Part A: Group Protocol Assignment
Living with Early-Onset Dementia: Development of a Psychoeducation Group

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Literature Review

Early-Onset Dementia

Dementia is the diagnosis given when both cognitive impairments and decline in activities of daily living (ADLs) are observed (Sheehan, 2012). Although dementia is not a normal part of aging, approximately 11 percent of individuals have a diagnosis of dementia by 65 years of age, and that number grows to 32 percent by age 85 (Hebert, Weuve, Scherr, & Evans, 2013). The presence of dementia before the age of 65 is referred to as early-onset dementia (EOD) (Vieira et al., 2013). In the EOD population, Alzheimer's disease (AD) accounts for the majority of EOD cases (Lambert et al., 2014; World Health Organization, 2012).

Dementia is categorized by the extent to which it impacts impairment: mild, moderate, or severe. Each category has a different set of symptoms associated with impairment. This paper focuses on mild dementia and the cognitive symptoms associated with the diagnosis. The primary cognitive symptoms include: (1) difficulty with memory, (2) aphasia, (3) apraxia, (4) agnosia, and (5) disturbances in executive functioning (Wetherell & Jeste, 2003). In addition, individuals often experience difficulties performing ADLs.

Early-onset dementia is a separate category that must be considered when developing psychoeducation groups and interventions as many of the existing intervention approaches are targeted towards a population over the age of 65. This is important to consider as 65 is often considered the age of retirement; thus, individuals with EOD might still work. This review examines the benefits of psychoeducation groups, continued participation in occupations, session goals for the psychoeducation group, and outcome measures for the sessions. The review supports the group protocol.

Psychoeducation Groups

Psychoeducation is a holistic and evidence-based treatment modality that brings together an educational framework and psychotherapeutic approaches (Lukens & McFarlane, 2004). Psychoeducation includes information on health promotion, collaboration, coping, and empowerment skills to enhance clients' strengths (Lukens & McFarlane, 2004). Schneider and Cook (2005) demonstrated that psychoeducation is an effective method when teaching clients and family members new life skills or behaviours. Psychoeducational groups offer long-term social benefits as group members are more inclined to express negative feelings about their diagnosis. This provides group members with a sense of belonging and purpose, and enhances communication between group members and their caregivers (Lodgson, McCurry, & Teri, 2006). Lodgson et al (2006) showed that psychoeducation is an effective intervention and offers an improved quality of life and decreased family conflict following support group participation.

The majority of the care for individuals with dementia takes place outside of the traditional healthcare system (Thompson et al., 2007). Family and friends are often responsible for the role of caregiving (Thompson et al., 2007). Statistics indicate that almost 8.9 million informal caregivers exist worldwide (Sorenson, Duberstein, Gill, & Pinquart, 2006). Caring for an individual with dementia can take a toll on the caregiver, impacting their physical and psychological well-being (Hepburn et al., 2005). Also, it is important to view individuals with dementia as active agents engaged in "maintaining a sense of self in the midst of a debilitating disease" (Pearce, Clare, & Pistrang, 2002).

Once an individual is diagnosed with dementia, the focus often becomes centered on the disability or diagnosis, rather than the person's capability. Individuals who are newly diagnosed with dementia may experience feelings of depression or anxiety, or family and friends may withdraw from or judge the person in ways detrimental to their well-being (Lodgson et al., 2006).

Psychoeducational interventions may improve both symptomology and attitudes of individuals (Sorenson et al., 2002). Providing education at an early stage can increase coping strategies as well as the ability to plan for the future (Zarit, Fernia, Watson, Rice-Oeschger, & Kakos, 2003). The psychoeducational group framework can facilitate strengthening of supports and relationships while allowing individuals to work through grief and loss (Zarit et al., 2003).

EOD and Participation in Occupation

Many people with dementia and their caregivers struggle with the loss of occupation that accompanies the progression of disease. One of the biggest changes that occur after a decrease in occupation is the transition of how people with dementia identify themselves. Before the onset of the diagnosis individuals identify themselves by their profession or activity; however, after a diagnosis, individuals start to identify themselves as a person with dementia (Egan, Hobson, & Fearin, 2006). Roach and Drummond (2014) revealed that maintaining purposeful activity might preserve the dignity and sense of self of a person with dementia. A lack of occupation affects the mental health of these individuals with many reporting increased anxiety and feeling that others were attacking them (Roach & Drummond, 2014). Additionally, there are concerns over job security. People with dementia frequently report that they are laid off without empathy (Roach & Drummond, 2014). This is problematic as many are diagnosed with EOD at the peak of their careers and will experience significant financial challenges due to work termination (Ducharme et al., 2014). Although individuals with dementia may experience job termination and loss of some leisure activities, this does not mean that they must retire from all purposeful and meaningful occupations. This is particularly important for individuals with EOD as they are often in a period of their life where they are still physically active and are often engaged meaningful occupations (Egan et al., 2006). Egan et al (2006) emphasized the importance of adapting occupations to enhance engagement in purposeful and meaningful activities. This not only

promotes engagement, but it also mitigates the psychoemotional factors that often are associated with dementia (Egan et al., 2006).

Session Goals for an EOD Psychoeducation Group

There are 10 sessions in this group. The first session is an introduction session. It provides an overview of the group and is designed as a lecture, followed by a meet-and-greet. The subsequent nine sessions follow Cole's (2012) 7 Stages. Each session has a specific goal, identified as common issues for individuals with EOD. These include: (1) treatment and self-management of the diagnosis; (2) managing changing relationships within the family; (3) coping with the stigma associated with receiving a diagnosis of dementia at a young age; (4) memory and cognitive strategies; (4) coping strategies, dealing with stigma, and sharing the diagnosis; (5) fear of safety at home and in the community; (6) loss of work roles and financial issues; and (7) feelings of extreme social isolation and exclusion and a desire for age-appropriate purposeful activities and services (Haase, 2005; Harris, 2004; Harris & Keady, 2004; Harris & Keady, 2009; Johanessen & Moller, 2011; Morhardt et al., 2015; Overshott & Burns, 2005; Rose et al., 2010).

Outcome Measures for an EOD Psychoeducation Group

The Canadian Occupational Performance Measure (COPM) and the Goal Attainment Scale (GAS) are widely recognized and validated goal-based assessments (Kiresuk & Sherman, 1968; Law et al., 2014). The COPM is designed to measure client-centered subjective goals and the GAS enables objective measurement of goal achievement (Bouwens et al., 2008; Doig et al., 2010). These two tools are useful outcome measures for clients with cognitive disorders as they capture the multidimensionality of dementia (Bouwens et al., 2008; Doig et al., 2010). Doig et al (2010) measured the clinical capacity for the use of the COPM and GAS in individuals with cognitive impairments. Their research established that these tools enable measurement of performance of real-life, meaningful, individualized goals. Results indicated that the benefits of

using the COPM to develop and monitor goals that are meaningful to the client, together with the GAS to operationalize goals and objectively measure change, substantially outweigh time and other costs (Doig et al., 2010).

The Coping Orientation to Problems Experienced (COPE) Inventory was developed to assess a broad range of coping responses. The Brief COPE allows for abbreviation and categorization of coping responses to tailor a more individualized and meaningful assessment tool (Carver, 1997; Cooper, Katona, Livingston, 2008). Cooper et al (2008) used the dysfunctional, problem-focused, and emotional subscales to assess coping strategies in caregivers of people with dementia. The reliability and validity of the Brief COPE, when operationalized within these subscales, is sensitive to change and proven for the problem-focused and dysfunctional coping scales (Cooper et al., 2008).

Conclusion

Individuals with EOD dementia face many of the same challenges as those with dementia; however, as they are younger, they may face additional burdens and challenges that can affect relationships, financial planning, and health and well-being. It is important that the development of a psychoeducational group for individuals with EOD address these needs, and that the group provides education, emotional support, and opportunities for engagement to both individuals with EOD and their caregivers.

Group Protocol

Name: Living with Early-Onset Dementia

Leaders: Mary McDonald, MSc., OT Reg(Ont.); Darrell Davidson, MSW, RSW

Time and length of meetings: Saturday 10:00-11:30a.m.

Duration: 10 sessions (1 session per week for 10 weeks)

Place: Kingston Community House, 99 York St., Kingston, Ontario

Group Format: Closed

Statement of Rationale: A closed group provides an environment that fosters the development of relationships, builds connections, and creates a positive climate, instilling trust between members and leaders (Schwartzberg, Howe, & Barnes, 2008). When working with a fragile population, such as those with EOD, it is important to consider the psychoemotional factors that can contribute to a sense of security between members. A closed group provides an environment that will enable a positive climate, and provide a platform for open communication and discussion between members, without feelings of stigma. Furthermore, due to the fact that dementia affects cognition, a closed group will help maintain consistency and may prevent confusion within group members (Schwartzberg et al., 2008).

Frame of Reference: Psychoeducation

Statement of Rationale: There is a period of transition and adaptation that begins when an individual receives a diagnosis of an illness such as EOD. This is a diagnosis that can affect self-perception and identity, and can have a huge emotional impact on the individual and their loved ones (Werner, Stein-Shvachman, & Korczyn, 2009). Both the practical and emotional consequences of this diagnosis need to be addressed in order for individuals to manage their illness. Psychoeducation addresses the practical education that people with EOD need, while also grounding teaching within a psychotherapeutic framework which can support the emotionally loaded nature of many of the questions that will arise (Lukens & McFarlane, 2004). Using psychoeducation in a group adds the benefit of peer support, which is invaluable in promoting a sense of universality (Lodgson et al., 2006).

General Group Goals and Rationale: The overarching and sessional group goals were developed based on a review of qualitative studies examining the unique experiences and challenges of individuals with EOD (Haase, 2005; Harris, 2004; Harris & Keady, 2004; Harris & Keady, 2009; Johanessen & Moller, 2011; Rose et al., 2010). First, the group will promote a positive, safe environment that enables and empowers members with EOD to manage their diagnosis and remain independent in daily life. Second, the group will foster relationships between members and their caregivers, friends, and family members. Third, the group will provide tools to help members advocate for their own health. The group aims to connect members with individual and community resources to help them manage their disease prognosis, make decisions about their health, and aid them in planning for their futures. Lastly, the leaders

will assist group members in staying involved and identifying community resources that promote occupational engagement.

Outcome Criteria for Successful Goal Attainment in Sessions: During ever session, each group member will give and seek information from other group members. This ensures discussion and participation throughout the session. In addition, members will demonstrate their satisfaction and enjoyment throughout the group process by indicating appropriate body language such as laughing and/or smiling. At the end of each session, members will be able to identify one strategy to assist them to advocate and manage their own health. Members are asked to share what they retained from the session to family members and/or caregivers.
members and/or caregivers.

Group Composition and Criteria for Selecting Members: Members of the group will be referred from a family doctor or from a hospital. If a group member has a comorbid disorder (e.g. substance abuse disorder) then they must be deemed medically stable by their family doctor prior to referral into the group. The group should be composed of both men and women. Each member must have a diagnosis of mild dementia. All group participants must be between the ages of 45 and 65. Prior to the onset of the group, both the occupational therapist and the social worker will screen each group member. Screening measures will include a phone interview in which the leaders will also complete the COPM and GAS to gain an understanding of the individual's goals. Group attendance is limited to six members with EOD. The group will not run if there are less than four members with EOD. Each member can bring one caregiver to the sessions for additional support. The decision to include caregivers in select sessions is so that group members will feel a greater sense of belonging and so that caregivers can help communicate their members' needs and goals (Lodgson et al., 2006). Incorporating caregivers in these sessions will provide both members and the caregivers with information on how to approach these issues and supports that are available all participants. See Appendix A for group member profiles.

Leadership Roles and Functions: The primary role of psychoeducation group leaders is to educate members and actively facilitate discussion (Galanter, Castaneda, & Franco, 1998). Leaders should be: caring, warm, genuine, and have a positive regard for others. The leaders roles and functions include: (1) helping to collaboratively establish and enforce group norms; (2) fostering engagement in group discussion; (3) promoting a positive group climate that encourages trusting relationships and nurturing connections; (4) helping members to develop insight and prepare for challenges; (5) preparing and promoting emotional activation; (6) being a resource both to group members and to their family members and caregivers; and (7) being a conduit to community resources (Yalom & Leszcz, 2005).

Characteristics of Group Contract: Each member is expected to attend all sessions. If a member is not able to attend a session he/she must notify the group leaders prior to the session. All members will arrive on time. They will also actively participate in group discussions. Members will treat other members and leaders with respect and understanding and will maintain confidentiality of member information throughout the group sessions and after the group concludes. If a member is unable to meet the group demands or if a member violates the group norms then that member will be asked to leave the group.

Group Methods and Procedures: Group sessions are based on Cole's 7 Stages (Cole, 2012). Each session will include: (1) introduction; (2) activity; (3) sharing of the activity; (4) processing; (5) generalization; (6) application; and (7) summary. This model provides a thorough debrief of education provided and is designed for individuals with communication skills and significant cognitive capacity for reflection (Cole, 2012). Members in this group are newly diagnosed with mild-EOD. As they are in the early stages of the disease they still retain this capacity for learning and reflection (Bird, 2008). Group leaders and caregivers will provide guidance and assistance to create an enriching learning environment within the group. All sessions except the introduction session (see below) will include a psychoeducation component in the introduction. In sessions three to ten the introduction will contain a debrief.

Each session focuses on issues identified by individuals with EOD. The sessions are designed to provide members with the tools and strategies to manage their diagnosis. This allows members to maintain their independence and communicate their needs with others. Each session will build from the previous session, beginning with a debrief of the previous session and will be followed by an overview of the current session. The sessions are task-oriented and aim to introduce concepts and strategies to enable EOD management. The sessional activities create opportunities for members to explore occupational performance issues identified in the literature. The group members will participate in a combination of parallel, associative, and collaborative group tasks (Donahue, 1999; Mosey, 1970). The sessions emphasize the psychoemotional underpinnings associated with each occupational task.

In the first few sessions of the group, it is expected that the leaders will assume an autocratic leadership style. Based on the literature, it is presumed that group members will be less likely to engage in member-to-member communication, thus it is imperative that the leaders encourage and facilitate these discussions (Tuckman, 1965). As the group progresses through the stages, and trust develops, it is expected that there will be increased interactions, and that both members and caregivers will become more involved in discussion (Tuckman, 1965). At this point, it is expected that the leaders will assume a more democratic leadership style, encouraged by member input and involvement. As the group moves towards the norming and performing phases the amount of cooperation, caring, and support between members and caregivers is expected to increase cohesiveness (Schwartzberg et al., 2008; Tuckman, 1965). This will foster positive relationships between members, their caregivers, and the group leaders.

Overview of all Sessions:
1. Introduction. The focus of the first session will be to provide an overview of the group sessions, clarify expectations of group members, introduce group members and leaders, and briefly discuss the nature of the disease. This will be a time where members can decide if they want to choose to stay in the group for the following sessions or opt-out.
2. What to expect. This session will focus on disease progression, reflect on how the disease impacts occupation, and explore feelings, fears, and expectations after diagnosis.
3. Treatment and self-management. This session will focus on different treatment options, providing an overview of the efficacy of treatments, understanding one's health, and to whom to turn for resources. It will also focus on self-care tasks and maintaining autonomy with respect to health.
4. Caregiving and family relationships. The caregiving and family relationships session will highlight possible changes in relationships, how to act and interact with caregivers, friends, and family members. Further, the session will integrate family and caregivers into the session to provide them with communication strategies to enhance the members' well-being.

5. Coping strategies and sharing your diagnosis. The session provides an opportunity for members to reflect on how their relationships with caregivers and family members have changed. It will also help to highlight stigma, and issues surrounding stigma. Along with this, it will identify resources that will help with coping with the diagnosis, and resources that can help mitigate the effects of stigma. Further, the session will provide more techniques to foster a positive outlook and positive atmosphere when discussing the diagnosis.

6. Memory strategies. Members and leaders will discuss memory and cognitive strategies that help them to maintain independence in their ADLs.

7. Safety skills. Safety skills session incorporates home safety, personal safety, and driving and community mobility. The session provides information to members about the dangers of driving, important considerations to make around the home to ensure safety, and ways that they and their caregivers can ensure the member is safe at all times.

8. Planning for your future. This session examines career planning, financial planning, and health planning. It incorporates strategies for speaking with one's employer, applying for disability funding, and planning for wills and power of attorney.

9. Getting and staying involved. This session highlights the importance of maintaining active social connections and contributing to one's community. Members and leaders are encouraged to brainstorm ideas of how to use strategies provided in earlier sessions to ensure that the members are able to stay engaged and participate in their chosen activities.

10. Looking for the future and group termination. The final session of the group will debrief the previous sessions in more depth through a focus group approach and will help prepare the group members with additional resources and supports after the group's conclusion.

Group Evaluation Plan

Formative Evaluation & Rationale: The following formative assessments will be conducted before, during, or after each session with the goal of improving the group's design and overall performance throughout the 10-week sessions.

Group Progress Notes. The leader will write down group progress notes at the end of each session. This allows tracking of the process, dynamic, and cohesion of the group during the particular task. The group progress notes will provide documentation of member participation and what was accomplished in the session. Also, having group progress notes helps when there is a different leader the following week as it can provide feedback for the next session and can help initiate the current session's debrief discussion.

Group Member Feedback and Debriefing. A debrief will occur at the beginning of each session where group members will briefly discuss their week and highlight one thing that they took from previous week's session. In addition, group leaders will informally ask for group member feedback on the structure of the sessions.

Directed Paraphrasing. The leader will initiate directed paraphrasing near the end of each session to ensure that group members have retained educational content from the session. Paraphrasing will allow group members to put concepts in their own words and identify if they remembered the main concepts of the session. The leader(s) and caregiver(s) are also encouraged to paraphrase and use repetition as a form of reinforcement and a memory strategy for group memories (Smith et al., 2011).

Observation. The leader will make an ongoing effort to observe whether group members seem attentive, ask questions, engage in discussion, and participate in activities during each session. Participant observation provides a means to monitor the way in which group members interact during the session and therapeutic activity. It is important for the leader to clarify the objectives of the activity prior to the observation in order to know what to observe. The notable observations made will be documented in the Group Progress Notes.

Summative Evaluation and Rationale: The following summative assessments, which focus on the outcome of the program, will be conducted during the 10th session and over the phone.

Focus Group. During session 10, the leader will facilitate a focus group to prompt discussion amongst group members about the overall group, sessions, and goal achievements. This evaluation provides valuable information on the group members' perspectives and experiences of taking part in the group (Vickrey et al., 2007). The focus group will use the ORID framework (observation, insights, reflection, and decision) to help provide qualitative information on the strengths and weaknesses of the group sessions based on the members' viewpoints. This process can provide valuable suggestions to improve for future programs.

Group Outcome Survey. This satisfaction questionnaire is to be administered by group members and caregivers during the last session. If group members have difficulties remembering certain aspects of the overall group caregivers and leaders can assist group members to fill out the survey by providing cues, paraphrasing, and reflecting on the group sessions and their experiences; (see Appendix B)

Outcome Measures. The following outcome measures will be used both pre and post evaluation to document change and determine progress. The pre evaluation will be done during the members' individual screening test prior to the sessions to objectively determine a baseline function. The post evaluations will be conducted after the 10th session concludes. Both pre and post measures will be conducted via phone.
  - Canadian Occupational Performance Measure (COPM) and Goal Attainment Scale (GAS): These two outcome measures will be used to determine the goals of each individual group member. The COPM is used to develop and monitor goals that are meaningful to the individual and the GAS will be used to operationalize goals to objectively measure change (Doig et al., 2010).
  - Brief COPE: This outcome measure assesses the varying coping strategies used by each individual in response to stress and aim to track progress following all the sessions. This outcome measure was chosen because coping strategies and education on self-management are incorporated throughout the program.

The formative and summative evaluations described above are critical to implement, as they will help to enhance group effectiveness. Essentially, the evaluations and assessments aim to capture the important group and individual criteria, such as: accomplishment of group tasks, achievement of both group and individual goals, and measure evidence of group growth and development.

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Appendix A: Group Members

Name: Rufus
Age: 54
Social History and Home Environment: Rufus is divorced and lives alone in a condo in downtown Kingston. He is within walking distance of all shops and stores. He has three adult children and two grandchildren, one of whom is a student at Queen's. They get together for Sunday dinner every week. Rufus works an actuary at Empire Life.
Medical Issues: Mild dementia
Occupational Issues: Rufus wants to continue to work; however, his boss has suggested he retire early as he is having issues reading and writing reports for clients. Although he has maintained the math component of his job, as a manager he is required to communicate via email, phone, via documents and in person, all which are affected by his dementia.

Name: Sheila
Age: 56
Social History and Home Environment: Sheila is married to her wife Sandy. They have three children, two are in university, and one is still in high school. Sheila has a home business making chocolate desserts for parties. Sheila's wife is a physiotherapist and works a KGH in the geriatric ward. She often works with clients with MCI or dementia.
Medical Issues: Mild dementia; Type I Diabetes
Occupational Issues: Difficulty remembering the recipes for her desserts. Difficulty managing her finances, and has lost some accounts because she is becoming increasingly irritated, and she is having issues budgeting and planning out recipe amounts when grocery shopping. Sheila relies on her child and wife to drive her, or she takes the bus; she has never had a license.

Name: Barbara
Age: 48
Social History and Home Environment: Barb and her husband Walter are ex-military. They are both retired and split their time between Kingston and Florida. Barb volunteers at a local breakfast program three days per week. Barb's sister and her family live nearby. They are close, but due to Barb's alcohol abuse, have drifted apart. Barb and Walt have two golden doodles.
Medical Issues: Mild dementia; alcohol abuse (managed)
Occupational Issues: Due to Barb's diagnosis and occupational problems, they have been spending more time in Kingston as travelling is becoming too difficult for both of them, causing stress on their marriage. At the breakfast program, Barb often forgets the names of the students she feeds, and forgets to put items on the tray when serving the food.

Name: Diego
Age: 59
Social History and Home Environment: Diego is widowed. His wife Maria passed away three months ago. Diego has recently moved in with his oldest daughter and her family. His daughter has 4 children under the age of 11. Diego owned a private computer store. He worked up until his wife passed away, and has since sold his store.
Medical Issues: Mild dementia; depression/grieving
Occupational Issues: His wife used to manage the house. His daughter expects him to take care of the house and do some childcare while she and her husband are at work. Diego hid his dementia

from his family. It is progressing, and without his wife there to support him, it is causing increased impairment in his daily functioning, further affecting his familial relationships.

Name: Arthur
Age: 51
Social History and Home Environment: Arthur lives in North Frontenac with his wife Jan. He works as a school librarian in the county, alternating days. He is set to retire at age 65. Arthur's wife is a teacher at one of the schools. This is the second marriage for both of them. They are both on good terms with their exes and have blended families. Arthur has three children from his first marriage, two step-children from Jan's first marriage, and they have two children together. They currently have seven grandchildren. All of their children and grandchildren live in the same area. Three of the grandchildren attend Arthur's school.
Medical Issues: Mild dementia
Occupational Issues: He has noticed some changes at work, having trouble managing his schedule and forgetting children's names- something he used to be very good at. Further, he can no longer drive and occasionally has hallucinations when sitting in the passenger's seat of his wife's car.

Name: Fiona
Age: 57
Social History and Home Environment: Fiona is single. She is a professor of women's history and gender studies at Queen's University. She is an avid hiker in the summer and Nordic skier in the winter. She competes on the masters ski team out of Gatineau, and travels there every weekend in the winter to train. Fiona has a close social group of friends that get together every week for a book and wine club. She also lives in the same apartment complex as her best friend, Sydney, and relies on her for support. Fiona volunteers at Sydenham community garden two days per week. She has a family history of dementia. Her mother passed away after suffering from AD, and her eldest brother (age 72) was diagnosed with EOD three years ago.
Medical Issues: Mild dementia
Occupational Issues: Difficulty preparing and presenting lecture materials, remembering where the lectures are held. She has missed meetings with her graduate students, and she gets irritated at their "incompetence". She has had trouble following trail routes when hiking and skiing. Last fall, she got lost hiking the John Brooks Trail in the Adirondacks. She is also having some trouble keeping up with her basic self-care, including showering and dressing.

Appendix B: Summative Evaluation
Group Outcome Survey (Borg & Bruce, 1991)

Please answer each of the following questions:

1. The most helpful aspect of the group was:

2. The least helpful aspect of the group was:

3. During the group I felt:

4. During the group I learned:

5. Do you still use the knowledge and skills that you learned in the group? Please explain:

6. Did you feel free to participation in the activity? In the discussion?

7. How did others in the group help you?

8. In general, I felt the group experience was: (circle one)

    a. Very Poor

    b. Poor

    c. Good

    d. Very Good

    e. Excellent

9. Comments:

10. Suggestions:

Appendix C: Individual Session Plans

1. Introduction

2. What to expect: **Louise Chiasson**

3. Treatment and self-management: **Mohamed Al-Haj**

4. Caregiving and family relationships: **Andrea Mesones Scopa**

5. Coping strategies and sharing your diagnosis

6. Memory strategies: **Heather Shepherd**

7. Safety skills

8. Planning for your future: **Caitlin Preston**

9. Getting and staying involved: **Janice Huang**

10. Looking for the future and group termination