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The involvement of multiple caregivers in cognitive-behavior therapy for anxiety in persons with dementia

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Abstract

Objectives—Peaceful Mind, a cognitive-behavioral therapy for treating anxiety in persons with dementia, is a promising new treatment currently under investigation. This article reports results of our examination of a modification of the treatment protocol in two cases that included multiple caregivers in treating two persons with dementia.

Method—Two case presentations of the benefits and challenges of including multiple caregivers in treatment are discussed. Treatment outcome data for these cases were collected as part of a larger investigation of Peaceful Mind.

Results—The involvement of multiple collaterals resulted in several benefits, including increased family communication, as well as increased opportunities for the practice of new skills. These cases have also presented unique challenges requiring alterations in therapy structure and attention to issues of family conflict.

Conclusions—Including multiple collaterals in cognitive-behavioral therapy for treating anxiety in persons with dementia is feasible and may be beneficial in maximizing treatment gains and increasing the family's investment in therapy.

Keywords

cognitive-behavioral therapy; anxiety; dementia

Introduction

Anxiety is common in dementia (Hart et al., 2003; Seignourel, Kunik, Snow, Wilson & Stanley, 2008), with estimates of anxiety symptoms ranging from 10% to 70% (Lyketsos et al., 2002; Ballard et al., 2000). Among persons with dementia, anxiety has been linked with

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a number of negative outcomes, including decreased independence (Porter et al., 2003) and quality of life (Hoe, Hancock, Livingston & Orrell, 2006), as well as increases in agitation, behavioral disturbance (Ferretti, McCurry, Logsdon, Gibbons & Teri, 2001; Teri et al., 1999), and risk of nursing-home placement (Gibbons et al., 2002). Given these negative outcomes, there is a great need for effective treatment of anxiety in persons with dementia.

Cognitive-behavior therapy (CBT) is effective for a range of anxiety disorders (Barlow, 2002). Recently, a manualized approach for the treatment of anxiety known as Peaceful Mind has been developed for persons with dementia (Kraus et al., 2008). This treatment is based on approaches for reducing anxiety in cognitively intact older adults (Stanley et al., 2009) and has been adjusted to meet the needs of persons with dementia. The Peaceful Mind manual has demonstrated positive outcomes in an open trial (Paukert et al., 2008) and is currently being investigated in a randomized clinical trial. Treatment includes modified presentations of core CBT skills, including diaphragmatic breathing, coping statements, self-monitoring, and behavioral activation. These skills are taught across 10–12 home-based sessions over 3 months, along with between-session telephone calls. Patients also receive telephone maintenance sessions for an additional 3 months post-treatment.

An integral modification to the CBT package for this population is the inclusion of a caregiver or collateral to assist the patient in comprehension and practice of skills both within and between sessions. This is in concordance with research indicating that the most effective interventions in this population include a caregiver (Burgio et al., 2002; Teri, Logsdon, Uomoto, & McCurry, 1997; Teri, et al., 2003). In these interventions, treatment typically focuses on training the caregiver to deliver a behaviorally oriented intervention (Teri et al., 1997). In Peaceful Mind, the intervention is more patient-focused; but collaterals serve a key role by helping or reminding the patient to track symptoms, coaching the practice of skills, and enhancing the patient's understanding of skills between sessions.

In general, across interventions the focus is generally on the inclusion of a single collateral; with few reports on if and how multiple collaterals should be incorporated into treatment. The cultural background of the person with dementia is one important variable to consider given cultural differences in family structure as well as the expression of anxiety. Individuals from non-European backgrounds may display more somatic symptoms of anxiety which may be difficult for them to independently recognize. In addition, individuals from particular cultural groups may be at greater risk to experience chronic stress and negative life events which impact their appraisals of threatening situations (Barlow, 2002; Craske, 1999). In such cases, it could be advantageous to include multiple family members who can coach the patient to use coping-skills within their cultural expression of anxiety. In addition, the investigation of including multiple collaterals may be particularly relevant for certain minority groups that value interdependence and extended family networks. Aranda and Morano (2007) highlight the importance of including family caregivers when working with older Latino adults, to maximize the practice and effectiveness of interventions; however, the inclusion of family members may be helpful for patients from any cultural background that values family involvement in care for elders.

Most patients included in the Peaceful Mind open-trial (Paukert et al., 2008), had a single collateral, often a spouse or child. However, in some cases, circumstances called for the inclusion of multiple collaterals. The incorporation of multiple family members in psychosocial interventions in persons with dementia has been previously recognized as clinically meaningful (Mittelman, 2002). For example, in one intervention targeting caregivers, four family counseling sessions were included as part of a larger treatment package. These counseling sessions were aimed at improving caregiver support within the family. Results indicated that the intervention delayed nursing-home placement (Mittelman,

Ferris, Shulman, Steinberg, & Levin, 1996). The application of family therapy techniques has also been suggested when treating the family unit of a person with dementia (Qualls & Noecker, 2009). Although previous research on family therapy in dementia has offered some guidelines on how to treat interpersonal family conflicts (Qualls & Noecker, 2009; Benbow, Marriott, Morley & Walsh, 1993), to our knowledge the literature on how to maximize the family's involvement in a patient-focused CBT intervention without conducting family therapy is lacking. Here we present two cases of treatment involving the inclusion of multiple collaterals in Hispanic patients treated in the Peaceful Mind program, but outside the open trial, to illustrate how therapy structure can be modified. These cases also highlight the potential benefits, including cultural relevancy, as well as the possible difficulties of including multiple collaterals.

Methods

Measures of diagnostic status

Two instruments were used to determine diagnostic status. The Clinical Dementia Rating Scale (CDR; Hughes, Berg, Danziger, Coben & Martin, 1982) was administered at pre-treatment as an index of dementia severity. Scores on the CDR range from 0 to 3; and individuals can be classified as mild (0.5-1.0), moderate (2.0) or severe (3.0). The Mini International Neuropsychiatric Interview (MINI; Sheehan, Lecrubier & Sheehan, 1998) is a brief, structured diagnostic interview with diagnoses based on the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR). The MINI was administered at pre-treatment to both the patient and the collateral to determine the presence of any *DSM-IV-TR* diagnoses to describe the patient's symptoms.

Measures of anxiety symptoms

Three instruments were used to assess anxiety symptoms. The Rating Anxiety in Dementia scale (RAID; Shankar, 1999) is a 20-item, clinician-administered measure designed to assess anxiety in persons with dementia. Items assess a number of worries and physical symptoms of anxiety, with scores on each ranging from 0 (not present) to 2 (severe). The Structured Interview Guide for the Hamilton Anxiety Scale (SIGH-A; Shear et al., 2001) is a clinician-administered interview modified from the original Hamilton Anxiety Rating Scale. Items on the SIGH-A assess for a variety of anxiety symptoms, including disturbances in sleep and mood, with scores ranging from 0 (not present) to 3 (severe). Both the RAID and the SIGH-A were scored based on information obtained from the patient and the collateral. In the event of a significant discrepancy in ratings between the collateral and patient, the interviewer was instructed to make the final rating, taking into account the patient's level of cognitive capacity along with the degree to which the symptom was observable (during the interview, implying reliable observations by the collateral). The Neuropsychiatric Inventory - Anxiety subscale (NPI-A; Cummings et al., 1994) includes seven items that assess the frequency and severity of the patient's anxiety, as well as the level of distress caused by these symptoms. The NPI-A was administered only to the collateral.

Procedures

Both patients described below were recruited from the Michael E. DeBakey VA Medical Center in Houston, TX, to participate in the Peaceful Mind program. In both cases, a primary collateral was identified as the point of contact and the individual who completed all the assessments. To be offered treatment, several inclusion criteria had to be met. Patients had a documented diagnosis of dementia, with a CDR score between 0.5 and 2.0, along with an NPI-A score of 4 or higher. Patients also were required to have a collateral who spent at least 8 hours per week with them. Patients and collaterals received 10 to 12 sessions of CBT, each with brief weekly telephone follow-ups, once a week for 3 months. After in-person

CBT sessions were completed, telephone calls were then continued weekly for 1 month and bi-weekly for 2 months. Assessments were conducted at baseline, 3 months and 6 months. The RAID, SIGH-A, and NPI-A were administered on all three occasions; but the CDR and MINI were administered only during baseline assessment.

Case reports

Patient 1

Mr. A was an 83-year-old Hispanic married man with two daughters. His first language was Spanish, but he had been born in the United States and had learned English upon entering elementary school. He had completed the fifth grade, served in the Air Force during World War II and subsequently worked as a salesman. He had received a diagnosis of Alzheimer's disease 1 year before enrolling in Peaceful Mind. Mr. A's wife reported that he functioned well in most activities of daily living. He took care of his own colostomy bag (obtained 1 year earlier), drove by himself in the neighborhood, and dressed and groomed himself. However, he rarely remembered the date, his wife had taken over paying bills, he was prone to confabulation in social situations, and his memory had declined in the year prior to enrollment in the study.

During the baseline assessment, Mr. A and his family reported he worried primarily about health problems, having to depend on others, and his colostomy bag leaking. He reported that he had decreased his activities in the last several years because he feared others did not like him and he would not be able to breathe if he went outside. Mr. A and his family reported that he had a long history of believing that other people were talking negatively about him. Because of these beliefs, he refused to go certain places. He frequently experienced agitation as he became frustrated with others, especially his wife, when he did not remember something. At these times, he stated that he believed they also had dementia. Mr. A's wife participated as his primary collateral and was present for all assessments. Results of the MINI indicated he met criteria for Anxiety Not Otherwise Specified and Delusional Disorder, Persecutory Type.

His baseline CDR rating was 1.0, and his responses on the RAID (23) and SIGH-A (26) indicated clinically significant anxiety. Mr. A's wife indicated that she perceived his anxiety to be significant (NPI-A = 8).

Mr. A, his wife, and, typically, one of their daughters attended 10 treatment sessions. The patient and his wife also received midweek telephone check-in calls. Mr. A was taught the skills of self-monitoring of his anxiety, diaphragmatic breathing, coping statements, and behavioral activation using a calendar and scheduling. During each treatment session it was determined how Mrs. A and their daughters would help Mr. A with the skills over the next week. Because of some conflicts between Mr. and Mrs. A, the inclusion of their daughters as additional collaterals was vital as they became more involved in his care through the treatment.

The first three sessions introduced self-monitoring and diaphragmatic breathing. Mr. A demonstrated proficiency in these techniques by session three, and the focus then shifted to coping statements in session four. Coping statements were designed with Mr. A and his family to counter his agitation with his family, his worry about his colostomy bag, and his agitation over memory problems. These coping statements included the following: "My family loves me," "I take good care of my bag," and "It is okay to forget." Mr. A often needed an index card to remind himself of the coping statements and other skills learned during the treatment. Use of this index card was practiced during sessions using spaced retrieval (SR; Camp, 2006) and Mr. A's family also used SR to help remind him to use the

note card outside of session. His daughter helped him use the coping statements during anxiety-provoking situations, such as when he was going out to eat and became nervous about having an accident with his colostomy bag. Both Mr. A and his daughter reported that the use of coping statements aided by his daughter decreased his anxiety and allowed him to go out to restaurants. Behavioral activation was introduced in session six to increase pleasurable activities and decrease isolation, as Mr. A often avoided leaving his house. Mr. A and his family were encouraged to increase the frequency with which he was involved in light exercising, eating out with his family, going to church, gardening, and playing cards with his grandchildren.

During treatment it became apparent that the family interaction patterns were interfering with the learning of new coping tools. Mr. A, for example, became angry when his wife or daughters told him that he was forgetting things or misremembering. In addition, the daughter who began therapy sessions asked her sister to participate in treatment in her place because it was too difficult for her to hear her father and mother discussing his anxiety and memory decline. Another factor was that Mr. A stated that he did not like Mrs. A helping him to complete activities; as the couple had a reported history of Mr. A's being dominant or "king" and not having a close relationship. In sessions, Mr. A was asked directly whether he would accept encouragement from his wife to do activities. When he agreed, activities were chosen that Mr. A believed would be in his best interest. Mr. A's daughters were encouraged to take more of a leadership role as Mr. A's memory declined to help him use his coping tools and stay active.

Following treatment, Mr. A reported that he was more active by going out to eat, attending church, and gardening. He also spoke less often about others thinking negatively about him. The post-treatment assessment indicated a reduction in anxiety according to the RAID (pre = 23, post = 17) and the SIGH-A (pre = 26, post = 9). The total NPI subscale score showed virtually no change post-treatment (pre = 8; post = 9), indicating that Mrs. A still perceived Mr. A's anxiety as a source of distress. Mr. A and his wife received follow-up phone calls for 3 months after treatment. Within this time frame, Mr. A suffered health problems and was diagnosed with prostate cancer. He continued to report finding the coping tools helpful, most notably staying active and using his coping statements. During the final phone call, Mr. and Mrs. A reported that Mr. A had been practicing the tools by engaging in activities (taking a walk, doing minor household chores) whenever he worried about his health. The final assessment at 6 months indicated that his anxiety levels remained lower than pre-treatment assessments (RAID = 5; SIGH-A = 16); however, scores on the SIGH-A had increased from the post-treatment assessment (post = 9, 6-month follow-up = 16), most likely influenced by changes in Mr. A's physical health. Scores on the NPI-A remained relatively consistent (6-month follow-up, = 8).

Patient 2

Mr. B was an 83-year-old Hispanic widowed man and father of seven children. His first language was Spanish, but he had learned English at an early age. He had completed an eighth-grade education and had served in the Army during World War II. During his time in the service, he had experienced a traumatic incident when he fell short of breath and passed out during an airplane training exercise. Mr. B and his family reported that he had not found stable employment after his discharge from military service because of his "nerves." He was referred to Peaceful Mind by his VA psychiatrist for help with social concerns and worry. Mr. B had a unique caregiving situation, as he lived during the week with his son and alternated weekends with one of his three daughters. He had glaucoma and hearing loss. Five years prior to his entering treatment, Mr. B's wife died, he received a diagnosis of Alzheimer's dementia, and he moved in with his son. At this time, he stopped performing independent activities, such as paying bills and driving. Mr. B's daughter reported that Mr.

B functioned well in some activities of daily living, including dressing and grooming himself and had no difficulties remembering important life events. However, she also reported that his memory had declined significantly in recent years and that he had difficulty remembering recent events, people's names, and the date.

Mr. B and his family reported that he had a lifetime history of anxiety, beginning after his military accident. Given Mr. B's cognitive decline, and his reluctance to discuss such issues when he was younger, neither he nor any of his children could offer specific details as to the nature of this anxiety throughout his life. All reported that he had been taking Librium for approximately 50 years. The initial assessment indicated that Mr. B experienced significant worry about the past, his medication, and evaluative concerns from others. He reported difficulty falling asleep, as he could not stop thinking about the past and the rightness or wrongness of his actions.

One of Mr. B's daughters participated as his primary collateral on self-report measures and was present for all assessments. At baseline, his CDR was 2; and his responses on the RAID (10) and SIGH-A (22) indicated clinically significant symptoms of anxiety. Additionally, Mr. B's daughter indicated that she perceived his anxiety to be significant (NPI-A = 8). Mr. B met criteria for generalized anxiety disorder and social phobia, according to the MINI. Although he continued to discuss physical symptoms of anxiety and worry related to his military accident, it was unclear whether he met criteria for post-traumatic stress disorder, as his cognitive decline made it difficult for him to report on symptoms in each required category (re-experiencing, avoidance and emotional numbing, and hyperarousal).

Mr. B attended 12 treatment sessions over 3 months at his daughter's home. The first seven of these sessions included Mr. B and the primary collateral, Ms. R. All three of his daughters attended the treatment sessions, beginning with session eight. The initial sessions focused on self-monitoring and diaphragmatic breathing. Mr. B had considerable difficulty remembering to fill out the self-monitoring forms. To address this difficulty, the collateral began to call him nightly and filled out the forms based on his verbal report. Mr. B was able to learn diaphragmatic breathing in session but had difficulty remembering to use it between sessions. The use of a notecard with the word *breathe* was introduced; and, using SR (Camp, 2006), Mr. B was able to learn to pull the note card from his pocket, which prompted him to breathe deeply when he felt anxious. The phrase, "What can you do when you feel nervous?" became the cue for Mr. B to use his notecard. Ms. R was instructed to use this phrase to help her father practice between sessions.

Beginning with session four, coping statements were introduced particularly for use when he felt anxious around his daughter-in-law, whom he thought perceived him negatively. The statement, "It's okay when others are quiet," was developed and written on the back of the *breathe* note card. Although Mr. B learned to use the card in session using SR, he often lost the note card when moving from one of his children's houses to another. Mr. B's son was not an active participant in treatment and did not coach his father between sessions. Mr. B's other children, however, were interested in learning and coaching the skills. Therefore, an additional goal of the sessions, beginning with session four, was to address ways in which the primary collateral could train her sisters to help their father use the tools.

The focus of sessions shifted to behavioral activation during session six. From Monday to Friday, Mr. B spent most of his time during the day alone while his daughter-in-law was busy taking care of her two young children. Activity scheduling was introduced to reduce his anxiety and increase the frequency of his involvement in pleasurable activities during the day. Mr. B and his daughter developed a list of activities, which included, "playing with grandchildren, listening to music, and going for a walk in the yard." This activity list was

placed in the patient's bedroom and the living room. However, Mr. B had difficulty remembering to perform these activities without the help of those with whom he resided. Ms. R reported that she felt burdened having to be the sole person to remind her father to use the skills. Initially, she reported feeling frustrated with her father for "not trying" but later realized that he needed more support in using these tools than she alone could offer. At this point, Ms. R was encouraged to see whether her siblings would be interested in attending the treatment sessions. Mr. B's other two other daughters began attending during session eight; Mr. B's son declined invitations to participate in treatment. There was no indication from any of Mr. B's daughters of being unhappy with their brother for his non-participation.

From sessions eight through 12, Mr. B and his three daughters participated in treatment sessions. Together, the daughters brainstormed activities that Mr. B could do while at each of their homes, as well as while he resided with his son during the week. They also alternated days between one another when they could call their father during the day to remind him to use the tools. Additionally, each of the daughters received copies of the note cards and other treatment materials so that the patient had these available at each of his residences.

The participation of his other daughters reduced the burden reported by the primary collateral and also allowed the family to communicate and problem-solve about their father's care, as a unit. For example, Mr. B's daughters discussed with each other and their father the idea of hiring a day care-giver to increase his activity while he was with his son. The inclusion of three of his children resulted in more consistent practice of the tools across settings, improved understanding of their father's memory decline, and better appreciation of the nature of their father's anxiety. At the end of treatment, Mr. B's daughters reported a decrease in their father's anxiety and felt the use of diaphragmatic breathing was of most help. Mr. B reported his "nerves" still bothered him on occasion, but that he was no longer worried about being around his daughter-in-law, stating he "got used to it."

Mr. B's post-treatment assessment revealed decreases in his anxiety on the RAID (pre = 10, post = 7) and SIGH-A (pre = 22, post = 17). The primary collateral's perception of his anxiety decreased significantly on the NPI-A (pre = 8, post = 0). Following this assessment, Mr. B and the primary collateral were called once weekly for 1 month and then bi-weekly for 2 months. During this time, Ms. R reported that her father continued to use the breathing note card but had difficulty remembering to use the other skills. Phone sessions with Mr. B focused on reviewing the tools he had learned, particularly his breathing note card, as it had been of the greatest utility. At the 6-month assessment, Mr. B had maintained his treatment gains on the RAID (6-month follow-up = 7) and the NPI-A (6-month follow-up = 0); although the SIGH-A indicated a slight increase from the post-treatment assessment (6-month follow-up = 20).

Discussion

The inclusion of multiple collaterals may offer several benefits, yet such instances are not often detailed in the empirical literature. In this article we report on the inclusion of multiple collaterals in the treatment of two Hispanic patients. Several treatment advantages were similar in the two cases described. For these patients, including multiple collaterals likely resulted in more frequent practice of skills than would have been achieved through the involvement of a single collateral, particularly when family conflict may have interfered. This may have functioned, in part, as a cultural variable, given prior suggestions that the inclusion of family members in treatment increases practice and treatment adherence in Hispanic populations (Aranda & Morano, 2007). However, the inclusion of multiple collaterals may offer similar benefits to families from any cultural group in which multiple

members are valued in the care of the elderly. Furthermore, in both cases each family member offered subjective reports of increased family communication and understanding of the patient's anxiety and memory problems. These reports are consistent with the subjective reactions to other treatments targeting patient-caregiver dyads (Zarit, Femia, Watson, Rice-Oeschger & Kakos, 2004). Psychoeducation of caregivers has been associated with a decrease in anxiety among patients (Haupt, Karger & Janner, 2000), and the skill training and symptom recognition involved in the treatment may also have served a psychoeducational function in the Peaceful Mind intervention. Additionally, these two cases illustrate that secondary caregivers can be successful collaterals in treatment. Primary caregivers are often more involved in assisting patients with activities of daily living (Stommel, Given, Given & Collins, 1995), which may influence the time and energy they can devote to assisting in psychological functioning. The inclusion of secondary caregivers may prove to be a useful strategy in future interventions. While the use of multiple collaterals increased the use of therapy skills and improved family communication in both cases, it was necessary for different reasons. In the case of Mr. A, a history of marital conflict and persecutory ideas interfered with his receptiveness towards receiving help from his wife as he experienced increasing cognitive difficulties. In a different way, Mr. B's cognitive decline made independent use of the tools unlikely. His unique caregiving situation also necessitated multiple caregivers' involvement in order to transfer learning to multiple environments. In addition, the two men differed in the amount of collateral assistance necessary to facilitate the practice of skills. Although Mr. A. exhibited some impairment in memory, his cognitive functioning was less impaired than Mr. B, most likely explaining why Mr. A required less assistance in using the tools. However, Mr. A's cognitive impairment may have also necessitated the need for multiple collaterals as it led to increased dependence and irritability with his wife.

Given the promising outcomes, further research is needed to determine in which cases it may be advantageous to incorporate additional collaterals. As with Mr. B, patients with large families whose members are involved in their care may benefit from inclusion so that all family members are aware and knowledgeable about the patient's problem areas and treatment. In addition, the inclusion of additional family members may offer positive psychological and physical benefits that have been associated with care giving (Beach, Schulz, Yee & Jackson, 2000; Narayan, Lewis, Tornatore, Hepburn & Corcoran-Perry, 2001). Multiple family-member involvement may be helpful in cases where conflict exists between the patient and the primary caregiver. For example, Mr. A's daughters were able to remind their father to use the coping tools without the interpretation of "nagging" that accompanied his wife's requests. Similarly, the inclusion of multiple family members can be valuable when the primary caregiver is under increased burden. Additionally, it may not always be possible for one caregiver to attend all treatment sessions. In such instances, the inclusion of multiple caregivers may help to keep the patient's use of new coping tools on track. Finally, the inclusion of multiple collaterals may offer increased benefits for members of certain cultural groups that place emphasis on the role of the family. Including multiple family members may reflect the therapist's respect and awareness of cultural values, which in turn enhances therapeutic effectiveness. As exemplified by the case of Mr. B, the incorporation of multiple collaterals may also serve to increase a family's adherence to treatment and allow each family member to help the patient practice skills.

While acknowledging the importance of cultural relevancy, this strategy is not limited to use with any one cultural group. The inclusion of multiple collaterals may work well in extended close-knit families, a characteristic which may occur across a range of cultural groups. In both cases presented the families were Hispanic and further research may help to clarify if the inclusion of multiple collaterals is more effective for Hispanic populations. Our experience with other cases not presented suggest that the inclusion of multiple collaterals

may be of benefit to families of any background in which multiple members are involved in the care of the person with dementia.

Although the roles of multiple collaterals are likely to differ as a function of the reasons for their inclusion and family interaction patterns, the Peaceful Mind program has suggested three promising benefits of including multiple collaterals. First, the inclusion of multiple collaterals may allow for the division of labor that will likely decrease burden (Joling et al., 2008). Previous research has shown family planning meetings to be helpful in reducing caregiver depression, as well as delaying nursing home placement (Mittelman, Roth, Coon & Haley, 2004). Although not formally included in the intervention, sessions on occasion facilitated the discussion of caregiving decisions, as was the case with Mr. B's daughters. It may be the case that more open discussions surrounding caregiving are linked to any intervention in which the person with dementia is the target of services, rather than being specifically related to the involvement of multiple collaterals. As noted earlier, the inclusion of secondary collaterals may help reduce the coaching tasks and possible subsequent burden experienced by a primary collateral. Second, including multiple collaterals may increase emotional support for the primary caregiver as well as the patient. A consistent finding in the literature is the link between increased social support in caregivers and lower levels of burden (Mitrani & Czaja, 2000), which mediates patient outcome (Selwood, Johnston, Katona, Lyketsos & Livingston, 2007). Third, each collateral can be trained to act as a coach, thereby decreasing possible family resistance and increasing the patient's practice of skills.

Along with these potential benefits there may also be possible negative consequences of including multiple collaterals. First, in a structured treatment approach such as Peaceful Mind, it can be tempting for the therapist to shift the focus to family or couples therapy. For some families, family therapy may be beneficial in minimizing conflict and burden associated with caregiving as well as in restructuring roles and responsibilities surrounding caregiving decisions (Qualls & Noecker, 2009). While family therapy for dementia may be beneficial in interventions focused on the family unit, (Benbow et al., 1993; Qualls & Noecker, 2009), the Peaceful Mind intervention focuses on treating the anxiety of the person with dementia directly, with the help of collaterals, which is part of what makes this intervention unique. In the case of Mr. A, the therapist managed the relationship difficulties only to the extent that they interfered with the delivery of the intervention and the practice of skills. When working with multiple collaterals, the therapist should be prepared to assess the impact of family conflict on the patient's symptoms and offer referrals to help address family-focused issues. In instances of high family conflict, family therapy may be recommended (Qualls & Noecker, 2009) before, or in addition to, a structured CBT program such as Peaceful Mind. Additionally, it can be challenging to remain focused with an increased number of participants in session. In the case of Mr. B, the daughters on occasion would reminisce about the past with their father, which distracted from the focus of learning and practicing skills to help manage their father's anxiety. A related difficulty can arise when collaterals use the sessions to focus on their own anxiety; although this did not occur in either of the two cases presented. While the coping skills can be used by everyone, the therapist is responsible for reminding the family that the anxiety of the person with dementia is the focus of treatment.

The cases described here demonstrate that the inclusion of multiple collaterals is feasible and may be beneficial. It is unclear how these patients would have responded without the inclusion of multiple collaterals, but these two cases highlight the potential for maximizing treatment gains by use of this strategy. These cases also highlight the need for therapists to remain cognizant of possible cultural values when including multiple family members in treatment. As the rates of dementia continue to grow, so, too, will the demand for effective

treatment of emotional difficulties. Given the variety of caregiving situations that families employ, continued investigation of how these family interaction patterns influence treatment delivery is necessary. Future research may further help determine if this strategy is indeed more effective for specific cultural groups, including Hispanic families, or whether the presence of particular family characteristics is the deciding factor in including multiple caregivers. In addition, future studies may also clarify the impact of the intervention on all the family members included in addition to the experiences of the person with dementia. The inclusion of multiple collaterals is a promising option to maximize treatment gains as well as the family's investment in therapy.

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