functions of the Self-Criticizing/Attacking Scale (FSCS), The Forms of the Self-Criticizing/Attacking and Self-Reassuring Scale	6 patients at a cognitive-behavioral based day center in UK; ages 39-51, mean 45.2 years	Overall result: This paper offers a short overview of the role of shame and self-criticism in psychological difficulties, the importance of considering different types of affect system (activating versus soothing) and the theory and therapy process of Compassionate Mind Training. Completed a study of Six patients attending a cognitive–behavioral-based day center for chronic difficulties completed 12 two-hour sessions in

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							(FSCRS), Social Rank Variables, External Shame (the Other as Shamer Scale; OAS), Social Comparison Scale, Submissive Behavior Scale (SBS)		compassionate mind training. Results of the study showed significant reductions in depression, anxiety, self-criticism, shame, inferiority, and submissive behavior.
13	Hofmann, S. G, Grossman, P, & Hinton, D. E.	2011	Loving-Kindness and Compassion Meditation: Potential for Psychological Interventions	Loving-kindness meditation, Mindfulness, Compassion, meditation, Anger, Anxiety, Depression	Article	Literature review	n/a	n/a	Review of the background, the techniques, and the empirical contemporary literature of loving kindness meditation (LKM) and compassion meditation (CM), which suggests that they are associated with an increase in positive affect and a decrease in negative affect and may reduce stress-induced subjective distress and immune responses. Neuroimaging

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									studies suggest that LKM and CM may enhance brain activating in areas associated with emotional processing and empathy.
14	Kemper, K. J, Mo, X., & Khayat, R.	2015	Are Mindfulness and Self-Compassion Associated with Sleep and Resilience in Health Professionals?	mindfulness, self-compassion, resilience, sleep	Article	Research study	Cross-sectional survey design to describe the relationship between trainable qualities of mindfulness and self-compassion with factors conceptually related to burnout and quality of care (sleep and resilience) in young professionals and trainees. MEASURES: The Hospital Anxiety and Depression Scale (HADS), Weekly Diary Measuring Self-Attacking and Self-Soothing, The Functions of the Self-Criticizing/Attacki	213 clinicians and trainees at a large, Midwestern US academic center; average age 28, 73% female; Professions included dieticians (11%), nurses (14%), physicians (38%), social workers (24%), and other (12%).	Findings: Sleep disturbances were significantly correlated with perceived stress and poorer health; also with less mindfulness and self-compassion. Resilience was strongly and significantly correlated with less stress and better mental health, more mindfulness, and more self-compassion. Conclusions: In a cohort of young health professionals and trainees in the Midwestern US, sleep and resilience correlated with mindfulness and compassion, warranting prospective studies to determine any directionality of these findings; meaning to explore if mindfulness and self-compassion may elicit improvements in

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							ng Scale (FSCS), The Forms of the Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS)		clinicians' sleep and resilience or whether decreasing sleep disturbances and building resilience increases mindfulness and self-compassion.
15	Keng, S.-L., Smoski, M. J., Robins, C., Ekblad, A. G., & Brantley, J. G.	2012	Mechanisms of Change in Mindfulness-Based Stress Reduction: Self-Compassion and Mindfulness as Mediators of Intervention Outcomes	Self-compassion, MBSR, mindfulness, mechanisms of change, rumination	Article	Research study	DESIGN: Experimental - randomized control; PROGRAM: 8-week Mindfulness Based Stress Reduction Program	n/a	Results: This study's findings highlight the importance of mindfulness and self compassion as the key processes of change that underlie MBSR-s outcomes and posits that mindfulness allows for greater clarity in developing self-compassion, while self-compassion provides opportunity for mindfulness by reducing attention-interfering cognitions such as rumination

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16	Keng, S. L., Smoski, M. J., & Robins, C. J.	2011	Effects of Mindfulness on Psychological Health: A Review of Empirical Studies	Mindfulness Psychological health Mindfulness-Based Stress Reduction Mindfulness-Based Cognitive Therapy Dialectical Behavior Therapy Acceptance and Commitment Therapy	Article	Literature review	review of empirical studies, explores correlational research on the relationship between trait mindfulness and psychological health, Relationship between mindfulness meditation and psychological health; explores MBSR, MBCT, ACT, DBT, as well as brief mindfulness interventions	wide range; significant number of studies reviewed (56+ studies included)	Conclusion of empirical research review: The authors assert that mindfulness brings about various positive psychological effects, including increased subjective well-being, reduced psychological symptoms and emotional reactivity, and improved behavioral regulation.
17	Körner, A., Coroiu, A., Copeland, L., Gomez-Garibello, C., Albani, C., Zenger, M., & Brähler, E.	2015	The Role of Self-Compassion in Buffering Symptoms of Depression in the General Population	self compassion, depression, German	Article	Research study	Survey; Measures: Self-Compassion Scale (SCS), PHQ-9	2404 individuals in the general population of Germany in 2012 in 320 geographical sampling points; 53.7% female (who comprise 50.9% of the census population); mean age 50.19 years	The overall findings of this article provide data to suggest that self-compassion has the potential to buffer 'self coldness' (one factor in SCS measurement: self-judgment, isolation, and over-identification) related to depression, suggesting benefit of interventions that foster self-caring, self-kindness, and

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									forgiving attitudes toward oneself in the context of depression.
18	Laird, K. T., Krause, B., Funes, C., & Lavretsky, H.	2019	Psychobiological Factors of Resilience and Depression in Late Life	Depression, Aging, resilience, psychobiological factors of resilience, late life depression, treatment	Article	Review article	n/a	n/a	This article explores the current understandings of resilience as multidimensional and dynamic capacity influenced by internal and contextual resources as introduction to a review of the psychological and neurobiological factors associated with resilience to late-life depression (LLD). Some of these factors associated with LLD include insecure attachment and neuroticism, which can be targeted with interventions that support self-efficacy, sense of purpose, coping behaviors, and social support. Psychobiological factors are also reviewed, including endocrine, genetic, inflammatory, metabolic, neural, and cardiovascular processes, as they bidirectionally relate to risk with an onset and course of LLD.

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									Authors suggest resilience-enhancing intervention modalities such as: (a) cognitive, psychological, or mind body (i.e. positive psychology, psychotherapy, HRV biofeedback, meditation); (b) movement based (aerobic, yoga, tai chi); (c) biological (pharmacotherapy, ECT). Authors explore need for ongoing research to identify psychobiological factors that are predictive of positive intervention response for LLD.
19	Lavretsky, H.	2012	Resilience, Stress, and Mood Disorders in Old Age.	resilience, stress, mood disorders, aging, geriatric mental health,	Chapter	Literature review	n/a	n/a	This chapter summarizes the literature on resilience and factors of vulnerability as related to later life mood and anxiety disorders, identifying key concepts of resilience. It reviews psychosocial and biological factors contributing to resilience that are universal and distinct from aging as well as those that are unique within the context of aging, specifically the

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									emotional/cognitive models as well as physiological mechanisms, including neurobiological, of resilience to stress and depression in late life. The chapter provides suggestions for interventions to promote resilience and well-being as a prevention strategy for late-life mood disorders. It also offers suggestions for future resilience research and resilience-targeting interventions.
20	Lavretsky, H., Siddarth, P., Nazarian, N., St. Cyr, N. S., Khalsa, D. S., Lin, J., Blackburn, E., Epel, E. S., & Irwin	2013	A Pilot Study of Yogic Meditation for Family Dementia Caregivers With Depressive Symptoms: Effects on Mental Health, Cognition, and Telomerase Activity	dementia caregivers, depression, yoga, telomerase activity, cognition	Article	Research study	Randomized clinical trial, pilot study. Measures: Structured Clinical Interview for the DSM-IVR (SCID), Hamilton Rating Scale for Depression (HAM-D-24 item); Folstein Mini-mental State Examination (MMSE), all for participant selection criteria.	Thirty-nine family dementia caregivers (mean age 60.3 years old (SD = 10.2)); 45–91 years of age, two men, 36 adult children, 13 spouses);	Results: "The meditation group showed significantly lower levels of depressive symptoms and greater improvement in mental health and cognitive functioning compared with the relaxation group. In the meditation group, 65.2% showed 50% improvement on the Hamilton Depression Rating scale and 52% of the participants showed 50% improvement on the

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						Intervention procedure: A brief 12-m yogic practice included an ancient chanting meditation, Kirtan Kriya, which was performed every day at the same time of the day for a total of 8 weeks, based on a utilized and previously tested protocol with recorded CD; relaxation group utilized a 12 min relaxation instrumental music. Study instruments: Medical Outcomes Study SF 36-Item Health Survey, MMSE, Cumulative Illness Rating Scale, brief neuropsychological battery (California Verbal Learning Test II (CVLT II) (Delis et al., 2000), to test		Mental Health Composite Summary score of the Short Form-36 scale compared with 31.2% and 19%, respectively, in the relaxation group ($p < 0.05$). The meditation group showed 43% improvement in telomerase activity compared with 3.7% in the relaxation group ($p = 0.05$)." Conclusion: brief daily meditation practices by family dementia caregivers can lead to improved mental and cognitive functioning and lower levels of depressive symptoms. It is also correlated with an increase in telomerase activity, suggesting improvement in stress-induced cellular aging. Suggestions for follow up studies are expressed.

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							verbal memory, Trail Making A (Reitan, 1958) to test attention and speeded information processing, and Trail Making B to test executive function), and telomerase samples		
21	Neff, K. D.	2011	Self-Compassion, Self-Esteem, and Well-Being	Self-compassion, self-esteem, well-being	Article	Conceptual	n/a	n/a	Primary foundational article of self-compassion, exploring how self-compassion (SC) differs from self-esteem (SE), as well as how SC relates to well-being. Presents research that demonstrates that SC provides greater resilience that SE, particularly given its manner of relating to self with kindness, connection and clear-sightedness, even in instances of failure, perceived inadequacy, and imperfection.

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22	Neff, K. D., & Germer, C. K.	2013	A Pilot Study and Randomized Controlled Trial of the Mindful Self-Compassion Program	self-compassion; mindfulness; compassion; intervention; well-being; meditation	Article	Research study	Randomized clinical trial. Measurements: 26-item Self-Compassion Scale (SCS), Freiburg Mindfulness Inventory (Walach, Buchheld, Buttenmuller, Kleinknecht, & Schmidt, 2006), Social Connectedness Scale (Lee & Robbins, 1995), 4-item Subjective Happiness Scale (Lyubomirsky & Lepper, 1999); Diener's Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985); Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Speilberger State-Trait Anxiety Inventory – Trait form	Study 1 was a pilot study that examined change scores in self-compassion, mindfulness, and various wellbeing outcomes among community adults (N = 21; mean [M] age = 51.26, 95% female, 87% White). Study 2 was a randomized controlled trial that compared a treatment group (N = 25; M age = 51.21; 78% female) with a waitlist control group (N = 27; M age = 49.11; 82% female)	Primary research for Mindful Self Compassion (MSC) 8-week group intervention. Focus of this study: to evaluate the effectiveness of the Mindful Self-Compassion (MSC) program, an 8-week workshop designed to train people to be more self-compassionate. Results: Study 1 found significant pre/post gains in self-compassion, mindfulness, and various wellbeing outcomes. Study 2 found that compared with the control group, intervention participants reported significantly larger increases in self-compassion, mindfulness, and wellbeing. Gains were maintained at 6-month and 1-year follow-ups.

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							(Speilberger, Gorsuch, & Lushene, 1970), Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983).		
23	Neff, K. D., Rude, S. S., & Kirkpatrick, K. L.	2007	An Examination of Self-Compassion in Relation to Positive Psychological Functioning and Personality Traits	self compassion, personality, psychological health, Self-attitudes, Self-criticism, Self-acceptance, Positive psychology, Big Five	Article	Research study	Correlational research; Measures: 26 item SCS, 39-item Three-Dimensional Wisdom Scale, 9-item Personal Growth Initiative Scale (PGIS), Curiosity and Exploration Inventory (CEI), 4-item Subjective Happiness Scale (SHS), 6-item Life Orientation Test-Revised (LOT-R), Positive and Negative AVect Schedule (PANAS), 60-item NEO Five-Factor Inventory, Form S (NEO-FFI S)	177 undergraduates at a Southwestern university. 68% female, 32% male. 56% Caucasian, 25% Asian, 14% Hispanic, 5% Mixed Ethnicity, and 1% Other.	This study demonstrated that self-compassion had a significant positive association with self-reported measures of happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness. Overall, study findings provide evidence that self-compassion does more than ameliorate for psychopathology but also predicts positive psychological strengths. It also demonstrated a significant negative association with negative affect and neuroticism. SC also predicted significant variance in positive

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									psychological wellbeing beyond that which was attributable to personality.
24	O'Dwyer, S. T., Moyle, W., Taylor, T., Creese, J., & Zimmer-Gembeck, M.	2017	In Their Own Words: How Family Carers of People with Dementia Understand Resilience	dementia; caregivers; resilience; acceptance; adversity; Australia	Article	Research study	Qualitative research	Twenty-one in-depth interviews were conducted in Australia with people who were currently, or had previously been, caring for a family member with dementia	This article provides caregivers' own perfectives, definitions of resilience, and opinions on the factors associated with resilience, including identification of traits values, environments, resources, and behaviors associated with resilience. Caregivers did not agree on whether resilience was a trait or process. Thematically analyzed interviews demonstrated three emergent themes: the presence of resilience, the path to resilience, and characteristics of the resilient caregiver.

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25	Pearlin, L. I., Mullan, J. T, Semple, S. J., & Skaff, M. M.	1990	Caregiving and the Stress Process: An Overview of Concepts and Their Measures	caregiving, stress, model of stress	Article	Theoretical	Created conceptual scheme for caregiver stress and presented developed measures to assess components of the scheme. Conducted three interviewed over a 2-year period, with primary caregivers of non-institutionalized spouses or parents of individuals with Alzheimer's disease or a similar dementia.	555 caregivers in the SF Bay Area and Los Angeles	Provides a comprehensive understanding of the developmental process and outcomes in caregiver burden. 1. Demographic/contextual variables: includes demographic variables such as the caregiver's and care recipient's age, gender, and race. This component also includes contextual factors such as relationship type, living arrangements, education, and employment status of the caregiver. 2. Primary stressors: includes objective indicators such as care recipient problem behaviors, functional dependence, and cognitive impairment. 3. Secondary stressors: stressors related to roles and activities outside of the caregiving situation, such as parental and/or employment responsibilities or one's role as a spouse. 4. Moderators: variables

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									that change the strength or lessen the impact of stressors in the relationship between two variables. 5. Outcomes: the outcome variable in the stress process, which can include the health and well-being of the caregiver.
26	Raab, K.	2014	Mindfulness, Self-Compassion, and Empathy Among Health Care Professionals: A Review of the Literature	clinician self-care, health care professionals ' wellbeing, mindfulness, mindfulness-based stress reduction, self-compassion, compassion	Article	Literature Review	n/a	multiple samples reviewed, primarily age 18-65, in United States	Mindfulness and self compassion promote non-judgment and curiosity toward present moment experience and these interventions, especially those with loving-kindness (a type of meditation) components have potential to increase self-compassion among healthcare workers.

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				fatigue					Results of review suggest possible mechanism of mindfulness and MBSR of reducing perceived stress and increasing effectiveness of clinical care.
27	Raes, F.	2010	Rumination and Worry as Mediators of the Relationship Between Self-Compassion and Depression and Anxiety	Self-compassion Rumination Worry Depression Anxiety	Article	Research study	Surveys completed by sample. MEASURES Self Compassion Scale (SCS), Beck depression inventory-II (BDI-II), State-trait anxiety inventory, trait version (STAI-T), Ruminative response scale (RRS), Penn state worry questionnaire (PSWQ)	271 nonclinical undergraduates in Belgium; 214 female. All participated in return for course credit. The sample's mean age was 18.14 years (SD = 1.25)	Results: within the relationship between self-compassion and depression, rumination (brooding) shown as a significant mediator. For anxiety, both rumination (brooding) and worrying emerged as significant mediators; however the mediating effect of worry was significantly higher than that of brooding. These findings suggest that a way in which self-compassion has buffering effects on depression and anxiety is through its positive impact upon unproductive repetitive thinking. This also suggests that "self-compassion may be a promising approach as a cognitive ‘‘immunization

	Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
									strategy" against the development and/or maintenance of depressive and anxious symptoms and associated clinical disorders."
28	Richards, K. C, Campenni, C. E., & Muse-Burke, J. L.	2010	Self-Care and Well-Being in Mental Health Professionals: The Mediating Effects of Self-Awareness and Mindfulness	self care, mindfulness, burnout, healthcare, mental health professionals	Article	Research study	survey; measured utilizing self-care activities on the Likert scale, The Self-Reflection and Insight Scale (SRIS), the Mindful Attention Awareness Scale (MAAS); and Schwarts Outcomes Scale-10 for wellbeing	148 mental health professionals holding a bachelor's degree or higher, practicing in northeastern United states; 77% women, average age 42 years old, 93% White, 2% Asian American, 2% Latino/a, <1% African American, <1% native American	Results demonstrated self care frequency significantly, positively correlated with self-care importance and well-being; self awareness positively correlated with self-care importance, well-being, and mindfulness; mindfulness also found strongly positively correlated with well-being.
29	Ross, L., Holliman, D., & Dixon, D.	2003	Resiliency in Family Caregivers	Caregivers, resiliency in caregiving, dementia caregivers, rural caregivers, social work practice, survey of caregivers, managing	Article	Research study	Measure: Caregiver Resilience Instrument	23 informal caregivers in rural area in the southeast who had been identified as resilient in the context of AD/dementia family caregiving	Among the findings of this study included qualitative themes in the context of informal caregiving, including: difficult aspects (overwhelming, all consuming, stressful, and lonely), benefits (knowing that you are handling what you feel is your responsibility, personal satisfaction of

Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
			stress, benefits of caregiving, caregiver role, coping					more meaningful relationships, fulfillment, learning to be more tolerant, an inner sense of well-being, personal satisfaction, getting to know the care recipient more personally, keeping your loved one as long as you can), and effective stress management strategies (talking with friends for support, exercise, maintaining a strong religious faith, and participating in hobbies, like listening to music (or playing guitar), reading, art (drawing), gardening, and aromatherapy, taking time off. The study also explored characteristics of resilient caregivers, including: years identified as a caregiver, distancing/taking time for self, physical exercise, hobbies, support, religion, philosophical beliefs, and use of humor.

	Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
30	Scott, C. B.	2013	Alzheimer's Disease Caregiver Burden: Does Resilience Matter?	Alzheimer's disease, informal caregivers, caregiver burden, resilience	Article	Research study	cross-sectional study design; research question: Does resilience moderate the relationship between caregiver stressors and caregiver burden? Hypothesized that resilience does moderate the relationship between identified caregiver stressors and caregiver burden. The stress process model (Pearlin et al., 1990) was used to guide this study. MEASUREMENTS: Knowledge About Memory Loss and Care (KAML-C; Kuhn, King, & Fulton, 2005); ADL/IADL scoring, 24-item Revised Memory and Behavior Problems Checklist (RMBPC; Teri et	One hundred ten (N=110) caregivers, recruited from community agencies that provide education and support to Alzheimer's disease caregivers in the southeastern region of the US	Review of literature demonstrates that due to caregiver burden, caregivers are more likely to experience depression & compromised physical health. Also explores foundational work in resilience in AD family caregivers, including: Garity (1997) findings of coping mechanisms utilized effectively to focus on positive aspects of caregiving; Ross, Holliman, and Dixon (2003) findings of relationship between resilience and caregivers distancing selves from their role for a period of time to laugh, participate in physical exercise, and hobbies; and Gaughler, Kane and Newcomer (2007) of the link between high resilience and decision to provide in home care rather than placing in a nursing home. FINDINGS: "resilience was not identified as a moderator between stressors and caregiver

	Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
							al., 1992); Resilience Scale (Wagnild & Young, 1993); Caregiver Burden Inventory (CBI; Novak & Guest, 1989)		burden; however, a relationship exists between resilience and caregiver burden. Specifically, as resilience in Alzheimer's disease caregivers increases, their caregiver burden decreases. These findings highlight the importance of supportive interventions that will increase resilience in Alzheimer's disease caregivers."
31	Warren, A. E., Schmid, K. L., Agans, J. P., Chase, P. A., Arbeit, M. R., Weiner, M. B, & Lerner, R. M.	2012	Resilience Across the Life Span	resilience, lifespan, model of resilience, context, environment, self-regulation	Chapter	Conceptual	n/a	n/a	This chapter explores the concept or resilience from a lifespan perspective, informed by relational developmental systems theory, which incorporates adaptive relationship between characteristics of individuals and features of the ecology. It posits that resilience is an attribute of positive human development achieved through adaptive relations between individual and context. Summarily, the authors suggest that resilience is a concept denoting relationship between a person and their

	Author(s)	Year	Title	Focus (variables, keywords, population, etc.)	Source (article, chapter, presentation, etc.)	Type (research study, conceptual, theoretical, review, etc.)	Methodology (design, measures, etc.)	Sample characteristics & population variables (other)	Results/Key content
									ecology, or multilevel and integrated (relational) developmental system; or the fit between the individual and their characteristics and the environment, including threats, challenges, etc. It also provides rationale for the importance of self-regulation via altering one's thoughts, attention, emotions, and behaviors in order to adapt to one's experience in order to attain personally-relevant goals. It explores self-regulation as physiological and intentional.
32	Wasson, R. S, Barratt, C., & O'Brien, W. H.	2020	Effects of Mindfulness-Based Interventions on Self-Compassion in Health Care Professionals: A Meta-Analysis	mindfulness, self-compassion, healthcare professionals, treatment outcomes	Article	Meta analysis	A meta-analytic review of the literature was conducted to quantitatively synthesize the effects of mindfulness-based interventions on self-compassion among health care professionals	Twenty-seven articles (k = 29, N = 1020) were utilized in the pre-post-treatment meta-analysis. Fifteen samples (52%) included health care professionals and fourteen (48%) professional health care students.	Meta-analytic review of literature explored to quantitatively synthesize the effects of mindfulness-based interventions on self-compassion among healthcare professionals. Findings suggest mindfulness-based interventions (MBIs) improve self-compassion in healthcare workers, and may be useful for employees and trainees.

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APPENDIX B

Evaluation of Curriculum Form

1. The curriculum is thorough and provides adequate information regarding the stressors that are unique to family caregivers of individuals diagnosed with Alzheimer's disease.

1	2	3	4	5
Strongly Disagree				Strongly Agree

2. The curriculum is thorough and provides adequate information on appropriate mind-body/contemplative interventions effective in work with caregivers of individuals diagnosed with Alzheimer's disease.

1	2	3	4	5
Strongly Disagree				Strongly Agree

3. The curriculum is easy to read and understand.

1	2	3	4	5
Strongly Disagree				Strongly Agree

4. The curriculum is well organized.

1	2	3	4	5
Strongly Disagree				Strongly Agree

5. The curriculum provides practical coping strategies that can assist mental health clinicians when working to reduce stress in clients who are caregivers of individuals diagnosed with Alzheimer's disease.

1	2	3	4	5
Strongly Disagree				Strongly Agree

6. The curriculum directly addresses the stated purpose of the workshop.

1	2	3	4	5
Strongly Disagree				Strongly Agree

7. The learning activities in the curriculum seem appropriate and sufficient for a one-day workshop.

1	2	3	4	5
Strongly Disagree				Strongly Agree

8. This is a program that will be helpful for family caregivers of individuals with Alzheimer's disease.

1	2	3	4	5
Strongly Disagree				Strongly Agree

9. What do you consider to be the strengths of the curriculum?

_____
_____
_____
_____

10. What do you consider to be the weaknesses of the curriculum?

_____
_____
_____
_____

11. What are some suggestions of additional stress-reduction/management interventions that are appropriate for caregivers of individuals diagnosed with Alzheimer's disease?

_____
_____
_____
_____

12. Please provide any other suggestions for improving this workshop.

_____
_____
_____
_____

13. Additional comments:

_____
_____
_____

Evaluator information:
Age:
Gender:
Ethnicity:
Highest degree earned: ❑ Masters ❑ Doctorate
Degree type: ❑ PhD ❑ PsyD ❑ LPCC ❑ LCSW ❑ MFT ❑ Other: _____
Years of clinical experience:
Years of research experience:
Years of geriatric specialty experience (clinical & research):
Years of mind-body/contemplative practice experience (clinical & research):

Any other useful information about your expertise (i.e. certifications, training, specialty licenses, honors, related positions held, etc.):

Thank you for your time!

APPENDIX C

IRB Approval Notice

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 10, 2020

Protocol Investigator Name:

Protocol #: 19-10-1207

Project Title: Self-Compassion Based Stress Management Workshop for Family Caregivers of Individuals with Alzheimer's Disease

School: Graduate School of Education and Psychology

Dear

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today February 10, 2020, and expires on February 09, 2021.

The consent form included in this protocol is considered final and has been approved by the IRB. You can only use copies of the consent that have been approved by the IRB to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond February 09, 2021, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research

APPENDIX D

Evaluator Recruitment Email Script

PEPPERDINE
UNIVERSITY

Dear (Potential Participant):

My name is and I am a doctoral student of clinical psychology in the Graduate School of Education and Psychology at Pepperdine University. I am conducting a research study that includes the development of a one-day self-compassion based workshop to assist caregivers of individuals with Alzheimer's disease in managing stress and promoting wellness, and you are invited to participate in this study. If you agree, you are invited to participate by reviewing and evaluating the curriculum via a brief questionnaire regarding your perceptions of the curriculum. The evaluation is anticipated to take approximately one hour and can be completed on any computer at your chosen location, or I will provide a hardcopy if preferred.

Participation in this study is voluntary. Your identity as a participant will remain anonymous during and after the study.

At this point in the project, I am seeking licensed mental health professionals with experience in *either* of the proceeding domains: (*clinicians/researchers must only fit the criteria in one of the areas listed below, not both.)*

Geriatric mental health:
(a) a minimum of five years of clinical and/or research experience in the geriatric population
(b) a general understanding of the stressors experienced by family caregivers of individuals with dementia, including Alzheimer's disease and/or other dementias

Mind-body/contemplative practice:
(a) a minimum of 5 years of clinical and/or research experience in mind-body or contemplative practices
(b) preferred but not required: some general understanding of/experience in self-compassion based interventions

If you decide to participate in this study, I will e-mail you an eligibility form to submit. Upon affirmation of eligibility, I will send an informed consent form, the developed curriculum, and a brief assessment of the curriculum, which is requested to be returned within two weeks. Upon return of a fully completed evaluation, you will be offered a $20 e-gift card to an online store of choice, and will also be requested to select a non-profit organization to which an anonymous $20 donation will be placed as compensation for your time.
If you have questions or would like to participate, please reply to me by email at

Thank you for your participation. Your support in sharing this with other prospective professionals is also greatly appreciated.

Sincerely,

Pepperdine University
Graduate School of Education and Psychology
Doctoral Student

APPENDIX E

Evaluator Recruitment – Email to Listservs and/or Professional Groups

Dear (Group Name):

My name is and I am a doctoral student of clinical psychology in the Graduate School of Education and Psychology at Pepperdine University. I am conducting a research study that includes the development of a one-day self-compassion based workshop to assist caregivers of individuals with Alzheimer's disease in managing stress and promoting wellness, and you are invited to participate in this study. If you agree, you are invited to participate by reviewing and evaluating the curriculum via a brief questionnaire regarding your perceptions of the curriculum. The evaluation is anticipated to take approximately one hour and can be completed on any computer at your chosen location, or I will provide a hardcopy if preferred.

Participation in this study is voluntary. Your identity as a participant will remain anonymous during and after the study.

At this point in the project, I am seeking licensed mental health professionals with experience in *either* of the proceeding domains: (*clinicians/researchers must only fit the criteria in one of the areas listed below, not both.)*

Geriatric mental health:
(a) a minimum of five years of clinical and/or research experience in the geriatric population
(b) a general understanding of the stressors experienced by family caregivers of individuals with dementia, including Alzheimer's disease and/or other dementias

Mind-body/contemplative practice:
(a) a minimum of 5 years of clinical and/or research experience in mind-body or contemplative practices
(b) preferred but not required: some general understanding of/experience in self-compassion based interventions

If you decide to participate in this study, I will e-mail you an eligibility form to submit. Upon affirmation of eligibility, I will send an informed consent form, the developed curriculum, and a brief assessment of the curriculum, which is requested to be returned within two weeks. Upon return of a fully completed evaluation, you will be offered a $20 e-gift card to an online store of choice, and will also be requested to select a non-profit organization to which an anonymous $20 donation will be placed as compensation for your time.
If you have questions or would like to participate, please reply to me by email at

Thank you for your participation. Your support in sharing this with other prospective professionals is also greatly appreciated.

Sincerely,

Graduate School of Education and Psychology
Doctoral Student

APPENDIX F

Evaluator Recruitment – Social Media Post

PEPPERDINE
UNIVERSITY

Friends and Peers,

My name is and I am a doctoral student of clinical psychology in the Graduate School of Education and Psychology at Pepperdine University. I am conducting a research study that includes the development of a one-day self-compassion based workshop to assist caregivers of individuals with Alzheimer's disease in managing stress and promoting wellness, and you are invited to participate in this study. If you agree, you are invited to participate by reviewing and evaluating the curriculum via a brief questionnaire regarding your perceptions of the curriculum. The evaluation is anticipated to take approximately one hour and can be completed on any computer at your chosen location, or I will provide a hardcopy if preferred.

Participation in this study is voluntary. Your identity as a participant will remain anonymous during and after the study.

At this point in the project, I am seeking licensed mental health professionals and/or researchers with experience in *either* of the proceeding domains: (*clinicians/researchers must only fit the criteria in one of the areas listed below, not both.)*

Geriatric mental health:
(a) a minimum of five years of clinical and/or research experience in the geriatric population
(b) a general understanding of the stressors experienced by family caregivers of individuals with dementia, including Alzheimer's disease and/or other dementias

Mind-body/contemplative practice:
(a) a minimum of 5 years of clinical and/or research experience in mind-body or contemplative practices
(b) preferred but not required: some general understanding of/experience in self-compassion based interventions

If you decide to participate in this study, I will e-mail you an eligibility form to submit. Upon affirmation of eligibility, I will send an informed consent form, the developed curriculum, and a brief assessment of the curriculum, which is requested to be returned within two weeks. Upon return of a fully completed evaluation, you will be offered a $20 e-gift card to an online store of choice, and will also be requested to select a non-profit organization to which an anonymous $20 donation will be placed as compensation for your time.
If you have questions or would like to participate, please reply to me by email at

Thank you for your participation. Your support in sharing this with other prospective professionals is also greatly appreciated.

Sincerely,

Pepperdine University
Graduate School of Education and Psychology
Doctoral Student

(accompanying image optional)

APPENDIX G

Evaluator Eligibility Form

PEPPERDINE
UNIVERSITY

1. For ALL potential participant evaluators:

Are you a licensed mental health clinician, such as a psychologist, LCSW, MFT, or equivalent?

❑Yes ❑ No

If yes,

what is your license type: _____

what is your degree: ❑ PhD ❑ PsyD ❑LPCC ❑ LCSW ❑ MFT ❑ Other _____

2. Next, please fill out either A or B below. If both categories relate to your expertise, you may fill out both.

(A) Geriatric mental health clinicians/researchers:

1. Do you have at least five (5) years of experience working with and/or researching the geriatric population?

❑Yes ❑ No

2. Do you have a general understanding of the stressors experienced by caregivers of individuals with Alzheimer's disease and/or other dementias?

❑Yes ❑ No

(B) Mind-body or contemplative practice clinicians/researchers:

1. Do you have a minimum of five (5) years of experience leading and/or researching mind-body or contemplative practices?

❑Yes ❑ No

2. Do you have some general understanding of/experience in self-compassion based interventions?

❑Yes ❑ No (This question is a preference, not eligibility requirement)

APPENDIX H

Qualified Evaluator Email

PEPPERDINE
UNIVERSITY

Dear (Evaluator),

Thank you for your interest in participating in my dissertation research study. It has been determined that your qualifications are a match for the current study and this email provides further details regarding your participation. Your participation is greatly appreciated.

You will find the following information attached to this email:

a) *Evaluator Consent Form*, which outlines the following:
   - nature and purpose of the study, author's affiliation, associated risks and benefits of participation, considerations for evaluators' privacy and confidentiality
b) *Workshop Curriculum*, the information which you will be evaluating
c) *Evaluation of Curriculum Form*, which is to be used for your assessment of the curriculum

If you prefer to receive this information via fax or in print via mail, please reply to this email and you will be sent all information in your preferred format.

The following details provide information for the next steps of your participation in this research study, including a timeline beginning as of today, <<insert date>>.

1. Please respond to this email with a signed copy of the informed consent within three (3) business days, <<insert date>>.
2. It is estimated that the review of the curriculum will take approximately one hour.
3. It is requested that you evaluate the curriculum as soon as possible, preferably within two weeks of today's date, which is <<insert date>>.
   a. If the evaluation is not received within two weeks, I will contact you via email to discuss the status of the evaluation and to be available to provide any further information or answer any questions regarding the study.
   b. Your participation is completely voluntary and you may choose to discontinue participating as an evaluator at any point.
4. As compensation for your time, each participating individual who completes an evaluation will receive the following:
   - Item 1: a $20 gift card to an online store of choice (store must allow gift card purchase); and
   - Item 2: an anonymous $20 donation to their Alzheimer's non-profit organization of choice.
   - Details: All items on the evaluation form must be completed in order to qualify. This compensation will be offered within one week of submission of a completed evaluation. Participants will be reminded twice, in two-week

intervals, to select their online gift card store and online non-profit donation recipient. If they do not respond within four weeks, they will be sent an Amazon e-gift card for $20 and an anonymous donation to an Alzheimer's non-profit organization will be placed in the amount of $20.

If you have any further questions, please contact Jessika Bailey, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson, at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, (310) 568-5600.

Again, thank you for your interest and willingness to participate. I am grateful you have chosen to share your time and expertise with this research project.

In gratitude,

APPENDIX I

Evaluator Consent Form

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INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

IRB#: 19-10-1207

Study Title:

"Self-Compassion Based Stress Management Workshop For Family Caregivers Of Individuals With Alzheimer's Disease"

Authorized Study Personnel

Principal Investigator:		(XXX) XXX-XXXX
Secondary Investigator:	Shelly Harrell, Ph.D.	(XXX) XXX-XXXX

Key Information:

If you agree to participate in this study, the project will involve:

- Males and females over the age of 25, of any racial-ethnic group
- Procedures will include the development of a workshop manual that will utilize self-compassion as means for stress reduction and resilience building in family caregivers of individuals with Alzheimer's disease
- One visit is required
- This visit will take a approximately one hour total
- There are minimal risks associated with this study, which includes boredom and minimal stress
- You will be compensated with a $20 e-gift card and a separate $20 donation to your charity of choice for your participation
- You will be provided a copy of this consent form

Invitation

You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to participate. If you have any questions, please ask.

Why are you being asked to be in this research study?

Initials: _____

You are being asked to be in this study because you are a licensed mental health clinician with expertise in either geriatric mental health or mind-

body/contemplative practice. You must be 25 years of age or older to participate.

What is the reason for doing this research study?

Family members who provide caregiving to individuals with Alzheimer's disease experience significant stress. This research is designed to provide caregivers with self-compassion based tools to reduce stress and build resilience.

What will be done during this research study?

You will be asked to evaluate the workshop curriculum and complete one questionnaire to evaluate the materials. The survey will take approximately one hour to complete and you may complete it from your home computer.

What are the possible risks of being in this research study?

This research presents risks of mild levels of boredom and fatigue during the review of the intervention curriculum and completion of the evaluation questionnaire.

What are the possible benefits to you?

Participation in the evaluation of this Intervention Manual has the potential benefit of exposing participants to ideas for interventions with family caregivers of individuals with Alzheimer's disease, as well as increased knowledge about self-compassion, particularly as it applies to this population. However, you may not get any benefit from being in this research study.

What are the possible benefits to other people?

The results of the study have potential future benefits to the mental health field, service delivery agencies, service providers, and potential consumers with respect to the implementation of a self-compassion based stress management group with informal caregivers of individuals with Alzheimer's disease.

What will being in this research study cost you?

There is no cost to you to be in this research study.

Will you be compensated for being in this research study?

Upon completion of an evaluation, you will receive the following:
(1) a $20 gift card to an online store of choice (store must allow gift card purchase); and
(2) an offer to have an anonymous $20 donation to your non-profit organization of choice.

What should you do if you have a problem during this research study?

Your welfare is a major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the beginning of this consent form.

How will information about you be protected?

Reasonable steps will be taken to protect your privacy and the confidentiality of your study data.

For any electronic data that is received, the data will be stored electronically through a secure server and will only be seen by the research team during the study and for three years after the study is complete. For any hardcopy data that is received, the data will be stored in a locked cabinet in the investigator's office and will only be seen by the research team during the study and for three years after the study is complete.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person, agency, or sponsor as required by law. The information from this study may be published in scientific journals or presented at scientific meetings but the data will be reported as group or summarized data and your identity will be kept strictly confidential.

What are your rights as a research subject?

You may ask any questions concerning this research and have those questions answered before agreeing to participate in or during the study.

For study related questions, please contact the investigator(s) listed at the beginning of this form.

For questions concerning your rights or complaints about the research contact the Institutional Review Board (IRB):

Phone: +1 (310) 568-2305
Email: gpsirb@pepperdine.edu

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study ("withdraw") at any time before, during, or after the research begins for any reason. Deciding not

to be in this research study or deciding to withdraw will not affect your relationship with the investigator or with Pepperdine University.

You will not lose any benefits to which you are entitled.

Documentation of informed consent

You are voluntarily making a decision whether or not to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study. You will be given a copy of this consent form to keep.

Participant Feedback Survey

To meet Pepperdine University's ongoing accreditation efforts and to meet the Accreditation of Human Research Protection Programs (AAHRPP) standards, an online feedback survey is included below:

https://forms.gle/nnRgRwLgajYzBq5t7

Participant Name:

_____
(Name of Participant: Please print)

Participant Signature:

_____ _____
Signature of Research Participant Date

Investigator certification:

_____ _____
Signature of Person Obtaining Consent Date

APPENDIX J

Unqualified Potential Evaluator Email

PEPPERDINE
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Dear (Interested Evaluator),

Thank you for your interest in participating in my dissertation research study. Unfortunately it has been determined that your qualifications are not a match for the current study. Please see below for details:

____ Does not meet criteria for licensed mental health clinician, such as a psychologist, LCSW, MFT, or equivalent

____ Licensed mental health clinician/researcher with specialty in geriatric mental health but does not meet criteria for at least five (5) years of experience working with and/or researching the geriatric population

____ Licensed mental health clinician/researcher with specialty in geriatric mental health but does not meet criteria for possessing a general understanding of the stressors experienced by caregivers of individuals with Alzheimer's disease and/or other dementias

____ Licensed mental health clinician/researcher with specialty in mind-body or contemplative practice but does not meet criteria of a minimum of five (5) years of experience leading and/or researching mind-body or contemplative practices

If you have any further questions, please contact or Shelly Harrell, Ph.D., Dissertation Chairperson, at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, (310) 568-5600.

Again, thank you for your interest and willingness to participate. I wish you very well in all your endeavors.

In gratitude,

APPENDIX K

Intervention Manual

Self-Compassion Workshop for Alzheimer's Disease Family Caregivers

A RESILIENCE PROMOTING STRESS MANAGEMENT INTERVENTION

In Honor

For my mom, who embodied the true meaning of patience, unconditional love, and grit. And for my dad, who has become her guide, her rock, and her AD family caregiver as we lose her piece-by-piece.

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INTRODUCTION

Group Rationale and Purpose

As the number of elderly individuals rises, suggesting that older people with chronic illnesses such as Alzheimer's disease will also increase, family involvement in caregiving will become more important than ever. In 2012, approximately 15.4 million Americans provided an estimated 17.5 billion hours of unpaid care for people living with dementia (Thies & Bleiler, 2013).

Providing care for an individual with Alzheimer's disease adds strain and stress to one's life. The caregiving experience causes pressure due to increased time limitations, shifts in typical familial roles, interference with work, and a burden on finances. According to a review by the MetLife Study of Alzheimer's Disease (2006), Alzheimer's disease caregivers provided an average of 47 hours of care each week. This amount of time would surely impact any individual's capacity for their other roles and personal, occupational, social, and self-care needs. Caregivers must also constantly learn to manage changes in their patient's requirements as the disease progresses, which include changes in mood and personality, new behavioral disturbances, and their ability to communicate.

Providing care for an individual with Alzheimer's disease has been associated with significant risks to the caregiver's own health and well-being. Given that chronic stress is the most deleterious threat to health (McEwen & Stellar, 1993; Thoits, 2010), it is imperative to understand the specific risks experienced by caregivers. Existing research suggests that a caregiver's physical health may be compromised when he or she is psychologically distressed (Pinquart & Sorensen, 2007; Schulz & Beach, 1999; Schulz & Martire, 2004). One study reported that stress levels rose 13.5% when caring for an individual with Alzheimer's disease and that 32% of caregivers indicated that their health had gotten worse because of the strain of caregiving (MetLife Mature Market Institute, 2006). Caregiver emotional stress has been shown to be significantly associated with older age, female gender, greater caregiving burden, high functional impairment in the patient, and additional behavioral symptoms (Kim & Schulz, 2008; Jennings, et al., 2015). Higher levels of caregiver strain are also related to worse outcomes for those individuals with dementia, including higher rates of being placed in a nursing home (Gaugler & Krichbaum, 2009).

Caregiver stress has the potential to negatively impact their physiological well-being and physical health. Dementia caregivers are more likely to report poor and/or worsening health due to caretaking, and have difficulty with health maintenance (Alzheimer's Association, 2016). Compared to non-caregivers, they are at greater risk of producing

higher levels of stress hormones (von Kanel et al., 2006), suffering from reduced immune function (Kiecolt-Glaser, Dura, Speicher, Trask, Galser, 1991), and developing cardiovascular disease (Mausbach et al., 2010; Vitaliano et al., 2002). For those experiencing the highest levels of stress, their mortality is in jeopardy as well (Fredman et al., 2010; Schulz et al., 1999). Recent research has also demonstrated that extreme levels of perceived stress are associated with a thirty percent greater risk of amnestic mild cognitive impairment (Katz et al, 2016).

Alzheimer's disease and dementia caregiver stress also cause negative mental health outcomes, though caregiver mental health is insufficiently addressed (Richardson, et al., 2013). Fifty-nine percent of family caregivers of people with Alzheimer's disease and other dementias rated their emotional distress due to caregiving as high or very high (Alzheimer's Association, 2016). Alzheimer's disease caregivers under stress are at greater risk for mental health issues such as depression (Richardson et al., 2013), and higher stress levels are associated with more depressive symptoms (Wimo et al., 2013). One study revealed that one in seven dementia caregivers demonstrated factors associated with moderate to severe depression (Jennings et al., 2015), while another found that spouses caring for dementia patients are four times more likely to experience depression than non-caregivers (Joling et al.,2010). Further research estimates that approximately 40 percent of family caregivers suffer from depression (Pinquard et al. 2003; Schulz & Martire, 2004), which may increase as the severity of the patient's cognitive impairment rises. Low levels of self-efficacy for dementia caregiving have been correlated with higher levels of strain, more depressive symptoms and a lower perception of self-rated health (Jennings et al., 2015).

Cultivating Resilience Using the Mind Body Approach of Self-Compassion

A systematic review of the resilience of caregivers of people with dementia found that higher levels of resilience were associated with lower depression rates, greater physical health, a lower sense of burden, stress, and neuroticism, and greater perceived control (Dias et al, 2015). Their findings also revealed that social support was a moderating factor, relieving the physical and mental experience of overload caused by stress. As such, resilience in the context of caregiving is an important goal.

A thorough body of research (Paller, et al., 2015; Cash, Ekouevi, Kilbourn, Lageman, 2015; Jain, Nazarian, & Lavretsky, 2014, Whitebird et al, 2013; Lavretsky et al., 2012; Innes et al., 2012; Franco et al., 2010; Oken et al., 2010; Waelde, Thompson, & Gallagher-Thompson, 2004; McBee, 2003) demonstrates the utility and positive impact of mind-body or contemplative practices for caregiver stress alleviation, including studies utilizing meditation, mindfulness, and yogic-based psychosocial interventions. One investigation demonstrated the feasibility of a Central Meditation and Imagery Therapy Center for family caregivers of individuals with dementia, revealing that it could reduce symptoms of anxiety, depression, and insomnia, as well as increase mindfulness (Jain, Nazarian, & Lavretsky, 2014). Another study examined the effects of a brief daily yogic meditation on mental health, cognitive functioning, and immune cell

telomerase activity in family dementia caregivers with mild depressive symptoms (Lavretsky et al., 2012). Their findings showed improvements across measures of mental health, cognitive functioning, psychological distress, and telomerase activity; this demonstrates the intervention's ability to impact the biological stress response. It also shows that a low-cost behavioral intervention has the power to positively affect caregiver's coping skills and quality of life.

Numerous studies have explored the benefits of utilizing self-compassion when confronting suffering, demonstrating its capability to promote positive mental health outcomes. A review of self-compassion conceptualizations, correlates, and interventions highlighted that greater self-compassion has been associated with lower levels of depression and anxiety (Barnard & Curry, 2011). Numerous studies have also found links between self-compassion and positive psychological qualities such as happiness, optimism, wisdom, curiosity and exploration, personal initiative, and emotional intelligence (Herrernan, Griffin, McNulty & Fitzpatrick, 2010; Hollis-Walker & Colosimo, 2011; Neff, Rude, & Kirkpatrick, 2007). Self-compassion has also been demonstrated to moderate people's reactions to negative events (Leary, Tate, Allen, and Hancock, 2007), and training in self-compassion has been shown to increase self-compassion, mindfulness, life satisfaction, social connectedness, optimism, and self-efficacy (Breines & Chen, 2012; Neff & Germer, 2013; Neff et al., 2007). Finally, practicing self-compassion for a brief period of time has been determined to produce sustainable mental health changes (Shapira & Mongrain, 2010).

Program Overview and Vision

"Self-Compassion Workshop For Alzheimer's Disease Family Caregivers" is a resilience-oriented stress management intervention for AD family caregivers, adapted from the "Resilience and Reconnection" group intervention designed by Dr. Shelly Harrell and her research team. The original intervention employs a resilience-oriented stress management approach developed over a three-year period using a diverse sample of three groups of psychology graduate students at a community mental health center. The intervention will continue to be tested more systematically at outpatient clinics amongst adults experiencing mental health challenges. The group format is a culturally-adaptive and integrative affirmative psychology approach to stress management, designed to enhance positive outcomes such as resilience and wellbeing (Harrell, 2020). The development of resilience is targeted by facilitating a positive adaptation to stress. The intervention focuses on three essential pillars of resilience, including (1) Contemplative Processes (Awareness – "What am I experiencing?); (2) Communal Processes (Allies – With What and/or Who Will I Connect?); and, (3) Empowerment Processes (Action – What Choices will I Make?) (Harrell, 2020).

Integrated with the primary components and practices of self-compassion (mindfulness, common humanity, and kindness) (Neff et al., 2007), this program aims to empower Alzheimer's disease family caregivers. It seeks to arm them with increased adaptive skills for moderating stress and building resilience during difficult moments that are potentially harmful to a caregiver's wellbeing and so common within the caregiving experience.

Given that this proposed intervention has been developed as a full-day workshop lasting approximately 6.5 hours, and implies significant group participation, it is suggested to include between 4-12 participants, though this number is ultimately left to the discretion of the group leader(s).

Identification and Recruitment of Group Members

Participant Identification

This group intervention is intended for family caregivers of individuals with Alzheimer's disease, including partners, siblings, children, or any other individual who is considered 'family' or a non-professional caregiver to an individual with Alzheimer's disease. Group participants may be recruited through the dissemination of flyers containing group information at a variety of local community institutions, such as elder care institutions, senior centers, libraries (where many senior and/or community events are held), doctor's offices, mental health clinicians' offices, community centers, churches, establishments that provide mind-body wellness offerings (i.e. mindfulness, yoga, tai chi, chi gong, etc.), and other locations frequented by aging individuals in your community. Information can also distributed via online postings and message boards. (See *Appendix A: Sample Recruitment Flyer*)

Participant Screening

It is suggested that facilitators take time to consider relevant participation criteria for their target population and implement appropriate screening procedures. This may include the caregiver's capacity to attend a full day session away from their family member*, language abilities, the caregiver's cognitive functioning/capacity, and/or any physical or mental health condition that may prohibit the caregiver from fully engaging in the session or cause him or her to become disruptive. It is quite common for caregivers to experience depression and anxiety and research provides some evidence for the efficacy of self-compassion in building positive mental health. It is not, however, a treatment for mental health conditions. As such, careful consideration should be taken regarding the severity of any mental health conditions. For example, if a caregiver is experiencing severe depression and/or suicidal ideation, they are unlikely to be a good candidate for this program. Possible participants should also be screened for additional mental health conditions such as active severe panic disorder, obsessive-compulsive disorder, eating disorders, psychotic disorders, and active substance abuse (i.e. alcohol or drugs). If a caregiver is suffering from one of these conditions, they should not participate in this intervention and should instead be provided with a referral to local mental health resources and/or recommended to speak with their team of medical professionals. It is also imperative that participants are not actively using mind-altering substances during the session.

Ability needs must also be considered. If an individual is legally blind and cannot read a piece of paper, they may need a support person present to help them or a facilitator

may need to assist them during some activities. Please consider any other factors particular to your group, workshop location, community, and/or participants.

As this is not a workshop for treating mental health conditions, it is suggested that individuals with significant mental health concerns are individually screened and informed that this program is not aimed at mental health treatment.

*Partnering this workshop with a professional elder care center is an idea that could aid the caregiver in assuring care for their loved one on the day of the workshop (i.e. for individuals with Alzheimer's disease who still live at home).

Facilitator Recommendations

Facilitator Experience and Criteria

(1) For the most effective implementation of this workshop curriculum, a facilitator will:

(a) have experience with self-compassion and mindfulness;
(b) be a trained mental health clinician or applied researcher;
(c) have experience in the geriatric community and/or with caregiver support; and,
(d) have training, interest, and/or scholarship in diversity.

Given that all four criteria may be prohibitive, co-facilitation is strongly suggested (i.e. using 2 or 3 facilitators) so as to join experience and strengths (see co-facilitating recommendations below). As such, a minimum of meeting three of the above criteria is suggested, with a requisite for criteria (a) – experience with self-compassion. This experience may range from having taken an eight week or one-week intensive Mindful Self-Compassion (MSC) course, demonstrable research or scholarship in self-compassion, or being a certified, trained or in-training Mindful Self-Compassion Teacher. A facilitator or co-facilitator may also be a trainee under the direct supervision of a clinician or researcher with this experience.

(2) Facilitators will be most effective if they possess a strong knowledge and experiential understanding of Self-Compassion (work of Kristin Neff and Chris Germer), some familiarity with the Resilience and Reconnection (R&R) Stress Management Group (Shelly P. Harrell) model, and basic understandings of Alzheimer's disease and caregiving.

The following is a guide to various resources that a facilitator can explore to have a baseline understanding and preparedness to lead this group. Extensive information is available on many of these topics.

Self-Compassion:

About: Self-Compassion work was pioneered by Dr. Kristen Neff, Ph.D., and developed into a Mindful Self-Compassion training with Dr. Chris Germer, Ph.D.

The following information describes self-compassion and its three components (from www.self-compassion.org). This workshop utilizes many of the primary self-

compassion interventions, while applying these three components as themes for the various activities in the workshop intervention (see Workshop Outline Table for details). It is important to note that this is likely a new way of relating to one's own struggles, thus it is important to emphasize and model empathy that it may be difficult to engage with oneself in this manner. For example, it is vital to approach participant responses in a non-judgmental manner, accepting their experience as it is without wishing for anything different from their responses. It may also be useful to openly give participants the permission to recognize or express that these practices do not work for them, even when inviting such responses.

Definition of Self-Compassion: *Having compassion for oneself is really no different than having compassion for others. Think about what the experience of compassion feels like. First, to have compassion for others you must notice that they are suffering. If you ignore that homeless person on the street, you can't feel compassion for the difficulty of his or her experience. Second, compassion involves feeling moved by others' suffering so that your heart responds to their pain (the word compassion literally means to "suffer with"). When this occurs, you feel warmth, caring, and the desire to help the suffering person in some way. Having compassion also means that you offer understanding and kindness to others when they fail or make mistakes, rather than judging them harshly. Finally, when you feel compassion for another (rather than mere pity), it means that you realize that suffering, failure, and imperfection is part of the shared human experience. "There but for fortune go I."*

Self-compassion involves acting the same way towards yourself when you are having a difficult time, fail, or notice something you don't like about yourself. Instead of just ignoring your pain with a "stiff upper lip" mentality, you stop to tell yourself "this is really difficult right now," and ask yourself "how can I comfort and care for myself in this moment?" Instead of mercilessly judging and criticizing yourself for various inadequacies or shortcomings, self-compassion means you are kind and understanding when confronted with personal failings – after all, who ever said you were supposed to be perfect?

You may try to change in ways that allow you to be more healthy and happy, but you do this because you care about yourself, not because you are worthless or unacceptable as you are. Perhaps most importantly, having compassion for yourself means that you honor and accept your humanness. Things will not always go the way that you would like. You will encounter frustrations, losses will occur, you will make mistakes, bump up against your limitations, and fall short of your ideals. This is the human condition, a reality shared by all of us. The more you open your heart to this reality instead of constantly fighting against it, the more you will be able to feel compassion for yourself and your fellow humans in the experience of life.

The three elements of self-compassion include:

1. ***Self-kindness*** *vs. Self-judgment. Self-compassion entails being warm and understanding toward ourselves when we suffer, fail, or feel inadequate, rather than ignoring our pain or flagellating ourselves with self-criticism. Self-compassionate people recognize that being imperfect, failing, and experiencing difficulties in life is inevitable, so they tend to be gentle with themselves when confronted with painful*

experiences rather than becoming angry when life falls short of set ideals. People cannot always be or get exactly what they want. When one denies or fights this reality, their suffering increases in the form of stress, frustration, and self-criticism. When this reality is accepted with sympathy and kindness, greater emotional equanimity is experienced.

*2. **Common humanity** vs. Isolation. Frustration at not having things exactly as we want is often accompanied by an irrational but pervasive sense of isolation – as if "I" were the only person suffering or making mistakes. Yet all humans suffer, however. The very definition of being "human" means that one is mortal, vulnerable, and imperfect. Therefore, self-compassion involves recognizing that suffering and personal inadequacy is part of the shared human experience – something that we all go through rather than something that happens to "me" alone.*

*3**. Mindfulness** vs. Over-identification. Self-compassion also requires taking a balanced approach to our negative emotions so that feelings are neither suppressed nor exaggerated. This equilibrated stance stems from the process of relating our personal experiences to those of others who are also suffering, thus putting our own situation into a larger perspective. It also stems from the willingness to observe our negative thoughts and emotions with openness and clarity, so that they are held in mindful awareness. Mindfulness is a non-judgmental, receptive mind state in which one observes thoughts and feelings as they are, without trying to suppress or deny them. We cannot concurrently ignore our pain and also feel compassion for it. At the same time, mindfulness requires that we not be "over-identified" with thoughts and feelings, so that we are caught up and swept away by negative reactivity.*

Books:

Neff, K. (2011). Self-compassion: stop beating yourself up and leave insecurity behind (1st ed.). William Morrow.

Germer, C. K., & Neff, K. (2019). Teaching the mindful self-compassion program: a guide for professionals. Guilford Press.

Websites:

http://www.self-compassion.org
www.chrisgermer.com

Resilience and Reconnection (R&R) Stress Management Group: (from Harrell, 2020)

This workshop manual uses the framework of the Resilience and Reconnection (R&R) Stress Management Group intervention as its foundation. While the R&R curriculum targets 21 resilience qualities amidst it's multi-session group format, this Intervention Manual focuses on one specific resilience factor – compassion – and further narrows the focus to self-compassion, given ongoing research that demonstrates the positive correlation between self-compassion and resilience.

The following material provides information regarding the R&R model's greater context (excerpts from Harrell, 2020):

R&R is a flexible group intervention for stress-related disorders and the presence of significant psychosocial stressors (with or without a primary diagnosis). It is an application of the Resilience-Oriented Intervention (ROI) approach, which is centered in activating contemplative, communal, and empowerment processes in the service of positive adaptation, transformation, and growth in the context of biopsychosocial risk, stress, adversity, and/or traumatization. It is grounded in "psychoecocultural" PEaCE meta-theory with cultural responsiveness and adaptation of the intervention strategies being central to any implementation.

What is the intervention's goal? *R&R aims to increase RESILIENCE: "a multilevel biopsychosocial and ecocultural process that reflects positive adaptation, transformation, and/or growth in the context of significant risk, challenge or adversity". The emphasis is on cultivating, enhancing, and sustaining culturally-syntonic strengths and strategies that build stress resilience. The group motto is "from stressed out to energized within".*

What is stress resilience? *Stress resilience involves the activation of internal and external resources for managing stress that result in: (1) reducing the intensity of the psychophysiological stress response in order to "bounce back", (2) building and enhancing strengths and strategies for managing future stressors, and (3) transforming stressful experiences toward stress-related growth and thriving. Thus, a "resilient" person is able to regulate the stress response (PREVENT the debilitating effects of stress), utilize strengths (PREPARE for future stressors by developing and enhancing internal and external strengths), and exhibit growth (PROSPER personally, relationally, and collectively) in the context of stress and adversity.*

Why focus on resilience for stress management? *Traditional stress management interventions have focused on skills training primarily targeting psychophysiological processes (MBSR, Benson's Relaxation Response) and cognitive restructuring (e.g. Stress Inoculation Training). These interventions emphasize the reduction of negative symptoms. R&R is part of a movement in the field towards "resilience training", a recent development in stress management that is informed by resilience science and positive psychology and emphasizes the development of strengths and positive ways-of-being.*

How are expressions of resilience developed and sustained? *Expressions and qualities of resilience are supported by the three primary mechanisms of change or resilience processes: Communal, Contemplative, and Empowerment Processes. Within the intervention these processes are referred to as the Three Pillars of Resilience: ALLIES, AWARENESS, and ACTION. These processes reflect Wellness-Promoting, Person-in-Culture-in-Context Transactions. Positive adaptation, transformation, and growth require activation of these wellness-promoting resilience processes such that one has to "work the OWTs" in order for them to contribute to stress resilience. Session activities are designed to activate these three change processes in the service of strengthening the targeted resilience qualities.*

What is the meaning of "Reconnection"? *Developing resilience is a continual process of reconnecting to self (experientially, identity, strengths, etc.), others (relationships, community), and something "bigger" (meaning, purpose, wisdom, values, spirituality). Reconnection is the meta-communication that is woven throughout the intervention. A primary message is that reconnection must be intentional and ongoing because the challenges of daily living put us at constant risk for losing "connection" to what is most important.*

What is the evidence for this intervention? *The intervention is informed by and grounded in the empirical and conceptual literature in psychology and related fields. There is a particular incorporation of work in the areas of Stress Science, Applied Positive Psychology, Lifestyle and Behavioral Medicine, Trauma Studies, Contemplative Practices and Spirituality, Mindfulness and Acceptance-based Behavioral Therapies, Community Psychology, Multicultural Psychology, and Expressive Arts Therapies.*

Triadic Change Model: The R&R group intervention is based on the Triadic Change Model (Harrell, 2020). The following information describes this process, which is layered into this workshop's curriculum (see Workshop Outline Table for details). Below is the description of this model of change, including a descriptive diagram.

The "HOW" of R&R: THE TRIADIC CHANGE MODEL (Harrell, 2020)

The specific strategies of the R&R group intervention aim to nurture and strengthen Harrell's three core change processes that optimize positive outcomes. In R&R these are referred to as Awareness, Allies, and Action (aka "The Three Pillars of Resilience"). It should be continuously emphasized to participants that the group is designed to help them become more "stress resilient" (i.e. Prevent, Prepare, and Prosper) by utilizing the Awareness, Allies, and Action processes to have positive and fulfilling lives despite the inevitability of experiencing stress.

The Three Pillars correspond to the three Person-in-Culture-in-Context transactional processes in Harrell's PEaCE-informed Triadic Change Model: Contemplative Processes, Communal Processes, and Empowerment Processes. In the context of PEaCE meta-theory (a psychoecocultural theory of positive health and wellness), these processes are conceptualized as types of wellness-promoting transactions that emerge from Person-in-Culture-in-Context activity.

These processes are the hypothesized mechanisms of change for the R&R intervention and the intervention strategies specifically chosen and used in group sessions should explicitly incorporate each of these interrelated processes.

Awareness = Contemplative Processes ("Consciousness"; Attention; Reflection)
Allies = Communal Processes ("Connectedness"; Relationality; Belonging)
Action = Empowerment Processes ("Commitment"; Transformation; Choice)

THE TRIADIC CHANGE MODEL (TCM; Harrell, 2019)

(revised November 2019)

Additional Resource:
https://www.slideshare.net/ShellyHarrell/getting-some-rr-the-resilience-and-reconnection-group-intervention-as-a-positive-psychology-approach-to-stress-management

Alzheimer's Disease

Understanding Alzheimer's disease is important in order to understand the basics, progression of the disease, and associated stresses with the changes and losses in functioning affiliated with Alzheimer's disease.

The following information includes some basic information from www.alz.org

Alzheimer's is the most common cause of dementia, a general term for memory loss and other cognitive abilities serious enough to interfere with daily life. Alzheimer's disease accounts for 60 to 80 percent of dementia cases.

Alzheimer's is not a normal part of aging. The greatest known risk factor is increasing age, and the majority of people with Alzheimer's are 65 and older. But Alzheimer's is not just a disease of old age. Approximately 200,000 Americans under the age of 65 have younger-onset Alzheimer's disease (also known as early-onset Alzheimer's).

Alzheimer's worsens over time. Alzheimer's is a progressive disease, in which the symptoms of dementia gradually worsen over a number of years. In its early stages, memory loss is mild, but with late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment. Alzheimer's is the sixth leading cause of death in the United States. On average, a person with Alzheimer's lives four to eight years after diagnosis, but can live as long as 20 years, depending on other factors.

Alzheimer's has no current cure, but treatments for symptoms are available and research to find a cure is ongoing. Although current Alzheimer's treatments cannot stop its progression, they can temporarily slow dementia symptoms from worsening and improve quality of life for those with Alzheimer's and their caregivers. Today, there is a worldwide effort under way to find better means to treat the disease, delay its onset, and prevent its development.

Alzheimer's and the brain: Microscopic changes in the brain begin long before the first signs of memory loss. The brain has 100 billion nerve cells (neurons). Each nerve cell connects with many others to form communication networks. Groups of nerve cells have special jobs. Some are involved in thinking, learning, and remembering. Others help us see, hear, and smell. To do their work, brain cells operate like tiny factories. They receive supplies, generate energy, construct equipment, and get rid of waste. Cells also process and store information and communicate with other cells. To keep everything running requires coordination as well as large amounts of fuel and oxygen. Scientists believe Alzheimer's disease prevents parts of a cell's factory from running well. They are not sure where the trouble starts. But just like a real factory, backups and breakdowns in one system cause problems in other areas. As damage spreads, cells lose their ability to do their jobs and eventually die, causing irreversible changes in the brain.

The role of plaques and tangles: Two abnormal structures called plaques and tangles are prime suspects in damaging and killing nerve cells. Plaques are deposits of a protein fragment called beta-amyloid (BAY-tuh AM-uh-loyd) that build up in the spaces between nerve cells. Tangles are twisted fibers of another protein called tau (rhymes with "wow") that build up inside cells. Though autopsy studies show that most people develop some plaques and tangles as they age, those with Alzheimer's tend to develop far more and in a predictable pattern, beginning in the areas important for memory before spreading to other regions. Scientists do not know exactly what role plaques and tangles play in Alzheimer's disease. Most experts believe they somehow play a critical role in blocking communication among nerve cells and disrupting processes that cells need to survive. It's the destruction and death of nerve cells that causes memory failure, personality changes, problems carrying out daily activities, and other symptoms of Alzheimer's disease.

Research and progress: Today, Alzheimer's is at the forefront of biomedical research. Researchers are working to uncover as many aspects of Alzheimer's disease and other dementias as possible. Some of the most remarkable progress has shed light on how Alzheimer's affects the brain. The hope is that this better understanding will lead to new treatments. Many potential approaches are currently under investigation worldwide.

Resource:

Alzheimer's Association: https://www.alz.org

Caregiving Stress

Caregivers frequently report experiencing high levels of stress, which impacts not only their ability to engage in effective caregiving, but also their own health and overall wellbeing. It is important for a facilitator to be familiar with symptoms of caregiver stress. The following 10 symptoms are commonly seen signs of caregiver stress (provided by www.alz.org), though this is not a comprehensive list, particularly given differences in caregiving based on culture and context.

1. Denial about the disease and its effect on the person who has been diagnosed. I know Mom is going to get better.
2. Anger at the person with Alzheimer's or frustration that he or she can't do the things they used to be able to do. He knows how to get dressed — he's just being stubborn.
3. Social withdrawal from friends and activities that used to make you feel good. I don't care about visiting with the neighbors anymore.
4. Anxiety about the future and facing another day. What happens when he needs more care than I can provide?
5. Depression that breaks your spirit and affects your ability to cope. I just don't care anymore.
6. Exhaustion that makes it nearly impossible to complete necessary daily tasks. I'm too tired for this.
7. Sleeplessness caused by a never-ending list of concerns. What if she wanders out of the house or falls and hurts herself?

8. Irritability that leads to moodiness and triggers negative responses and actions. Leave me alone!
9. Lack of concentration that makes it difficult to perform familiar tasks. I was so busy, I forgot my appointment.
10. Health problems that begin to take a mental and physical toll. I can't remember the last time I felt good.

Further, it is important to recognize that caregiving differs based upon the stage of the disease's progression. The following links provide basic information for caregiving in the various stages, which will facilitate an understanding of the changes and behaviors with which caregivers cope:

https://www.alz.org/help-support/caregiving/stages-behaviors/early-stage

https://www.alz.org/help-support/caregiving/stages-behaviors/middle-stage

https://www.alz.org/help-support/caregiving/stages-behaviors/late-stage

https://www.alz.org/help-support/caregiving/stages-behaviors

Resources:

Caregiver Stress, Alzheimer's Association: https://www.alz.org/help-support/caregiving/caregiver-health/caregiver-stress

"Surviving Caregiving ", presentation by Linda Ercoli, PhD, UCLA Health: https://www.youtube.com/watch?v=GfKS98UTjB4

Workshop Implementation

Rationale for a Full Day Workshop

This workshop was developed as a one-day workshop. This format considers the needs and abilities for caregivers to obtain access to supplemental caregiving. While all caregivers are in unique situations, this one-day model is designed so that caregivers may be able to find support for one day only. With that in mind, this workshop is highly recommended to be designed in partnership with an all-day adult care center that can satisfy the caregiving responsibilities for individuals who are able to attend that center for a day. For participants whose individual with Alzheimer's disease is unable or unwilling to attend an all-day care center, the hope is that the caregiver is able to access support for one day (as opposed to multiple days of a weekly group format for the delivery of this curriculum).

Additional formats for this curriculum were considered (i.e. weekly 1.5 hour sessions, an online format), but were ruled out due to possible time and/or travel constraints and technological limitations for the target age cohort (older adults) of this workshop. However, these formats may be a viable option for future development in certain communities, particularly in order to serve individuals who are geographically limited.

This curriculum is designed to be approximately 6 hours and 35 minutes in duration, including around 85 minutes of breaks, which translates to about 5 hours and 10 minutes of direct engagement in the curriculum's activities. As such, it is important to provide caregivers with information on the session's length ahead of time so that they are prepared. Facilitators will want to schedule around the caregivers' needs. For example, it is important to consider of a time of day that allows the caregiver to arrive on time and also depart for their daily evening meal and night preparation. It is also critical to consider afternoon fatigue, common amongst older adults, and sun downing that may occur among individuals with Alzheimer's disease. Finally, note that each activity listed includes an approximate time duration; these times are estimates and facilitators should adjust the schedule according to their group's needs.

Overview and Scaffolding of the Workshop

This workshop was designed by applying the structure of R&R group scaffolding. The following information provides details about the order of the curriculum. Further, the workshop was developed to teach what may be a new experience for many participants. It is noteworthy that many people are able to access compassion more easily for others than for themselves. Because of this, the workshop Intervention Manual is designed to first utilize the ability of identifying compassionate responses for others, and then create a bridge to self-compassion.

SECTION 1 – INTRODUCTION & CONNECTION

Section 1 of the curriculum introduces the workshop's objectives and discusses the rationale for its development. Incorporated herein is an overview of the workshop, which includes attending to any questions. Basic foundational information relevant to workshop attendees is provided, such as its premise and intent. The workshop facilitator begins with personal introductions and a group activity used as an ice-breaker in order to promote cohesion amongst workshop participants. This segment allows for a check-in, or an opportunity for participants to explore and share their experiences of stressors. Attendees will be invited to discuss their current methods of coping with stress. This sharing aims to further enhance a cohesive group environment for the participants.

SECTION 2 – CENTERING & LEARNING

Overview: In section two, the focus moves further into exploring caregiver stress or burden and the concept and practices of self-compassion. This section begins by utilizing a focused or centering meditation. The facilitator will lead the centering exercise, which introduces an aspect of mindfulness and state of focused attention and calm, followed by group sharing about this experience. Next, the workshop facilitator will provide psychoeducation about basic definitions and factors that contribute to caregiver burden, as well as stress and its potential deleterious effects. This is followed by a case vignette to highlight the possible use of self-compassion and better understand the

multi-faceted concept of self-compassion. It will conclude with more psychoeducation regarding caregiver burden and its relationship to self-compassion, as well as an exploration of resilience and wellness promotion.

SECTION 3 – EXPERIENCING & SHARING

Overview: The third section will begin with a movement exercise in which participants will explore physical movement that symbolizes self-compassion. Next, the group facilitator will lead an interactive exercise, providing group members the opportunity to share their experiences and struggles related to caregiver burden and self-compassion.

SECTION 4 – EMPOWERING AND COMMITTING

Overview: In this section, participants engage in additional skills training, learning and participating in multiple self-compassion exercises or activities tailored specifically to the caregiver population and aimed at addressing their stress. Finally, participants are introduced to ways in which they can continue to plan ongoing engagement in self-compassion, explore possible barriers, and make and share commitments to their future practices.

SECTION 5 - CLOSING

Overview: The workshop's last segment consists of a final process of reflection as well as a review of the information provided in the workshop. Resource information is provided to participants and reviewed with them, so that they can further explore self-compassion experiences that may aid them in their caregiving experience. The workshop ends with a final self-compassion exercise.

Group Preparation: Setup & Other Logistics, and Materials Needed

Setup and Other Logistics

First and foremost, please note the importance of providing a space that is accessible to all participants, whether for language ability, mobility, hearing ability, vision, or other access considerations. Please communicate with participants prior to the workshop to enquire about any specific needs (particularly those related to any disability access). Parking or public transportation suggestions may be recommended depending on your location and community.

Given that this workshop has been designed as an all-day experience, it is important to ensure that participants either bring food or that you and/or your organization provide food and drinks, and that accessible restroom facilities are available.

Additional setup considerations include:

- adequate/comfortable seating
- tables for participants to write on (creating a 'U' or rectangular shape is suggested, with the opening/short end in the front of the room is suggested to

facilitate participants looking at one another and also able to see the group facilitators)
- good lighting
- accessible space (i.e. wide walkways, the ability to push in chairs (so that participants do not trip, etc.)
- adjustable temperature
- a space that lacks significant distractions or disturbances (i.e. loud noises, interruptions due to people passing through, etc.) given the need for quiet times to practice contemplative and/or meditative experiences

Materials needed

Below is information on specific materials needed for the workshop activities. Overall, you will need:

- **Printed hand-outs** (found in the 'Handouts' section of this Intervention Manual) ahead of the session
    - Given that receiving many papers may cause confusion, disorganization, feelings of being overwhelmed, or agitation, it is highly suggested to provide participants with a folder to store handouts after use.
    - Alternatively, you may choose to print out all handouts and place them into a stapled packet or handbook for participants (note that this curriculum is written with instructions based on handing out papers individually so you will need to alter your instructions accordingly)
- **Writing utensils** for participants
- **Large presenter papers** to hang in front of the group for collective activities (or a large dry erase board; however, keep in mind that some participants may enjoy seeing the progress of the day through written materials as opposed to information being erased)
- Watching videos is another option, using a projector or a television. A laptop may or may not suffice given possible vision and hearing limitations.

Other alternatives have been provided in this curriculum given economic feasibility of possessing these materials.

Facilitator Preparation

A key aspect to leading this group is personal experiential awareness of the practices you will be leading. It is important to have practiced them many times yourself so that you can lead from an embodied presence (as opposed to a simple dictation of words).

Many scripts do not need to be read word-for-word; you are invited to "be in" the practices while leading. Depth of familiarity with the practices will aid in integrating knowledge and will likely produce a better experience for participants.

Cultural and Clinical Considerations

Cultural Adaptation Considerations & Suggestions

This workshop is designed to invite and explore cultural and contextual factors into the experience. As such, it is important that the facilitator(s) provide care in an intersectional and culturally competent manner (https://www.apa.org/about/policy/multicultural-guidelines.pdf).

He or she should engage with cultural humility, which is understood as “lifelong process of self-reflection, self-critique, continual assessment of power imbalances, and the development of mutually respectful relationships and partnerships” (Gallardo, 2014, p.3).

If able to learn this information prior to the session, the ADDRESSING Framework (Hayes, 2001) may serve as a model for identifying or exploring cultural influences of the caregivers in the group. Considering this frame while working with participants may provide additional context in order to modify content or language while facilitating this workshop.

See figure below.

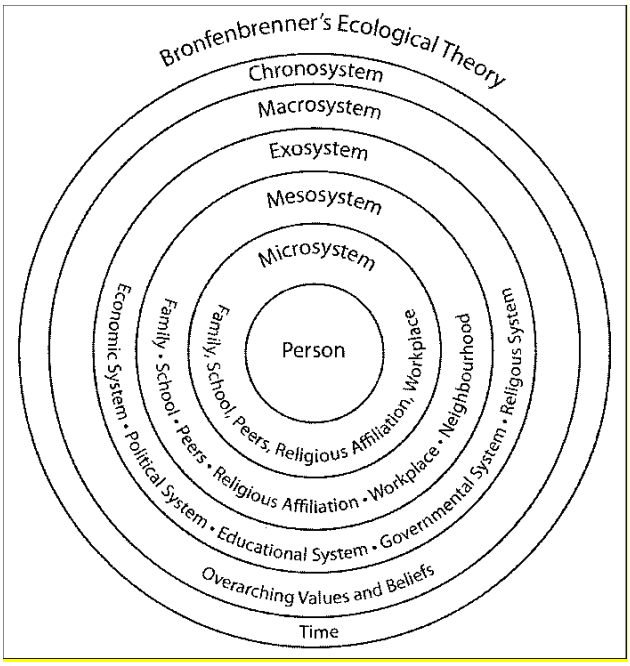
Worksheet 2.7 Using the ADDRESSING Framework (Hayes, 2001) to Facilitate Understanding of Client Cultural Influences

By using the ADDRESSING acronym as a guide, you can become more familiar with the multiple group memberships and cultural identities of your clients. Examination of this information can provide useful information regarding areas of client strength/resources and areas of weakness/deficits. Although you may not ask every client questions about all of the ADDRESSING categories, you are encouraged to at least consider the relevance of each dimension for each client and to follow-up on those influences and identities that appear to be highly valued by your clients (Hayes, 2001).

Definitions of ADDRESSING framework	**Client information Client name:**
Age and generational influences	
Disability status (developmental disability)	
Disability status (acquired physical/ cognitive/psychological disabilities)	
Religion and spiritual orientation	
Ethnicity	
Socioeconomic status	
Sexual orientation	
Indigenous heritage	
National origin	
Gender	

Another model for understanding and exploring contextual variables that influence individuals' development and current experience is Brofenbrenner's Ecological Systems Theory (1979). This model offers a framework to demonstrate that an individual and their development is embedded in their context by showing the relationships between the individual and varying levels of the environment, or systems, and their interactions over time. These systems include the microsystem, mesosystem, exosystem, macrosystem, and chronosystem.

Below is a diagram that may aid in understanding of this model:



Self-Compassion Backdraft.

"Backdraft" is a term used in firefighting that is also used as a metaphor within the context of self-compassion. When a fire lacks oxygen and new air is let in or a new door opened, the flames will expand rapidly in an explosive manner. A similar reaction is possible when self-compassion touches upon areas of criticism, anger, negativity, or other present challenging and painful thoughts or emotions. It is important to provide the caregivers with education beforehand to let them know that this phenomenon may exist in their experience. It is also imperative that they are provided with some guidance, in the sense that they can choose to be mindful of it (i.e. 'notice it'), attend to themselves in a way that provides kindness, care, or soothing (i.e. kind statements to self, soothing touch, etc.), or they may take a break.

Trauma and Safety

This workshop is not designed as a treatment for any mental health conditions, but is developed as a resilience building intervention to address the stress and burden of Alzheimer's disease caregiving. Many caregiving individuals experience significant stressors in multiple domains of life and this workshop asks them to utilize some of their experience in this group intervention. As such, it is important that facilitators are informed of two important concepts: ***trauma-informed and safety & backdraft***.

Trauma-informed: Some key aspects of leading this group include considerations to attempt to address the physical, emotional, and environmental safety of participants. This may include such things as:

- Showing participants exits and doors

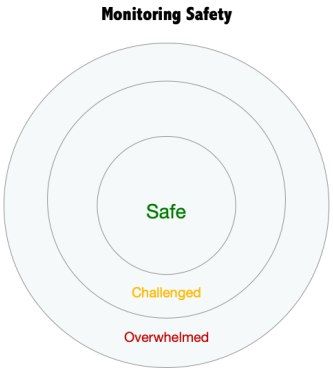
- Making them feel welcome to use facilities, to take care of oneself, move their bodies, or take breaks at any time and reminding them of this throughout the session
- Monitoring noise or interruptions within the space
- Providing participants with an agenda and expectations for the session ahead of time
- Encouraging feedback, including a structure for communicating needs to the group leader(s) at any time during the session if someone is having any sort of difficulty
- Providing as many options throughout the session and reinforcing choice
- Providing education regarding trauma-related emotional, physical/somatic, and cognitive trauma responses in simple language (see 'Monitoring Safety' and 'Backdraft' below)
- Providing predictability, reliability, and transparency
- Allowing flexibility

This list of suggestions is not comprehensive but provides some groundwork for conducting a trauma-informed session.

Monitoring Safety in this context refers to providing participants with information about being skillful in noticing their experience. They are encouraged to choose to engage with content and practices in a manner that fits their fluctuating needs at a given moment. See the diagram below for descriptions and behaviors that correlate.

- *Safe*: Low arousal zone. Easeful, calm, and relaxed. Can mean taking a break or doing something soothing or nurturing for yourself. Particularly useful to return to this zone if feeling overwhelmed.
- *Challenged*: Optimal arousal zone. Ready to receive, learn, and process. The participant has entered 'working and learning' mode.
- *Overwhelmed*: Over-stimulated zone. Unable to process. Has difficulty thinking and may often feel unsafe, angry, anxious, shut down or disconnected.

See the following diagram:



WORKSHOP OUTLINE TABLE

About:

This table provides a visual reference and overview of the workshop, including: estimated times, names of each activity, type of activity, a very brief description of the activities and their associated handouts, and the components of Self-Compassion (Mindfulness, Common Humanity, and Self-Kindness) and/or the Triadic Change Model (Awareness, Allies, and Action) – the particular workshop component to which they relate.

Section	Section Theme		Min	Time	Name / Content	Type	General Description	***Handout Name***	***Self Compassion Components*** *(Mindfulness, Common Humanity, Self-Kindness)*	***Triadic Change Model Components*** *(Awareness, Allies, Action)*	*Psychoeducation*	*Experiential*	*Dyad/Triad Share*	*Group Share*
SECTION 1	Introduction & Connection	1.1	5	9:00-9:05	Group leader welcome, self introductions & group rules	Welcome & Introductions	Group Leader intro + welcome		*Common Humanity*					
		1.2	25	9:05-9:30	Participant Intros/Ice Breaker - My Caregiver Name	Group Exercise	Group Exercise 1: Naming Ceremony + caregiving role, 1-2 little things they do to 'fill their cup' (that can be done daily/regularly)	*Handout 1: Centering Breaths; Handout 2: Naming Ceremony*		*Allies*		*x*		*x*
		1.3	10	9:30-9:40	Overview of Session + Safety	Psychoeducation	Basic Rationale for group, Provide participants with a schedule for day, Introduce safety and taking care of self (trauma-informed)	*Handout 3: Group Overview; Appendix B: Signs of Hyperarousal*			*s*	*x*		*x*
		1.4	10	9:40-9:50	Participant Stressors	Group Exercise (Dyad optional)	Group Exercise 2: collaboration to list stressors [on board]		*Common Humanity*	*Awareness, Allies*	*x*	*s*		*s*
		1.5	10	9:50-10:00	Participant Coping Used	Group Exercise (Dyad optional)	Group Exercise 3: collaboration to list attempts to alleviate stressors (demonstrates how hard they're trying!) [on board]		*Common Humanity*	*Awareness, Allies*	*x*	*s*		*s*
SECTION 2	Centering & Learning	2.1	15	10:00-10:15	Centering Meditation + Participant Reflections	Practice + Dyad Share	Practice 1: R&R Meditative Moment; then participants share in dyads what their experience was like, what they noticed during exercise, etc.	*Handout 4: Meditative Moments*	*Mindfulness*	*Awareness*		*s*	*x*	
		2.2	10	10:15-10:25	Effects of Caregiver Stress	Psychoeducation	Group leader shares definitions and brief research for caregiver stress impacts for participant learning	*Handout 5: Caregiver Stress Impacts*	*Common Humanity*	*Allies, Awareness*	*x*			
		2.3	10	10:25-10:35	Self-Compassion Intro	Psychoeducation	Basic definitions of Self-Compassion, How it Helps, Tips for Practice, including Backdraft	*Handout 6: Self-Compassion: What is it, How it Helps, Tips for Practice*			*x*			
		2.4	20	10:35-10:55	Learning Compassion - What Would You Say To A Friend?	Group Practice	Group Exercise 4 - Caregiver burden based example prompts read by group leader & group members provide compassionate responses	*Handout 7: Learning Compassion - What Would You Say To A Friend?*	*Common humanity, Kindness*	*Allies*	*x*	*x*	*x*	*x*
			15	10:55-11:10	(brief break)	(brief break)								
		2.5	10	11:10-11:20	Caring Body Connections	Individual Practice	Practice 2: Caring Body Connections	*Handout 8: Caring Body Connections*	*Mindfulness, Self-kindness*	*Awareness, Action*		*x*		
		2.6	20	11:20-11:40	Self-Compassion Break	Individual Practice	Practice 3: Self Compassion Break for personal caregiving experience; then journal & offering of participation for group share of the experience	*Handout 9: Self Compassion Break, Handout 10: Reflection on Self Compassion Break*	*Mindfulness, Common Humanity, Self-Kindness*	*Awareness, Action, Allies*		*x*		
		2.7*	30	11:40-12:10	Real Stories* (*optional; can omit for time, ability, or other reasons)	Dyad/Triad/Group Exercise	Group Exercise 5: Members get in groups of 2-3 and use case vignettes; first vignette is a caregiver who uses self-compassion in the context of caregiver stress, second is an example of not utilizing self-compassion. Then re-join whole group to discuss the vignettes.	*Handout 11: Case Vignettes*	*Common Humanity*	*Allies, Awareness*	*x*		*x*	*x*
			60	12:10-1:10	(longer break - 60 min)	(longer break - 60 min)								
SECTION 3	Experiencing & Sharing	3.1	5	1:10-1:15	R&R Meditative Moment or Mindful Movement	Experiential	Group facilitator leads another Centering Meditation; alternatively, may lead brief mind-body movement practice	*Handout 4: R&R Meditative Moments*				x		
		3.2	35	1:15-1:50	Burdens in a Box	Group Exercise	Group Exercise 6: Participants list one of their caregiver burdens on small pieces of paper (1-3 each depending on group size) and place in a box. Then burdens are selected from box and possible self-compassionate responses are devised, then shared with the group.	*Handout 12: Burdens in a Box Exercise*	*Common Humanity, Self-Kindness*	*Awareness, Allies, Action*		*x*	*(x)*	*x*
		3.3	20	1:50-2:10	Caregiver Breathing	Individual Practice	Practice 3 - Take One, Give One breathing (or imagery) + Group Share	*Handout 13: Caregiver Breathing*	*Mindfulness*	*Awareness*				x
SECTION 4	Empowering & Committing	4.1*	20	2:10-2:40	Learning Review* (*optional; can omit for time, ability, or other reasons)	Review & Reflections	Participants fill out review worksheet individually, then share in partners	*Handout 14: Learning Review*		*Awareness*			*x*	
		4.2	15	2:40-2:55	Action Plan Journaling	Individual Practice + Dyad	Listing top 3-5 responses or practices learned in session today, then set SMART goal for Action Plan; share with a peer	*Handout 15: Self-Compassion Action Plan*		*Action*			*x*	
		4.3*	15	2:55-3:10	Barriers Brainstorm*	Group Exercise	Group exercise 7: brainstorming barriers to utilizing self-compassion in daily caregiver experience + How to respond with resilient self-compassion to barriers [on board]			*Awareness, Action*				*x*
			10	3:10-3:20	(brief break)	(brief break)								
SECTION 5	Closing	5.1	10	3:20-3:30	Participant Evaluation	Evaluations	Participants fill out individual evaluations	*Handout 16: Participant Evaluation*						
		5.2	10	3:30-3:40	Resource Review + Q&A	Resource review + Q&A	Group leader provides and reviews resources for self-compassion practices and support (online + local)	*Handout 17: Resources*			*x*			
		5.3	5	3:40-3:45	Loving Kindness Meditation & Closing	Individual Practice	Practice 5 - Loving Kindness Meditation	*Handout 18: Loving Kindness Meditation*		*Awareness, Allies*		*x*		*x*

WORKSHOP CURRICULUM

SECTION 1 – INTRODUCTION & CONNECTION

Overview: Section 1 of the curriculum serves to introduce the workshop objectives and discuss the rationale behind its development. Incorporated herein is an overview of the workshop, which also addresses any questions. Also provided is basic foundational information relevant to workshop attendees, such as the workshop's premise and intent.

The workshop facilitator begins with introductions and a group activity as an ice-breaker, in order to promote cohesion amongst participants. This segment offers a check-in, or an opportunity for participants to explore and share their experiences of stressors. Attendees will be invited to discuss their current methods of coping with stress. This sharing of input aims to further enhance a cohesive group environment for the participants.

1.1 WELCOME AND FACILITATOR INTRODUCTIONS

I. Materials:

- Whiteboard, chalkboard, or easel pad + writing utensil

II. Estimated Time
   a. 5 minutes

III. Intention(s)
   a. Warm welcoming, begin to establish common humanity, begin to develop safety via establishing group rules.

IV. Instructions
   a. Group facilitator(s) introductions include: warmth in welcome, self introductions (i.e. name, preferred pronouns or other identity information related to self, community, or group, professional role, and personal connection or interest in this workshop. Write group leaders' names where they are visible to all participants.

Sample: "Greetings everybody, and welcome to the Self-Compassion Workshop for Alzheimer's Disease Family Caregivers. We are so happy you are here and hope today's session will be beneficial to you. We are your group leaders.

First, before we introduce ourselves, let's just take a moment to 'arrive'. This means: let's leave our commute, our difficulty with parking, and our recent

stressors, etc., behind us, letting go of them in our minds – and our bodies – by perhaps noticing your breathing or taking a deep breath. Or just touch something near you, perhaps the table or your chair and notice it's temperature on your skin. This simple little action helps us transition and become present to what is happening here and now. We will use this throughout the day as a really quick practice to remind ourselves to be present.

[Facilitators then introduce themselves and suggest that participants provide the following: name, preferred pronouns and any other salient identity information that may relate to them and/or the group, professional role, and personal interest in this group that aids in establishing Common Humanity.]
We will have this full day together and in a little bit we will be providing you with a schedule and outline for the day. But first, we want to share some information about the group rules."

b. Confidentiality:
    i. Discuss confidentiality and limits to confidentiality as it pertains to your license, organization, community, etc.
        1. If you are a mandated reporter, be certain to name elder abuse reporting per your license/agency/etc.
    ii. Discuss confidentiality as it relates to group, i.e. privacy and establishing safety for participants to feel comfortable sharing with the group.

c. Other suggested considerations for group rules:
    i. Sharing as it relates to one's own experience; no or limited advice should be given unless requested by an individual.
    ii. Use respectful language.
    iii. No use of cell phones and/or turn its setting to silent or airplane mode for less disturbance.
    iv. Leader(s) should decide on a structure for questions (i.e. on the fly, at the end of lesson/practice, etc.).

d. Prompt group for questions and confirm group members' agreements

e. Trauma-informed/"Taking Care of Self" introduction. Lead group in the following:
    i. Showing participants exits and doors
    ii. Providing welcome to use facilities, to take care of oneself, move their bodies, take breaks, or sit out at any time
    iii. Naming any expected noise or interruptions in the space
    iv. Informing participants that you will provide them with expectations for the session, including an agenda
    v. Encouraging feedback, including a structure for communicating needs with group leader(s) at any time during the session if they are having difficulty
    vi. Letting them know that you will be providing as many options throughout the session and reinforcing choice

vii. Expressing the wish to provide predictability, reliability, flexibility, and transparency
viii. Questions?

V. Review
   a. At the end of this section, consider saying something like, “If any further questions arise, please don’t hesitate to return to any of this.”

VI. Transition
   a. “Now let’s move to a group exercise to get to know one another and shift gears toward more ease and empowerment…”

1.2 PARTICIPANT INTRO / ICE BREAKER: MY CAREGIVER NAME

I. Materials:

- ○ Handout 1: Centering Breaths
- ○ Handout 2: My Caregiver Name (pages 1-2, one handout per participant; pg. 3 for group leader or option to pass out to group)
- ○ Name Tags or Name Cards (i.e. a folded paper that stands up for other participants to be able to see)
- ○ Personal writing utensil (i.e. pencil, pen, etc.) + marker(s)

II. Estimated Time
   a. 25 minutes

III. Intention(s)
   a. Facilitates group members to begin to get to know one another
   b. Begins group process
   c. Invitation to try something new while facilitating choice and safety
   d. Participants ground selves in a XXX

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: “Let’s just take a moment to ‘shift gears’, leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or by taking a deep breath; or a few. Perhaps you may prefer to touch something near you, be it the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you’d like to come up with a phrase that you use to remind yourself, such as, “I am here, now, with openness to this moment.” This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present.”

b. You may select other objects of attention as fitting to your setting and community.

V. Instructions

a. Hand out copies of Handout 2: My Caregiver Name

b. Sample instructions:
"We are going to begin today by first introducing ourselves to one another. But today we're going to do it in a slightly different way. We have just handed out a table that you will use to develop a name for yourself for today's group, which helps us get to know more about who you are as a whole, thriving, empowered being. This may be a new way of expressing yourself and for some it may feel a little awkward – that's ok! Even if what you come up with feels more aspirational than authentic, meaning that it feels more like what you'd like to feel like as opposed to what you do feel like, that's actually great! Worst case scenario, consider just being playful with it. But as always in this group, while we ask you to try new things, we also never want to push you, so please be true to you.

"Before we begin with the exercise, we are going to take a moment for some Centering Breaths. We will be breathing in and out of our noses. If you find breathing too restricted, frustrating, activating, or otherwise uncomfortable, please feel free to not use breathing. You may instead consider some kind of visualization, such as a light brightening and dimming, or something else that comes to you in lieu of breathing. You may also just follow without breathing.

"So now we will sit in comfortable, upright but easeful posture. You may close your eyes, or take a soft, lowered gaze in front of you.
[Read Handout 1: Centering Breaths]

Now we turn to the table to develop your name for today."

c. Instruct how to develop their new name using the table, including:
    i. Demonstrate with your name and how you would fill out the first part of the handout:
        1. New names (First, Middle, Last)
    ii. Then show them how to fill out the second portion:
        1. Actual name
        2. Caregiver Role
        3. New Caregiver name

d. As they work on the sheet, pass around nametags/cards and pens, instructing group to put their actual name and new Caregiver name on their nametag/card.

e. Have group introduce themselves to one another including all info just completed.

VI. **Additional Options for using Caregiver Name:** You may also utilize the following instructions for sharing group names/group naming ceremony/ritual and/or dyad/triad discussion questions.

a. Group Ceremony/Ritual
    i. Each person introduces themselves with their new name saying "I **AM** (or I CLAIM MY IDENTITY AS…)_____." The group responds with "I see you _____", or simply "Yes, you are". (This can be done at the beginning and/or end of every group meeting if it is an ongoing group.)
    ii. You can also have each person create a movement or pose that they do as they are saying their name. The group responds with the same movement. This brings a bodily experience into the process so that the name carries a physical sense, as well as the verbal/meaning aspect.

b. Dyad/Triad Discussion Questions
    i. What was your immediate first reaction/feeling to the name when you generated it?
    ii. In what ways do you connect to the name? In what ways do you not connect to the name?
    iii. Can you think of a time in your life when you really felt or lived your name?
    iv. What in your daily life takes you away from or blocks you from manifesting your name?
    v. Think of one area of your life and consider how things might be different if you manifested your identity more strongly in that area? (e.g. work, parenting, relationship, friendship, finances, health, etc.)

VII. Review

a. At the end of the exercise, consider saying something like, "Thank you all for introducing yourselves to one another in a way that helps us get to know each other better. My/our hope is that each of you do embody and experience these ways of being and things you do to continue to cultivate and/or give yourself what you need, especially in the face of the challenge it is to be a caregiver."

VIII. Transition

a. "Now let's move to a little group learning…"

1.3 OVERVIEW OF SESSION & SAFETY

I. Materials:

- Handout 3: Session Overview Handout (one for each participant)
- Appendix B: Signs Of Hyperarousal & Dissociation (Hypoarousal) (for facilitator)
- White Board or Easel Paper that can hang at front of room (for diagram & group created list) & marker

II. Estimated Time
   a. 10 minutes

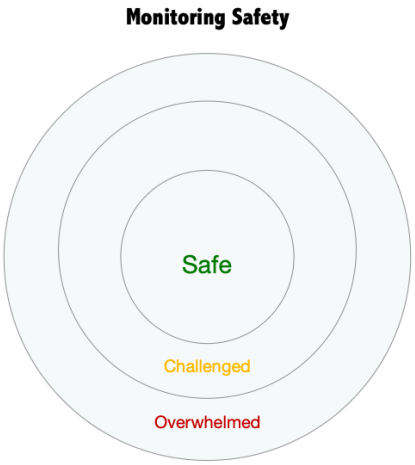
III. Intention(s)
   a. Briefing/basic rationale for group, aiming to increase motivation for active participation
   b. Providing participants with a schedule for the day
   c. Introducing the concepts of 'zone of tolerance' and taking care of oneself; aids in cueing groups to their own physiological, emotional, and mental experience of stress/distress as well as safety/calm.

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."
   b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
   a. Utilizing *Handout 3: Group Overview*, distribute one copy to each participant and guide the group through the handout in a manner that works best for you and the group.
   b. Read through the handout with the group.
      i. Consider having volunteers take turns reading bullets in order to get more voices into the room. However, consider vision and

literacy issues that may exist; do not call upon people or 'go around' in the room, but ask for volunteers.

c. Introduce the idea of a window of tolerance and safety. Draw diagram on a large piece of paper, whiteboard, etc.



i.

ii. Next, explain the concepts of Monitoring Safety and Backdraft.

iii. Sample Instructions: "Here you see a diagram that aids in helping us explore and understand an important concept that relates to distress and learning. We are likely all aware that we learn best when we are comfortable, right? We may consider that to be the smallest circle labeled as 'Safe' [points to diagram]. On a scale of distress ranging from 0-10, with 0 being no distress at all and 10 being 'completely freaked out and overwhelmed', we would consider this 0-3 or 4 [may draw numbers inside the circle]. Other descriptors include calm, relaxed, chill.

In the next zone, labeled as 'Challenged', we are often also able to learn; this would be anywhere between a 3 or 4 to perhaps a 7 or so. We may be challenged, which is sometimes helpful for us to engage in new learning or experiencing, but we are still feeling ok, safe, and comfortable enough in the discomfort. What are some examples of learning to do something that is challenging but we are able to do it?"

1. Prompt group. Examples may include simple childhood things such as 'riding a bike,' or more adult activities, such as golf, knitting, learning a new language, etc.

iv. "Finally, in the outer circle, we have 'Overwhelmed', which is about an 8-10 on our scale. I don't know about you, but when I'm overwhelmed, there is no learning happening – I can get hot and antsy, frustrated, sometimes even mad; or on the other end, I can go totally blank and suddenly feel exhausted. Anybody else ever felt like any of that when just totally overwhelmed?"

1. Prompt group. This may be more difficult so you may want to provide some silly but easy to answer questions, such as being overly physically engaged and trying to do something that requires concentration. This may get the point across that being overly-taxed physically, emotionally, or mentally provides a context that is not helpful for learning.
    a. For example: “Let’s see, how about some examples here. Does anybody think they could do a crossword puzzle while standing on one foot and writing with their non-dominant hand? No? Ok, how about we think about a time when we have perhaps seen a very small child, 3 or 4 years old, not get what they want – do you think that when they’re really upset about not getting something is a good time to teach them something new? No. Exactly. We want to try to engage and learn when we are slightly challenged but not overwhelmed, mentally, physically, or emotionally. This is a very important part of learning.”

v. Next, create lists beside or below the diagram so that people can name what they notice when they feel each of the zones: ‘Overwhelmed’, ‘Challenged’, and ‘Safe’. Use your facilitator discretion as to which to explore first. You are cueing for physiological, emotional, and mental/cognitive reactions to distress.
    1. See *Appendix B: Signs Of Hyperarousal & Dissociation (Hypoarousal)* if you need additional ideas. You may also use other descriptive words, such as ‘calm,’ ‘relaxed,’ ‘growing,’ ‘learning,’ and ‘overloaded.’
    2. Sample instructions: “Actually, this is a great time for us to explore just a little bit, because its important for us to have a heads up about our own body and mind’s responses. Can anybody tell me what your body or mind feel like when you’re totally overwhelmed like I just described for me? [or feeling ‘Safe’ or ‘Challenged, in any order].
    3. Participants may struggle to name the ‘Challenged’ zone, so consider cueing by asking for examples of times they learned something new or practiced something they are interested in, such as an instrument, dancing, sewing/knitting, teaching their dog/grandchild something, a new hobby, etc. This attempts to cue for experiences of being ‘energized’ or ‘engaged’ and physiological, mental, emotional, motivational, and/or other experiences while in that state.

VI. Review
    a. Upon completion of this activity, remind participants to notice their responses as the session goes on throughout the day.

Sample Instructions: "*This is great information we're already getting into. It is so important that we know how our bodies respond to stress. With that in mind, please feel free to take breaks any time you need one, to pass on activities, to take a step out of the session, to communicate with facilitators about any overwhelming distress responses, and to engage in self-care in any way you may need (that hopefully does not disturb the group significantly). Are there any questions about this?"*

VII. Transition
   a. "Now let's move to a group exercise…"

1.4 PARTICIPANT STRESSORS

I. Materials:

- White Board or Large Paper that can hang at front of room (for diagram & group created list) & marker
- Optional: blank paper for dyad work

II. Estimated Time
   a. 10 minutes

III. Intention(s)
   a. Invite participants to begin identifying stressors and how they are impacted by then (can be used later in self-compassion activities)
   b. Facilitate group process

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."
   b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
   a. Facilitator should consider the following in introducing and conducting this activity:

i. Introducing the idea that people do not have to share 'level 10' stressors and in fact may be too overwhelmed to do so (based on previous exercise/learning), so they should choose what feels right for them. Also advising them that it can be helpful to name stressors and to express what feels comfortable to share.
ii. Acknowledging or empathizing with stressors as they are named or at the end, also emphasizing their resilience, bravery, or other ways of recognizing and honoring the experience as suffering.

b. Create the following table on board or easel paper at the front of the room

Caregiving Stressor	Related Thoughts	Associated Emotions or Feelings	What you notice in your body / body sensations

i. Ask participants to name a stressful experience in caregiving. It can be an experience related to caregiving or a social, financial, medical, aging-related, or other burdensome experience that is impacted by or impacts their ability to engage in caregiving.
ii. Then guide participants to explore any thoughts, feelings, or bodily sensations that they link to that stressful experience, whether it is as its happening or in this moment as they discuss it.
- Option: You may also first provide a couple of examples and then place group members in dyads to begin creating a list of some of their caregiving stressors, coming together in the group afterwards to name these stressors as the facilitator writes them on the board/paper at front of room.
- Provide simple group psychoeducation on how stressors are related to and may impact thoughts, emotions, and body sensations.
- You may continue to add to the list as the session goes on.

VI. Review
a. At the end of the exercise, consider saying something like, "Wow, thank you all for sharing some of the challenges you experience in being a caregiver. The simple act of noticing a difficult moment or a stressor aids in providing choice for how to respond to it – and this is mindfulness, which we will discuss more later on. But as a brief preview, since I have used that word, I would like to dispel the myth that mindfulness is about being in peace, always feeling calm, or having no difficulties. In fact, noticing the signals or the patterns in our bodies, minds, or feelings/emotions allows us more access to taking a pause and choosing our response rather than reacting. That is mindfulness in action."

VII. Transition
a. "But I'm getting ahead of myself. Let's move on to another exercise…"

1.5 PARTICIPANT COPING USED

I. Materials:

- White Board or Large Paper that can hang at the front of room (for diagram & group created list) & marker

II. Estimated Time
   a. 10 minutes

III. Intention(s)
   a. Invite participants to begin identifying the coping mechanisms that they are using, which demonstrates how hard they are working at caregiving and that some of these strategies may be more or less effective, which also provides motivation to try a new coping tool
   b. Facilitate group process

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: “Let’s just take a moment to ‘shift gears’, leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you’d like to come up with a phrase that you use to remind yourself, such as, “I am here, now, with openness to this moment.” This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present.”
   b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
   a. On a new piece of paper or on the board beside the list of ‘Stressors,’ write the word ‘Coping’
   b. Using your clinical judgment, you may ask participants to begin to name aloud within the group or break into pairs to brainstorm some ‘coping’ mechanisms they use in the context of the stress of caregiving and/or general stressors in their current life; you may prompt them to list all coping mechanisms, whether they consider it helpful or unhelpful (see below).
   c. Facilitator writes list on board/paper at front of room.
      a. Examples in case the group needs additional support finding ways they attempt to cope with stress.
         i. Helpful: hobbies, music, movies, resting, breathing, meditating, nature, reaching out to friends or family, joke

books, riddles/crossword puzzles, exercise, healthy lifestyle habits (eating, drinking, etc.), or others.

ii. Less helpful: being frustrated with/angry at/or "snapping at" family and/or individual they are caring for, checking out, giving up, substance use, eating too much or too little, or others.

VI. Review

a. At the end of the exercise, genuinely acknowledge how hard they have been working! Also, add an expression of hopeful wishing that today's workshop will provide them with even more ways to cope, build resilience, and create new space to address stress.

VII. Transition

a. "Let's move to a grounding and centering exercise…"

SECTION 2 – CENTERING & LEARNING

Overview: In section two, the focus moves further into exploring caregiver stress or burden and the concept and practices of self-compassion. This section begins by utilizing a focused or centering meditation. The facilitator will lead the centering exercise, which introduces an aspect of mindfulness, and state of focused attention and calm, followed by group sharing about this experience. Next, the workshop facilitator provides psychoeducation about basic definitions and factors that contribute to caregiver burden, as well as stress and its potential deleterious effects. This is followed by a case vignette to highlight the possible use of self-compassion, deepening the understanding of the facets of the concept of self-compassion, and concluding with more psychoeducation about caregiver burden and the relationship to self-compassion, as well as an exploration of resilience and wellness promotion.

2.1 CENTERING MEDITATION & PARTICIPANT REFLECTIONS

I. Materials

- Handout 4: Meditative Moment

II. Estimated Time
   a. 15 minutes

III. Intention(s)
   a. Begin experiencing mindful awareness
   This centering meditation aims to modulate in-session activation or stress they may be experiencing after previous discussion of stressors

IV. Instructions
   a. Again, remind group to monitor their experiencing in this activity. Let them know that this activity may ask that they focus on breath, which can be difficult for some. If they know this of themselves or experience it in-vivo, suggest that they focus on feeling their feet grounded on the floor, open eyes and find something in the room that is visually appealing or pleasing to them and gaze at it softly, hold or rub their hands gently, or any other exteroceptive experiencing.
   b. Instructional prompts:
      a. take a comfortable and alert body position
      b. close eyes or soften downward gaze
      c. notice their body and mind before the guided activity (body sensations, mood/emotion, thoughts, etc.)
   c. Facilitator guides participants in one of the three '*Handout 4: Meditative Moment*' meditation scripts. You may select which ever seems most relevant to your group and/or that you feel most connected to.
   d. Option to have participants first share in dyads, then in the full group. Ask:
      a. What they noticed doing the exercise

b. What they notice about their current experience (body sensations, mood/emotion, thoughts, etc.)
c. Include an invitation to name any difficulties they had in the practice.

V. Review
   a. At the end of the exercise, acknowledge with enthusiasm that they engaged in the activity, even if it was challenging – especially if it was a new experience for any participants. Noticing that it is challenging or that they feel unpleasant experiences is a part of mindfulness; without awareness we cannot attend to our true present experience. Though it may be hard, it is a new step forward (as long as not in 'Overwhelm' zone).

VI. Transition
   a. "Let's move to more learning (or review if you have already been in some other caregiver groups)…"

2.2 CAREGIVER STRESS IMPACTS

I. Materials

- Handout 5: Effects of Caregiver Stress (one copy per individual)

II. Estimated Time
   a. 10 minutes

III. Intention
   a. Greater acknowledgement of stress/possible caregiver experiences
   b. Increase learning and awareness of the impact of stress; at the end, bridge and frame this as means to increase motivation to address stress using new methods, such as self-compassion

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."
   b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
   a. Hand out *Handout 5: Effects of Caregiver Stress* and review it with the group. Options include reading to the group or asking for volunteers to read it.
      a. You may spend a few minutes asking about previous awareness of these facts or symptoms, or reactions to this information. This may serve to facilitate group discussion and/or acknowledgement that significant stress is burdensome to caregiver wellness and care recipient outcomes as well.

VI. Review
   a. At the end of the exercise, inform participants that the reason for bringing up this information is because its important to understand the problem and symptoms so that we can work with our difficult experiences. One option is to utilize self-compassion.

VII. Transition
   a. "Let's move to learning about self-compassion…

2.3 SELF-COMPASSION INTRO

I. Materials

- Handout 6: Self-Compassion: What is it, How it Helps, Tips for Practice

II. Estimated Time
   a. 10 minutes

III. Intention(s)
   a. Use handout to teach definition of self-compassion
      i. Hand out and review *Handout 6: Self-Compassion: What is it, How it Helps, Tips for Practice*
   b. Use this information about how self-compassion is helpful to increase engagement and buy-in for participation

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."

b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
   a. Hand out and review Handout 6: Self-Compassion: What is it, How it Helps, Tips for Practice and review it with the group.
   b. Pay particular attention to highlighting the example about backdraft so that participants XXX (or provide one of your own)
   c. Ask participants if they have any questions

VI. Review
   a. n/a, content focused section.

VII. Transition
   a. "Let's move to exploring one way of learning self-compassion…"

2.4 LEARNING COMPASSION – WHAT WOULD YOU SAY TO A FRIEND? (KINDNESS)

I. Materials

- Handout 7: Learning Compassion – What Would You Say to A Friend?
- Optional: chalkboard or easel paper and writing utensil

II. Estimated Time
   a. 20 minutes

III. Intention(s)
   a. Aid participants in learning 'compassionate' responding/voice that they use with others
   b. Increase awareness and motivation to be compassionate with themselves

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."
   b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
   a. Group leader introduces the idea of learning self-compassion by exploring compassion for others.
   b. Before directing the group to the handout, the leader asks participants to sit comfortably, with their eyes closed (if comfortable), listen to a script, and notice what their responses are as if experiencing it as a meditation, noticing their thoughts and body sensations. This allows participants to experience this exercise in an experiential manner.
      i. *Handout 7: Learning Compassion – What Would You Say to A Friend?*
   c. Then 3 options for bringing participants' experiences into the room include:
      i. Hand out and have participants fill in *Handout 7: Learning Compassion – What Would You Say to A Friend?* for their own reference
      ii. Place participants in dyads or small groups to discuss (they do not have to fill out the handout)
      iii. Discuss as a group (with the option to write at the front of room on board or easel paper)

VI. Review
   a. At the end of the exercise, congratulate participants for doing their first self-compassion exercise.

VII. Transition
   a. "Let's move to another way of engaging with ourselves with self-compassion…"

2.5 CARING BODY CONNECTIONS

I. Materials

- Handout 8: Caring Body Connections

II. Estimated Time
   a. 10 minutes

III. Intention(s)
   a. Provide participants with brief self-compassion skill that is accessible and based in the body.
   b. Deepen experiential awareness of kindness toward self, soothing, taking care of self.
   c. Increase knowledge about self-compassion.

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you,

such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."

b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
   a. Use *Handout 8: Caring Body Connections* (pgs. 1-2) as a script.
   b. After the experiential component, pass out *Handout 8* and guide participants to '*Reflecting on Caring Body Connections*,*'* using the instructions to help them identify their top three body connections and what they noticed. You may suggest noticing their bodily sensations, thoughts, feelings, or other.
      i. Try to help guide participants' responses to be present-focused, i.e. not going into too much 'story' of the past or present
   c. Sharing
      i. Based on your clinical judgment, you may select to have participants share their experience in the larger group or in dyads.
      ii. Include an invitation to name their experience of the practice. Also invite responses that may include difficulties with the practice.

VI. Review
   a. At the end of the exercise, express something like: "This Caring Body Connection can be used at any time during caregiving – and in fact is a great practice to add to your days at regular intervals to ameliorate stress you may accumulate without awareness. For example, one could do this when they first wake and before or after meals – just to show our body, mind, and spirit that we care for ourselves. Because even caregivers…no, especially caregivers, need care! And this is a way of giving it to ourselves."

VII. Transition
   a. "Let's move to a self-compassion exercise that builds on what we learned in the exercise where we checked in about what we'd say to a friend who was struggling…"

2.6 SELF-COMPASSION BREAK

I. Materials

- Handout 9: Self-Compassion Break
- Handout 10: Reflection on Self-Compassion
- Writing utensils for participants

II. Estimated Time
    a. 20 minutes

III. Intention(s)
    a. Provide participants with brief self-compassion skill
    b. Deepen experiential awareness of kindness toward self, soothing, taking care of self.

IV. Optional brief mindfulness transitional moment/informal practice
    a. Sample instructions: “Let’s just take a moment to ‘shift gears’, leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you’d like to come up with a phrase that you use to remind yourself, such as, “I am here, now, with openness to this moment.” This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present.”
    b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
    a. Experiential: Use *Handout 9: Self-Compassion Break* as script. Have participants sit comfortably with eyes closed or downward soft gaze prior to beginning the script.
    b. After the experiential component, pass out *Handout 9: Self-Compassion Break* and *Handout 10: Reflection on Self-Compassion,* using the instructions to help them identify and deepen their experience of taking a Self-Compassion Break.
        i. Try to help guide participants’ responses to present-focused, i.e. not going into too much ‘story’ of the past or present
    c. Sharing
        i. Based on your clinical judgment, you may select to have participants share their experiences in the larger group or in dyads.
        ii. Include an invitation to name their experience of the practice. Also invite responses that may include difficulties with the practice.

VI. Review
    a. At the end of the exercise, express something like: “This Self-Compassion Break can be used at any time during caregiving, especially during challenging or hard moments. But you don’t have to be having a difficult moment. Again, this is another great practice to add to your days at regular intervals to ameliorate stress you may accumulate without even

realizing it. For example, one could do this at regular times of the day, like after any particular regularly-scheduled caregiving activity, such as providing food, medication, or other regular daily care. What could it hurt to check in with ourselves, connect with the idea that we are all united, even in our individual difficulties and/or brighter moments, and then say kind things to ourselves?"

VII. Transition
   a. "Let's move to a case vignette for some more practice…"

2.7 REAL STORIES*

(*If time is limited, your participants need more break time, a shortened session is needed, or there are any ability considerations in the group (vision, hearing, attention), this learning exercise can be omitted)

I. Materials

- Handout 11 – Real Stories
- Selected video (some suggestions below)
- Supplies for group to watch video (projector, larger screen that is visible to all, link for caregivers to watch on personal devices on own or in small groups)
- Alternative: write up a scenario (can utilize these videos) and read the case vignette aloud

II. Estimated Time
   a. 30 minutes

III. Intention(s)
   a. Normalize stress of caregiving (speaks to the shared humanity aspect of self-compassion)
   b. Provide first step of impersonal experience of exploring suffering to utilize self-compassion for (imaginal self-compassion, i.e. participants suggest ideas for self-compassion responses for individual(s) in different case(s)).

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This

simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."

b. You may select other objects of attention as fitting to your setting and community.

V. Instructions

a. Select a video for your group to watch for this exercise. You may select one or more. Consider a particular video that may have similar identities or experiences as your group. The following are a list of examples, though you may choose something different.
    i. The toll of Alzheimer's disease on caregivers. Mike and his wife; 2 min. https://www.youtube.com/watch?v=h_u8PybU__w
    ii. Alzheimer's Effect on Caregivers. Eugene and wife, Carol; 3 min, 48 sec. https://www.youtube.com/watch?v=9Qh8TNQTfPg
    iii. Day in the Life of an Alzheimer's Caregiver: Heartbreaking. Maite and her mother; 4 min, 38 sec. https://www.youtube.com/watch?v=0jlL85H5Ohw
    iv. Faces of Dementia: A Daughter's Sacrifice. Dee and her mother; 3 min 21 sec. https://time.com/5434345/alzheimers-caregivers-struggle/
    v. Select your own
    vi. Alternative: Write up a case vignette that participants can identify with; you will not be able to make it a match to all participants, but attempt to provide some demographic information that connects to your community of caregivers. This may include gender, age, ethnicity, race, nation of origin, language, socioeconomic status, family status, education, cultural barriers, housing status, health status/medical conditions, and more.
        a. Example: "Karla is a caregiver to her husband, Darryl, who has Alzheimer's disease. Karla's birthday is coming up but he is no longer able to track dates. She is feeling sad and lonely, and also angry that their only son, Angel, who is in his late 30s, recently moved across the country for a job opportunity. She is tired of doing all the cooking and housework, and she has some achy joints. She cannot leave Darryl home alone for fear that he may become confused or do something that harms him, so she can't even go for her daily walks that she used to enjoy. Seeing friends is also difficult because Darryl gets agitated when new people enter the house, since he no longer remembers anybody but his closest family. Though she recognizes that Darryl's loss of short-term memory is what causes him to ask the same questions over and over throughout the day, Karla is feeling extra frustrated and irritated lately, and is having a hard time responding with

simple answers and warmth to Darryl, and has even snapped at him."

b. Look online for other case examples.

b. Then, guide participants through *Handout 11 – Real Stories*
    a. Step 3 is an extra practice in experiential learning of mindfulness. If you are short on time, this piece may be skipped based on your clinical judgment.

VI. Review
    a. At the end of the exercise, express something like: "We have already established earlier that caregiving is difficult – and you among anybody are aware of that. But hopefully this exercise further demonstrates the idea we discussed of 'Common Humanity' – that we all struggle, just in different ways."

VII. Transition
    a. *"We are going to take a break now."* Provide instructions around your break time, food, facilities, or other pertinent information.

SECTION 3 – EXPERIENCING & SHARING

Overview: The third section will begin with a movement exercise wherein participants will explore physical movement that symbolizes self-compassion. Next, the group facilitator leads an interactive exercise and group members share their experiences and struggles related to the theme of caregiver burden and self-compassion

3.1 R&R MEDITATIVE MOMENT (or MINDFUL MOVEMENT)

I. Materials
   - Handout 4: Meditative Moment

II. Estimated Time
   a. 5 minutes

III. Intention(s)
   a. Continue experiential learning of mindful awareness
   b. This centering meditation aims to modulate in-session activation or stress that participants may be experiencing after the previous discussion or stressors and/or as centering after prior activities.

IV. Instructions
   a. See Section 2.1 – CENTERING MEDITATION, in the previous section of this Intervention Manual for instructions.
      i. Note: It is not necessary to do dyad sharing as done in 2.1.
   b. If you are experienced in a form of Mindful Movement, you may choose to use that as an alternative to another Meditative Moment script.
   c. Include an invitation to name their experience of the practice afterwards. Also invite responses that may include difficulties with the practice.

V. Review
   a. At the end of the practice, consider saying something like, "Getting present is as easy as slowing oneself down and taking a moment to notice our experience. Even just one or two breaths can help us get 'here'. My/our hope for you today is that you will create more tiny moments to take with you throughout your days in caregiving."

VI. Transition
   a. "Now let's move to a group exercise…"

3.2 BURDENS IN A BOX

I. Materials
   - Any type of box – a shoe box, an empty tissue
   - Writing utensils
   - Handout 12: Burdens in a Box or Blank paper (approx. size

of ½ - ¼ sheet of regular printer paper), or Index Cards
- Optional: the 3 components of Self-Compassion written at the front of the room

II. Estimated Time
   a. 35 minutes

III. Intention(s)
   a. Enhance learning of the three components of Self-Compassion
   b. Increase awareness of one's own caregiver burdens that participants experience
   c. Provide opportunity for one's caregiving burden to be held compassionately by others (modeling)
   d. Increase a sense of community

IV. Instructions
   a. Pass out paper and ensure participants have a writing device.
   b. Use the following guidance:
      "Let's take a brief mindful moment, settling into our seats, taking a few breaths, eyes closed or lowered with a soft gaze. Next, allow the mind to bring forth some of the burdens you experience as a caregiver. These may be emotional, financial, specific behavioral patterns such as anxiety or depression, common difficult moments they encounter, a recent challenge, a medical condition, pain, or other trying experiences."

      As this list of challenges arises, take a moment to ensure that they are present and select one that is mild to moderate – a level 3 or 4 out of 10 on the 0-10 scale, with 10 being the highest and hardest thing you could ever experience. State "We will be writing these down* and placing them into an empty box, then randomly selecting one another's difficulties to respond to using the three steps of self-compassion, as if it were our own difficult experience – so select one that feels appropriate to be shared anonymously with the group. You will not be writing your name down on the paper.

      Now, open your eyes if they are closed and write down this difficulty."

      *You may use a blank paper or an index card for participants write on. You may also use *Handout 12: Burdens in a Box*; however you may want to allow participants to keep that piece of paper.
   c. Collect the pieces of paper and place them in the box. Then, distribute them to group members (or have them pick one out of the box). Ensure that nobody gets their own difficult experience; if they do, collect them all and redistribute.
   d. Next, have participants write down on the piece of paper they chose what they might imagine doing/saying if they were to experiencing this difficult experience themselves.
   e. Using your facilitator discernment, choose to have participants share experiences with the group:

i. the experience they selected on paper,
i. the self-compassionate response they would use if it was their actual experience.
ii. Important note: If you select a full group response, ensure that all scenarios are read out loud so that nobody is left out.

f. Another option is for participants to form dyads for sharing instead of sharing with full group.
g. Debrief by inviting participants to generally recount what it was like to hear other self-compassion responses to their difficulties.
    i. Upon invitation, remind participants that they do not have to identify their own stressor.

VIII. Review
a. At the end of the exercise, express a recognition of the group's efforts, honoring of one another, learning, support of one another, and/or recognition that we all struggle in many ways and that self-compassionate responding is always available to each person.

IX. Transition
a. "Now let's move to a more experiential exercise that you can take with you into caregiving."

3.3 CAREGIVER BREATHING

I. Materials

- Handout 13: Caregiver Breathing

II. Estimated Time
a. 20 minutes

III. Intention(s)
a. Provide participants with a skill for self-care, self-soothing, compassion for self, and also the opportunity to include the person they care for in a practice imaginally.

IV. Instructions
a. Guide participants through *Handout 13: Caregiver Breathing* script.
b. Optional:
    i. Do a brief check-in with group to share their experiences of the practice and to learn from one another.
c. Distribute *Handout 13: Caregiver Breathing* for participants to keep for their records.
d. Allow time for questions about the practice.
    i. Include invitation for a discussion of difficulties with the practice.

V. Review
a. At the end of the exercise, in accordance with script, be sure to remind participants that they can use this breathing any time.

VI. Transition

a. “Now let’s move to reviewing (optional: some of what we have learned here today, then) how we can use what we have experienced and learned going forward.”

SECTION 4 – EMPOWERING AND COMMITTING

Overview: In this section, participants engage in additional skills training, learning and participating in multiple self-compassion exercises or activities tailored specifically to the caregiver population and aimed at addressing stress. Finally, participants are introduced to ways in which they can continue to plan ongoing engagement in self-compassion, explore possible barriers, and make and share commitments to their future practices.

4.1 LEARNING REVIEW*

*If time is limited, your participants need more break time, a shortened session is needed, or any ability considerations in the group (vision, hearing, attention), this learning exercise can be omitted

I. Materials
   - Handout 14: Learning Review

II. Estimated Time
   a. 20 minutes

III. Intention(s)
   a. Increase learning

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: “Let’s just take a moment to ‘shift gears’, leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you’d like to come up with a phrase that you use to remind yourself, such as, “I am here, now, with openness to this moment.” This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present.”
   b. You may select other objects of attention as fitting to your setting and community.

V. Instructions

a. Distribute *Handout 14: Learning Review* to participants and give them time to fill out the sheet.
b. Using your discretion, review with the whole group, or place participants in small groups or dyads for review.

VI. Review
a. At the end of the exercise, congratulate participants for all their presence and effort in today's session, noting how much was learned.
i. Provide broad summarizations as it pertains to what they express as most important or impactful, such as 'how much this group seems to have become aware of xxx.'

VII. Transition
a. "Now let's move to using what we have learned and put it into action."

4.2 ACTION PLAN JOURNALING

I. Materials

- Handout 15: Self-Compassion Action Plan

II. Estimated Time
a. 15 minutes

III. Intention(s)
a. Help participants establish a plan for using Self-Compassion

IV. Optional brief mindfulness transitional moment/informal practice
a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."
b. You may select other objects of attention as fitting to your setting and community.

V. Instructions
a. Distribute *Handout 15: Self-Compassion Action Plan* to participants.
b. Explain the top portion (these are the components of SMART goals). Ask participants if they have any questions.
c. Provide participants with time to fill out the sheet. Move about the room to answer questions or guide participants with the sheet.

d. Using your discretion, review with the whole group or place participants in small groups or in dyads for review of the goals they named.

VI. Review
   a. At the end of the exercise, review importance of making a plan in order to attain a goal, and that it takes intentional planning to start doing something new, but 'once the wheel is rolling,' this practice will get easier.

VII. Transition
   a. "One other important aspect of implementing a new plan is to also think about what might get in the way. Let's do that now…."

4.3 BARRIERS BRAINSTORMING*

* If time is limited, your participants need more break time, a shortened session is needed, or any ability considerations in the group (vision, hearing, attention), this exercise can be omitted

I. Materials

- White Board or Large Paper that can hang at front of room (for diagram & group created list) & marker

II. Estimated Time
   a. 15 minutes

III. Intention(s)
   a. Help participants identify barriers to using self-compassion so that they have more success using self-compassion in the future

IV. Optional brief mindfulness transitional moment/informal practice
   a. Sample instructions: "Let's just take a moment to 'shift gears', leaving the last activity behind us and becoming present in this moment, here and now. You may choose between any of the following – whatever you choose to try, bring an attitude of curiosity and playfulness to the experience. So you may notice your breathing, just as it is; or take a deep breath; or a few. Perhaps you may prefer to touch something near you, such as the table or your chair, your pants, and notice its temperature, texture, or other qualities of touch. You might also find something in this room that is pleasant to look at, such as a plant or outside a window. Maybe you'd like to come up with a phrase that you use to remind yourself, such as, "I am here, now, with openness to this moment." This simple little action helps us transition and become present to what is happening here and now. We will continue to use this throughout the day as a really quick practice to remind ourselves to be present."
   b. You may select other objects of attention as fitting to your setting and community.

V. Instructions

a. Ask participants to name any barriers they can think of to achieving their Action Plan Goals. As they name them, write them down at the front of the room.
    i. You may want to prompt them using categories, such as:
        1. Internal – i.e. forgetting, feeling bored, tired, etc.
        2. Familial – i.e. commitments, pressures, etc.
        3. Larger community/societal – i.e. feels strange to use this, against gender norms, confronts ways of being consistent with culture/religion, etc.
        4. Other – i.e. uncertainty of effectiveness, etc.
b. Prompt participants to name a few examples of what they might say to themselves or one another (perhaps using self-compassion!) if they are slowed or blocked by these barriers.
c. You may want to use some motivational interviewing questions to inform how to brainstorm barriers .
    i. How will they start anew?
    ii. What will help them re-align with their goals?
    iii. What will motivate them to start anew?
    iv. Are there any drawbacks to using self-compassion?

VI. Review
a. At the end of the exercise, say something affirming, like, “Well, it really seems like you guys are ready. While I’m hoping my job here is done, we’re going to review some more resources in a little bit in case you want to learn more or need extra support.”

VII. Transition
a. “First though, we want to check-in to find out what you thought of the workshop. We are now going to do a little evaluation so we can get feedback on your experience of the day.”

SECTION 5 – CLOSING

Overview: The final segment of the workshop consists of a final process of reflection as well as reviewing the information provided in the workshop. Resource information is provided for participants to explore further self-compassion experiences to aid them in their caregiving experience, and this information is reviewed. The workshop ends with a final self-compassion exercise.

5.1 PARTICIPANT EVALUATIONS

I. Materials
   - Handout 16: Participant Evaluation

II. Estimated Time
   a. 10 minutes

III. Intention(s)
   a. Provide feedback to group facilitators

IV. Instructions
   a. Say something like: “We want to check in to find out the ways in which the workshop has been useful, as well as areas for improvement. These evaluations can remain anonymous. We are grateful for your feedback.”
   b. Provide participants with *Handout 16: Participant Evaluation* and ask them to fill it out and turn it in. Collect and place aside.

5.2 RESOURCE REVIEW AND Q & A

I. Materials
   - Handout 17: Resources

II. Estimated Time
   a. 10 minutes

III. Intention(s)
   a. Provide caregivers with ongoing resources for more learning and possible local community resources for self-compassion and/or resilience building.

IV. Instructions
   a. Provide participants with *Handout 17: Resources* and review it together aloud.
      i. Participants may be aware of other good resources that have been helpful to them. You can invite them to share things that have also been helpful for them on their caregiving journey.
   b. Prompt participants to ask any final questions to facilitator(s).

5.3 LOVING KINDNESS MEDITATION & CLOSING

I. Materials
   - Handout 18: Loving Kindness Meditation

II. Estimated Time
   a. 10 minutes

III. Intention(s)
   a. Give participants another experiential meditation (skill)
   b. Provide closing meditation

IV. Instructions
   a. MEDITATION:
      i. Use *Handout 18: Loving Kindness Meditation* script to guide this final practice. Discuss the practice before distributing the handout.
      ii. At the end of the practice, before having participants open their eyes, ask them to come up with one or two words that describe how they feel right now in regard to their experience today.
   b. CLOSING:
      i. Ask participants to open their eyes and check in with themselves in order to come up with one word that describes their experience of the day.
         a. The facilitator may want to offer their word first: i.e. *grateful, inspired, warmed, etc.*
      ii. Then, ask participants to take turns naming their word for their experience today.
         a. Participants most commonly express statements of gratitude, warmth, etc. at this point in the activity. However, it is also important to maintain an open space and welcoming attitude to individuals who express more challenged experiences in this moment, such as 'resentful,' 'overwhelmed,' 'sad,' etc.
         b. Provide participants equally welcoming nonverbal (i.e. head nod, small smile, etc.) and/or very brief verbal (i.e. sounds like 'mmm,' 'hmm,' or 'uh-huh' with the nonverbal communication) affirmations. You may also reinforce at the end that all experiences are welcome.
      iii. Thank participants for their participation today and express any feelings of gratitude, inspiration, or wishes for the participants in their ongoing journey as a caregiver.

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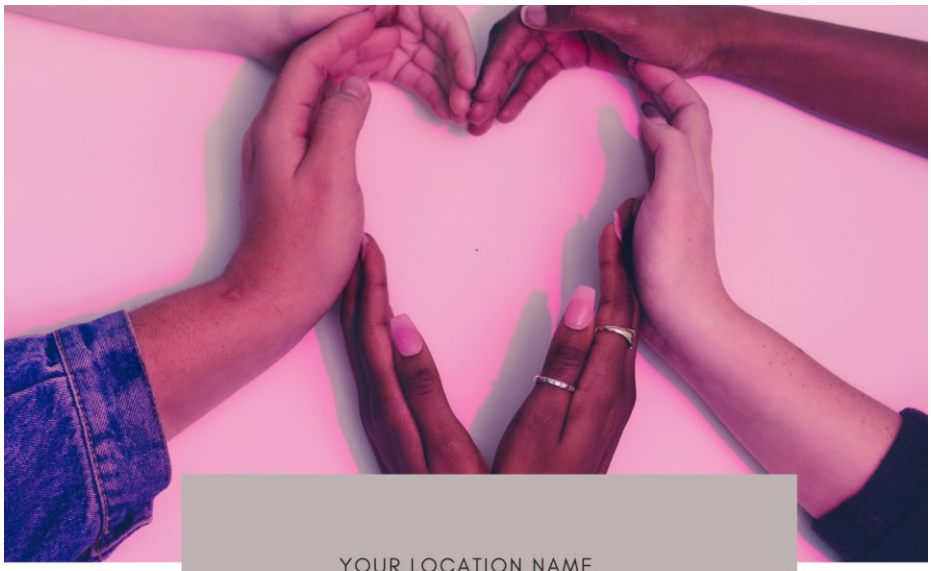
WORKSHOP APPENDICES

Appendix A

SAMPLE RECRUITMENT FLYER



YOUR LOCATION NAME

Self Compassion for Alzheimer's Disease Caregivers

MONTH, DATE 2020
9:30 A.M.- 4 P.M.
THE AUDITORIUM

CONTACT PERSON
CONTACT INFO

Location address
Parking information

Appendix B

SIGNS OF HYPERAROUSAL & DISSOCIATION (HYPOAROUSAL)

compiled and distributed by Willoughby Britton via Institute for Mindfulness in Psychotherapy 2019-2020 Course Curriculum; Mar 5, 2020

Signs of Hyperarousal

(Treleaven 2017, Magyari 2016, Ogden 2006)

Body/somatic
- Agitation, difficulty relaxing
- Psychomotor hyperactivity
- Tingling
- Twitching
- Hyperventilation, difficulty breathing
- Exaggerated startle
- Increased heart rate
- Hot flashes, flushing
- Sweating
- Cold hands + feet
- Muscle tension
- Chronic pain
- Insomnia

Cognitive
- Racing, repetitive, obsessive, intrusive thoughts
- Worry, rumination
- Rapid or disorganized speech;
- Jumping from topic to topic
- Executive dysfunction (memory, planning, decisions)

(continued on next page)

Emotion
- Emotional volatility, mood swings
- Euphoria, mania, grandiosity
- Anxiety, panic
- Reports of flashbacks,
- Nightmares
- Irritability, anger

Conative/Motivational
- Excessive, obsessive striving/effort
- Scrupulosity/perfectionism
- Apathy/withdrawal

Perception
- Perceptual hypersensitivity
- Sounds too loud
- Light sensitivity

Social
- Social engagement dysregulated
- Inhibition/withdrawal (also disinhibition, disruptive, interrupting)
- Inability to make eye contact during interviews/interactions

Signs of Dissociation
(also known as Hyperarousal)

(Treleaven 2017, Magyari 2016, Ogden 2006)

Body/Somatic
- Flaccid muscle tone
- Extremely still (frozen)
- Pale skin tone
- Fixed gaze ("thousand yard stare"), glassy eyes

Cognitive
- Few thoughts, "mind is blank"
- "Can't think"
- Concept loss
- Slow responses
- Difficulty evaluating surroundings
- Executive dysfunction (memory, planning, decisions)
- Slowed/slurred or disorganized speech
- "Spacey" ,"ungrounded"
- Hypernowness, no past or future

Self
- Disconnected from body, emotions, thoughts
- Outside body or at distance
- Disownership
- Don't exist, not here

Emotion/Motivation
- Affective flattening, blunted emotions, loss of emotion
- Normal emotions but "can't feel them" or "not mine"
- Apathy, feeling dead, nothing matters
- Lack of meaning, motivation

Perception
- World appears unreal or dreamlike
- Objects appear flat/2-dimensional; "cartoon-like"
- Distance distortions
- Visual hyper-clarity or fog

Social + Occupational
- Social engagement system offline
- Not seeking social support
- Withdrawn/avoidant

Dissociation vs. Meditative calm
- Disconnected from thoughts, body, emotions, world, others
- Not here
- Immobility; frozen quality
- Sudden resolution of distress
- "Feel fine"
- "Nothing going on"

Workshop Handouts

Handout 1

CENTERING BREATHS

(Modified from Harrell, 2020. Copyright Shelly P. Harrell, Ph.D. / Resilience & Reconnection, 2020.)

"Let's take a moment to get centered and breathe, connecting to your inner wisdom, calm, ease, and strengths, and our collective intention to build resilience in the midst of caregiving. Take a comfortable, alert seat with feet flat on the floor, hands on your lap, beside your body, in the arms of the chair, etc.

Close your eyes or take a soft, downward gaze and as we breathe in and breathe out, we are moving from being 'stressed out' to 'energized within.'

Remember that it is completely normal for your attention to wander during the meditation, just gently bring your attention back to my voice and to being present here-and-now in this group.

INHALE deeply, allowing your lungs to fill with air and your belly to relax and expand. As you are breathing in, imagine a gentle breeze sweeping through and clearing space in your mind, sweeping away the mental clutter. EXHALE through your mouth with intention – allowing your outbreath to make a sound of release as you loosen the tightness and tension in your face and body, even circling your head, rolling your shoulders, or stretching your fingers or toes if you feel like it.

As you INHALE and breathe in, you continue to clear mental and emotional space and allow your heart and your mind to open even more; as you EXHALE you breathe out your worries, fears, or whatever chains you to stress, you allow yourself to feel increasing interconnectedness with others in the group, knowing our shared humanity and shared struggles.

As you INHALE, you open your mind and heart to this workshop's theme of Self-Compassion. As you EXHALE, you breathe out distractions and center in on beginning to make contact with the feeling of self-compassion, expressing kindness to ourselves, and feeling connected to one another.

Continue to breathe, intentionally centering yourself more and more in this room, in this moment, focusing on our theme, and becoming as present as possible in the group today.

INHALE and as you breathe in you continue to make contact with kindness to ourselves, and bring your full attention to being here today in this workshop; and as you breathe out and EXHALE you invite ease as we move into the group experience we are going to have with each other today."

Handout 2

MY CAREGIVER NAME

(Modified from 'Naming Ceremony', developed by Shelly P. Harrell, Ph.D., 2020)

Instructions for creating new name:

First Name: _____

On the line above, write a quality or way of being that would help you in your caregiving role.

Examples: calm, grounded, supported, loved, strong, courageous, empowered, peaceful, joyful, connected, etc.

Middle Name: _____

On the line above, write a place or part of nature, or an object that is meaningful to you, that brings you peace, joy, or fulfillment or with which you strongly identify.

Examples: ocean, river, forest, garden, mountain top, sunset, sunrise, garden, church, warm cup of tea, or your favorite flower, tree, animal, color, stone, etc.

Last Name: _____

On the line above, write down something you do or have done in your life that makes/made you feel empowered, deeply connected to yourself, at ease, emotionally strong, or joyful.

Examples: gardening, knitting, singing, praying, dancing, hiking, sitting with my dog/cat, etc.

Introducing yourself to the group:

Actual name: _____

Caregiving to: _____

Your New Name (from above):

_____ _____
(first) (middle) (last)

Here are a few examples:

"Loving Lion Singing"

"Courageous Oak Tree Swimming"

"Peaceful River Napping"

Handout 3

GROUP OVERVIEW

SELF-COMPASSION WORKSHOP FOR ALZHEIMER'S DISEASE FAMILY CAREGIVERS

Group Leader Names
Today's Date
Start time – end time

(break times: xxx, xxx, xxx)

THIS WORKSHOP AIMS TO:

- ☑ *explore caregiver burden & stress*
- ☑ *build resilience using self-compassion*
- ☑ *provide new ways to approach caregiving*
- ☑ *develop new responses to challenging experiences*
- ☑ *increase connections with community*
- ☑ *empower you with new tools, practices, and resources*

Section	Section Theme		Min	Time	Name / Content
SECTION 1	Introduction & Connection	1.1	5	9:00-9:05	Group leader welcome, self introductions & group rules
		1.2	25	9:05-9:30	Participant Intros/Ice Breaker
		1.3	10	9:30-9:40	Overview of Session & Safety
		1.4	10	9:40-9:50	Participant Stressors
		1.5	10	9:50-10:00	Participant Coping Mechanisms
SECTION 2	Centering & Learning	2.1	15	10:00-10:15	Centering Meditation & Participant Reflections
		2.2	10	10:15-10:25	Effects of Caregiver Stress
		2.3	10	10:25-10:35	Self-Compassion Intro
		2.4	20	10:35-10:55	Kindness: Learning Compassion – What Would You Say To A Friend?
			15	10:55-11:10	Brief Break
		2.5	10	11:10-11:20	Caring Body Connections
		2.6	20	11:20-11:40	Self-Compassion Break
		2.7	30	11:40-12:10	Real Stories
SECTION 3	Experiencing & Sharing		60	12:10-1:10	Lunch Break
		3.1	5	1:10-1:15	Centering Meditation or Mindful Movement
		3.2	35	1:15-1:50	Burdens in a Box
		3.3	20	1:50-2:10	Caregiver Breathing or Imagery & Group Sharing
SECTION 4	Empowering & Committing	4.1	20	2:10-2:40	Learning Review
		4.2	15	2:40-2:55	Action Plan Journaling
		4.3	15	2:55-3:10	Barriers Brainstorm
SECTION 5	Closing		10	3:10-3:20	Brief Break
		5.1	10	3:20-3:30	Participant Evaluation
		5.2	10	3:30-3:40	Review of resources provided & Q&A
		5.3	5	3:40-3:45	Loving Kindness Meditation

Handout 4

MEDITATIVE MOMENTS

STOP / "The Sacred Pause"

- **S**low down and be still.
- **T**ake a deep breath.
- **O**pen Space.
- **P**ractice Presence.

(Modified from Harrell, 2020. Copyright Shelly P. Harrell, Ph.D. / Soulfulness Meditations, 2020.)

Re"CENTER"ing

- **C**lose your eyes and open your heart-mind.
- **E**xhale into the present here-and-now moment.
- **N**otice your internal experience by observing (without evaluating) what is going on physically, mentally, emotionally, and spiritually.
- **T**rust in what matters most to you by bringing it to consciousness using a meaningful word, an affirmation, proverb, sacred text passage, image, symbol, etc.
- **E**xplore your choices.
- **R**elease what does not serve your highest purpose and return to the situation more centered.

Creating "PEACE"

- **P**ause and connect to being **P**resent with yourself in the here-and-now.
- **E**xhale into your **E**xperience allowing yourself to become more consciously aware of what you are experiencing; observing what is going on physically, mentally, emotionally, spiritually, and inter-subjectively
- **A**nchor your **A**ttention in your breath, sound, word, object, or other sensation in order to ground yourself and stabilize your mind.
- **C**onnect to a symbol, image, song, phrase that **C**enters you in your peace internally, relationally, and collectively- helping you access what matters most to you.
- **E**xpress what matters most as you live your life with the energy of **E**mpowerment, knowing that you can liberate yourself from traps of the mind that separate you from yourself, others and the world, and reconnect you to the interconnectedness that is the foundation of all peace.

(both above modified from Harrell, 2020. Copyright Shelly P. Harrell, Ph.D. / Resilience & Reconnection, 2020.)

Handout 5

EFFECTS OF CAREGIVER STRESS

What is Caregiver Strain?

☒ stress and anxiety which may result from the perception that external caregiving demands exceed available resources

Risk factors:

☒ female gender, advanced age, decreased emotional state, poor physical health, caregiver depression, caregiver stigma, poor current relationship with care-recipient, low inner motivation, high external motivation, decreased quality of life, hours providing care, low income, low self-efficacy, and coping style

Some Facts:

☒ Dementia caregivers are more likely to report poor health, worsening health due to caretaking, and difficulty with health maintenance

☒ Higher levels of caregiver strain are also associated with worse outcomes for individuals with dementia, including higher rates of nursing home placement

☒ Caregiver strain is relates to higher risk of experiencing high levels of stress hormones, reduced immune function, and developing cardiovascular disease

☒ spouses caring for dementia patients are four times more likely to experience depression than non-caregivers

10 COMMON SIGNS OF CAREGIVER STRESS

1. **Denial** about the disease and its effect on the person who has been diagnosed.
   I know Mom is going to get better.

2. **Anger** at the person living with Alzheimer's or frustration that he or she can't do the things that once came naturally.
   He knows how to get dressed — he's just being stubborn.

3. **Social withdrawal** from friends and activities.
   I don't care about visiting neighbors anymore.

4. **Anxiety** about the future.
   What happens when he needs more care than I can provide?

5. **Depression** that affects your ability to cope.
   I just don't care anymore.

6. **Exhaustion** that interferes with daily tasks.
   I'm too tired for this.

7. **Sleeplessness** caused by worrying.
   What if she wanders out of the house?

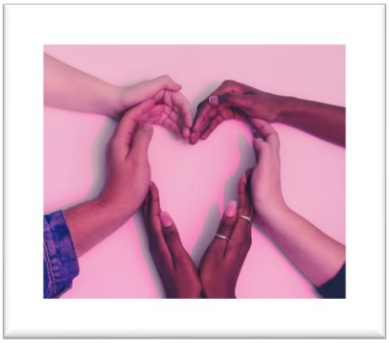
8. **Irritability** that triggers negative responses.
   Leave me alone!

9. **Lack of concentration** that disrupts familiar tasks.
   I was so busy, I forgot my appointment.

10. **Health problems** that begin to take a mental and physical toll.
    I can't remember the last time I felt good.

Handout 6

SELF-COMPASSION:
WHAT IT IS, HOW IT HELPS, TIPS FOR PRACTICE



What Is Self-Compassion?

- Self-compassion consists of three primary elements.

1. Mindfulness

- Noticing or being aware of and not judging experience (thought, feeling, sensations, urges) in the moment.
- Being present with our experience, whether pleasant or unpleasant and simply noticing it.
- May involve a 'pause,' 'stepping back,' or 'checking in.'
- This allows us to create a space of our choice to respond to our experience (rather than living in a reactionary mode).
- *Not*: swept away by or stuck in experience, living in our heads and identified with thoughts or feelings, which happens so commonly when we're frustrated, stressed, overwhelmed, anxious, depressed, or other mood states.

2. Common Humanity (meaning = we all have hard times!)

- Recognizing and connecting to idea that we ***all*** encounter challenges, limitations, struggles, losses, failures, and difficult experiences.
- *Not*: feeling alone, isolated, or frustrated in experience of 'my' difficult situation, or feeling like 'I am the only one struggling with this.'

3. Self Kindness

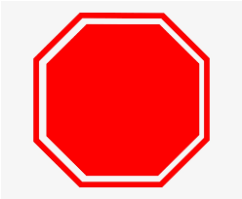
- Responding to self, especially during difficult moments in a soothing, kind, encouraging, and supportive manner.

- *Not*: telling self ‘shoulds,’ self-judgment, criticizing, minimizing, or being harsh with self; or ‘pushing’ self in hopes of motivating.

How Is Self-Compassion Helpful?

- Research links higher levels of self-compassion to:
  - More: happiness, optimism, life satisfaction, social connectedness, optimism, wisdom, curiosity, initiative, intelligence
  - Less: depression and anxiety, stress hormone (cortisol) level, emotional avoidance
- Provides a way to respond to self during a difficult moment and may reduce distress in moment

Self-Compassion Practice Tips & Cautions



1. This may be very new to you. Please be easy with yourself! It takes practice (and we’re here to support you today).

2. Some (many) difficulties do not have a solution and this is part of the practice. Our aim together is to provide internal responses that build resilience to stress and difficult experiences. Self support, if you will.

3. Noticing our difficulties can make them feel more challenging or overwhelming at first. Not always, but sometimes – especially depending on our mood. Above all else, choose using your own wisdom about how you engage.

4. Backdraft: This is a term used in firefighting that is also used as a metaphor for an experience that can occur when using self-compassion, especially in the beginning. When a fire lacks oxygen and new air is let in or a new door opened, the flames will expand rapidly in an explosive manner. A similar reaction is possible when self-compassion touches upon areas where a person once experienced criticism, anger, negativity, or other challenging painful thoughts or emotions.

    a. Example:

i. *Zena recently yelled at her partner, Bob, who has middle stage Alzheimer's disease, when he moved things around the house and she couldn't find her keys and needed to get her blood pressure medication. When she tried to use self-compassion, she had a hard time using kindness toward herself and saying "May I forgive myself." She experienced a flood of other incidents she felt like she needed forgiveness for and began judging her ability to be a 'good' caregiver, becoming so upset she could feel her blood pressure rising and feeling like she wanted to run away. (At this point, it may be wise for her to do any of the following…)*

b. What to do if you experience backdraft:
    i. Take a break
    ii. Provide yourself with soothing (words, touch, movement, rest, warm tea, fresh air, wash hands, or other moment that provides a sense of ease and soothing)
    iii. Engage with feeling grounded or use other senses to ground yourself in experiencing, such as looking at objects in your space, feeling you body in chair or connected to earth
    iv. Move your body in a way that grounds, settles/stills, or activates/moves energy (depending on your needs)
    v. Internally recite words of support, affirmation, or prayer
    vi. Imagine the support of an individual, creature, or place

Handout 7

LEARNING COMPASSION – WHAT WOULD YOU SAY TO A FRIEND?

(Adapted from Kristin Neff, PhD, 'Exercise 1: How would you treat a friend?' on self-compassion.org)

A dear friend or beloved person to you made a mistake or is struggling in some way. It could be anything – that they made an error on a form or forgot to send it in, missed a birthday of somebody they really care about, burned or dropped a meal or drink, lightly scratched their car on a branch while reversing, were harsh with somebody when they were overtired and frustrated…anything that has made them feel a bit down, perhaps even feel a little self-critical or hard on themselves.

1. You really care about them and you are in a good place at this moment so you want to respond to them and comfort them.

What is your tone of voice? _____

What words arise when wanting to comfort them? _____

_____

2. Next, think about how you may react if you were in a similar situation.

What is your internal tone of voice? _____

What words arise when responding to your mistake or difficult experience? _____

_____

3. Did you notice a difference? Y / N? If so, what? _____

Check in and ask yourself why there may be a difference between the two.

4. Let's explore what would happen if you responded to yourself in the same way that you respond to a friend.

How might it feel in your body? _____

What might your mood be like? _____

How might it change how you engage next? _____

5. On a scale of 0-10 (0 = not at all, 10 = the most possible), how interested are you in caring for yourself like you would for a good friend? 0 1 2 3 4 5 6 7 8 9 10

Handout 8

CARING BODY CONNECTIONS

Activity

One easy way to care for and comfort yourself when you're feeling badly is to give yourself supportive touch. Touch activates the care system and the parasympathetic nervous system to help us calm down and feel safe. It may feel awkward or embarrassing at first, but your body doesn't know that. It responds to the physical gesture of warmth and care, just as a baby responds to being cuddled in its mother's arms. Our skin is an incredibly sensitive organ. Research indicates that physical touch releases oxytocin, provides a sense of security, soothes distressing emotions, and calms cardiovascular stress. So why not try it?

Start by tuning in to your body. You may sit, lie, or stand for this practice. If you're comfortable, close your eyes. If you prefer to not close your eyes, soften your gaze and find a spot to maintain a gentle focus (not looking at others).

Bring to mind something that is a stressor. Nothing overwhelming – perhaps a 3 or 4 on a scale from 0-10, where 10 is highest.

Hand-on-Heart

- When you notice you're under stress, take 2-3 deep, satisfying breaths.
- Gently place your hand over your heart, feeling the gentle pressure and warmth of your hand. If you wish, place *both* hands on your chest, noticing the difference between one and two hands.
- Feel the touch of your hand on your chest. If you wish, you can make small circles with your hand on your chest.
- Feel the natural rising and falling of your chest as you breathe in and as you breathe out.
- Notice what your experience is right now.
- Linger with the feeling for as long as you like.

Some people feel uneasy putting a hand over the heart. Feel free to explore where on your body a gentle touch is actually soothing. Let's notice how we respond to several other ways of giving yourself caring body connections.

(continued on next page…)

Some other possibilities include…

___ One hand on your cheek
___ Cradling your face in your hands
___ Gently stroking your arms
___ Crossing your arms and giving a gentle squeeze
___ Crossing your arms and placing hands on opposite shoulders for a self hug/softening in the shoulders
___ Gently rubbing your chest, or using circular movements
___ Hand on your abdomen
___ One hand on your abdomen and one over heart
___ Cupping one hand in the other in your lap
___ (Perhaps again exploring) one or both hands over the heart

When you are ready, return to any last caring connection for another two to three cycles of your natural breath, noticing your experience right now. When ready, open your eyes.

Hopefully you'll start to develop the habit of physically comforting yourself when needed, taking full advantage of this surprisingly simple and straightforward way to be kind to ourselves. You might want to try putting your hand on your body during difficult periods several times a day for a period of at least a week.

(adapted from Kristin Neff, PhD, 'Exercise 4: Supportive Touch' from self-compassion.org)

Reflecting on Caring Body Connections

Rank your top 3 body connections that you experienced in the list above. Place the numbers 1, 2, and 3 in the boxes above for the top three caring body connections you experienced.

Then, write below what you noticed for each of those three that you ranked.

1._____

2._____

3._____

Handout 9

SELF-COMPASSION BREAK

When we are having a challenging moment in caregiving, using a self-compassion break may be helpful. Distress may already be present, or you may use this as a practicing exercise to build your self-compassion muscle by thinking of a situation that is difficult. Call a stressful situation to mind (practice with mild to moderate stressors, as strong stressors can be harder to work with until you have built the muscle), and see if you can actually feel the stress and emotional discomfort in your body, or what thoughts or feelings it may bring up.

Now, say to yourself:

1. I'm experiencing stress right now.

That's the mindfulness part of self-compassion – noticing what is happening. Other options include:

- *This hurts.*
- *Ouch.*
- *This is a moment of struggle; of stress; of difficulty; or of suffering.*

2. Stress is a part of life

That's common humanity. Other options include:

- *Other people feel this way.*
- *I'm not alone.*
- *We all struggle in our lives.*

Now, put your hands over your heart, feel the warmth of your hands and the gentle touch of your hands on your chest. Or adopt the soothing touch you discovered felt right for you.

Then, say to yourself:

3. May I be kind to myself

You can also ask yourself, "*What do I need to hear right now to express kindness to myself?"* Is there a phrase that speaks to you in your particular situation, such as:

- *May I give myself the care that I need.*
- *May I have compassion for the pain I am feeling.*
- *May I learn to accept myself as I am.*
- *May I forgive myself.*
- *May I be strong.*
- *May I be patient with myself.*

(Adapted from Kristin Neff, PhD, 'Exercise 2: Self-Compassion Break' on self-compassion.org)

Handout 10

SELF-COMPASSION BREAK REFLECTION

What did you notice when you were asked to feel the stress and emotional discomfort in your thoughts, emotions, or body at the beginning of the exercise?

_____

_____

_____

What was it like to notice your particular stressor as a moment of stress that others experience as well, or to recognize that other people also struggle?

_____

_____

_____

What did you notice when placing your hands over your heart or in another soothing way on your body during this exercise?

_____

_____

What words felt most suitable for your moment of kindness toward self?

_____

_____

_____

What did you notice in your thoughts, emotions, or body after the exercise? Or right now?

_____

_____

_____

Handout 11

REAL STORIES

STEP 1: *Identify Stress*

As you listen to or watch the experiences presented here, listen for any stressors that are named or that you may imagine the individual may experience.

Example: financial stress

A) _____

Consider experiencing this yourself and then list any stress response you notice either in your body, or challenging emotions or thoughts that arise in you as you listen to the experience shared.

Example: fearful or worried thinking about money; sad, hopeless, stuck feelings; tight jaw and aching back, shortness of breath.

B) _____

STEP 2: *Use Self-Compassion Break*

1) **NAME DIFFICULT EXPERIENCE IN THE MOMENT**: In response to lines A and B above, imagine that you were the person in the story/vignette and come up with a phrase that may identify the stress in a present moment manner. Write it in the first person ("I" statement), as if you were that person, i.e. "I am noticing that right now I am…"

Example: "Wow, I am noticing that I am really worrying about money right now and I notice that it's making me grumpy and my body feels tense."

_____

_____

_____

2) **SEE THRU LENS OF COMMON HUMANITY**: Carrying on from the experience named above, write a response that might help to broaden the situation to create a perspective that many people go though this and/or similar difficulties or feelings; that everybody experiences hard times and suffering.

Example: "A lot of caregivers are impacted by financial stress. I am not alone in this. More people have this difficulty than don't in the world," etc.

_____

_____

_____

3) USE **SELF-KINDNESS**: List any responses that you can come up with that might be kind, soothing, or calming in response to this stress.

Example: "May I trust that I will be ok," "May I give myself kindness," "May I forgive myself," or "I'm safe/ok right now in this moment and that's enough for now."

_____

_____

_____

STEP 3: ***Notice Your Current Response***

Now quietly take a moment to check in with yourself to notice your response to this exercise. Below are some prompts to show some possible ways we may notice our responses. Be as descriptive as you are comfortable being. You may notice an experience that arises or you may happen to notice a difference from before the exercise.

Body Sensations: _____

Thoughts: _____

Feelings: _____

Other: _____

Now, as best you can, respond with kind words, soothing, or a caring body connection to what you have noticed above.

Handout 12

BURDENS IN A BOX EXERCISE

(A) In the box below, please write down a caregiving burden (stress) you experience.

Please select an experience that is:
(1) At the distress level of approximately a 3 or 4 on a scale of 0-10 (10 highest)
(2) Appropriate to be shared in the full group (it will be anonymous/another person will read it aloud, but please be sure to select something you are comfortable being shared)

Examples:
- My husband keeps asking the same question all day.
- My mother won't eat the healthy food I give her and is gaining weight and I'm worried it will make her more sedentary and sick.

STOP HERE and Follow Group Facilitator Instructions

(B) On the lines, please write down the three components of self-compassion that you would say to yourself if the above experience was your caregiving burden.

MINDFULNESS

_____
_____

COMMON HUMANITY

_____
_____

SELF-KINDNESS

_____
_____

Handout 13

CAREGIVER BREATHING

The following practice is particularly useful for caregivers when experiencing any kind of interpersonal difficulty. For example, if you are finding that the person you are caring for is having their own difficult moment of unwillingness, frustration, fear, or other scenarios, you may encounter that this causes a moment of difficulty for you.

The following is provided as a practice that should take at least a few minutes, though you can extend it for as long as you like.

After building this muscle with repetition, you may find yourself taking breaths automatically at difficult moments – even just a couple of breaths for yourself and/or sharing the breaths with your individual may be helpful.

Now, let's breathe…

- *Sit comfortably, close your eyes if you like, and put a hand or two hands over your heart (or wherever you need some soothing touch). Feel the warmth and comfort of your hands as a loving reminder that you can bring awareness and compassion to yourself in this experience.*
- *Take a few breaths, letting yourself be held and rocked by the breath. Let it nourish you, hold you. Let the breaths move with you and comfort you as you inhale and exhale.*
- *Take a moment to find a natural flow right now. Stay with the sensation of breathing in and breathing out. If you like, imagine the breath as sustaining and nourishing you at this difficult time.*
- *Now focus on your in-breath, feeling the sensations of breathing in, letting your breath revitalize your body, breath after breath.*
- *As you breathe in, take in some nourishment for yourself – something good that you might need right now. Maybe some kindness, some compassion, some love? You can either feel this quality or use a word or an image. Take a moment and breathe it in.*
- *Now focus on your out-breath. Feel the sensations of breathing out, perhaps a sense of letting go, of release.*
- *Now call to mind your individual or whoever it is you're struggling with and needs your compassion. Visualize that person in your mind's eye.*
- *Begin directing your out-breath to this person, offering the sense of ease. If it is difficult, start with just one or two breaths.*
- *If you like, send some warmth and kindness – something nourishing – to this person with every exhalation.*

(continued on next page)

One for me, one for you.

- *Now returning to you, just focus on the sensations of breathing compassion in and out for yourself. When you're ready, try breathing in for yourself and out for your person, saying to yourself, "In for me, out for you." "One breath for me, one breath for you."*
- *If you are having a really hard time, you can focus more on yourself if you need a little extra care. Or if the other person needs more right now it is fine to focus on his or her needs. Or it can be an equal flow – whatever feels right in this moment.*
- *If there's more than one person in need, feel free to send something good to other family members or friends.*
- *Let your breath flow in and out, like the gentle waves of the ocean. Let the flow feel boundless, without limits, blowing in and flowing out. Let yourself be part of this fast flow. Feel this ocean of compassion.*
- *When you are done, gently open your eyes feeling that you can take this compassion with you throughout the day.*

(Adapted from Susan Pollak, EdD, (2019) Self-Compassion for Parents, 'When You Both Really Need Compassion"; similar practices found in Mindful Self-Compassion (MSC) program and by Pema Chodron)

Handout 14

LEARNING REVIEW

The three parts (things I say or do) of a Self-Compassion Break are:

1) _____

2) _____

3) _____

Something I learned about being a caregiver:

_____

_____

Something I learned about myself in this group:

_____

_____

Something that helped or inspired me in this group:

_____

_____

A stressor or hard thing I cope with and can bring self-compassion to is:

_____

_____

Handout 15

SELF-COMPASSION ACTION PLAN

An action plan includes:

What you are going to do **How much** you will do it

When you will do it **How often** you will do it

Example: *This week I will sit with a cup of soothing tea either outside or looking outdoors to do caregiver breathing (**what**) for 10 minutes (**how much**) in the afternoon when my partner naps or watches TV (**when**), three times per week – Monday, Wednesday, and Friday (**how many**).*

What	
How Much	
When	
How Often	

YOUR PLAN: This week I will…

Confidence Level that you will complete the action plan this week: **0 1 2 3 4 5 6 7 8 9 10**
(circle a number)

PROGRESS TRACKING

Day	☑	**Comments.** Hint: Use this space to give yourself self-compassionate responses if you don't complete your action plan. Like: "It's ok! Just start anew and with kindness toward yourself." ☺
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Handout 16

PARTICIPANT EVALUATION

Please circle the a number that best represents your experience today

(0 = lowest, not at all/none; 10 = highest, a lot)

YOUR EXPERIENCE

This session was helpful for me:	0 1 2 3 4 5 6 7 8 9 10
This session gave me new knowledge:	0 1 2 3 4 5 6 7 8 9 10
This session gave me new skills I will use:	0 1 2 3 4 5 6 7 8 9 10
I felt supported in community:	0 1 2 3 4 5 6 7 8 9 10
My uniqueness was honored and valued:	0 1 2 3 4 5 6 7 8 9 10
This session will help me in caregiving:	0 1 2 3 4 5 6 7 8 9 10

LEADERS

The group leader(s) were knowledgeable:	0 1 2 3 4 5 6 7 8 9 10
The group leader(s) were supportive:	0 1 2 3 4 5 6 7 8 9 10
The group leader(s) modeled self-compassion:	0 1 2 3 4 5 6 7 8 9 10

OTHER

What were the most helpful practices or experiences?

Were there any practices or experiences you might leave out? If so, which?

Other comments:

Handout 17

SELF-COMPASSION RESOURCES FOR PARTICIPANTS

Online Resources

Kristin Neff**:** **www.self-compassion.org**

Chris Germer: **www.chrisgermer.com**

The Center for Mindful Self-Compassion: **www.CenterforMSC.org**

Books

Neff, K. (2011). Self-Compassion: Stop Beating Yourself Up and Leave Insecurity Behind. New York: William Morrow.

Germer, C. K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions.* New York: Guilford Press.

Brach, T. (2019). Radical compassion: learning to love yourself and your world with the practice of rain. New York: Viking.

Silberstein-Tirch, L. (2019) *How to Be Nice to Yourself: The Everyday Guide to Self-compassion*. San Antonio, TX: Althea Press.

Kornfield, J. (1993). *A path with heart.* New York: Bantam Books.

Salzberg, S. (1997). *Loving-kindness: The revolutionary art of happiness.* Boston: Shambala.

Salzberg, S. (2005). *The force of kindness: change your life with love and compassion.* Boulder, CO: Sounds True.

Local Resources

(to be provided by location/local group leader)

Handout 18

LOVING KINDNESS MEDITATION

- Let yourself settle, either sitting or laying down. Feel free to put your hand on your heart or any other place that feels comforting. Try to bring not only awareness, but loving awareness, to yourself.

- ***(1) Beloved other:*** Think of a living being who makes you smile. It could be a grandparent, a child, a supportive relative, or a beloved pet. Whoever brings you happiness. If many beings arise, choose one…
- Let yourself experience what it's like to be with this person. Allow yourself to relax in this presence. Create as clear an image as you can in your mind's eye.
- Notice that just like you, this person or place wants to be happy and free from suffering. With warmth and kindness, repeat the following words:
    - *May you be safe.*
    - *May you be healthy.*
    - *May you be peaceful.*
    - *May you live with ease.*
- Repeat these phrases two or three more times.
- While these are the classic loving kindness meditation phrases, feel free to add your own words if you like, or continue with these phrases.
- If you notice that your mind has wandered, just returned to the phrases. No rush; take your time.

- ***(2) Self with beloved other:*** When you're ready, add yourself. Try to create an image in your mind's eye of you being together with this being who makes you smile.
- Now try these phrases, including yourself.
    - *May we be safe.*
    - *May we be healthy.*
    - *May we be peaceful.*
    - *Me we live with ease.*
- Repeat these phrases two or three times more.

- ***(3) Self:*** Now let go of the image of the other, letting your attention rest on yourself.
- Notice what is happening in your body, being aware of any stress or discomfort, and offer yourself these phrases.
    - *May I be safe.*
    - *May I be healthy.*
    - *May I be peaceful.*
    - *May I live with ease.*
- Repeat these phrases two or three times more.
- ***(4) Self with community:*** When you're ready, add any community that feels meaningful to you – it may be this group in the room, a group of family or friends, a group of people who share a special identity with you, or even all beings everywhere. Try to create an image in your mind's eye of you being in community presence with them in compassion.
- Now try these phrases, including the community and yourself.
    - *May we be safe.*
    - *May we be healthy.*
    - *May we be peaceful.*
    - *Me we live with ease.*
- Repeat these phrases two or three times more, noting the ever-present interconnection between you and all you have selected.
- Take a few deep breaths and just rest quietly, noticing what you're feeling.
- When you're ready, stretch, open your eyes, and find some movement in your arms and legs.
- Know that you can return to this at any time.

Adapted from Susan Pollak, Ed.D. (2019) Self-Compassion for Parents, 'Rewiring with Loving-Kindness Meditation (LKM)"