






## “I Feel Guilty”. Exploring Guilt-Related Dynamics in Family Caregivers of People with Dementia

Laura Gallego-Alberto, PhD <sup>a</sup>, Andrés Losada, PhD <sup>b</sup>, Isabel Cabrera, PhD <sup>a</sup>, Rosa Romero-Moreno, PhD <sup>b</sup>, Ana Pérez-Miguel, MA<sup>a</sup>, María Del Sequeros Pedroso-Chaparro, MA<sup>b</sup>, and María Márquez-González, PhD <sup>a</sup>

<sup>a</sup>Biological and Health Psychology Department, Universidad Autónoma de Madrid, Madrid, Spain; <sup>b</sup>Clinical Psychology Area, Universidad Rey Juan Carlos de Madrid, Madrid, Spain

### ABSTRACT

**Objectives:** Family caregivers of people with dementia often report feelings of guilt. However, the number of studies analyzing guilt and the factors associated with its appearance are scarce. The aim of this study is to explore the subjective experience of guilt in the family care of people with dementia.

**Methods:** A qualitative analysis of the narratives of 13 family caregivers of people with dementia about their feelings of guilt was done.

**Results:** Seven categories for understanding guilt in caregiving were obtained: guilt derived from actions themselves; guilt derived from one's limitations; guilt for feeling negative emotions; guilt associated with the change in the relationship with the person cared for; guilt for neglecting other areas; guilt induced by the person cared for, and guilt induced by others. The results showed the existence of cases in which guilt is absent by distress-avoiding processes.

**Conclusions:** Guilt is a relevant variable in understanding caregiver distress, and its analysis is necessary for therapeutic work in the field of care.

**Clinical implications:** Psychological interventions aimed at family caregivers should include specific techniques in order to address guilt feelings.

### KEYWORDS

Dementia; caregiving; guilt; induced guilt; avoidance patterns



## Introduction

Research has shown the negative effects which the task of caring for an older person can have on the psychological health of the caregiver (Sallim, Sayampanathan, Cuttilan, & Ho, 2015). The most frequently studied outcome variables in the context of research on care have been depression, burden and anxiety (Losada et al., 2015). Studies aimed at assessing and analyzing other variables such as guilt are few, even though it is a frequent and incapacitating emotion in caregivers (Gonyea, Paris, & Saxe Zerden, 2008; Losada, Márquez-González, Peñacoba, & Romero-Moreno, 2010; Losada et al., 2018). Guilt has been proposed as a major factor in the development and maintenance of depression and distress in caregivers of people with cancer (Spillers, Wellisch, Kim, Matthews & Baker, 2008). In this population, guilt has specifically been associated with poorer psychological and physical health, as well as with their self-perceptions about their ability to deal with

difficult situations (Duggleby et al., 2014; Spillers et al., 2008). Guilt is also a predictor of anxiety and depression in caregivers of children with intellectual disabilities (Gallagher, Phillips, Oliver, & Carroll, 2008). In addition, in family caregivers of patients with schizophrenia guilt has been proposed as a relevant predictor of psychological distress of those caregivers (Boye, Bentsen, & Malt, 2002).

### *Feelings of guilt in family care of people with dementia*

In caregivers of people with dementia, guilt has been described as the emotion resulting from the perception of having violated (or being able to violate) a moral or social norm related to family care, both in terms of thought and action (Gonyea et al., 2008). Recently, Prunty and Foli (2019) have proposed three key factors in the appearance of guilt: a) beliefs of responsibility or obligation regarding the task of caring for the relative with dementia; b) negative

**CONTACT** Laura Gallego-Alberto  laura.gallego-alberto@uam.es  Facultad de Psicología, Biological and Health Psychology Department, Universidad Autónoma de Madrid, c/Ivan Pavlov, 6, Campus de Cantoblanco, Madrid 28049, Spain

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perception toward one's actions as carer, believing one is acting against the person being cared for; c) perceptions of neglect toward oneself and other areas in the effort given over to the task of caring. The few existing studies which have analyzed the effects of guilt on family caregivers of older adults with dementia have found significant associations between feelings of guilt and higher levels of distress, specifically depressive symptomatology, anxiety, burden, and a lower frequency of leisure and free time activities (Feast, Orrell, Russell, Charlesworth, & Moniz-Cook, 2017; Gonyea et al., 2008; Losada et al., 2010). The profile of women caring for a parent seems to be particularly vulnerable to feelings of guilt, and these feelings are especially associated with depressive symptomatology in caregivers who do few leisure activities (Romero-Moreno et al., 2014). Recent studies suggest that levels of guilt in caregivers can be reduced through psychological interventions (Mahmoudi, Mohammadkhani, Ghobari Bonab, & Bagheri, 2017), reducing distress associated with guilt in caregivers (Gallego-Alberto, Márquez-González, Romero-Moreno, Cabrera, & Losada, 2019).

Despite the above, which shows the growing interest in guilt in the area of caregiver research, the number of studies aimed at analyzing this variable is very small (Gallego-Alberto, Losada, Márquez-González, Romero-Moreno, & Vara, 2017; Gonyea et al., 2008; Losada et al., 2018). Given the distress associated with the presence of guilt in the caregiver population, greater knowledge regarding the experience of guilt and the different aspects related to its appearance and maintenance would increase the possibilities of developing effective interventions to reduce the levels of suffering related to this emotion. This study therefore aims to explore the subjective experience of guilt feelings in dementia family caregiving.

## Methods

### Participants

Participants were thirteen family caregivers of people with dementia (10 women and 3 men, ranging from 34 to 77 years of age). Regarding the kinship with the person cared for, two out of the three male participants were husbands, and one was

caring for his sibling. Among the female participants, three of them were spouses and the rest were daughters of the care recipient. The length of time spent providing care to their relatives ranged from four months to seven years.

### Procedure

The participants were referred to the study by day care centers for people with Alzheimer's disease in Madrid (Spain). All of them showed significant clinical levels of anxiety and/or depression as measured on the stress subscale of the Profile of Mood States (POMS; McNair, Lorr, & Droppleman, 1971) and the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977). Caregivers were invited to participate in a psychotherapeutic intervention. More specifically, this was a group intervention of eight weekly sessions, based on Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999). The intervention was focused on reducing caregivers' feelings of guilt, and preliminary results revealed clinically significant changes in guilt, as well as in anxious and depressive symptomatology (Gallego-Alberto et al., 2019).

The Ethics Committee of the URJC approved the study. All participants signed informed consent forms.

For the present study, we analyzed the transcripts of the different excerpts of the exercises carried out during the intervention sessions, which included discussion and reflection on the feelings of guilt experienced by the participants in their day-to-day caring (please see examples of exercises and contents of the intervention in Table 1). In the intervention, between 15 and 30 minutes of each session were devoted to eliciting guilt feelings through experiential exercises and to discussing and reflecting on the guilt experiences in caregivers' daily life. Procedures derived from thematic analysis were used (Braun & Clarke, 2006). First, the authors read all the verbalizations regarding guilt that emerged in the sessions, as transcribed by the co-therapists during the sessions. After this, a list of initial codes from the data was created. These codes identified a situation or factor that appeared interesting for the topic. A second reading of the data was performed and all the initial codes were filtered and

**Table 1.** Examples of exercises carried out during the intervention sessions.

Exercise	Basic content
Contacting with our guilt emotion (session 1)	I want you to think about a situation that has happened to you that made you feel guilty ..., what kind of thoughts came to your mind?
Reflecting about guilt (session 1)	What is guilt? Where does it come from? What consequences does it have in our life? Is it always bad?
The origins of guilt (session 2)	Are there norms or principles that guide your way of thinking or behaving?
Thinking about mistakes (session 2)	Is it possible to not make mistakes? Are we perfect?
Emotions diary (session 3 and others)	Searching for the reasons that make us feel guilty, and how others may have felt
Introduction to personal values (sessions 3 and 4), through the garden metaphor	If our life is a garden, and each plant is something very important (good or bad) for us: Which are our main values and how are we caring for (watering) them? What has guilt to do with these values?
Watering can metaphor (session 4 and others)	Have you watered all your important values? Are you satisfied with the distribution of water for each value? Guilt derived from the distribution of water.
Analyzing guilt as a barrier toward the values (session 5 and others)	Did you avoid any action because of guilt? Guilt as a sign of changing behavior
What is meant by being a good caregiver? (session 6)	The impossibility of always doing things right, and the need for acceptance
We make mistakes (session 7)	Coping with mistakes, thinking about self-compassion

grouped. In this step, all the researchers examined the codes that were most repeated in the data and explored the existence of relationships between them and other thematic codes. Finally, the authors grouped the different codes into broader categories with similar content, covering the various sources or aspects related to guilt in the context of care. The authors coded the data together in research team sessions. Potential discrepancies were discussed and resolved through consensus.

## Results

The analysis of the participants' narratives resulted in a proposal of seven categories reflecting the origin or sources associated with the appearance and maintenance of guilt, as described below.

### *Guilt derived from one's actions*

Committing errors or the perception of one's actions as erroneous was one of the causes of guilt most frequently mentioned by caregivers. The actions in caring perceived as errors which produced the greatest interference were losing control with the person being cared for. For example, A. M., aged 75, who has been taking care of her husband, commented:

*"When he doesn't want to take the pills I don't know what to do, how to behave ... In the end I just yell at him and he at me, I feel very guilty, it really gets to me ..."*

Another caregiver, M. E., aged 71, reported the following situation: *"A few days ago my husband wanted to go out to the street in his pajamas and I lost my temper ... I don't know why I got like that ... it wasn't that bad. Knowing how he is ... I argue with him ... I felt guilty"*.

Even situations prior to the family member's diagnosis are seen to be originators of this emotion. One example of this is A. B., a 41-year-old woman who has been taking care of her mother: *"I remember it every day ... A couple of years ago when we still did not know the diagnosis, we were in the car together, and I asked her where we were going, but my mother did not know what to tell me, just kept repeating there we go ... Then I thought I'd force her to tell me, I shouted and slammed on the brakes ... I thought she would react and remember, but no. Then I stopped the car and sobbed with my mother next to me saying nothing ..."*

One of the causes of these losses of control and also feelings of guilt is the lack of strategies or knowledge about how to address different situations that arise in the day-to-day care of the person with dementia, such as behavioral problems (aggressiveness, wandering, repeating questions, etc.). Reflecting on her feelings of guilt and distress, A. P., aged 57, mentioned the following:

*"When my mother goes crazy you don't know what to do, it's incredibly stressful, you just don't know what to do"*.

The experience of guilt for one's own actions ("errors", loss of control, self-care, etc.) seems to be linked to the maintenance of beliefs related to how to care, with the models of "good care" and

“bad care” that all caregivers have and apply automatically to evaluate their own behavior. As an example, F. A., a 77-year-old caregiver, who talked about his possible failures in the care of his wife over the past six years, commented: *“I shouldn’t act that way, I must be patient”*.

Throughout the sessions, it became evident that actions which resulted in a negative response (e.g., agitation) in the person being cared for were another relevant source of guilt. For example, J. B., aged 64, caring for his sister, mentioned the following: *“One night I went to adjust my sister’s sleep apnea machine while she was sleeping, it was badly placed, but she woke up and complained, I felt stupid, I should not have gone, because of me she got agitated”*.

Other types of actions carried out by the caregivers which could trigger guilt were all those directed toward self-care and/or leisure and free time activities. In most cases, caregivers admitted that annoying thoughts and feelings of guilt frequently appeared while they took part in this type of activity. For example, L. C., a carer for her parents, both affected by dementia, said that during her vacations she was tormented by numerous annoying thoughts:

“Here I am on the beach ... I ought to be home with them ... ” “I’m an idiot ... I feel bad about leaving for three days, but my brother doesn’t care if he’s off for three weeks ...”.

Another example of guilt about self-care may be that of M. P., 75 years old, who has been taking care of her husband:

“I feel guilty for going to the therapy group, I have to wake my husband from his nap to come along, the poor guy comes home very tired from the center ...” .

Meanwhile, M. M., 34 years old, who has been caring for her mother, told herself repeatedly before a leisure outing with her husband and son: *“You shouldn’t be doing this, you shouldn’t go out without mom.* . These difficulties in self-care associated with feelings of guilt sometimes extended to questioning one’s acceptance of the help provided by social programs aimed at relieving the burden of care. In the case of M. E., while explaining that she had been granted a 30-hour

-a-week home help to help with the care of her husband, she expressed her doubts about this, concerned about the following: *“How am I going to allow someone else to bathe my husband if I’m here, what kind of carer am I if I let others do it? ”*.

### **Guilt for experiencing negative emotions**

Feeling negative sensations and emotions such as getting annoyed or angry was noted as a source of guilt throughout the intervention. Here, we can highlight the case of M. P. when she expressed feeling guilty for experiencing negative emotions derived from the care of her husband:

“I guess I don’t love him enough ... If it’s difficult for me, if I get angry ... If I loved my husband very much, it wouldn’t be difficult ...”.

Another example is the case of M.I., a 59-year-old carer of her mother who wondered about the impact of her emotions on her mother, *“When I am less stressed she is better, but when she notices my sadness and worries she is more depressed ... because of me ... ”*.

L.C. reported feeling guilty for experience negative emotions toward her brother: *“Sometimes I think that he is a selfish person and only cares about his own business, but he is my brother ... and I feel in that way toward him ... ”*.

### **Guilt associated with changes in the relationship with the person cared for**

One of the reflections shared by the participants is the distress associated with changes in the relationship with their family member after dementia is diagnosed. In fact, confessions about feelings of distress and guilt about the change in relationships were frequent. P. D., aged 70, carer for his wife affected by a frontotemporal dementia, mentioned:

“I married one person and now I live with another ... ” “We no longer have a relationship”.

A. B. reported that during telephone calls to her parents before the diagnosis, her relationship was closer with her mother and they talked for hours. However, after the decline of her mother, she was forced to talk more with her father and have fewer conversations with her mother: *“I don’t pay so*

*much attention to her, I find myself asking her right away to pass me to my father ... I don't feel good about this ...*”.

In addition to the change in interactions with their relative, caregivers pointed to the change of roles as one of the most difficult aspects to accept and one which favors the appearance of guilt. For example, M. P. commented: *“I've taken the attitude of a sergeant, now I am in charge ...*”. On another occasion A. B. pointed: *“I have four children ... my two children and my two parents”*.

### **Guilt for neglecting other areas**

It is not uncommon for family caregivers to abandon or dedicate less effort and/or time to vital areas other than caring, thereby creating feelings of frustration, disappointment, sadness and/or guilt over their neglect. M.I. said:

*“I don't have a life of my own anymore, I've stopped going out with my friends ... I don't have any friends anymore, I had to quit my job to take care of my mother ...*”.

M. M., who became a mother recently, sometimes mentioned feelings of guilt for not being able to attend to her baby one hundred percent when she was with her mother at home since she had to be aware of both at the same time. In this same case, guilt and distress were also frequently felt because she had stopped spending time with her husband on weekends in order to visit her mother: *“Before, we used to go to the country on Saturdays or Sundays, but now or I go to see my mother or we take her with us, we no longer do so many things alone together as before ...*”.

A. I., a 41 years old mother caring for her mother expressed her guilt for not paying the same attention to other members of her family since her mother's diagnosis: *“I no longer speak with my father as before, my mother is now the center of all attention ... The same thing happens with my brother, we don't talk about anything else, only about the situation, I wish I could dedicate more time, do more things with them ...*”. Another example of this was A. B. She pointed out: *“Because of this situation, on the weekends my husband and my children can't go out to do something fun or go out for a while, we have to go see the grandparents ...*” *“When*

*I have time to play with my children ... I'm exhausted ... I can't enjoy it like this ...*”.

### **Guilt induced by the person cared for**

Although all the aspects mentioned above are related to the non-fulfillment of the caregivers' own expectations, wishes or beliefs, complaints about distress and guilt caused by the behavior of the family member being cared for were not uncommon. During family care, there are different situations in which the person with dementia makes comments or behaviors which can give rise to various negative emotions in the caregiver, among them guilt.

Situations involving a separation between the person being cared for and their carer, such as going to the day care center or having the caregiver go to some activity without the family member, can trigger behaviors in the person being cared for which generate feelings of guilt in the caregiver. L. G., aged 36, who was taking care of her mother, told us the following situation which happened that same afternoon when leaving home to come to the intervention program:

*“It's always the same, every time I go out of the house, she tries to blackmail me emotionally, she tells me that I'm abandoning her, that I am a bad daughter, even grabs me so I don't leave. She even tells me sometimes: “if you don't look after me, I'll kill myself”.*

Similarly, every weekend that M. M. did not visit her Alzheimer's-suffering mother and took part in some leisure activity, she said she felt guilty, not only for doing the activity without her family member, but for various comments made by her mother and related to her feelings of loneliness: *“My mother is sad and she tells me that she's lonely, that she only has me and my brothers and sisters, and that we don't love her, she blames us for her sadness”*.

Other occasions were noted in which guilt appeared as a consequence of problematic situations caused by the appearance of the relative's symptoms. A. M. described several situations in which the behavior of her husband generated distress and guilt:

“When my husband refuses to take medication, he tells me: you just want me to die, why don’t you leave me alone? Just leave me in peace, can’t you?”

### **Guilt induced by other people**

Just as throughout the sessions caregivers pointed out the guilt feelings caused by the behavior of the cared-for relatives, they also on several occasions mentioned the appearance of these feelings after interacting with other relatives. Among the different behaviors of other family members which could create guilt in the caregiver, complaints and comments about the way in which the carer tackled the cared-for family member’s problematic behaviors were common sources of this type of distress. L. G. described it thus:

“When my brothers and sisters come and I tell them how aggressive my mother is, they ask me what I did to make that happen ... I even have to justify myself”.

The comments of other relatives indicating that the situation is the result of the carer’s own choice and the carer’s sole responsibility was highlighted as another source of guilt and distress. For example, M. P. said she felt guilty after a conversation with her son, in which she explained her distress and difficulties in caring for her husband: *“My son said to me: It’s what you chose, mom ... and it hurt a lot”*.

### **Other feelings close to guilt and anticipated guilt**

A very interesting finding of this study was the observation during the sessions that when the caregivers talked about their situation as caregivers and the feelings and thoughts associated with it, it became clear to the therapists that there was an emotional experience very close to guilt, even though the caregivers explicitly denied this emotion and labeled their experience as another emotion, such as anger or grief. After telling the story of a difficult situation with her husband, M. P. mentioned:

*“After scolding him, he told me: please don’t scold me anymore. And I felt devastated ... I tell myself that I shouldn’t scream at him if I already*

*know how bad he is, the poor thing ... it’s not guilt, I feel sorry for him”*.

Another example is J. B. who commented: *“After repeating the same question several times I shouted, it really gets on my nerves ... I feel irresponsible, but not guilty”*.

At this point, it should be noted that what is observed in several cases is that guilt is indeed not experienced by caregivers because they organize their behavior in order to prevent its occurrence or prevent it from getting worse. Thus, the anticipation of guilt itself seems to activate patterns of behavior, mainly of evasion or control, aimed at avoiding experiences (avoidance of leisure activities, asking for help, etc.). This was the case of A. M.: *“When I try to leave him on his own to go for a walk, I feel terrible, he weighs on my conscience ... I can’t do it, so I simply don’t do it”*.

A conclusion emerges from this reflection: sometimes, the non-experience of guilt by caregivers can really be a marker of dysfunctionality, linked to avoidance and passivity; along similar lines, the presence of guilt could be an indicator of functionality when this is a result of adaptive behaviors by caregivers, as in the case of those related to their behavioral activation (self-care and leisure activities) or assertive communication (request for help).

## **Discussion**

The aim of this study was to analyze the subjective experience of guilt feelings in the process of caring for a family member with dementia. The exercises in which participants reflect on feelings of guilt in their daily care routines have allowed us to identify different causes or factors in the origins of this emotion. The definitions of guilt in the context of caregiving (Losada et al., 2010; Prunty & Foli, 2019) propose that this type of emotion is the result of negative self-evaluation of the inadequacy of one’s own behavior when compared to one’s beliefs and ideals of meaningful action. The meetings with caregivers produced numerous occasions in which the experience of guilt was found to originate in the caregivers’ evaluation of their own actions as inadequate or insufficient. The times when caregivers considered that their behavior with the relative did not come close to

matching their beliefs or ideals about how a good caregiver should be or how they should behave and/or handle the situation were a key factor in the appearance of guilt. At other times, doing activities that involved a break from care duties and leaving the person (for example, leisure activities, self-care, etc.) were important sources of guilt and distress, as already pointed out in other qualitative studies (e.g., Hellström, Håkanson, Eriksson, & Sandberg, 2017).

Furthermore, guilt and distress may come from the change in the relationship with the relative with dementia once the role of caregiver is taken on, since this implies a change in role relations with the person cared for. The change from the previous relationship (Braun et al., 2009), combined with witnessing the anticipated loss of a loved one, generates greater psychological distress, and the guilt manifested by the caregivers is part of this distress.

Assuming the role of caregiver often implies devoting most of one's efforts to the demanding task of caring, and this negatively influences the number of actions or time caregivers can devote to other areas of life (Pearlin, Mullan, Semple, & Skaff, 1990), which in turn favors feelings of guilt for not being able to attend to other family members, friendships and/or aspects relevant to themselves. Rosa et al. (2010) identified the association between higher levels of guilt and perceptions of role incompatibility in a sample of family caregivers of people with dementia. Similarly, the third factor underlying the appearance of guilt proposed in Prunty and Foli (2019) is consistent with this category: neglecting or paying insufficient attention to oneself and other responsibilities.

However, guilt appears not only to originate at the cognitive level of the person who suffers it, but it is clearly shaped by the caregiver's social context and interpersonal relationships. A source of guilt can be found in the comments and behaviors of the family member with dementia in which they show their dissatisfaction or anger about the situation, thereby leading the caregivers to infer that they did not behave in the way desired or congruent with the role of a good caregiver. This type of process was studied by Fisher and Lieberman (1996) in caregivers of parents affected by dementia, and showed that this kind of emotional manipulation predicted greater psychological and physical distress. Similarly, the guilt experienced by the caregivers was also influenced by other

close relatives who played an important role in this process. Verbalizations which qualified the actions of the caregiver as inadequate or even claimed that he or she was the cause of the problematic situation or distress of the cared relative were relevant factors when explaining caregiver guilt. To understand the guilt induced by the cared-for family member as well as by other people, it would be helpful to consider the vulnerability-stress model (Zubin & Spring, 1977), assuming that the experience of guilt is always an interaction between the individual and their context: there are caregivers who, due to their personal characteristics (beliefs, self-concept, etc.) are more vulnerable to experiencing guilt in the face of comments or behaviors of people from within their immediate environment.

This study confirms the complexity of the analysis of this emotional experience in caregivers, as they are often not aware of this emotion, identify it with difficulty and give it another name or label. It has been shown that there are substantial difficulties when working with guilt for psychotherapeutic purposes. The greatest of these problems encountered by the authors throughout the study is the denial of guilt in the initial stages of exploration. It was not uncommon for caregivers to deny or be reluctant to acknowledge experiencing guilt feelings. Future studies should further analyze the possible existence of guilt-denial strategies as a coping mechanism for stress in the caring process, a strategy that has been associated with greater anxiety (Cooper, Katona, Orrell, & Livingston, 2008).

These reflections are suffused with the idea that guilt is an emotional experience of great complexity, and understanding it is an ambitious goal. In this sense, it may be worth considering the possibility that the cognitive-behavioral model has limitations in terms of attaining an adequate understanding of the different manifestations and explanatory mechanisms of guilt in this population. It is possible that other therapeutic approaches offer interesting conceptual tools to achieve this objective. Both in the reflection exercises analyzed in this study and in the clinical experience of the authors, it is not uncommon for caregivers to regulate their behavior with the aim of evading distressing experiences. Thus, caregivers frequently avoid carrying out activities that would be important for them in relation to their own well-being or other areas away from care so as not to face

the guilt for not dedicating themselves to the family member at that moment. As suggested by Lee, Martin, and Poon (2017), caregivers can invest a great deal of effort in order to succeed in their aim to avoid feeling negative emotions about the people they are caring for, such as increasing the time and dedication in their caring for fear of not doing enough for their family member. These efforts prevent guilt from arising, but increase their burden and distress (anxiety, depression, etc.). In addition to the above-mentioned dysfunctional mechanism of negation, this type of process can be analyzed as a manifestation of experiential avoidance. Various studies have highlighted the association of experiential avoidance with greater psychological distress in caregivers (Márquez-González, Cabrera, Losada, & Knight, 2018; Romero-Moreno, Losada, Márquez-González, & Mausbach, 2016). In such cases, therapeutic efforts would be better aimed at helping the caregiver to adopt more adaptive strategies, consistent with their values, even when they imply the experience of guilt.

Given the important associations between the experience of guilt and psychological distress in caregivers, it could be relevant for caregiver interventions to include the use of specific techniques aimed explicitly at working with guilt feelings and the processes that generate them (Gallego-Alberto et al., 2019). Taking into account the difficulties involved in labeling and accepting this type of experiences, interventions based on the Acceptance and Commitment Therapy approach are likely to be particularly useful (Hayes et al., 1999), promoting the identification of emotions of guilt and acceptance and openness to experiencing them, while simultaneously working on the behavioral activation of the caregiver within their own values. Along these lines, therapists can help caregivers with the acknowledgment, emotional acceptance and validation of guilt feelings, showing that some changes derived from their situation (e.g., changes in roles and relationship, including coping with behavioral and psychological symptoms of the dementias) increase the chances of experiencing distress feelings such as ambivalence and guilt (e.g., Losada et al., 2018). Also, other therapeutic approaches, such as self-compassion techniques, may be useful for increasing the ability to cope with guilt in caregivers (Lloyd, Muers, Patterson, & Marczak, 2019). In fact, higher levels of self-

compassion have been associated with better psychological health (e.g., depression and anxiety), and these techniques have been shown to be useful for people with high levels of self-criticism and self-judgment, two variables that may be part of the phenomena of feeling guilty (Barnard & Curry, 2011). Bearing this in mind, there is a need for studies about the impact of self-compassion strategies on guilt feelings in caregivers.

## Limitations

Some limitations must be taken into account when analyzing the present results. The sample size is low and composed of caregivers who already have taken steps to seek help. Future studies are needed in order to assess the extent to which the contents described here are generalizable to broader samples, evaluating the possible existence of differences depending on variables such as the caregiver's gender, the stage of the care process, etc. Furthermore, the fact that the sessions were not audio or video recorded limits the analysis of the transcripts of the participants' verbalizations, which may have missed or overlooked some relevant aspects.

Despite its limitations, this study has reflected on factors that can contribute to a greater understanding of guilt feelings in caregivers. These findings can be helpful for guiding the development of assessment and therapeutic tools that may be helpful for managing this complex emotion capable of generating high levels of suffering in caregivers.

## Clinical implications

- The origin of guilt is not only associated with caregivers' negative self-evaluations, as a third person (the care-recipient or other relatives) can induce it.
- The absence of manifest/explicit guilt may be a sign of distress and dysfunctional coping strategies in caregivers.
- Therapeutic interventions aimed at family caregivers should include specific techniques or exercises in order to address guilt feelings.



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## ORCID

Laura Gallego-Alberto  <http://orcid.org/0000-0002-0094-834X>

Andrés Losada  <http://orcid.org/0000-0002-3134-7133>

Isabel Cabrera  <http://orcid.org/0000-0001-8362-764X>

Rosa Romero-Moreno  <http://orcid.org/0000-0001-5454-3586>

María Márquez-González  <http://orcid.org/0000-0001-6572-8949>

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