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# The Benefits and Limitations of a Behavioral Intervention for Caregivers of Dementia Patients: A Qualitative Study

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*This study used qualitative methods to understand dementia caregivers' experience of personal and therapeutic factors contributing to outcome following REACH VA, a behavioral intervention designed to alleviate caregiver burden and depressive symptoms. Caregivers and their interventionists were queried about their experiences of the treatment in semistructured interviews. Interviews were transcribed and analyzed using thematic analysis. The following themes emerged reflecting aspects of the intervention caregivers and interventionists found helpful: self-care, shared goals, psychoeducation, and stress-management skills. Some caregivers and interventionists found the provision of problem-solving skills to be helpful and others did not. Finally, some caregivers and interventionists reported that interpersonal support/bearing witness, insight, emotional transformation, and the discussion of interpersonal process were useful when part of the intervention or, when not included, would have been helpful. While behavioral interventions tend to be highly structured, interventionists' ability to work flexibly within the protocol and tailor it to the caregiver's needs was related to positive treatment response. The beneficial aspects of this treatment represent multiple theoretical orientations highlighting the importance of transtheoretical models of therapeutic action.*

The impact of Alzheimer's disease and other dementias is significant and increasing. As of 2010, approximately 35.6 million individuals were diagnosed with dementia worldwide with prevalence expected to double every 20 years (Prince et al., 2013). The task of caring for individuals with dementia often falls to family who subsequently experience significant physical, emotional, and psychological stress. Caregivers of individuals with dementia suffer from rates of psychiatric symptomatology as high as 48% (Draper, Poulos, Cole, Poulos, & Ehrlich, 1992; Pinquart & Sorensen, 2003). Additionally, caregivers experience significant health problems including lower rates of preventive health behaviors, decrements in immunity, greater cardiovascular reactivity, and increased risk of illness and mortality compared to noncaregivers (Schulz & Martire, 2004).

Over the last 40 years, psychosocial interventions tailored to families caring for individuals with dementia have been developed; however, the efficacy of those interventions has been highly variable. One of the most successful interventions for caregivers is Resources to Enhance Alzheimer's Caregiver Health (REACH). The initial REACH study (REACH I), supported by the National Institute on Aging/National Institute of Nursing Research (NIA/NINR), involved six feasibility studies that tested several interventions to identify the most promising approaches to reducing caregiver negative outcomes (Gitlin et al., 2003; Wisniewski et al., 2003). The result of these studies was REACH II, a behavioral intervention that systematically targeted problem areas and tailored the intervention to the needs of the individual caregiver. REACH II was tested using a multisite NIA/NINR randomized controlled trial of the intervention ($N = 642$). REACH II caregivers showed improvements in burden, emotional and physical well-being, social support, caregiver frustration, and management of care-recipient behaviors (Belle et al., 2006; Elliott, Burgio, & DeCoster, 2010; Nichols et al., 2008). REACH VA represents the first national clinical translation of an empirically supported behavioral intervention for caregivers in the United States and part of the nationwide effort to disseminate evidence-based therapies throughout the VA health care system (Karlin & Cross, 2014). Staff at the VA Medical Center in Memphis translated REACH II research materials for clinical care use including intervention manuals, scripts, certification procedures, and evaluation materials. Caregiver

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and training materials for those delivering REACH VA were also developed (Nichols, Martindale-Adams, Burns, Graney, & Zuber, 2011). The REACH VA clinical translation study examined the effect of REACH VA on 127 caregivers across 27 Veterans Health Administration (VA) sites in the United States (Nichols et al., 2011). Since that time, REACH VA has continued to evolve and enrollment and analysis of the program is ongoing. Thus far, program evaluation of REACH VA has demonstrated that caregivers receiving the intervention report significant decreases in caregiver burden, depression, frustration, and impact of depressive symptoms on daily life, as well as decreases in the care-recipients' troubling dementia behaviors and increase in care-recipients' safety (Nichols et al., 2011; Nichols, Martindale-Adams, Burns, Zuber, & Graney, 2016). Additionally, REACH VA was associated with a 33% reduction in VA costs of care for the care-recipient and has been successfully adapted for specific cultural populations (Belle et al., 2006; Nichols et al., 2017; Martindale-Adams et al., 2017). REACH VA increases access to support services for caregivers through the VA that they may not otherwise receive, particularly for non-veteran caregivers of veterans with dementia, and facilitates the delivery of services to older adults by VA providers who might not have had previous professional education or training in gerontology.

Even the most effective psychosocial interventions are characterized by nonresponse or partial response among a significant portion of those treated. Few caregiver intervention studies publish the percentage of participants that continue to experience clinically significant symptoms postintervention; however, one study did report that the average caregiver remained moderately depressed posttreatment (Gallagher-Thompson et al., 2003). Another indicated that rates of clinically significant depression and anxiety postintervention were nearly 50% (Andrén & Elmståhl, 2008). Despite substantial rates of nonresponse or partial response, both of these interventions demonstrated statistically significant change in caregiver symptoms. Similarly, for REACH VA, although the intervention results in statistically significant change in depression and caregiver burden, the effect sizes are small to medium (Nichols et al., 2016). As is true of many behavioral interventions, it is likely that a significant portion of caregivers who receive REACH VA continue to experience significant levels of depression or burden and many show little change in their symptoms over the course of intervention. Investigators at the VA Medical Center in Manhattan, one of the sites of the REACH VA clinical translation, became interested in identifying factors that predict treatment response to REACH VA. The current study enrolled a new set of caregivers separate from the REACH VA clinical translation and program evaluation for purposes of gathering data on treatment response and the lived experience of caregivers receiving REACH VA. We obtained qualitative data from caregivers and their interventionists in order to identify aspects of the treatment that are most helpful to those who respond as well as additional interventions that could be provided to nonresponders as part of a stepped care model of treatment. It also aims to clarify personal factors that influence treatment response to assist in making appropriate referrals for this type of caregiver intervention.

## Method

The current study represents an independent investigation of REACH VA at a Veteran's Administration Medical Center (VAMC) that was not involved in the national study. The primary investigator of the project was a clinician in the national study and all interventionists were trained and certified in REACH VA by the VA National Caregiver Center at Memphis VA by the developers of REACH VA.

### Participants

Caregivers were referred by staff in the geriatric, mental health, and primary care clinics, as well as by other participants and self-referral from flyers posted throughout a VAMC. Caregivers were romantic partners, adult children, and other family members of persons with dementia (PWD), in which one member of the caregiving dyad was a veteran. Caregivers who reported an average of at least 4 hours per day devoted to caregiving and were experiencing elevated burden or depressive symptoms, as defined by a 12-item Zarit Burden Interview score greater than or equal to 9 and a PHQ-9 score greater than or equal to 5, were offered the REACH VA intervention. The 22 caregivers who completed the REACH VA intervention were included in this analysis. See Table 1 for demographic descriptions of the caregivers.

A total of 15 interventionists (2 doctoral-level psychologists and 13 advanced predoctoral trainees), certified in REACH VA, provided treatment to the 22 caregivers included in this study. Of the interventionists who treated multiple caregivers, one treated one responder and two nonresponders, one treated one responder and one nonresponder, one treated two responders, one treated two nonresponders, and one treated three nonresponders. All predoctoral trainees had at least some exposure to CBT and manualized treatments prior to delivering REACH VA and underwent more extensive training in cognitive behavioral approaches to treatment, conceptualization, and dementia/caregiving issues during the training year. Licensed psychologists certified in REACH VA provided weekly supervision of trainee's REACH VA cases.

Table 1
Demographic Description of Current Participants vs. REACH VA Implementation

| Variable | Label | Current Study (n=22) | REACH VA Implementation* (n=127) |
|---|---|---|---|
| Age | Mean | 64.5 | 71.6 |
| | Min-Max | 48-85 | |
| Gender | Female | 13(59%) | 93.7% |
| Racial Identification | White | 14(64%) | 78.0% |
| | Black | 2(10%) | |
| | Other | 6(27%) | |
| Ethnic Identification | Latino or Hispanic | 2(10%) | |
| Highest Education Level | High School | 1(5%) | |
| | Some College | 9(41%) | |
| | College Graduate | 9(41%) | |
| | Post-graduate | 3(14%) | |
| Veteran Status | Caregiver | 5(23%) | 0% |
| | Care Recipient | 17(77%) | 100% |
| Relationship to Care Recipient | Romantic Partner | 13(59%) | 80.3% |
| | Adult Children | 8(36%) | 15.0% |
| | Other Family Member | 1(5%) | |

*Note.* *Where available in Nichols et al., 2011

## Procedure

Caregivers were provided with the 12-session REACH VA behavioral intervention, which focuses on psychoeducation, problem-solving around typical challenges facing caregivers, and stress management strategies. These strategies are designed to impact a range of caregiver outcomes through a variety of points on the stress-health process model (Cohen, Kessler, & Gordon, 1995; Lazarus & Launier, 1978). The protocol outlines content to be covered during each session designed to target key areas of caregiver risk, including: information regarding the disease course, safety of the care-recipient, caregiver self-care, social support, and management of typical behavioral problems. The intervention is tailored to the needs of each care-recipient through an initial risk priority assessment that is completed collaboratively with caregivers to identify their specific goals and needs. The intervention provides caregivers with a range of strategies including problem solving, cognitive restructuring, stress management (breathing exercises, stretching, guided imagery), pleasant events planning/behavioral activation, and communication skills. These strategies are detailed in a Caregiver Notebook that is provided to all caregivers, which contains 30 behavioral management topics and 18 caregiver stress and coping topics with corresponding strategies (Nichols et al., 2016). Additionally, participants were offered five supplemental group sessions by phone, with group sizes ranging from 2–5 members. The group structure consisted of: (a) members check-in, (b) presentation of caregiving topic, and (c) discussion. The caregiving topics consisted of the following: self-care, communicating with the care-recipient, communicating with health care providers, community resources, and financial and legal issues. Caregivers were seen at the VAMC with the option of completing occasional sessions over the phone.

Following the intervention, caregivers and interventionists independently completed semistructured qualitative interviews conducted by trained nonclinical research staff. Interventionists were interviewed following each treatment they completed and asked to respond to the questions for the particular caregiver they treated; thus, some interventionists were interviewed multiple times. Caregivers and interventionists were asked what they found most helpful and what they felt could be changed to make a new intervention for nonresponders. They were also asked about caregiver factors that impacted the ease of the intervention's implementation. Interviews lasted between 20–60 minutes, were electronically recorded, and transcribed verbatim by research assistants not involved in the intervention arm or the data analysis.

Depression and caregiver burden were measured pre- and postintervention using the Patient Health Questionnaire (PHQ-9) and the Zarit Burden Scale, respectively. These measures were used to determine responsiveness to intervention. Treatment response was defined as caregivers who did not attain at least a 50% reduction in depression or caregiver burden at the end of treatment—a commonly used operationalization in clinical trials for depression (Cuijpers et al., 2014; Lekman et al., 2008; Souery et al., 1999). Caregivers were divided into responders ($\Delta \geq 50\%$ on PHQ9 and Zarit) and nonresponders ($\Delta < 50\%$ on PHQ9 and/or Zarit). While nonresponders may have shown substantial improvement on one measure, significant symptoms persist in at least one of the two measured areas, suggesting that additional treatment is indicated. Average pretreatment PHQ-9 and Zarit scores were slightly lower for responders (PHQ-9 = 8 and Zarit = 24) than nonresponders (PHQ-9 = 10.5 and Zarit = 26.5). Of note, in our sample, the effect sizes (Cohen's *d*) for change in depression (PHQ-9) was -.44 and burden (Zarit) was -.75. The effect sizes for these variables in the REACH VA implementation study were -.26 for depression and -.33 for burden (Nichols et al., 2011).

## Measures

### *Patient Health Questionnaire (PHQ-9; Spitzer, Kroenke, Williams, & Patient Health Questionnaire Primary Care Study Group, 1999)*

The PHQ-9 consists of 9 questions based on the DSM-IV criteria for depression rating the presence and severity of depression on a scale ranging from 0 (*not at all*) to 3 (*every day*). The validity of the PHQ-9 depression severity has been shown to correlate with the scores of the short version of BDI ($r = .73$; $p < .0001$; Martin, Rief, Klaiberg, & Braehler, 2006).

*Zarit Burden Interview (O'Rourke & Tuokko, 2003; Zarit, Reever, & Bach-Peterson, 1980)*

The Zarit Burden Interview is a 12-item unidimensional scale of caregiver strain. Caregivers rate the amount to which they experience a statement such as "DO YOU FEEL stressed between caring for your relative and trying to meet other responsibilities (work/family)?" on a scale ranging from 0 (*never*) to 4 (*nearly always*). This measure has been shown to have good internal validity ($\alpha = .85$) and predict depression scores among caregivers (O'Rourke & Tuokko, 2003).

### Qualitative Analysis

Twenty-two transcribed semistructured interviews of caregivers and interventionists (44 total) were analyzed in two phases using thematic analysis as outlined by Braun and Clarke (2006). In the initial phase, line-by-line coding of each transcript was completed by two of the authors and all potentially meaningful responses were noted. Once all initial codes were compiled, one author reviewed each transcript to ensure that codes were evenly applied. In the second phase, initial codes were organized into specific categories that were discussed and agreed upon by three of the authors. Finally, categories were organized into broader conceptual themes by two authors. In some cases, categories were reorganized and renamed to ensure that conceptual themes, categories, and codes were coherent and accurately represented the data.

## Results

Analysis of the responses regarding elements of the intervention that were most helpful or could be improved indicated nine conceptual themes related to common mechanisms of therapeutic action: problem-solving skills, stress management skills, psychoeducation, self-care, shared goals, interpersonal support/bearing witness, insight, emotional transformation, and interpersonal process between caregiver and interventionist. These mechanisms of therapeutic action are transtheoretical, reflecting both common factors and aspects of cognitive behavioral, supportive, psychodynamic, and emotion-focused therapies. The subcategories within each theme and representative codes are discussed below. In each section, the most helpful aspects of each theme are discussed first, followed by aspects of the intervention that could be improved or included in a follow-up treatment. From the questions regarding unique caregiver factors that made this intervention easier or harder to implement, we identified two conceptual themes: characteristics of caregivers that would make it easier and more difficult to benefit from the intervention. Surprisingly, there was often substantial agreement between caregivers and interventionists from both the responder and nonresponder categories. Any areas of difference are specified but otherwise the groups are collapsed. The results are summarized in Table 2.

### Problem-Solving Skills

The majority of caregivers and interventionists found the materials provided, which detail specific strategies for trouble-shooting problem behaviors in PWD (e.g., repeated questions) and problems among caregivers (e.g., asking for help), to be a useful resource for problem-solving in the present and in the future. Most caregivers and interventionists found these materials well-organized and user-friendly. One responder caregiver felt it covered "all the essential parts of what you need to know and be aware of as a caregiver" and several participants discussed the benefits of improving communication skills, including one nonresponder caregiver who specified that "speaking up" in order to let others know what she needs allowed her more "freedom" in her caregiving role.

Some caregivers found these materials overwhelming, with too much information to cull through in order to find individual solutions. Additionally, some responder caregivers found that they were not specific enough to address their particular issues. One responder caregiver stated, "You need a lot more real life situations, where people say to you this happened and then that happened. . . . Everything was laid out, but when you got into a real situation it had nothing to do with what was laid out." A few caregivers across responder categories suggested including role-plays to bring situations to life and address communication difficulties. More practically, some nonresponder caregivers felt the materials, compiled in a large notebook, were too cumbersome to bring to each session and wished they were available in e-reader form or that pages could be removed and brought to sessions as needed.

Despite the intervention's attempt to tailor treatment to individual caregivers based on an initial assessment of their difficulties, a substantial proportion of caregivers and interventionists across responder categories wished the intervention could be even more specifically tailored to match the caregiver's level of ability and knowledge and meet their individual needs. This included providing more advanced materials as some caregivers found those provided to be "too basic" and "patronizing," catering the level of structure to the caregiver's needs, having more flexibility in terms of the time allotted to aspects of the protocol, and include problems beyond the target

Table 2
Summary of Qualitative Results

| Themes based on mechanisms of therapeutic action | Benefits in this area | Limitations in this area |
|---|---|---|
| Problem-Solving Skills | -Many liked materials detailing specific strategies for trouble-shooting problem behaviors | -Some found the materials:<br>• Overwhelming<br>• Not specific enough to address their needs; did not translate to real life situations<br>• Too basic for some |
| Stress Management Skills | -Majority of CGs found breathing exercises useful and easy to implement<br>-Reinforced some CG's use of such skills and re-engaged some others in practices they used to find helpful<br>-Helped to balance the needs of the CG with those of the CR | -Some wished for additional time to practice skills in session<br>-Skills were insufficient for managing more severe symptoms some CGs experienced |
| Psychoeducation | -Increased understanding of CR behaviors for some responder CGs<br>-Some responder CGs appreciated practical information (e.g., how to increase safety in the home) | -Some responder interventionists wished to provide more information on recent research and global perspectives of AD |
| Self-care | -Increased responder CGs' attention to their own health<br>-Some non-responder CGs viewed the intervention itself as self-care | |
| Shared goals | -Responder CGs appreciated the collaborative process of arriving at the goals<br>-Non-responder CGs appreciated that the interventionist maintained the focus of the sessions<br>-In addition to the above, interventionists appreciated that shared goals made the materials manageable | |
| Interpersonal support/ bearing witness | -CGs appreciated being able to share their experiences with someone supportive and trustworthy<br>-Respondent CGs were more likely to report valuing the relationship with the interventionist | -Because this aspect was so helpful, most wished for more time for these supportive aspects of the intervention which meant for some going "off protocol" |
| Insight | -Many CGs reported taking a different perspective that allowed them to approach caregiving in a new way (e.g., increasing understanding of CR's experience) | -Some non-responder interventionists wished that they could have focused more on increasing insight into CGs' contributions to their caregiving difficulties |
| Emotional transformation | -Responder CGs and interventionists described the CG feeling calmer and losing their temper less<br>-Some interventionists opted to focus more on emotional processing for CGs who were more skilled in the practical aspects of REACH VA | -Interventionists wished for more time to focus on CG's emotions<br>-The structure and practical focus of REACH VA allowed some CGs to avoid their emotions |
| Interpersonal processes between caregiver & interventionist | -A couple of interventionists integrated exploration of the therapeutic process into the intervention as a way to help the CG recognize patterns that related to problems caregiving | -Some interventionists wished to address the relationship more explicitly as a way to help CGs recognize how their interpersonal difficulties impacted caregiving<br>-A few interventionists wanted more time to process termination |

behaviors identified in the protocol. Many of these wishes will be addressed more specifically in the following sections. Interestingly, a few interventionists, mostly in the responder group, took some license with the structure of the intervention in order to tailor it to the caregivers' needs. One nonresponder interventionist stated, "The challenge of being the interventionist is to find that balance between using the intervention materials and making it personal."

### Stress Management Skills

Caregivers and interventionists from both the responder and nonresponder groups generally found stress management skills very helpful for managing stress, anxiety, and anger. Simple breathing exercises were described by the majority of caregivers as useful and easy to implement, while the other stress management techniques such as the stretching and music program were less frequently cited as useful. Several caregivers noted that the stress management techniques reinforced activities they were already engaged in and/or reconnected them with previous self-care activities they had discontinued. One responder caregiver stated, ". . . some of the breathing techniques and the stretching, . . . the music, I was already doing something in that area but I didn't realize . . . that it was just me finding ways to be me, not getting so consumed by some of my husband's issues that I forgot who I am." One responder interventionist discussed the benefits of using strategies similar to behavioral activation and pleasurable activities to reduce the caregiver's depression. Several interventionists noted that helping the caregiver manage stress created a balance between addressing the care-recipients' and caregivers' needs.

Some interventionists wanted more stress management options for caregivers who are already utilizing the skills taught in the protocol or did not respond to those offered. A couple of caregivers wanted more time to practice the stress management techniques in session to facilitate generalization of skills outside of session. One nonresponder caregiver noted, "signal breath . . . was good for minor stuff" but described long-standing PTSD and depression that the breathing technique was (understandably) ineffective at addressing.

### Psychoeducation

The benefits of psychoeducation were raised predominantly by responder caregivers and interventionists. One responder interventionist stated that psychoeducation helped address the caregiver's denial of his wife's illness and "put in perspective . . . why she might be doing some of the things she was doing." A couple of responder interventionists expressed a wish for more psychoeducation on Alzheimer's, specifically information on recent research and global perspectives on the illness. Responder caregivers reported appreciating practical aspects of the psychoeducation provided (e.g., topics such as safety in the home).

### Self-Care

A pattern of differences between responders and nonresponder caregivers and interventionists was particularly clear around this theme. While some responder caregivers described paying more attention to their own health and being reminded to do things for themselves as a result of the intervention, nonresponder caregivers were most likely to see involvement in the intervention as a form of self-care, taking time each week to concentrate on their situation. Similarly, nonresponder interventionists focused on both the importance of setting aside time each week for the intervention as well as focusing on the caregiver's health and its impact on caregiving. In contrast, responder interventionists did not discuss self-care aspects of the intervention. Overall, caregivers were more likely than interventionists to report the focus on self-care as a useful aspect of the intervention.

### Shared Goals

While interventionists and caregivers agreed on the benefit of having shared goals, responder and nonresponder caregivers differed in terms of how this aspect of the intervention benefited them. Responder caregivers described discussing their problems with the interventionist to arrive at agreed upon treatment goals as a useful aspect of the intervention. Nonresponder caregivers appreciated, more generally, that the interventionist maintained the focus of the sessions and served as a resource. Interventionists from both groups noted that the structure and opportunity to identify specific intervention targets helped create shared goals and maintain a focus, which made the material more manageable for caregivers. One responder interventionist stated, "Having a set structure really helped to keep us . . . focused more on the target behaviors rather than the things that came up weekly with regard to managing her dad's care." The same interventionist noted that the "collaborative nature" of the intervention allowed the caregiver to be the expert at times, which was an empowering position. In a few cases, the interventionists specifically noted that the structure helped balance the amount of time devoted to caregivers' emotional expression (e.g., venting) and working towards a solution to a specific problem. A few nonresponder interventionists also liked the weekly check-ins as a way of determining the focus of the session and holding the patient accountable for between-session work.

### Interpersonal Support/Bearing Witness

The majority of caregivers and interventionists across responder categories found the interpersonal support of the interventionist highly beneficial. Because of this, most caregivers and interventionists wanted more time for supportive aspects of the intervention, which they suggested achieving by loosening the structure to allow for more open dialogue and/or a longer intervention. Caregivers appreciated a regular outlet to share their experiences, bounce ideas off of, and "vent" to someone supportive. Interventionists also emphasized the benefits caregivers derived from the interpersonal support. Some interventionists specifically incorporated more opportunities for open dialogue to increase that experience for caregivers. For example, one responder interventionist, in tailoring the protocol to meet the caregiver's particular needs, stated, “I think for her, having a person to come to for support (was) big. She was big on keeping up appearances and minimizing … the effect that her husband’s dementia was having on the family. Having someone to talk to and a way to verbalize the issues was definitely good.” Responder caregivers, more often than nonresponder caregivers, tended to report valuing the therapeutic relationship and feeling personally connected to the interventionist. A few nonresponder caregivers also discussed the benefit of developing a trusting relationship in which they did not have to “hold back.” One nonresponder caregiver said, “The most important thing was having someone to listen to you. You can complain and cry and laugh . . .” Just having the space to “articulate the problem” was helpful for some. Similarly, a nonresponder interventionist said, “I think he benefitted a lot from allowing time in our relationship to just process various things that came up; to talk and go off protocol.”

### Insight

Many caregivers from both responder groups discussed taking a different perspective that allowed them to approach caregiving in a new way as an outcome of the intervention. Some caregivers described that greater understanding of the care-recipient’s experience allowed them to transform anger towards the care-recipient to compassion, which improved their capacity to cope with stressful situations. Other caregivers described reframing the problem as less focused on the care-recipient than how the caregiver manages stress. One nonresponder caregiver also said, “Do I have more awareness of Alzheimer’s? I would say perhaps. But I’m much more aware of my inner strength and that’s really more effective than knowing the facts.”

Some nonresponder interventionists wished that greater insight, particularly into caregivers’ contributions to their caregiving difficulties, could have been delivered. These interventionists felt that caregivers’ lack of insight into their interpersonal patterns interfered with successfully accessing support and created unnecessary conflict with others. These nonresponder interventionists believed that caregivers could be better helped by focusing on self-awareness and understanding their contributions to interpersonal problems with their family, friends, and health care providers.

### Emotional Transformation

Emotional transformation is the process of undoing maladaptive emotions by activating more adaptive emotions (Greenberg, 2010). Responder caregivers and interventionists agreed about the benefits of emotional transformation as an outcome of the intervention, though interventionists from both groups wished for greater focus on caregivers’ emotions in general. Responder caregivers and interventionists specifically described the caregiver feeling calmer and losing their temper less as an outcome of the intervention. One responder caregiver said, “. . . talking about guilt and anger and the emotional piece; that was very helpful because it’s not something that I would have done . . . I’m good at burying that. That’s the most difficult aspect of my life really . . .” A couple of responder interventionists reported focusing more on mood management and/or processing loss than troubleshooting target behaviors because their caregivers appeared in need of emotional processing and/or were skilled at implementing more practical solutions. Both responder and nonresponder interventionists wanted direct interventions to help caregivers elicit and process emotions. One nonresponder interventionist expressed, “I feel like she used the structure and the tasks to almost protect her. Like it kept her from going to a certain emotional place. . . . I think she was able to hide behind the ‘alright let’s talk about making his hygiene better . . .’ and not stress it.” In this case, and in others, the interventionist felt that the problem-focus of REACH VA allowed the avoidance of important emotional processing that may improve the caregiving experience.

### Interpersonal Process Between Interventionist and Caregiver

A couple of interventionists reported integrating some exploration of the therapeutic process into the intervention to good effect, particularly ways in which the caregiver’s pattern of relating to others or managing difficult issues outside therapy parallel the ways they behave with the interventionist. One responder interventionist stated, “There was a certain degree of processing my relationship with her that went on in our sessions and it wasn’t a focus of our work but it was important for keeping her on task . . . it was . . . an amendment to protocol but I think it was important to work on for that emotional aspect.” Beyond keeping caregivers on task, a number of responder and nonresponder interventionists discussed the importance of the therapeutic relationship and a wish to address it more explicitly as it pertained to the caregivers’ relationships outside the intervention, particularly for caregivers experiencing interpersonal difficulties related to caregiving. One nonresponder interventionist stated, “My patient was quite difficult and didn’t take to the protocol. I felt like I was at a loss in trying to help her and even utilizing my own relationship with her wasn’t a resource so I just felt really lost then.” A few wanted more time to process the termination of the therapeutic relationship. One responder interventionist explained, “It felt really abrupt . . . (In) session 12 you have to get through this huge review (of the intervention) and then not necessarily process our own relationship.”

### Characteristics of Caregivers Who Benefit Most From REACH VA

Some of the characteristics cited by caregivers and interventionists as facilitating caregiver benefit from REACH VA are common features of patients who could benefit from any intervention, such as openness to therapeutic work, a positive attitude, and intelligence. Caregivers and interventionists also reported some characteristics that implied a "goodness of fit" between REACH VA specifically and the patient's characteristics, such as an interest in practical solutions and self-care activities, motivation to implement solutions and practice skills, appreciation of structure and organization, being proactive, task-oriented, and skilled at problem-solving. One responder interventionist said, "…the fact that she is so problem-focused and solution-focused in her approach to life made . . . (the psychoeducation and information on dementia provided) a really good tool for her because it's what she would have tried to do on her own and we just gave her a system that was already intact."

Responder caregivers and interventionists also noted that aspects of caregivers' specific environment/circumstances, particularly their interpersonal environment, impacted their responsiveness to treatment. They noted that having the time and resources to engage in self-care activities (e.g., additional help in the home, not living with the care-recipient) and stability in other areas of life (e.g., financially, socially, psychologically) resulted in less overall burden and a greater capacity to successfully participate in the intervention. Responder caregivers and interventionists also specifically noted that aspects of caregiver interpersonal circumstances impacted caregiver responsiveness to treatment. Specifically, good boundaries between caregivers and their care-recipients (e.g., taking time for themselves, having their own interests) made it easier for these caregivers to implement the treatment, particularly the self-care aspects. They also noted that the ability to access additional interpersonal supports, whether through a support group, being socially skilled, or comfortable asking for help, made caregivers more likely to benefit from REACH VA, One responder interventionist said, ". . . she had a lot of friends and was able to live her own life. Her husband is a big part of her life but not her entire life. She was very invested in her own interests and I think that that benefitted her in some ways because his deterioration was not the end of her activity."

### Characteristics of Caregivers Who Benefit Less From REACH VA

Interventionists were not aware of their caregiver's status as nonresponder or responder posttreatment and thus responder interventionists reported on factors that may have attenuated the intervention's impact despite its successful effect. Not surprisingly, interventionists had more to say on this topic than caregivers, few of whom thought that any factors specific to themselves as caregivers made it more difficult to implement the intervention or kept them from benefitting fully. However, one consistent barrier mentioned by most interventionists and a few caregivers was the presence of psychological or situational problems beyond caregiving, which made it more difficult to implement or benefit from the intervention. These caregivers and interventionists noted the additional burden such issues caused and the impossibility of a caregiving-focused behavioral intervention sufficiently addressing other pervasive sources of distress. Some specific problems mentioned included psychiatric diagnoses such as PTSD or bipolar disorder and personality or other pervasive emotional difficulties. Interventionists associated such issues with a denial of care-recipient's illness, engaging in help-rejecting behaviors, and "anger issues" that could both exacerbate caregiver distress and interfere with the ability of caregivers to access needed support. Even caregivers who responded to the intervention could struggle in these areas as one responder interventionist said, "The intense need to keep up appearances within the social circle despite her husband's failing was the major source of stress for her."

Similarly, having a complicated or unique premorbid relationship between the caregiver and care-recipient was noted as an impediment to the intervention. Interestingly, responder interventionists noted that longstanding relationship issues (e.g., anger) between caregiver(s) and care-recipient created emotional detachment that could interfere with caregivers benefitting optimally from the intervention. Additionally, responder interventionists cited difficult family dynamics among multiple caregivers as another factor negatively impacting the intervention. In contrast, nonresponder caregivers and interventionists highlighted what they saw as unique aspects of the relationship such as caring for a same-sex partner, having a large age disparity between caregiver and care-recipient, and experiencing a role-reversal in the direction of care as a result of dementia.

Interventionists added that caregivers who were uninterested in practical solutions made REACH VA harder to implement. Among responder interventionists, it was noted that some caregivers had tried many of the strategies presented already and were primarily seeking greater emotional support. In contrast, nonresponder interventionists described the caregiver as *resisting* specific interventions or being dismissive of the utility of the strategies proposed in the protocol. Additionally, the majority of interventionists noted that when the focus of the intervention was not balanced between caregiver and care-recipient issues, they experienced greater difficulty helping caregivers. One such barrier to treatment is that some caregivers had difficulty accepting the care-recipient's illness, which could result in avoidance of directly addressing issues that were arising. Conversely, interventionists also noted that a tendency to view the care-recipient as "the problem" and resist exploring the caregiver's own contributions to difficult situations also negatively impacted treatment. One nonresponder interventionist said, "She didn't really want to express (her emotions), or think it was an appropriate place to express them because she viewed it as more like a classroom."

## Discussion

The aphorism, "You can please some of the people all of the time, you can please all of the people some of the time, but you can't please all of the people all of the time," is apt for the findings we discuss here. The REACH II protocol has a demonstrated history of significantly improving caregiver burden, depression, health and self-care, social support, and management of behavioral problems (Belle et al., 2006; Nichols et al., 2008). REACH VA, as the adaptation of REACH II for veterans, is also clearly helpful to many caregivers. Multiple studies have consistently indicated significant improvements in caregiver burden, depression, impact of depression on daily lives, and caregiving frustrations, effect sizes (d) ranging from 0.20 to 0.33 (Nichols et al., 2011; Nichols et al., 2016). One of the strengths of this behavioral intervention is that in offering a variety of avenues for intervention, it attempts to maximize its applicability across a range of caregivers. That was evident and reflected in the positive comments from interventionists and caregivers about their experience with the intervention. Identification and reflection on caregiver comments articulating aspects of the intervention that they found lacking allows us to develop interventions for caregivers who do not respond to REACH VA.

REACH VA attempts to address a key tension for caregivers: how to attend to both the needs of the PWD as well as their own. Its ability to address these aspects of caregiver experience was reflected in the positive comments about the usefulness of educational materials, problem solving, and stress management skills.

Some caregivers did not react positively to these core aspects of REACH VA. These caregivers described a lack of responsiveness to preexisting levels of knowledge or a lack of tailoring solutions to their specific circumstances. It is possible that the intervention was not appropriately delivered and did not attend to the specifics of the caregiver's circumstances as the protocol explicitly specifies. We find this unlikely given the intensity of supervision (weekly group and individual supervision) and review of sessions conducted for each intervention. Additionally, the effect size of the intervention in our study was larger than those reported in other studies of REACH VA (Nichols et al., 2011; Nichols et al., 2016). However, it is possible that at times individual interventionists did not provide sufficient inquiry into the specifics of a caregiver's circumstances to identify solutions that would be relevant to that caregiver. Another explanation our interventionists noted is that some caregivers were invested in presenting themselves as competent and knowledgeable despite significant deficits in knowledge or skills. For these caregivers, providing information about dementia, skills, and problem-solving had to be carefully balanced with validation of their existing skills and efforts. Some caregivers presented to our study stating that they were "doing fine" but were there to "help us" with our research. Some of these caregivers in fact had significant struggles around caregiving (at times because of their difficulty acknowledging limitations and asking for help). Often, these caregivers did not acknowledge the usefulness of the intervention despite interventionists noting their implementation of skills and shifts in behavior and attitude over the course of the intervention. Finally, some caregivers may indeed have knowledge of dementia and behavioral strategies that makes review of this information unnecessary. In those instances, an initial evaluation of the caregiver's knowledge about dementia and strategies for addressing difficulties may help interventionists tailor the sophistication and depth of the information and strategies provided. Alternatively, it could be used to assess whether the caregiver's distress may not be a function of a lack of knowledge, skills, or problem-solving difficulties, indicating that an alternative treatment may be warranted.

In addition to what REACH VA strives to explicitly provide, many caregivers and interventionists cited other aspects of the intervention that they found helpful. In particular, the intervention's shared goals, the provision of interpersonal support/bearing witness, insight, emotional transformation, and reflection on interpersonal process were identified as meaningful aspects of the treatment. Within the psychotherapy literature, each of these themes represents a proposed mechanism of therapeutic action and parallels some transtheoretical change processes not typically associated with behavioral therapies such as consciousness raising and catharthis (Prochaska & DiClemente, 1982). For instance, the therapeutic alliance literature has identified agreement on goals and tasks and collaborative work relationship as important aspects of treatment response, particularly from the client perspective (Bachelor, 2013).

The interpersonal support and experience of interventionists "bearing witness" echoes the literature on psychotherapy for trauma (Herman, 1997). Although trauma and caregiving may seem unrelated, similarities exist between these phenomena. Caregivers of PWD faced with the potential psychological loss of the care-recipient even as the PWD is physically present (Boss, 2011) can experience symptoms similar to reactions to highly stressful events. For example, caregivers may experience intrusive thoughts/memories about caregiving (e.g., times when the care-recipient has forgotten who the caregiver is, injuries sustained because of confusion, danger associated with wandering or disorientation). They may avoid triggers that may force them to face the reality of the PWD's condition (e.g., restricting their knowledge of the disorder, refusing to acknowledge changes in functioning). Some experience negative alterations in mood and cognition and hyperarousal and attentiveness to changes in the PWD. Furthermore, these experiences can be difficult to share and can result in shame, disconnection, and isolation that mirrors that of survivors of trauma (Boulanger, 2011). The process of bearing witness may provide caregivers with support, an acknowledgment of the reality of their experience, and assistance in formulating their experience (Stern, 2012). Additionally, while the authors know of no empirical studies that specifically examine "bearing witness" as a mechanism of therapeutic action, the vast literature identifying the importance of social support as a protective factor and loneliness/isolation as a risk factor for psychopathology speaks to the importance of this aspect of human experience (Bøen, Dalgard, & Bjertness, 2012).

Insight has also been identified across therapeutic approaches as an important aspect of treatment progress. Psychodynamic psychotherapy, in particular, emphasizes the role of insight as a factor in successful treatment (Ulberg, Amlo, Dahl, & Høglend, 2017). In cognitive behavioral therapy, insight may take the form of shifts in attribution, changes in automatic thoughts or core beliefs, or new learning from the experience of exposure. Although findings are somewhat mixed, such insights have been identified as potential mediators of therapeutic action (Casey, Newcombe, & Oei, 2005; Furlong & Oei, 2002; Hofmann, 2004; Smits, Julian, Rosenfield, & Powers, 2012; Smits, Powers, Cho, & Telch, 2004; Smits, Rosenfield, McDonald, & Telch, 2006). For caregivers, insights often included shifts in the caregiver's empathy for the care-recipient and/or shifts in caregiver perception of the experience of caregiving. Some caregivers may have gained insight from psychoeducation regarding dementia. For these caregivers, behaviors previously attributed to stubbornness or willful combativeness could be reattributed to deficits associated with the progress of dementia. Finally, as caregivers were taught stress management strategies, they may have become better equipped to face the painful realities of their present and future circumstances.

The concept of emotional transformation is seen as a core principle of emotional processing in emotion-focused therapy (EFT) and involves the process of using adaptive emotion to transform maladaptive emotion (Greenberg & Pascual-Leone, 2006). The activation of an incompatible, adaptive emotional experience in the context of maladaptive feeling is believed to result in changes in an individual's core emotions, memories, and responses. Emotional transformation has been found to predict outcome at termination and 18-month follow-up of EFT (Greenberg, 2002). Feelings of frustration, anger, or impatience at a PWD's impairments may function to allow caregivers to avoid painful feelings of loss and sadness in response to the care-recipient's diminishing capacity and psychological presence. Techniques designed to facilitate caregiver access to avoided feelings of sadness may result in greater access to the caregiver's feelings of affection, desire for connection, and greater responsiveness towards care-recipients.

Finally, discussion of the interpersonal process between interventionist and caregiver (Linehan, 1987; Safran & Muran, 2000) may be particularly critical in times where interventionists reach an impasse in the treatment. In such cases, explicit discussion of the nature of the intervention, their interaction, and renegotiating the focus of the work can be critical to ensuring that an intervention gets "back on track." For task-focused caregivers, such explicit discussions of process may be unnecessary. The transtheoretical model (TTM) of change (Prochaska & DiClemente, 1982) describes these task-focused caregivers as being in the "preparation" or "action" phase of stages of change. REACH VA may be a perfect fit for their needs. In contrast, some caregivers report distress but are less focused on identifying areas to address. These caregivers may be seen as being akin to the TTM stage of "precontemplation" or "contemplation" where intervention strategies like those found in motivational interviewing, such as clarifying ambivalence, values, or recognizing and eliciting the caregiver's "change talk" (i.e., statements that articulate disadvantages of the status quo, advantages of change, intention to change, and optimism about change), may be necessary (Miller & Rollnick, 2012).

Some aspects of what caregivers found to be helpful emerged from the process of interventionists displaying flexibility and responsiveness to what caregivers were presenting. Responder interventionists were more likely to work flexibly with the protocol in order to create the therapeutic experience that their caregiver seemed to need. This meant providing more room for the caregiver to "vent," greater focus on their emotions either by containing them or encouraging their expression, discussing themes of loss and grief, and processing the therapeutic relationship. Nonresponder interventionists were more likely to express feeling "stuck" at times when the caregiver did not appear to respond to the material presented or the structure of the protocol appeared to conflict with the needs of the caregiver. Although these departures from protocol may have been seen as "tangents" that maintained rapport while interventionists attempted to redirect caregivers to protocol content, it is clear that caregivers and interventionists alike viewed these interactions as significant and meaningful aspects of the intervention experience. In fact, our findings on the kinds of caregivers that did not benefit from REACH VA suggests that an intervention that focuses on these nonprotocol aspects of the intervention may serve as a useful focus for some caregivers.

The accessibility of behavioral interventions such as REACH VA for caregivers is critical as most benefit in some way. REACH VA's pragmatic strategies to assist caregivers in the concrete aspects of their role are helpful for many caregivers; however, other caregivers struggle with less tangible aspects of caregiving. A stepped care model of treatment may be indicated in which a short-term, skill-based intervention may be the most economical first-line treatment. If indicated, alternative treatments or resources, tailored to the caregiver's specific needs beyond what REACH VA provides, can be offered. For example, helping caregivers reflect on emotions that arise over the course of caregiving, such as bereavement, loss, lack of control, and anger, may be meaningful for some caregivers (Chen & Bailey, 2016). Additionally, some caregivers struggle to successfully access support from family, friends, health care providers, and institutions. These caregivers may also struggle interpersonally with their care-recipient, as well. Addressing these interpersonal deficits may be a prerequisite for successfully implementing strategies offered in REACH VA. Finally, family caregiving occurs in the context of family history, thus caregiving processes are impacted by the caregiver's (often longstanding) experience and relationship with the care-recipient (Chen & Bailey, 2016). For some caregivers, an intervention that focuses on areas typically outside the scope of REACH VA, such the emotional processing of caregiver relationship history with the PWD, may be helpful in navigating aspects of their caregiving experience.

### Limitations and Future Directions

These are preliminary findings and data collection is ongoing. Further quantitative analyses will test moderators of response and adjust for relevant covariates. A limitation of the current study is the absence of interventionist data that might test whether interventionist-specific factors contributed to caregiver response/nonresponse to REACH VA. Future research could investigate interventionist characteristics such as demographic variables, level of training, experience working with older adults, and the interaction between interventionist and caregiver variables to assess therapeutic fit.

One striking aspect of our findings was that responders and nonresponders did not differ when asked what aspects of the intervention they found meaningful and helpful. Thus, although nonresponders did not experience as great of a reduction in their symptoms of depression or burden, they described finding the intervention extremely useful in a variety of ways. Further analysis of the "nonresponder" intervention experience may be worthwhile as describing these caregivers as "nonresponders" may be a misnomer or, at least, an oversimplification of their experience with the intervention. For many caregivers, REACH VA may offer an extremely important and meaningful experience irrespective of change in self-report measures of burden or depression.

Finally, these findings suggest that there are aspects of caregiver the experience that may be addressed with alternative interventions. REACH VA's pragmatic approach and concrete strategies for addressing issues faced by caregivers may not appeal to all caregivers. Additionally, some caregivers present with difficulties beyond the scope of REACH VA (e.g., psychiatric diagnoses, difficulties with acceptance and grief, complex family dynamics, or longstanding interpersonal difficulties that negatively impact access to support). The accessibility of behavioral interventions such as REACH VA for caregivers is critical as most benefit in some way; however, for many caregivers additional approaches may be necessary to address unique issues and complex experiences evoked by caregiving.

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