

A cognitive behavioural family intervention reduced psychiatric morbidity in caregivers of patients with Alzheimer's disease

Marriott A, Donaldson C, Tarrier N, et al. *Effectiveness of cognitive-behavioural family intervention in reducing the burden of care in carers of patients with Alzheimer's disease*. *Br J Psychiatry* 2000 Jun;176:557-62.

QUESTION: Does a cognitive behavioural family intervention reduce psychiatric morbidity in caregivers of patients with Alzheimer's disease, and improve patient symptoms?

Design

Randomised (allocation concealed*) †, blinded (outcome assessors)*, controlled trial with follow up at 3 months.

Setting

Old age psychiatric service in 2 NHS trusts in Manchester, UK.

Patients

42 patient-caregiver dyads. Patients (mean age 77 y, 71% women) met *DSM-III-R* criteria for primary degenerative dementia of the Alzheimer type, and were living in the community with a caregiver who provided their main support. Caregivers (mean age 64 y, 69% women) had General Health Questionnaire (GHQ) scores ≥ 5 , indicating psychiatric caseness. Follow up was 98%.

Intervention

14 dyads were allocated to the 14 session family intervention, which comprised 3 sessions of caregiver education, 6 sessions of stress management, and 5 sessions of coping skills training. 14 dyads were allocated to the interview control group and received the Camberwell Family Interview (CFI), which was a 1 session cathartic interview; the family intervention group also received the CFI. 14 dyads were allocated to the no interview control group.

Main outcome measures

Main outcomes were caregiver psychiatric morbidity (GHQ cut off of 4/5 indicating caseness) and depression (Beck Depression Inventory [BDI]). Secondary outcomes were patient cognitive function, depressive symptoms, psychiatric symptoms and behavioural disturbances, and overall severity of dementia.

Main results

At 3 months, fewer caregivers in the family intervention group met the criteria for psychiatric caseness compared with those in the 2 control groups (table); they also had lower (better) scores on the BDI than caregivers in the interview and no interview control groups (BDI scores of 6.3, 11.4, and 11.1, $p=0.004$ and $p=0.001$, respectively). Patients in the family intervention group had better functioning on activities of daily living than patients in the 2 control groups, but did not differ for cognitive function, depression, psychotic symptoms, behavioural disturbances, or overall severity of dementia.

Conclusion

A 14 session cognitive behavioural family intervention reduced psychiatric morbidity in caregivers of patients with Alzheimer's disease compared with a 1 session cathartic interview or a no interview control group, and improved patient activities of daily living at 3 months of follow up.

*See glossary.

†Information provided by author.

COMMENTARY

Alzheimer's disease is a major public health problem.¹ Until it is prevented or substantially controlled, the deleterious effects of caring for relatives with Alzheimer's disease in the community will continue to be an important issue for mental health professionals. This evaluation represents an important step forward in a two decade research agenda to understand and manage or prevent carer distress.² This trial bears examination by clinicians working in community or outpatient settings, especially those involved in programme development of geriatric services.

The framework of this cognitive behavioural family intervention is consistent with current stress and coping research. The model focuses on carers' characteristics and perceptions of caregiving demands and the ability to cope with them.³ Targeting individual carer perceptions and coping styles, within the context of a structured intervention, is probably responsible for the positive carer outcomes and improved daily patient functioning. Unfortunately, a specialist trained in the cognitive behavioural family intervention model is required to implement the programme, thus decreasing its applicability to many community settings.

As in Marriott *et al's* trial, previous research has shown important, albeit low, levels of psychological morbidity among carers. Using a robust measure of psychiatric caseness, Marriott *et al* selected carers with a clinically important level of psychological distress and found that the intervention was potent enough to decrease distress to a non-clinical level.

Despite the strengths of this study, it must be viewed as a preliminary report because of 3 methodological considerations. Notwithstanding the clinical and statistical significance of the observed results, a confirmatory trial with a larger sample size is needed. Secondly, such a study should examine a longer follow up period that better mirrors the chronic, degenerative nature of this disease. Finally, further research should include an economic evaluation covering 4 categories of data: physical quantities of resources, unit costs of resources, descriptive quality of life data, and associated health state preference values.⁴

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- 1 Trabucchi M. An economic perspective on Alzheimer's disease. *J Geriatr Psychiatry Neurol* 1999;12:29-38.
- 2 Drebing CE. Trends in the content and methodology of Alzheimer caregiving research. *Alzheimer Dis Assoc Disord* 1999;13:S93-100.
- 3 Donaldson C, Burns A. Burden of Alzheimer's disease: helping the patient and caregiver. *J Geriatr Psychiatry Neurol* 1999; 12:21-8.
- 4 Drummond M. Economic analysis alongside clinical trials: problems and potential. *J Rheumatol* 1995;22:1403-7.

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Family intervention v interview and v no interview for caregivers of patients with AD†

Outcomes at 3 months	Family intervention	Interview control	No interview control	RRR (95% CI)	NNT (CI)
Met criteria for psychiatric caseness	23%	85%	—	73% (36 to 91)	2 (2 to 5)
	23%	—	77%	70% (27 to 90)	2 (2 to 7)

†Missing data on 2 caregivers. Abbreviations defined in glossary; RRR, NNT, and CI calculated from data in article.