SUPPORT FAMILY CAREGIVERS TO SUCCEED: Lessons from REACH

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Sponsored by Huger Mercy Living Center

Learning Objectives:
- Identify the key impacts of family caregiving (mental and physical health consequences, financial and social consequences)
- Describe the chronic stress trajectory across the caregiving career and provide an overview of the current state of intervention research designed to reduce caregiver distress across this trajectory
- Review the key strategies that have been found to reduce caregiver distress (relaxation techniques, values clarification, increasing pleasant events and strategies to manage care recipient behavioral challenges.

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People....

There are four kinds of people in the world. Those who
- have been caregivers,
- are currently caregivers,
- will be caregivers,
- will need caregivers.

Rosalynn Carter
The Case for Caregiving as a National Public Health Priority

Caregiving plays a unique and valuable role in our society. As the number of caregivers grows, the issues surrounding caregiving have gained national attention from a variety of sectors...National adoption of public health priorities is guided by specific principles (Rao, Anderson, & Smith, 2002).

These principles include large burden, major impact with respect to health costs or consequences, and potential for prevention.

CDC’s Assuring Healthy Caregivers (2008).

Value of Family Caregiving is Staggering

- In 2009, 42.1 million Americans provided unpaid care to another adult with ADL limitations at any given point and 61.6 million provided care at some time during the year.
- Economic value of their unpaid contributions = $450 billion. (Walmart sales = $409 billion)
- Family care is the most important source of assistance for people with chronic conditions who need LTSS. The “care coordinator.”
- Without this “informal” workforce, the entire health care and LTSS system would be in jeopardy.
- Backbone or Bedrock—either fits. And, caregiving doesn’t end with placement.

Value of Family Caregiving is Staggering

- Economic value of informal care is measured as the cost of replacing informal (unpaid) care with formal (paid) care
- In 2011, nearly 15 million Americans provided 17.4 billion hours of unpaid care to family & friends with ADRD.
- Estimated value of this unpaid care: Almost $210 billion
  - More than what Medicare and Medicaid spent combined on those with Alzheimer’s disease.
  - (Alzheimer’s Association 2012)
Caregiving is Beyond the Critical Tipping Point

- Family caregivers must...
  - Care for patients discharged “sicker and quicker”
  - Navigate health care systems that lack care coordination
  - Deal with “information overload” and choices
  - Manage difficult medication schedules and sophisticated technology in the home
  - Juggle competing demands of work and care
  - Often provide/coordinate caregiving long distance
  - Locate, access, and monitor quality paid help

Caregiver - The Hidden Patient

**AT RISK FOR:**
- Depression (>50% depressed)
- Extreme fatigue, stress, anger/ frustration
- Anxiety, upset, feeling overwhelmed
- Guilt
- Financial loss
- Social isolation
- Physical health problems/ Morbidity
- Mortality

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Cautionary Statement, Caveat, Disclaimer, etc.!!!!!!

- A matter of degree
- Exceptions to the rule
- Differences between
- Heterogeneity within
Sociocultural Influences on Caregiving

- The meaning of illness
- Who is “family”
- Values and attitudes
- Decision-making concerning elders
- Style of communication
- View of outside help and authority
- Definitions of acceptable behavior
- Coping strategies

Variations in the Impacts of Caregiving

- **Caucasians** (non-Hispanic Whites):
  - chronic fatigue, depression, anxiety, burden, self-reported anger & frustration, plus substantive risk for mortality

- **African Americans**:
  - less self-reported depression and “burden” but less engagement in self-care behavior & poorer self-rated health

- **Latinos**:
  - high levels of depression and anxiety & greater physical complaints BUT less distress over behavioral problems of the care-recipient & less reported “burden”

- **Chinese**:
  - less self-reported depression and “burden” but significant problems managing difficult behaviors along with significant family conflicts about caregiving

Is This All There Is? Positive Aspects & Caregiver Gain

- Opportunity to give back
- Serve as a role model
- Draws family members closer
- Prevention of loved one’s deterioration
- Increase self-esteem
- Enhanced sense of purpose or meaning
- Feeling appreciated

(Farran et al., 1991; Kramer, 1997; Miller & Lawton, 1997; NAC/AARP, 2004)
Variations in Positive Aspects of Caregiving?

- African Americans report higher PAC levels than non-Hispanic Whites (Haley et al., 2004; Hilgeman et al., 2009).
- Latinas reported higher PAC levels than Anglo women. Less acculturated Latinas reported higher PAC levels than their more acculturated counterparts (Coon et al., 2004).
- PAC played a role in care recipient placement such lower PAC levels accounted for greater rate of placement by more acculturated Latinas compared with less acculturated Latinas and Anglo women (Mausbach, Coon, et al., 2004).

Involvement: Recruitment and Retention

Think Like a Caregiver

- People: Am I a caregiver? Who qualifies?
- Products: What am I offered?
- Price: What are the costs/the benefits?
- Promotion: How/From whom did I learn about it?
- Partners: Who are these professionals/volunteers?
- Avoiding the Myth: "If we build it, they will come."

Richie et al., 2004
Enrollment Success

Confianza Triangle of Successful Recruitment

1. Community agency establishes trust with Latino individuals
2. Researcher establishes trust with the agency
3. Researcher indirectly establishes trust with the individual

Intervention Programs:
Chronic Stress Trajectory of Caregiving

Psychological Appraisal

Health Effects

Initiate IADL CG

Expand ADL CG

Placement

Death

Benign?

Distress

Minor?

Psychiatric/ Physical Morbidity

Death

Caregiver Intervention Research

What's Successful? Implementing Caregiver Interventions

- Education alone.
- Care Management.
- Respite.
- Support Groups.
- Environmental.
- Technological.
- Education & Skill Training (CR, CG, both).
- Psychotherapy/ Counseling.
- Multi-component.


Cooperative agreement among:
NIH (NIA and NINR)

6 Intervention sites
- Birmingham
- Boston
- Memphis
- Miami
- Palo Alto
- Philadelphia
- Coordinating Center
- Pittsburgh
**Types of Interventions**

- Skill training
- Behavioral management
- Stress management
- Psychoeducational skill building classes
- Support group
- Environmental skills building
- Voicemail / support / advice / behavioral distraction
- Family Therapy (+) Technology
- Minimal support (empathic listening)
- Usual care

**What We Learned**

- Feasible to recruit large numbers of culturally diverse caregivers and care recipients
- Wide range of intervention approaches acceptable and highly valued
- Those in most need (Hispanic, low education) may benefit most
- No silver bullet solution
  - Differential effects for both outcome measures
  - No one intervention reduced both burden and depressive scores
- Subgroup and subscale analyses provide more nuanced understanding of treatment effects

**California Site: Psychoeducational Skill Building Groups**

- always time-limited (e.g. 6-10 sessions)
  - Coping with Caregiving (ADRD): 10 sessions
- usually 6-10 caregivers who commit to attending weekly
- detailed agendas with specific goals; a structured treatment manual
- active in-class participation to learn skills
- extensive use of home practice

*(Beck et al., 1979; Lewinsohn et al., 1986; Coon et al., 2003; Coon, Gallagher-Thompson, & Thompson, 2003; Gallagher-Thompson et al., 1988; 2001; 2003; 2007; 2008; 2010)*
Tailoring Psychosocial Interventions to Latino Caregivers

- Revise Recruitment Strategies.
- Platicar and Socialization.
- Validate complementary yet conflicting feelings.
  - Role and reality.
  - Family before me.
- Address roadblocks to “Taking Care of the Caregiver.”
- Conceptual Translation.
  - Community Advisory Board/Partners.
  - Caregiver and service provider feedback.

### Analysis of Covariance (ANCOVA) Treatment and Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>T*</th>
<th>E*</th>
<th>T x E*</th>
<th>d*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-D, Total</td>
<td>4.06*</td>
<td>0.09</td>
<td>0.09</td>
<td>.24</td>
</tr>
<tr>
<td>CES-D, Well Being</td>
<td>0.68</td>
<td>0.22</td>
<td>0.00</td>
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</tr>
<tr>
<td>CES-D, Depressive Affect</td>
<td>5.14**</td>
<td>0.21</td>
<td>0.21</td>
<td>.26</td>
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<tr>
<td>CES-D, Somato-Motor</td>
<td>1.64</td>
<td>0.05</td>
<td>0.00</td>
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<tr>
<td>CES-D, Interpersonal</td>
<td>6.92**</td>
<td>0.31</td>
<td>1.33</td>
<td>.30</td>
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<tr>
<td>Positive Coping</td>
<td>6.77**</td>
<td>0.09</td>
<td>0.00</td>
<td>.35</td>
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<tr>
<td>Negative Coping</td>
<td>2.86</td>
<td>0.48</td>
<td>2.51</td>
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<tr>
<td>Support Satisfaction</td>
<td>0.05</td>
<td>0.05</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Negative Interaction</td>
<td>3.60**</td>
<td>2.69</td>
<td>0.05</td>
<td>.19</td>
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<tr>
<td>RMBPC Conditional</td>
<td>2.20</td>
<td>0.19</td>
<td>0.41</td>
<td></td>
</tr>
</tbody>
</table>

*p < .06; **p < .05

T = Treatment main effect, E = Ethnicity main effect, T x E = Treatment X Ethnicity interaction
The effect size values for Cohen’s d correspond to the significant F in each row.

### Community Partners Wish List

- Evidence based; empirically supported
- User Friendly- Staff Ready (AKA minimal training time)
- Complementary to existing programs
  - Respite, care management, support groups
- Appeal to & be effective with caregivers from diverse backgrounds
- Less “intensive” and less structured “time away”
  - But POWERFUL! (The “Pill”, the Silver Bullet)
- …and, preferably something we already do.
CarePRO Pilot - Coach Calls
Quasi-Experimental Pilots based on CWC

CWC components delivered across 4 workshops/4 coach calls

<table>
<thead>
<tr>
<th>Male Caregiver Pilot</th>
<th>Latino/ Anglo Pilot</th>
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<tr>
<td>(N=20)</td>
<td>(Mixed N=23)</td>
</tr>
<tr>
<td>CES-D</td>
<td>CES-D</td>
</tr>
<tr>
<td>State Anger</td>
<td>Interpersonal</td>
</tr>
<tr>
<td>Positive Aspects of</td>
<td>Somatic</td>
</tr>
<tr>
<td>Caregiving</td>
<td>Negative Coping</td>
</tr>
<tr>
<td>Negative Coping</td>
<td>Positive Coping</td>
</tr>
</tbody>
</table>

CarePRO: Care Partners Reaching Out

- 10 Weeks
  - Alternating Weeks of Psychoeducational/ Skill-building Groups & Coach Calls
  - Built on CBT principles
    - Mood management
    - Stress management
    - Effective communication
    - TBR & Problem solving
    - Pleasant Events
- Over 600 Arizona and Nevada family caregivers in the next 3 years.
CarePRO Evaluation

- **Primary outcomes** (focused on original trial)
  - Symptomatology (caregiver depression)
  - Quality of life (positive/adaptive coping, negative coping; negative social interactions).
- **Secondary outcomes**
  - Quality of life: caregiver burden; patient memory/behavior problem impact; caregiver self-efficacy; caregiver target complaints
  - Social validity: caregiver perceptions of the utility of project services (e.g., ability to continue to provide care at home),
  - Social significance: cost of implementation; amount of service utilization (particularly for underserved).
- **Timing**
  - Pre/Post (3 months)
  - Maintenance: Post (6 and 12 months)

CarePRO Social Validity

- Over 300 family caregivers to date
- 100% reporting overall benefit (85% benefited “a great deal”). Caregivers also reported they benefited with regard to:
  - understanding memory loss and its impact (97%);
  - more confidence in dealing with memory problems (98%);
  - made their lives easier (97%);
  - enhanced their ability to provide care (97%); and,
  - improved the patient’s life (95%).

Case Example

- Valeria is a 57-year-old Latina who has been caring for her 64-year-old husband Ernesto. The couple has an 18-year-old grandson living with them who provides minimal assistance with Ernesto’s care. She came to the group stating that after 25 years of marriage, she was having a difficult time understanding her husband’s behavior: he was diagnosed with Alzheimer’s disease a little over a year ago, and in this short period of time, had his driver’s license revoked and lost contact with many of his friends.
Behavioral Chain

Trigger — Behavior — Reaction

The only thing that you as a caregiver have control over are TRIGGERS and REACTIONS.

Occasionally, however, we can’t change the TRIGGERS. During those times, changing how you REACT to the behavior could keep the situation from getting worse.

Behavior Log

Please use this log to write down the things your relative does (or that you do) that upset you.

<table>
<thead>
<tr>
<th>Date/Day of week</th>
<th>Time</th>
<th>Person Present</th>
<th>Trigger</th>
<th>Behavior</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyday</td>
<td></td>
<td>Myself and Husband</td>
<td>He wakes up in the morning and knows that it is time to get dressed.</td>
<td>When he dresses himself, he insists on wearing the same outfit he has worn for the past five days</td>
<td>I am feeling angry because he does not want to look and smell clean</td>
</tr>
</tbody>
</table>

Strategies Caregiver Can Use to Prevent the Problem Behavior

1. Set out fresh clothes for him and reward him when he wears them; give him a compliment on how nice he looks or make him his favorite breakfast.

2. Hide the outfit he really likes where he cannot find it.

3. Buy him several pairs of the same pants and shirt so that he thinks he is wearing his favorite outfit.

4. When he goes to bed, take his clothes and put them in the laundry machine. Set the machine on the soak cycle so that if he looks for them and notices they are wet, he will need to find something else to wear.
Mood Management

- Learn new forms of “self-talk” so that you can be encouraging yourself mentally as you go through the day.
- Three steps to managing your feelings:
  1. Stop and identify current thoughts.
  2. Challenge & replace unhelpful thoughts.
  3. Pay attention to how you feel.

Thought Record

<table>
<thead>
<tr>
<th>Situations</th>
<th>Current Thoughts</th>
<th>Feelings</th>
<th>Challenge &amp; Replace</th>
<th>New Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>My neighbors and children will see my husband in the same clothes.</td>
<td>Everyone will think I don’t care about my husband. Everyone will still think he is dirty and his clothes are dirty. My children will think I have given up.</td>
<td>Stressed. Guilty. Sad. Embarrassed.</td>
<td>I told my neighbors. They asked for information about Alzheimer’s. I had my daughter with me. They all told me how much they believe I do for Ernesto. My children say “You are smarter than ever”, “You do a great job”, “We hope our spouses love us as much as you love Papa”. He is clean; he is happier; We are not arguing.</td>
<td>Less trapped and less guilty. Happier. More relaxed. Less embarrassed with those who knew me.</td>
</tr>
</tbody>
</table>

Psychological Appraisal

Health Effects

Initiate IADL CG
Expand ADL CG
Placement
Death

Chronic Stress Trajectory of Caregiving

Caregiver/CR Trajectory
Psychological Appraisal
Health Effects

Benign?
Minor?
Distress
Psychiatric/Physical Morbidity
Death

Caregiver Intervention Research
EPIC: Early Stage Partners in Care

- Group based dyadic intervention
  - Early stage individuals & care partners
- Stress inoculation, education, skill building
  - Communication
  - Relaxation
  - Problem solving
- Care Values & Preferences
- Preparedness

Coon & Whitlatch, 2011

Four Pleasant Events a Day
Keep the Blues Away

- Don’t have to be huge pleasant events.
- Must be Consciously Chosen, and Deliberately Done to experience control.

1. Events Control Mood.
2. To some extent you can control events.
3. Therefore, you can control mood.

Tracking Pleasant Events:
Learning To Put Pleasure into One’s Life

<table>
<thead>
<tr>
<th>Pleasant Events</th>
<th>Days 1</th>
<th>Days 2</th>
<th>Days 3</th>
<th>Days 4</th>
<th>Days 5</th>
<th>Days 6</th>
<th>Days 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working on Computer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Reading Religious Books</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Attending a Good Movie</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Going for Walks</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Browsing in Library</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>6. Listening to Car-Talk</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>7. Listening to Music</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>8. Doing Physical Exercises</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>9. Meeting with Friends</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>10. Getting out for a Drive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Total</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>7</td>
</tr>
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</table>
Chronic Stress Trajectory of Caregiving

Post-Bereavement and Post-Institutionalization

- 217 Care-Recipients died within 18 months of randomization; end-of-life dementia care and effects on bereavement (Schulz et al., NEJM, 2003)

- 180 Care-Recipients were placed in a long-term care facility within 18 months of randomization; effects of placement transition (Schulz et al., JAMA, 2004)

Caregiver Responses Following Care Recipient Placement

- No significant change in either depressive symptomatology (CES-D) or anxiety (State Trait Inventory)

- CES-D was higher for caregivers who were married to the care recipient, visited more frequently, or were less satisfied with help received from others

- Anxiety was higher for caregivers who visited more frequently, or were less satisfied with help received from others

Schulz et al., JAMA. 2004;292:961-967
Post-Bereavement CES-D Scores As a Function of Time Since Death (n=217)

Predicted CES-D Score

Time (Weeks)

Schulz et al. AJM. 2003;349:1936-1942.

Chronic Stress Trajectory in Caregiving

Psychological Appraisal

Initiate IADL CG

Expand ADL CG

Placement

Death

Psychiatric/Physical Morbidity

Continued Depression/Reengagement

Recovery

Benign

Distress

Distress

Relief

Minor

Death

Social Support & Effective Communication

- We get by with a little help from our friends....
- Or in spite of...?
REACH II

- Caregiving characterized by multiple diverse challenges
- Caregivers are at moderate risk for adverse outcomes in multiple domains but not at extreme risk for any 1 outcome
- Argues for multicomponent approaches that matches intervention with individual risk profile
  - Belle, Burgio, Burns, Coon, Czaja, et al., 2006

REACH II Design

- Systematically builds on REACH I.
- Stress-health Process Model
- Multi-component: a range of treatment modalities and behavioral techniques.
- Transdisciplinary & portable; targeted public health outcomes.
- Randomized Clinical Trial—one active treatment and one control condition implemented at all sites.
- 5 sites (Birmingham, Memphis, Miami, Palo Alto, and Philadelphia).
- Recruit equal numbers of African Americans, Whites, and Hispanic Americans (N=600 total).

REACH II Intervention

A multi-component intervention designed to address five areas linked to caregiver risk profile:

- Safety Issues
- Social Support
- CR Problem Behaviors
- Emotional well-being
- Self-care and Health Behaviors
Linking Risk Assessment to Intervention

<table>
<thead>
<tr>
<th>Risk Area</th>
<th>Measure</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Emotional Well-Being</td>
<td>CES-D</td>
<td>Stress Management Mood Module, Pleasant Events, Caregiver Notebook, Risk Priority Worksheet</td>
</tr>
<tr>
<td>Social Support</td>
<td>Social Support</td>
<td>Health Passport, Caregiver Notebook, Caregiver Network, Risk Priority Worksheet</td>
</tr>
<tr>
<td></td>
<td>- Resolved Support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Lubben Social Network Index</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Negative Interaction Subscale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Satisfaction with Support</td>
<td></td>
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<tr>
<td>Self Care</td>
<td>Caregiver Health and Health Behaviors</td>
<td>Health Passport, Caregiver Notebook, Caregiver Network, Risk Priority Worksheet</td>
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<tr>
<td>Social Support</td>
<td>Short form Zarit Burden Inventory</td>
<td>Stress Management, Mood Module, Pleasant Events, Behavior Prescription, Risk Priority Worksheet</td>
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<tr>
<td></td>
<td>RAMPS: changes in memory, depression and disruptive behaviors</td>
<td>ABC Process, Behavior Prescription, Risk Priority Worksheet</td>
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<tr>
<td>Safety</td>
<td>Quality of Care Risk Appraisal</td>
<td>Caregiver Notebook, Caregiver Network, Risk Priority Worksheet</td>
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GEE models for the treatment and relationship effect on the integrated outcomes stratified by race (n=518)

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<thead>
<tr>
<th>Hispanic (n=168)</th>
<th>Treatment (baseline)</th>
<th>Estimate (se)</th>
<th>p-value</th>
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<td>Control</td>
<td>-0.29 (0.09)</td>
<td>0.0006</td>
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<tr>
<td>Intervention</td>
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<td></td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>0.10 (0.09)</td>
<td>0.25</td>
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</tr>
<tr>
<td>Non-spouse</td>
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</table>

<table>
<thead>
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<th>Treatment (baseline)</th>
<th>Estimate (se)</th>
<th>p-value</th>
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<tbody>
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<td>Control</td>
<td>-0.18 (0.08)</td>
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<tr>
<td>Intervention</td>
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<td>Relationship</td>
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<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>0.12 (0.08)</td>
<td>0.16</td>
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<td>Non-spouse</td>
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<table>
<thead>
<tr>
<th>Black (n=168)</th>
<th>Treatment (baseline)</th>
<th>Estimate (se)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>0.04 (0.10)</td>
<td>0.68</td>
<td></td>
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<tr>
<td>Intervention</td>
<td></td>
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<tr>
<td>Relationship</td>
<td></td>
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<tr>
<td>Spouse</td>
<td>0.39 (0.13)</td>
<td>0.004</td>
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<tr>
<td>Non-spouse</td>
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Interaction of Treatment by Relationship

What Does it Mean?

- Hispanic/ Latino and White/ Caucasian caregivers in the REACH II intervention greater improvement in quality of life
- Black/ African American spouse caregivers also experienced greater improvement
- Prevalence of clinical depression was lower among caregivers in REACH II intervention participants
- Trend toward difference in placement, but only 6 month follow-up
Interventions Needing Additional Support

- Respite
  - Effective use of “down time”
- Care Management & Memory Clinics
  - The “Box”
- Support Groups
  - Self-efficacy as Moderator (Rabinowitz et al., 2006)

Sustaining Behavior Change

- Home practice
- Maintenance Guides & Boosters
- Target both High-Risk & Large Segments of the Population
- Take the “Long View” of Outcomes
- Multiple Disciplines Working in Partnership
- Bridging the Research & Community Gap
- Multiple Levels of Intervention & Multiple Strategies
  - (Coon & Thompson, 2003; Coon, Lipman, & Ory, 2003; Coon, Gallagher-Thompson & Thompson, 2003; Coon et al., 2005)

A Call for Multiple Levels of Intervention

- Individual
  - I&R/Helpline, skill-building groups, psychotherapy.
- Interpersonal
  - Early stage groups for spouses.
- Organizational/System
  - MCO/CBO care pathway partnerships.
- Community
  - Media campaigns or CCRC.
- Policy
  - NFCSP, AMA Caregiver Self Assessment Tool
Stress MGT: Mindful Breath

- Choose a word that represents relaxation for you
  - (peace, relax, calm)
- Four deep breaths; mouth your word during exhale
- Rate tension (before & after)
- Practice!
- Alternative:
  - Tense muscles on inhale and release while mouthing your word.

Aging & Behavioral Health Projects

Family Caregiver of Dementia Patients in LTC
CarePRO: Care Partners Reaching Out
EPIC: Early Stage Partners in Care
Prostate Cancer Couples Project
For information, please call:
(602) 496-1239
1-877-852-5420 (out of area)
(English/Spanish)