LETTER TO THE EDITOR

Valuing Intervention Research

A recent Guest Editorial (Montgomery, 1996) raises some serious conceptual and research design issues related to the important aim of developing effective caregiver interventions. While the author’s intent is constructive, we suggest that the views expressed run counter to proven methods for developing effective clinical treatments, and the solutions offered are unlikely to be productive.

We agree with the author that it is unfortunate that so much caregiver research still uses cross-sectional data when the intention of interventions is to effect change over time. We also agree that greater emphasis on the ameliorative effects of potential interventions is needed. The author correctly notes the complexity of caregiving contexts. In fact, as the author comments, the diversity of caregiving contexts suggests that services should be targeted to appropriate segments of the caregiving population.

We are puzzled as to why the author then suggests that the field focus on broad interventions in heterogeneous groups. This approach is unlikely to yield definitive, useful results unless such studies build upon more restrictive and carefully controlled studies. Successful treatment research progresses through logical steps, eventually leading to feasible, real-world implementation. The steps include (1) initial, relatively small studies to develop the intervention, gather evidence for potential efficacy and determine optimal “dosage,” duration, and outcome measures; (2) larger studies to demonstrate efficacy in relatively homogeneous samples and under carefully controlled conditions; and (3) broad “field” testing in large, heterogeneous samples to confirm “real world” feasibility and effectiveness. These widely accepted treatment development phases are analogous to the standard, highly successful steps in clinical drug development, namely phase II, III, and IV clinical trials (phase I examines safety and toxicity).

There are several possible reasons for previous equivocal findings regarding the impact of interventions, other than that the interventions were not effective. For example, false negative findings might be partly due to the fact that the interventions were delivered in much the same way to all subjects. The diversity of caregiving situations suggests that interventions must be flexible and variable. Some previous intervention studies may, in fact, have helped a subgroup of caregivers (such as spouses), but because they included other kinds of family caregivers for whom they were less appropriate, they appeared ineffective for the group as a whole. An elderly person with a chronic disease generally requires long-term care. Previously tested interventions might have been found to be more effective if they had been delivered or assessed for lengthier periods of time (e.g., one or two years vs six to ten weeks).

Measurement issues add to the difficulty the field has had in documenting the efficacy of caregiver treatment programs. For example, the use of clinically oriented measures (such as depression scales) is appropriate when the caregivers are experiencing depressed mood. However, for those who are more guilty or angry than depressed, such scales will not be relevant and so will be insensitive to change. More thoughtful and psychometrically sound work needs to be done to develop measures that capture the multidimensional nature of caregiver stress. In addition, measures based on actual observation of behaviors need to be used more to document the fact that most caregivers do things differently after participating in a treatment program. Strong reliance on self-report measures (as is common practice in the field today) overlooks other important dimensions of change.

The author’s comment that by defining target populations and research questions narrowly we trivialize our research would be true only if our intention was to end with these narrow studies. However, if an intervention is demonstrated to work in a homogeneous population, it is then worth studying in other samples and in more heterogeneous populations. As indicated above, it is essential first to determine what works at all, and then determine the generalizability of these initial results.

The editorial concludes that we should resist the temptation to focus on resource-intensive services that might not be feasible in the field. We would agree if there were many effective interventions of equal efficacy that varied in resource requirements. Given the current paucity of proven treatments, we suggest that our goal should be to first determine what works, and then proceed to make what works less resource intensive. Otherwise we may end up with easy-to-implement treatments that do not work.

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