

The Principles and Techniques of Benefit-Finding for Dementia Caregivers: Reply to Gersdorf

Using cognitive reappraisal to promote positive gains is a distinctive feature of the benefit-finding intervention (BFT). The intervention would not appeal to caregivers, however, if it burdens them with extra training sessions, on top of a usual psychoeducation program. Furthermore, because the challenging aspects of dementia care (e.g., dealing with neuropsychiatric symptoms and impairments in activities of daily living)¹ provide exactly the context for searching for meaning,² positive reappraisal exercises are embedded within related topics when these challenging aspects are discussed, rather than being covered in stand-alone sessions.³ This is probably more acceptable to caregivers as they come mainly for knowledge and care skills.

BFT is often compared to cognitive-behavioral therapy (CBT)⁴ because of the common focus on cognitive reappraisal, but in fact it departs from CBT in important ways. Although the role of dysfunctional thoughts is discussed initially in BFT as a way to illustrate the impact of thoughts on behaviors and emotions, the emphasis quickly shifts to reappraisal and discovering positive gains rather than exploring and confronting dysfunctional thoughts.^{3,5} As Gersdorf⁴ has rightly pointed out, this approach avoids the perception that the caregivers are “being fixed” in a psychotherapeutic context and increases the acceptability of the intervention. Moreover, CBT aims at

correcting distorted thinking by realistic appraisal, not positive appraisal⁶—whereas positive reappraisals are the focus of BFT.

In BFT, caregivers are asked to use cognitive reappraisal to serve the purpose of finding positive implications for oneself. For example, a spouse caregiver whose wife complains that he is seeing another woman may also treasure the fact that his wife still cares about their marital relationship after so many years. It does not lessen the wife’s delusion but may reduce his anger when being accused. More examples can be found in earlier articles.^{7–9}

To help participants see the “benefits of benefit-finding” and to provide models of positive coping, three caregivers (a daughter, a daughter-in-law, and a wife) who had coped well shared their experiences in prerecorded videos.³ In order to enhance the likelihood that the participants would resonate with the stories, both difficulties and positive gains were covered in the videos. Hearing it directly from those in the same boat would be more convincing than listening to the trainer alone. We were not able to find male caregivers to record such videos; this is an aspect that can be improved in the future.

Although the stories in the videos were encouraging, participants needed to build up confidence and competence in using positive reappraisal to reframe their situations on a daily basis. The emphasis is not on realistic thinking, as in CBT,⁶ but on the *ability* to engage in *alternative thinking*. Even if a caregiver can find an alternative cognition to replace the current one, the ultimate goal of the training would be for the caregiver to come up with more, and more, alternative appraisals for his or her personal situation as well as for

others’ situations. Thus, besides reflecting on their experiences and coming up with personally relevant benefits, participants were given hypothetical caregiving situations and were asked to come up with as many positive reappraisals as possible.^{5,8,9} For example, when discussing particular neuropsychiatric symptoms, scenarios were presented about different fictitious caregivers frustrated by some symptoms and participants would be asked to “help” them by offering alternative appraisals. To consolidate learning during training sessions, caregivers were asked to keep journals of positive appraisals up to three times a week, which were then shared during the next training session.

In addition, participants were asked to examine how negative thoughts affect their motivation to provide care and how reappraisal can help sustain the motivation in the long run. A point needs to be highlighted. Because one of the reasons why neuropsychiatric symptoms (especially disruptive behaviors) are most distressing to caregivers is the damage they do to the bonding with the care-recipient (thus also affecting the motivation to care),¹ an exercise was designed in particular to address their feelings for the care-recipient using reappraisal.

BFT was shown to be more effective than two variants of psychoeducation—the most established form of intervention for dementia caregivers. More importantly, changes in self-efficacy in controlling upsetting thoughts (e.g., preventing one from thinking about what has been given up for the care-recipient), but not the extent of benefits found in real life, mediated the intervention outcomes.^{8,9} This suggested that BFT produced its

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effects primarily through giving caregivers a sense of control over negative thoughts by way of increased capacity to think alternatively and positively, whereas perceiving more benefits does not necessarily matter. This was an important hindsight. Thus, positive gain may be seen as a convenient concept to engage caregivers in alternative thinking; other approaches that can achieve the same goal may be explored.

Finally, both Gersdorf⁴ and Lingler¹⁰ noted that larger effects would be obtained when the intervention was delivered in a group format,⁸ rather than in a one-to-one format.⁹ As these were independent trials and the delivery formats were not directly compared within the same study, no firm conclusion can be made about the effects of method of delivery. Nevertheless, the group format did allow certain activities that were not possible in the one-to-one format. First, in the group intervention, participants were at times divided into smaller groups and competed with each other for the highest number of reappraisals for any given scenario, with the “winning group” getting a small

prize. This was intended to enhance their enthusiasm in participating in benefit-finding. Second, there were also times when participants were paired up and asked to offer advice (i.e., alternative appraisals) to each other. In other words, they served as counselors for another person. The implication of being able to help another person is that they should be able to help themselves, gaining self-efficacy in applying the technique in everyday life. Riessman called it the helper-therapy principle,¹¹ but I prefer to call it *internalizing the therapist*.

Lingler¹⁰ also made other observations such as the mutual support available in groups, which I will not repeat. I hope my response clarifies the BFT in greater detail than was possible in the regular article.

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