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Primary Impact Trajectories of a Psychoeducational Program for Nursing Home Caregivers: Insights from Clinical Case Studies

S Meziane-Damnée[1,2], J Cattoni[1,2], L Djabelkhir[1,2], C Bayle[2], C Ware[2], I Cantegreil[2], H Lenoir[1,2], M Pino[1,2], AS Rigaud[1,2]

[1]INSERM UMR-S 1144, Université Paris Cité, Paris, France; [2]Service Gériatrie 1&2 Centre Mémoire de Ressources et Recherches Ile de France AP-HP, Hôpital Broca, Paris, France

Correspondence: S Meziane-Damnée, Geriatrics Department, Hôpital Broca, 54-56 Rue Pascal, Paris, 75013, France, Tel +33 14 408 35 47, Email souad.damnee@aphp.fr

Abstract: The decision to place a loved one with dementia in a specialized facility is often associated with significant psychological distress among family caregivers, which often manifests itself in feelings of guilt, helplessness, and emotional tension. We conducted a pilot implementation of a seven-session psychoeducational group program designed to support family caregivers during the critical transition from home care to nursing home placement. The intervention included weekly modules addressing fundamental topics such as how nursing homes operate, managing behavioral disorders, end-of-life considerations, and sources of stress for caregivers. Among the 12 initial participants enrolled in the program, we present three illustrative cases that reflect distinct impact trajectories depending on caregiver profiles. Two caregivers showed substantial psychological and relational improvement, characterized by greater acceptance of institutional placement and enhanced coping strategies. In contrast, the third case highlighted the program's limitations in addressing more complex emotional and relational dynamics. These results suggest that, while psychoeducational intervention can facilitate emotional adaptation and promote reevaluation of the relationship between the caregiver and the care recipient, its effectiveness may be limited in cases requiring individualized psychological support. Adapting the intervention to include more flexible and personalized components, such as optional individual or family consultations, could enhance its relevance and effectiveness in meeting the diverse needs of caregivers.

Keywords: psychological distress, psychoeducational intervention, institutionalization, family caregivers, nursing homes, transition

Introduction

Neurodegenerative diseases, such as Alzheimer's disease (AD), lead to a progressive decline in cognitive abilities, behavioral disturbances, and loss of autonomy.[1–3] Currently, these diseases affect more than 55 million people worldwide. In France, approximately 1.3 million individuals are affected, and 11% of people aged 30 and over have a sick or dependent relative or spouse. The majority of these individuals are "family caregivers" (FC), who support their ailing loved ones. Their challenging situation has been recognized as a significant public health concern.[4]

As the disease progresses, the continued care of loved ones at home places an increasing burden on FC which can result in the placement of the affected individual in an institution.[5,6] This transition represents a highly emotional challenge for FC, who experience mixed feelings of guilt, sadness, and failure, but also, at times, relief.[7–11] While institutionalization may provide some respite for FC, it does not necessarily alleviate their emotional distress, depression, or sense of burden.[12,13] Anxiety related to institutional care,[14–16] difficulties in relationships with professional teams,[17,18] and feelings of exclusion from their loved one's life are common daily concerns.[19] These challenges compound the emotional strain caused by disease progression and the loss of meaningful interactions.[20]

From a therapeutic point of view, various authors have proposed different types of psychoeducational interventions for caregivers which aim to strengthen coping strategies,[21] change perception of the situation, increase self-efficacy,[22]

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and self-confidence through information reinforcement, and provide comprehensive support to the individual, taking into account their emotions, knowledge, and environment.[12] The impacts of these programs on family caregivers are heterogeneous, yielding positive outcomes in some domains (improvements in feelings of guilt, psychological distress, and caregiver burden following institutional placement) but no effect in others (reducing depression or improved satisfaction with care.[23,24] The observed heterogeneity in program outcomes can be attributed to the wide range of caregiving situations and caregiver characteristics (eg, family environment, available local resources, stage of the illness, caregiver's personality, etc) that influence how interventions are received and applied.[13,24]

In the context of developing a novel psychoeducational program to support FCs during the transition of their relatives with dementia from home to a nursing home, we initiated a first pilot implementation designed to identify primary impact trajectories across diverse FCs profiles. Although the program will subsequently be evaluated in a larger trial using both quantitative and qualitative measures, this preliminary study adopts a clinical case approach to generate in-depth qualitative insights into initial effects, which can later be cross-validated with objective and standardized clinical assessments. Through qualitative analysis of these cases, we aim to address the heterogeneity of caregiver responses, thereby refining the program content and guiding the design of future implementations.

Methods

Participants

The study sample was recruited from the initial pilot implementation of the psychoeducational program in nursing homes located in the Paris region, in which twelve family caregivers participated. Participants in the psychoeducational program were selected based on the following criteria: being the primary caregiver of a loved one with neurocognitive disorders, having a loved one institutionalized for less than six months, committing to attendance of at least five of the seven group intervention sessions to ensure sufficient engagement, being 18 years or older, and providing informed consent after receiving all necessary study-related information.

Exclusion criteria included being a professional caregiver, being a family caregiver (FC) for an individual who still resides at home, absence of depression and/or anxiety, having a diagnosed but untreated psychiatric disorder, presence of cognitive impairments, or already benefiting from another caregiver assistance program.

Clinical Case Selection

Three cases were selected from among the twelve observed for the case series based on their relevance to the study objectives, the diversity of their care experiences, and their representativeness of the overall population of family carers. They were also included based on how their difficulties evolved after the program—what we refer to as their trajectory. Indeed, the program had a positive impact on some family caregivers (FCs) but proved ineffective for others. The three cases presented in this article illustrate these main trajectories of program impact identified in that pilot study. Additionally, selection was guided by the richness and depth of participants' narratives, particularly their capacity to express and reflect upon their emotional experiences. Table 1 presents the demographic characteristics of the selected clinical cases.

Psychoeducational Program

The intervention is a structured therapeutic and educational program designed to support FC during the critical transition phase of institutionalizing their loved ones. The program consisted of nine sessions including two individual interviews, each lasting approximately one hour, conducted before and after the seven group sessions and seven group sessions.

Inspired by Lazarus's transactional model of stress and coping,[25] this intervention was designed to support family caregivers (FCs) in regulating distressing emotions such as guilt and anxiety, thereby enhancing their capacity to manage the challenges associated with institutionalization. The program offered tools to reduce stress, strengthen caregiving competencies and knowledge, improve communication with healthcare professionals, and facilitate caregivers' adjustment to their evolving role.

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Table 1 Sociodemographic Characteristics of Clinical Cases and Duration of Care

Characteristics	1	2	3
Age (years)	66	71	77
Sex (f, m)	f	m	f
Education (1–6)	6	6	4
Caregiving (years)	7	4	9

Abbreviations: 1, Clinical case 1; 2, Clinical case 2; 3, Clinical case 3; f, female; m, male; Socio-Cultural Scale Based on Level of Education (1 to 7), (1/7 corresponds to the lowest level (minimal education) and 7/7 to the highest level (long higher education).

The educational program was led by a rotating multidisciplinary team of experts, including a geriatrician, a facility director, a healthcare manager and a psychologist serving as the consistent facilitator across all sessions These four facilitators received the same initial training and participated in the entire psychoeducational program.

Each session was centered on a designated theme (Table 2) and included a presentation, followed by an opportunity for participants to engage in discussions with the facilitators and other caregivers. Each session integrated focused theoretical input, peer discussions for shared support, practical exercises for real-life application, and multimedia resources to reinforce and extend learning.

The intervention was implemented under the same conditions for all family caregivers in the core sample from which the clinical cases were drawn.

The program included the following elements:

1. The pre-program interview aimed to assess the relationship between the family caregiver (FC) and the care recipient, identify the caregiver’s needs, sources of dissatisfaction, stressors, goals, and motivation for participating in the program. This initial meeting also addressed crisis situations and adaptation challenges, providing an opportunity to offer personalized guidance.
2. Participant Introductions: Each person introduces themselves and their situation, creating a compassionate and supportive group atmosphere.
3. Neurodegenerative Disease Overview: A clear summary of common diseases, behavioral challenges, and how institutions typically handle them.
4. Nutrition in Institutional Care: A practical look at identifying malnutrition and implementing effective prevention measures within care settings.
5. Institutional Structure & Governance: An explanation of how the institution is organized, including roles, responsibilities, and rights of all parties.
6. Psychological Impact on Caregivers: Discussing the emotional effects for family caregivers when a loved one enters institutional care and strategies to adapt.
7. End-of-Life Laws & Support: A concise overview of relevant legal frameworks, ethical considerations, and available emotional and medical support.
8. Workshop Recap: Bringing together key points from all sessions, inviting questions, and mapping out next steps.
9. The post-program interview was designed to review the program with the caregiver, reinforce their knowledge, evaluate changes in dysfunctional patterns, and, if necessary, revisit topics not covered in the group sessions or explore new issues that may have emerged since the end of the workshops.

Table 2 Titles, Content, and Objectives of the Caregiver Program Sessions in Nursing Homes

Session Title	Content Covered	Session Objectives	Facilitators
Session 1:	- Participant history	- Assess the relationship between the family caregiver and the care recipient. - Identify the caregiver's needs, sources of dissatisfaction, stressors, goals, and motivation for participating in the program. - Address crisis situations and adaptation challenges.	Psychologist
Session 2: Program Introduction	- Presentation of program goals and content - Discussion of participants' expectations	- Familiarize caregivers with the program structure - Discussion of participants' expectations - Sharing participants' experiences and creating connections	Psychologist and geriatrician
Session 3: Memory-Related and Neurodegenerative Diseases	- Overview of neurodegenerative diseases and associated behavioral disorders	- Understand disease progression and behavioral impacts - Accept the prevalence of neurodegenerative conditions in nursing homes - Recognize remaining capacities of their relative (beyond lost abilities) - Adapt behaviors to their relative's current state - Acknowledge institutionalization as an appropriate solution for advanced stages	Psychologist and geriatrician
Session 4: Malnutrition, Risks, and Challenges	- Risks of malnutrition, choking hazards, and food refusal	- Explain nutritional risks in neurodegenerative diseases - Present practical solutions for dietary management	Psychologist and Geriatrician
Session 5: "A Day in the Life of a Resident"	- Roles of EHPAD staff in nursing homes - Typical daily routine of residents	- Understand institutional operations - Identify key staff contacts for specific needs - Align expectations with nursing homes realities - Obtain detailed health updates about their relative	Psychologist and health care manager
Session 6: Psychological Challenges of Institutionalization	- Participants' emotional experiences during their relative's transition	- share Participants' emotional experiences during their relative's transition	Psychologist and healthcare manager
Session 7: End-of-Life Care	- Legal frameworks for end-of-life care - Advance directives and trusted third parties	- Discuss end-of-life support resources in nursing homes - Create a safe space to share fears/emotions - Replace avoidance of death with proactive planning	Psychologist, geriatrician and facility director
Session 8: Program Synthesis	- Participants perception of the program - Ongoing interrogations	- Evaluate the program's impact on caregivers - Identify tailored solutions for ongoing stressors	Psychologist and geriatrician
Session 9:	Participant history	- Review the program with the caregiver. - Reinforce their knowledge. - Evaluate changes in dysfunctional patterns, - Explore new issues that may have emerged	Psychologist

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Clinical Case Presentation

Case 1

Mrs. K. was a retired teacher and had been the primary caregiver for her 91-year-old mother, who had advanced Alzheimer's disease, for seven years. She struggled to balance her caregiving responsibilities with her own well-being and experienced deep guilt over the decision to institutionalize her mother, despite recognizing that her mother's declining health made in-home care unsustainable.

During the interview, Mrs. K. expressed significant psychological distress, fluctuating between feelings of guilt and powerlessness. She acknowledged that continuing home care had become unbearable but blamed herself for placing her mother in a nursing home against her will:

> I felt completely lost. she didn't want to talk about the institution, and it weighed on me.

She was also troubled by the difficulty of distinguishing her mother's disease-related behavioral disturbances from her pre-existing personality traits.

Case 2

Mr. B. was a retired engineer who cared for his 75-year-old wife, who had mixed dementia (Alzheimer's and vascular disorders).

The decision to place his wife in an institution was largely imposed by the medical team, leaving him with a deep sense of powerlessness. He also struggled to establish a meaningful connection with the nursing home staff.

Mr. B. explained that managing his wife's illness at home had become overwhelming due to the increasing demands of caregiving:

> It was very difficult because it took more and more time, and I couldn't manage it anymore.

Although he acknowledged that the nursing home provided appropriate care for his wife's needs, he expressed frustration over the lack of transparency regarding its operations and the roles of the professionals involved. This uncertainty fueled his dissatisfaction with the facility.

Case 3

Mrs. O. was the caregiver for her 80-year-old partner, who had dementia. She shared caregiving responsibilities with her partner's son, with whom she had a strained relationship. Disagreements over care decisions, particularly the choice to institutionalize her partner—ultimately made by an external guardian—exacerbated her stress and sense of isolation.

She described the daily challenges of managing her partner's deteriorating condition, compounded by conflicts with his son. Additionally, she was deeply dissatisfied with the chosen facility, which was located far from her home. She criticized both the quality of care provided and the poor communication with the institution's staff:

> I have a two-hour journey to see him, [.] I have asked several times to see the doctor, and it's impossible [.] I always leave with a knot in my stomach.

Mrs. O. expressed profound psychological distress, feeling unsupported and unheard in the care process.

Qualitative Assessment

The pre and post program interviews were used for the trajectories analysis and they aimed to explore caregivers' personal experiences, emotional responses, and sources of stress, as well as to assess their expectations and perceived changes before and after the intervention. All interviews were audio-recorded and transcribed into verbatim. Transcripts were independently coded by two researchers (HL and ASR) and analyzed following Braun and Clarke's thematic analysis approach.[26]

Ethical Approval and Informed Consent

This study received approval from the *National Ethical Committee (Comité de Protection des Personnes Est II*, Ref. No. SI: 22.00264.000072 / National No.: 2021-A00553-38). The national clinical trial number is ID: NCT05651555. Institutional approval was not required to publish the case details. Participants read and signed the consent form for the study and for the publication of their case descriptions. They were informed that the descriptions would remain anonymous.

Results

The three FC attended all seven sessions and were evaluated one week after the seventh session.

Qualitative Results: Post-Intervention Interviews

Case 1

After the intervention, Mrs. K. reported significant emotional relief:

> Now, I feel like I've made progress. I've put myself more in her shoes, and I feel a little less… helpless.

She came to understand that institutionalization was inevitable, a realization made easier by a greater understanding and acceptance of the illness:

> This acceptance of her fragility […] makes entering an institution more acceptable—yes, inevitable.

Her previously strained relationship with her mother had improved:

> We walk together, there's interaction. […] You can feel it.

Shared moments became more meaningful, even in small gestures like observing the sky together:

> I took a photo, showed it to her, […] she was happy, and so was I.

Regarding emotional regulation, Mrs. K. learned to adjust her approach:

> Patients are like sponges […] I think my voice is softer now.

She became more focused on the present, acknowledged her mother's remaining abilities, and placed greater value on their time together:

> We're not going to focus on what's lost; we're going to focus on what remains.

Her sense of isolation also diminished through collective support. Conversations with other caregivers helped her feel less alone and gain perspective:

> The discussions helped me feel less isolated.

Through the intervention, Mrs. K. was able to alleviate her psychological distress, strengthen her bond with her mother, and develop a more peaceful and constructive outlook on the situation.

Ms. K's emotional relief allowed her to change her perspective on her mother's reality (acceptance of the progression of the disease and its consequences on her autonomy). This made institutionalization the most appropriate solution for their situation and resulted in a decrease in depression scores.

Case 2

After the intervention, Mr. B.'s perspective and attitude evolved with each session. He highlighted his growing acceptance of a partnership between himself, the institution, and his wife:

> I'm increasingly able to convince myself of what you said—that before, it was just the two of us, but now it's three: her, me, and the institution.

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He learned to temper his expectations and adopt a more balanced perspective, recognizing that care may not always be perfect:

> The problem is that I'm the one making demands… I think I should tone them down.

Mr. B. found comfort in his regular visits to the institution, a routine that brought him peace, despite recommendations from others to take more distance:

> I'm happy to be here; it does me good.

He believed that this new arrangement created a calmer environment for both himself and his wife:

> Thanks to the institution, everything is much calmer for everyone.

Through the intervention, he learned to appreciate the joyful moments he shared with his wife, particularly realizing that her laughter had become her primary way of communicating:

> She laughs all the time. Let's enjoy these moments; they're good moments.

Discussions with other caregivers also helped him understand that he was not alone in facing these challenges:

> The fact that there were several of us in the program made me realize this is a somewhat common issue.

One session, focused on end-of-life considerations, had a profound impact on Mr. B., prompting him to reflect on advance directives—a topic he had long avoided:

> Before, it made me laugh. Now, I realize my partner hasn't formulated any advance directives.

This realization encouraged him to approach these discussions more proactively.

The intervention helped him gain a deeper understanding of the institutionalization process, strengthen his relationship with his wife, and develop a more balanced approach toward the institution's staff. By adjusting his expectations and focusing on the present, he found a new sense of harmony in an otherwise difficult reality.

Case 3

After the intervention, Mrs. O. showed only slight improvement in her psychological state. However, her dissatisfaction with the quality of care provided by professionals remained unchanged. Suggestions from the team or other family caregivers during the sessions were consistently dismissed, and any attempt at negotiation proved impossible. For her, expressing her suffering remained the only way to demonstrate her unwavering commitment to her partner.

Faced with this impasse, the psychologist (SD) asked her what could bring her relief, to which she responded:

> Who told you I wanted relief?

Mrs. O. acknowledged that her approach to caregiving was not the most peaceful, but she attributed it to her unique situation, her age, and her small family network.

While she recognized the value of the program, she ultimately felt that it did not fully address her specific circumstances.

Discussion

The value of the psychoeducational program in this study lay in its dual structure: individual interviews tailored to address each caregiver's specific needs and concerns, and group workshops designed to provide knowledge, coping strategies, and emotional support. In addition, the opportunity to interact not only with professionals but also with peers fostered a safe space for open expression, which proved beneficial for family caregivers.[19] The three clinical cases highlighted common challenges, including a lack of understanding of the illness, feelings of guilt, difficulties in delegating and adapting, and communication issues.[14,17,18,20,27] The intervention addressed these factors by promoting a better understanding of the illness, facilitating acceptance of institutionalization, and improving relational dynamics,

ultimately influencing each FC's response. After completing the program, the three participants experienced distinct trajectories, as discussed in the following sections.

The Cases of Mrs. K and Mr. B: Evidence of Positive Outcomes Following the Psychoeducational Intervention

Mrs. K reported a positive impact from the program. Gaining a deeper understanding of the illness helped her recognize that her mother's behaviors were caused by the disease rather than personal intent. This shift reduced her resentment, increased her empathy, and ultimately facilitated acceptance of institutionalization while strengthening their relationship. Similarly, Mr. B gained a better understanding of the institution's functioning and came to see the staff as caregiving partners.[8] This perspective reduced his stress and helped him accept the transition to institutional care.

For these two cases – Mrs. K and Mr B –, the psychoeducational program initiated a progressive process for FC, leading to several key benefits:

1. **Reducing Psychological Distress**: The intervention's most immediate benefit was alleviating psychological distress among FCs. A better understanding of the illness allowed caregivers to take a step back, accept cognitive decline, and recognize behavioral symptoms as part of the disease rather than personal failings.[20,26–29] This shift helped them break free from a cycle of guilt and suffering, initiating emotional healing—a crucial first step toward more effective coping.
2. **Accepting Institutionalization**: With a clearer understanding of the illness, caregivers were better able to accept institutionalization, no longer seeing it as a failure but rather as a necessary and appropriate solution. This acceptance fostered a more collaborative and harmonious relationship with healthcare professionals.[15,30]
3. **Improving Caregiver-Patient Relationships**: Reduced psychological distress led to more empathetic and harmonious interactions, ultimately improving the quality of life for both caregivers and their loved ones.[27]
4. **Valuing Positive Moments**: As FC progressed through the program, they learned to transform daily interactions with their loved ones into meaningful experiences.[31] Mrs. K, for instance, began appreciating simple moments with her mother that she had previously perceived as insignificant or frustrating. Similarly, Mr. B redefined his visits to the institution as opportunities for comfort and connection. This ability to recognize and cherish shared moments strengthened their emotional resilience.[32]

The Case of Mrs. O: Revealing the Limits of the Psychoeducational Intervention

The case of Mrs. O. highlights the limitations of psychoeducational interventions. For some caregivers, such programs are insufficient to address deeply entrenched relational dynamics marked by pain and conflict. Mrs. O., for instance, appeared trapped in a cycle of suffering, in which her role as a home-based caregiver had become a core component of her identity. Several factors might have contributed to this, including overwhelming guilt, anticipatory grief, and a rigid perception of her caregiving role. The psychological vulnerability of spouses—particularly wives—whose partners have been institutionalized has been well documented in the literature.[20,26,29] Furthermore, the absence of familial support has been recognized as an additional source of stress for caregivers.[26]

Mrs. O.'s experience illustrates that some caregivers require a complementary approach—one that considers the deep emotional dynamics and the specific nature of the caregiver–care recipient relationship. A combined approach, integrating psychoeducation with one-to-one counselling or family therapy, might have supported Mrs. O. in developing greater psychological flexibility.[33]

This clinical case also underscores the importance of the initial assessment interview. To enhance the effectiveness of future psychoeducational programs, initial evaluations should include an in-depth analysis not only of caregivers' diverse needs—shaped by their personal circumstances and relationship with the care recipient—but also of their psychological distress and readiness for change.[34] A preliminary psychological assessment could help tailor interventions more effectively, particularly by identifying those caregivers who would benefit from individualized support, including therapy sessions adapted to their specific needs.

A key strength of this in-depth analysis of the evolving challenges faced by three family caregivers—each representing a distinct trajectory during the pilot implementation of the psychoeducational program—was its potential to inform improvements in caregiver support. In particular, it highlighted the importance of the initial psychological interview, which could help identify caregivers with heightened psychological vulnerability and offer them additional psychological support.

Limitations

The findings of this case study are subject to several limitations. The small sample size of three clinical cases limits the generalizability of the results and does not fully capture the diverse needs of caregivers. Additionally, cultural factors influencing caregiving perceptions were not explored. Other limitations are the lack of long-term evaluation to assess the sustainability of the intervention's impact over time and the reliance on self-reported outcomes. These limitations highlight the need for a larger trial using both quantitative and qualitative measures – which is currently ongoing– to validate the intervention's effectiveness.

Conclusion

In this pilot implementation study, we introduced a novel psycho-educational intervention for family caregivers (FCs) of persons with dementia during the transition from home to long-term care. Three illustrative cases were analysed to delineate the principal impact trajectories. Two FCs—Mrs K and Mr B—exhibited marked benefits, including reduced self-reported psychological distress, greater cognitive and emotional acceptance of institutionalisation, adoption of more adaptive interaction strategies, and reinforcement of affective bonds with the institutionalised relative. These findings indicate that the intervention can facilitate emotional adjustment and help caregivers recalibrate relational dynamics during placement. By contrast, the third FC—Mrs O—showed limited gains, highlighting the programme's constraints when confronted with complex pre-existing family tensions. This case underscores the need for a more flexible, individualised framework—such as optional one-to-one counselling or family therapy modules—to adequately address heterogeneous caregiver needs.

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Disclosure

The authors report no conflicts of interest in this work.

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