Psychotherapies to Reduce Depression in Dementia Family Caregivers: Review and Recommendations

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Overview

Multiple forms of psychotherapy are successful at improving depressed mood in dementia family caregivers (CGs)

- Cognitive Behavioral Therapy (CBT)
- Brief Psychodynamic Therapy
- CBT/psychoeducational approach
- Problem Solving Therapy
- Acceptance and Commitment Therapy
- Alternative treatments
- Technology-based programs

CBT (Laidlaw, Thompson, & Gallagher-Thompson, 2018)

- Present-oriented, problem-focused, and encourages clients to try out new ways to approach old problems
- Skill-building – clients learn and try out new coping strategies with the therapist's support
- Teaches clients to question and modify unhelpful negative thoughts, feelings, and behaviors
- Teaches clients to become their own therapists – e.g., assigning homework to produce an enhanced sense of agency and efficacy
- Highly effective with depressed adults and older adults

CBT modified for CGs (Gallagher-Thompson & Steffen, 1994)

- CGs learn to question unhelpful negative thoughts specifically about caregiving ("Why do I get so upset all the time"?) and develop more adaptive ways to think ("I'm not upset all the time; I learned deep breathing & can do that when I feel stressed.")
- CGs learn behavioral strategies – e.g., how to increase daily pleasant activities, focusing on shared positive activities with PWD
- In the first study we offered 16-20 individual sessions using skilled therapists; more recent studies provide fewer sessions, may be done in a small group format, and use specially trained interventionists
- A number of recent studies by other investigators have also successfully applied CBT to CGs

  Vernooij-Dassen, Draskovic, McCleery, & Downs, 2011; Kazmer, Glueckauf, Ma, & Burnett, 2013; Wilz, Meichsner, & Soellner, 2017; Wilz, Reder, Meichsner, & Soellner, 2018 – see reference list at end for citations

Psychodynamic Psychotherapy (Gallagher-Thompson & Steffen, 1994)

- Briefer and more focused than traditional long term PD in this study
- Based on the theory that **caregivers' past conflicts over dependence and independence are reactivated by the caregiving situation and expressed in the caregivers' difficulty in separating emotions and needs from those of the elderly relative they are caring for**
- Therapy sessions focus on one of the four following themes: independence, activity, self-esteem, or grief
- Typically, past losses are discussed, as well as conflicts in separation/individuation
- A corrective emotional experience occurs through reenactment of these conflicts within the therapeutic relationship (Rose & DelMaestro, 1990)

CBT vs. Psychodynamic (Gallagher-Thompson & Steffen, 1994)

Table 3
Posttreatment Beck Depression Inventory, Hamilton Rating Scale for Depression, and Geriatric Depression Scale Means (and Standard Deviations) Grouped by Length of Caregiving

Measure and therapy	≤44 Months		>44 Months	
	M	*SD*	*M*	*SD*
BDI				
CB	11.8	10.3	6.4	5.7
PD	7.8	3.2	15.5	5.4
HRS				
CB	8.7	7.1	9.5	6.5
PD	7.8	5.1	13.3	7.6
GDS				
CB	11.4	8.7	7.9	5.8
PD	8.8	6.4	17.4	5.7

Note. BDI = Beck Depression Inventory; HRSD = Hamilton Rating Scale for Depression; GDS = Geriatric Depression Scale; CB = cognitive–behavioral therapy; PD = psychodynamic therapy.

Why did we see these relationships between type of treatment and length of time caregiving?

CBT vs. Psychodynamic (Gallagher-Thompson & Steffen, 1994)

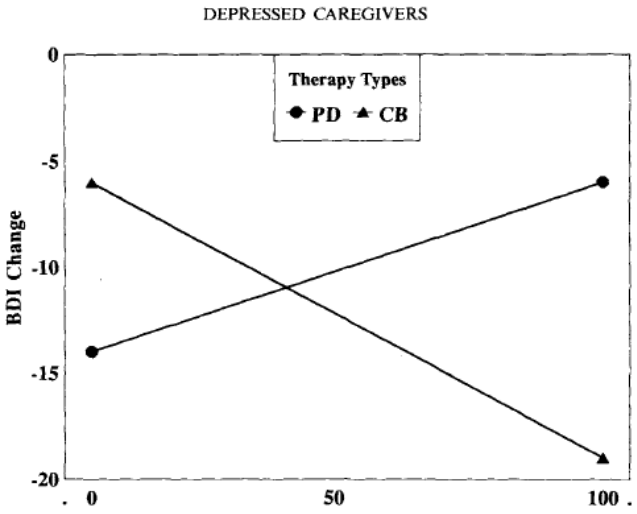

Figure 1. Plot of the regression lines of posttreatment Beck Depression Inventory (BDI) change and length of caregiving (in months) for psychodynamic (P/D) and cognitive–behavioral (C/B) treatments.

Why did we see these relationships between type of treatment and length of time caregiving?

CBT vs. Psychodynamic (Gallagher-Thompson & Steffen, 1994)

Summary of findings

- Length of time as a CG may be an important variable to consider when choosing treatment for depression
- CGs in the role for longer than 3.5 years showed greater posttreatment benefit from CBT
- CGs in the role for a lesser period of time improved more with psychodynamic therapy

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CBT vs. Psychodynamic (Gallagher-Thompson & Steffen, 1994)

<u>Why did we see this pattern of results?</u>

Theory: As CG-related stressors build up over time, CGs' social and emotional resources become depleted

- So: longer-term CGs may require very structured, skill-oriented interventions to continue to cope with the caregiving role as more and more demands are placed on them over time
- In contrast, therapy that helps CGs process the existential losses that occur when a dementia diagnosis is confirmed – loss of future possibilities, the person they knew, etc. – may be most helpful in the early stages as the magnitude of losses associated with this diagnosis begin to be realized

CBT/Psychoeducational Approach

- Small group programs providing psychoeducation and support that are CBT-derived, focusing on self-efficacy through skill-building
- CWC → OFJ → ACES

Gallagher-Thompson et al., 2003;
Gallagher-Thompson et al., 2012;
Luchsinger et al., 2016

Active
Caregiving:
Empowerment
Skills

Participant Packet

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CBT/Psychoeducational Approach

CWC
- Evidence-based, used as an intervention in REACH, translated & employed with diverse ethnic groups
- Limitations: too long; no focus on resilience – more on the 'negative' aspects of caregiving

OFJ
- Condensed from 12 sessions to 8, 6, and eventually 4
- Piloted in several workshops with excellent results in terms of reducing CG depression
- Feedback: remove one section; CGs wanted more emphasis on positive aspects of caregiving

ACES
- Removed section not considered useful and added content on resilience & other aspects of positive psychology such as: forgiveness, gratitude, and hope
- Piloted in February 2017, Fall 2017, Spring 2018 with some modifications made to improve clarity

Spanish
- Currently translated into Spanish; facilitators being trained
- Preparing to be disseminated in community centers and used as an education and recruitment tool among Latino/ Hispanic CGs in East Palo Alto, Redwood City, and Menlo Park

Problem Solving Therapy (PST)

- Focuses on teaching individuals skills ("tools") that enhance ability to cope with life stressors – similar to CBT
- ALSO places importance on emotions, early learning experiences, and emotional regulation – different from CBT
- Based on diathesis-stress model: genetic propensities and early stress produce vulnerabilities later in life and/or when the coping system becomes overwhelmed by the quantity and/or quality of new stressors
- In PST, clients learn increased emotional regulation and problem solving to build improved resilience to stress

(Nezu, Nezu, & Colosimo, 2015)

PST Adapted for CGs

- Designed for CGs of individuals with a recent diagnosis of MCI or early dementia
- Emphasis on skills training – problem solving, goal setting, and use of behaviorally-oriented "action plans" (Luchsinger et al., 2016)
- An early intervention was the "COPE program" – Creativity, Optimism, Planning, and Expert Information (Houts et al., 1996)
- Can be done in small group or individual formats; trained interventionists needed
- Feasible and acceptable for CGs; significantly reduced depression and anxiety (Garand et al., 2014)

Acceptance and Commitment Therapy (ACT)

- Focuses on learning specific skills starting with how to accept and tolerate uncomfortable emotions – anger, anxiety, or sadness
- Encourages the person to "stay in the moment" and act in line with personal values despite negative feelings
- Fosters acceptance of problems as an active coping strategy in itself – promoting the belief that many problems encountered in life cannot be "changed" or "controlled" but need to first be accepted for what they are

(Márquez-González, Losada, & Romero-Moreno, 2014; Losada et al., 2015)

ACT applied to CGs – Why is this a good fit?

- Dementia CGs face many problems that can't be "solved" or "controlled", and keep happening over time as their CR declines
- By focusing on the moment and learning techniques for mindfulness and self-acceptance, CGs become more 'centered' and less emotionally driven. They also learn to distinguish problems/ situations that can vs. cannot be changed/modified
- This enables CGs to take a problem solving focus to deal with problems that CAN be changed, or at least modified
  - Ex.: PWD will become less agitated if spoken to calmly and if loving touch/another form of nonverbal communication is used; this does not change the "problem" of difficult communication between CG & CR, but the situation is more manageable & less distressing to the CG

  (Márquez-González, Losada, & Romero-Moreno, 2014; Losada et al., 2015)

Alternative Effective Treatments for CGs

- Group meditation/guided imagery program to reduce depression, anxiety, insomnia (Jain, Nazarian, & Lavretsky, 2014)
- Yoga and meditation (combined) reduce depression and help caregivers cope with stress (Waelde, Thompson, & Gallagher-Thompson, 2004; Waelde, Meyer, Thompson, Thompson & Gallagher-Thompson, 2017)
- Tai chi has also been shown to reduce CG depression (Chan et al., 2016)

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Technology-Based Programs for CG Distress (Part 1)

- Most current technologies focus on improving home safety or giving reminders for medication, appointments, and the like – see www.alz.org Technology 101 section in the Caregiver Center
- Several psychologically-oriented programs to reduce distress were developed by Czaja et al. – e.g., a videophone-based small group workshop to increase interaction and support for dementia caregivers was found to be feasible and effective (Czaja, Loewenstein, Schulz, Nair, & Perdomo, 2013)

Technology-Based Programs for CG Distress (Part 2)

- In addition, there are several effective online, web-based programs that reduce depression and improve CGs' ability to deal with stress (Kajiyama et al., 2013; WHO pilot program in Bangalore, India, 2017; see also www.caregiver.org – home page of Family Caregiver Alliance, SF, section on caregiver statistics: health, technology, and caregiving resources)
- However, there are no current mobile apps developed specifically for family CGs, nor are most of these web-based programs accessible to the public since they were developed by researchers and are not well marketed
- This is an area for fertile future development

Stages or Phases of Caregiving (Pfeiffer, 1999)

- *Stage 1: Coping with the initial impact of being told the diagnosis*
- *Stage 2: To be or not to be…a caregiver?*
- *Stage 3: At-home caregiving—the long journey*
- *Stage 4: Considering institutional placement*
- *Stage 5: Caregiving during residential or institutional placement*
- *Stage 6: Death of the patient—grief and relief*
- *Stage 7: Resuming life—healing and renewal*

Each stage has its own unique characteristics, and what "works" at one stage may not be at all effective at another point in the process. Future intervention research needs to take account of the "caregiving trajectory" and develop (and test) programs designed to meet these changing needs within the cultural context of the family.

Stages of Caregiving: Additional Thoughts

- Caregiver Identity Theory
  - All CGs share common elements of the caregiving role, but also differ due to cultural and familial experiences, type of tasks, and caregiving duration (Montgomery & Kosloski, 2013)
- CGs have different levels of interest in receiving caregiver education and long-term care services depending on where they are on the CGing trajectory (Braun, Karel, & Zir, 2006)
- Therefore "one size does not fit all" – successful intervention will differ according to multiple factors, of which "length of time as a CG" seems to be an important one

Conclusions

- CBT has the strongest evidence base for improving depression symptoms in dementia family CGs, in both individual and small group formats
- Many other approaches are promising
- We need to know more about how minority CGs respond to interventions
  - Some evidence on effectiveness with minority CGs (Latino, Vietnamese, Chinese) in psychoeducational groups
- Length of time caregiving is a key variable that will determine which interventions/programs/forms of therapy are most likely to be successful at which points in the "journey"
- Effectiveness of technology-assisted programs is under-studied at present
- Given the ever-increasing number of CGs in this country, we need a "rapid-cycle" developmental process for CG interventions, as we do for development of new medications

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Questions?

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