


# “WOOP is my safe haven”: A qualitative feasibility and acceptability study of the Wish Outcome Obstacle Plan (WOOP) intervention for spouses of people living with early-stage dementia

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## Abstract

**Objectives:** As symptoms emerge and worsen in people living with dementia, their spouses can benefit from behavioral interventions to support their adjustment as a care partner. The Wish Outcome Obstacle Plan (WOOP) intervention improves the well-being of spouses of people living with dementia early in the disease course, but intervention mechanisms and opportunities for improvement are unclear. The present study gave voice to spouses who participated in a trial of WOOP, describing how WOOP was incorporated into their lives and how it could be improved for future implementation.

**Method:** For this qualitative study, we conducted longitudinal semi-structured interviews among 21 spouses of people living with dementia (three interviews over three months; 63 interviews total). Codebook thematic analysis was performed.

**Results:** Three meta-themes were derived: (1) *assessing baseline strengths and limitations* of WOOP, (2) *learning from experience*, and (3) *fine-tuning and sustaining* WOOP. Participants described how WOOP addressed their interpersonal and emotional stressors, their responses to behaviors of the person living with dementia, and their relationship quality. Considerations for future intervention delivery (e.g., solo vs. in group settings) and instructions (e.g., encouraging writing vs. thinking through the four steps of WOOP) were identified as areas of improvement.

**Conclusions:** WOOP was described as a practical, feasible, and desirable intervention for spouses at the early stages of their partner's dementia. Participants made WOOP easier to incorporate in their everyday lives by adapting the design into a mental exercise that they used as needed. Suggestions from participants specified how to make the everyday use of WOOP more feasible, sustainable, and applicable in a variety of contexts.

**Trial Registration:** [ClinicalTrials.gov](https://clinicaltrials.gov) HIC 2000021852.

#### KEYWORDS

behavior change, caregiving, feasibility, marital relationship, mental contrasting, qualitative research, WOOP

#### Key Points

- Wish outcome obstacle plan (WOOP) is an intervention that leads individuals to set and attain wishes through a few simple steps. This practice is known to be efficacious for improving quality of life for spouses of people living with dementia. Qualitative inquiry can characterize intervention benefits, support improvements, and guide dissemination.
- Our codebook thematic analysis of interviews across the 3-month delivery of this intervention showed that participants developed realistic wishes while making better sense of their spouse's diagnosis. WOOP was also perceived as helpful for reducing participants' self-blame for challenging behaviors of people living with dementia and focusing participants on their own needs as well as their partners' needs.
- With support from the facilitator, those who were initially skeptical or unsure of the purpose of WOOP were often able to reframe their understanding and find utility in the practice. WOOP was seen as a desirable and sustainable practice.
- Participants described opportunities for improving this intervention by revising: (1) recommendations for how WOOP is practiced, (2) the method of delivery of the intervention, and (3) the instructions for prompting written or mental WOOPs so that the user could choose what is more conducive for their lives.

## 1 | INTRODUCTION

Family care partners of people living with dementia face challenging roles and are particularly vulnerable to outcomes such as stress and depression,<sup>1-4</sup> cognitive decline,<sup>5</sup> and physical and emotional burden as compared to non-dementia-care partner counterparts.<sup>6,7</sup> Tailored support for care partners can directly improve their lives and the lives of their care recipients, including by reducing incidences of hospitalization and mortality.<sup>8-10</sup> However, little is known about how to bolster care partners' wellbeing in the early stages of cognitive decline.<sup>11</sup> As such, researchers have recently called for the development of early and targeted psychosocial interventions<sup>12</sup> that alleviate strain and promote wellbeing in these care dyads.

One intervention that shows promise for spouses of people living with early-stage dementia is the Wish Outcome Obstacle Plan (WOOP) intervention. WOOP is an evidence-based strategy that supports the development of self-care and interpersonal skills. WOOP helps individuals to work toward a desired future through self-regulated behavior change.<sup>13,14</sup> This leads to effective goal pursuit,<sup>15,16</sup> particularly in challenging contexts.<sup>17,18</sup> WOOP involves the completion of four steps:

1. identifying a personal *Wish* or goal,
2. imagining the best *Outcome* of accomplishing that wish,
3. picturing an internal *Obstacle* to accomplishing that wish,

4. developing an "if-then" *Plan* to overcome the obstacle and achieve the desired wish.

A WOOP exercise takes 5 min to complete and can be done anytime and anywhere. A website ([www.woopmylife.org](http://www.woopmylife.org)) and mobile application provide instructions on how to do the exercise. The website is the most accessible place to learn about WOOP, though it does not provide information tailored to care partners of people living with dementia specifically. The feasibility and efficacy of this practice for care partners of people living with dementia was tested in a randomized controlled trial (RCT) that showed significant improvements to the quality of life, positive affect, and perceived stress of spouses of people living with dementia.<sup>19</sup> This intervention also showed that people living with dementia in the intervention group tended to report lowered stress and improved quality of life as compared to those in the waitlist group.

The present study complements this recent RCT by presenting a qualitative examination of participants' experiences using WOOP at the initial training and the follow-up time points. Feasibility and efficacy intervention evaluations are strengthened by perspectives of end-users, which can be captured through qualitative analysis.<sup>20,21</sup> This qualitative study was designed to provide rich insights into: (1) *how* WOOP is feasible for spouses of people living with dementia, (2) what barriers and facilitators shape successful uptake and sustainability, and (3) what refinements to WOOP are needed prior to broader implementation for care partners of people living with dementia.

## 2 | MATERIALS & METHOD

### 2.1 | Participants

We performed multi-timepoint, semi-structured interviews with spousal dementia care partners who participated in a larger RCT that tested effects of WOOP on quantitative outcomes.<sup>19</sup> Twenty-four couples were assigned to the WOOP arm, and three couples withdrew after the baseline visit. Participants for this study were the remaining 21 participants randomized to the WOOP arm. Couples were recruited through a network of geriatricians, home health care, and adult day service contacts as well as community flyers. The study was listed on [clinicaltrials.gov](https://clinicaltrials.gov) and the Alzheimer's Association's TrialMatch sites. Eligibility criteria for the RCT were: (1) the couple was married or in a cohabiting, committed relationship, (2) one partner was told by a clinician they had Alzheimer's Disease or a related dementia (ADRD), (3) the person with suspected ADRD scored  $\geq 16$  and  $\leq 27$  on the Mini-Mental State Examination-MMSE<sup>22</sup> (4) the care partner scored a 27 or higher on the MMSE, (5) both participants agreed to participate, and (6) both partners were 55 years of age or older. Most participants were female (71%), white (92%), and retired (80%). Participant characteristics can be compared to those of the participants in the wait list control using previously published descriptive reports.<sup>19</sup>

### 2.2 | Setting and procedure

We employed a longitudinal qualitative approach, examining themes from the WOOP training at baseline and the follow-up interviews that occurred 2 weeks and 3 months after baseline. This approach allowed us to gain an understanding of participants' implementation of WOOP at different points of familiarity with the practice.<sup>23</sup> This was an inductive qualitative study, so we did not make hypotheses about change.

The primary facilitator for this study was a nursing student with no formal clinical training. She was the recreation facilitator at a local long-term care facility before starting nursing school. In addition, the PI of the study, a social psychologist with no clinical training, acted as a WOOP facilitator. Her expertise is in education and research on relationships, gerontology, and public health. All study visits were in-person, at participants' homes, with the exception of one participant who completed the visits through video-conference. Participants provided written informed consent prior to enrollment. At visit 1, each participant completed a background survey that captured socio-demographics, mental and physical health, and perceived support. Participants then completed an initial training session with the facilitator prior to using WOOP autonomously in their everyday life. This training was audio-recorded, transcribed, and treated as the first time point for the current study's data analyses. A follow-up interview was conducted after participants used WOOP for 2 weeks (study visit 2), and again after 3 months (study visit 3). During these interviews, participants were asked to describe their experiences using WOOP and provide feedback on the practice. They also

provided feedback on the assistance they received from the facilitator for practicing WOOP.

The interview guides for study visits 2 and 3 were developed by four researchers (GO, JKM, PVN, and RM) and pilot tested by two partners of people living with dementia prior to data collection. The content of the interview guides was informed by Proctor et al.'s<sup>24</sup> taxonomy and included questions that explored the implementation process and participants' experiences using WOOP. Interview guides are included as Supporting Information S1. Each interview lasted approximately 30 min to 1 h and was audio-recorded and transcribed by hand by members of the study team for analysis. Our study was approved by the affiliated academic institution's ethical review board (Yale University).

### 2.3 | Data analysis

The study team used *codebook thematic analysis* to generate a thematic codebook.<sup>25</sup> This form of analysis is best-suited for inductive, applied qualitative research that garners descriptive findings regarding engagement in activities, behaviors, or encounters. This strategy is well-suited to discovering themes related to intervention implementation, while accounting for the reality that the researcher's own experiences and personal characteristics can shape the findings (i.e., considering themes to be 'generated' rather than 'uncovered' during the qualitative process;<sup>26</sup>). After familiarizing themselves with the data and completing an initial process of open-coding, two coders developed a codebook that included provisional themes.<sup>27</sup> After applying the provisional themes to additional transcripts, the codebook was refined.

Nvivo 12.0 was used to code transcripts. Query development, a feature of the Nvivo software that helps users to organize data, allowed the coders to re-organize provisional themes into meta-themes. These were explored separately by two authors (AES and SV) through writing thick descriptions with illustrative quotes. Meta-thematic patterns and interpretations were compared and discussed with the entire research team. This process involved several additional rounds of rereading the interview transcripts and applying "pressure tests" to themes to ensure they were genuine.<sup>27</sup> Using this systematic approach in thematic analysis ensures the trustworthiness of emergent themes while accounting for the coders' interpretations of the data.<sup>28</sup>

## 3 | RESULTS

Descriptive characteristics for the study sample are provided in Table 1. Our results are organized into sections that encompass the three meta-themes we generated. We describe how each meta-theme was represented across the longitudinal interviews. The meta-themes are: (1) *baseline strengths and limitations* of WOOP, (2) *learning from experience*, and (3) *fine-tuning and sustaining* WOOP. These meta-themes comprise seven sub-themes, and all are presented in Figure 1. Figure 1 also shows from which timepoint

**TABLE 1** Characteristics of spouse participants ( $N = 24$ ) who completed qualitative interviews.

Gender $N$ (%)
Female: 17 (71)
Male: 7 (29)
Race $N$ (%)
White: 22 (92)
Black: 1 (4)
Other: 1 (4)
Hispanic $N$ (%)
Yes 1 (4)
No 23 (96)
Age groups
57: 1
60–69: 7
70–79: 12
80–89: 4
Education $N$ (%)
< High school: 0 (0)
High school: 3 (12)
Some college: 4 (17)
Associate's: 1 (4)
Bachelor's: 4 (17)
Some grad school: 7 (29)
Professional: 5 (21)
Employment status $N$ (%)
Full time: 2 (8)
Part time: 1 (4)
Homemaker: 2 (8)
Retired: 19 (80)
Not employed: 0 (0)
Years married $M$ ( $SD$ )
42.3 (16.5)
Children $N$ (%)
Yes: 20 (83)
No: 4 (17)

supporting codes were derived for each sub-theme, using gray Xs. Illustrative quotes are included throughout this Results section.

### 3.1 | Meta-theme 1: Assessing baseline strengths and limitations of WOOP

Examination of the WOOP training sessions revealed that participants first worked to balance *understanding the WOOP concepts while*

*coming to terms with the spouses' dementia.* The walk-through of WOOP with the facilitator supported their understanding of the exercise, and for some, also offered an opportunity to differentiate circumstances beyond their control (e.g., the dementia diagnosis) from addressable obstacles. This differentiation process allowed them to focus on realistic opportunities to improve their everyday life. Until this was clear, some participants doubted that WOOP could help them. For example, one care partner, who wished to physically exercise more consistently, considered his main obstacle to be his spouse's dementia, rather than an internal source, saying, "Nothing within me stops me [from exercising]. It's [my spouse's dementia] that stops me. I don't know how to deal with that." In this case, the facilitator helped this participant reframe his thoughts around obstacles within his control, and he was able to identify his guilt as the obstacle that was preventing him from exercising instead of his spouse's dementia.

While this introduction helped some participants pursue their wishes in light of their spouse's dementia, other participants took this discussion as an opportunity to articulate that they struggled to accept their spouse's dementia. In these cases, participants found it difficult to come up with wishes that were within their control, and rather wished for a different reality. When one participant was asked to think about her emotions related to her wish, she was frustrated about her life and the spouse's changes, saying:

The bigger part of me [is] not able to deal with [my spouse's decline]... I'm still trying to wrap my head around the bigger picture [that I've] got to accept... there is a part of my brain that can't differentiate between the old and the new. And it makes it harder to deal with the new.

Importantly, participants described that WOOP helped them learn the critical skill of making the best of situations for which they had little or no control by providing ways to detect elements remaining within their control. Some participants described in this initial session that they felt that, through WOOP, they could develop coping skills and respond more positively to difficult behaviors stemming from dementia. One participant shared, "My wish is [to] cope with some of the situations [with my spouse] better. The outcome would be less stress for me, health-wise and mentally, and I could then be better for [my spouse]." Many participants wished to be more patient with their spouse. Participants shared that their impatience and emotional burdens negatively affected their self-perceptions. They experienced this practice as a guide to help them improve their marriage and positively change how they saw themselves, as described by one participant, "My wish is that I can improve my response [to my spouse and have more] patience... I don't like myself when I am impatient, crabby, and tired."

Participants' ability to *understand WOOP concepts while coming to terms with the spouses' dementia* was revisited during the first follow-up visit. After using WOOP for 14 days, some participants described that they were better able to separate their wish that their spouse did not have dementia from their attainable wishes. This allowed

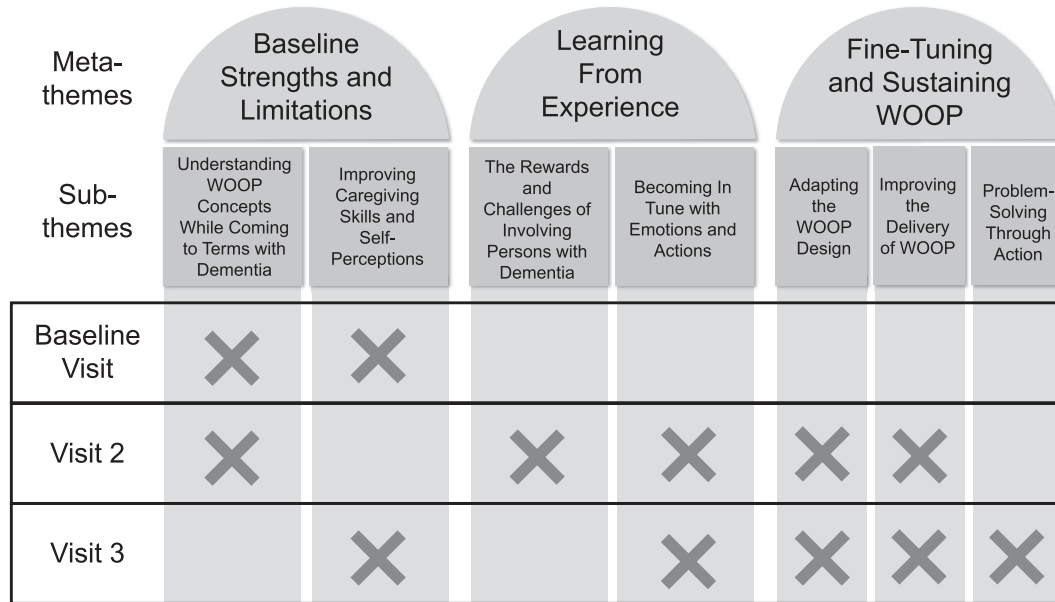


FIGURE 1 Meta-themes and sub-themes found in qualitative analysis at three timepoints.

them to engage regularly in exercises, as described by one participant, "Well my wish is that Alzheimer's would go away...but then I realized that I guess the wish is something that you, yourself can have some control over... so I finally got that." Despite honing their skills in setting realistic wishes, participants expressed feeling hopeful regarding their spouse's dementia. For example, one participant shared that he was hopeful for a miracle even though he had come to terms with the changes in his spouse. Balancing hope with pursuing realistic wishes was described as facilitating strong interpersonal relationships during the 14 days of using WOOP, as illustrated by one participant:

Right now, we're still happy.... we're still trying to go out and do things that we both want to do and enjoy life while we can...I look for changes all the time in her and pray each day for a miracle... [but our relationship] has gotten stronger.

In the final interview, participants continued to describe how WOOP helped them to *improve their caregiving skills and self-perceptions* across additional weeks of using WOOP. For some participants, their experience using WOOP involved, as one participant phrased it, "...convincing myself that it's not his fault...like watching the ball game, [my spouse] must have asked me four times, 'Where are they playing?'... I used to get annoyed, and now I just answer [his] questions...[WOOP] taught me to have more patience." Recognizing that their spouse's behaviors were related to dementia rather than an intentional act of instigation gave participants a sense of peace. One participant described coming up with an effective plan to adaptively respond to her spouse's behaviors. In this process, she became more understanding of his agitation and gained a new perspective that gave her the patience she always wanted to have:

[WOOP is] just an automatic response [to my spouse's behaviors]... A lot of times I will say to [my spouse], 'You know what? I'm not gonna argue with you... It's okay, honey. Just go upstairs and watch TV.' And then that's it. So, it's redirecting, it's acknowledging... It's understanding and letting them know you understand that their behavior...is not their fault.

After several weeks of engaging with WOOP, many participants also described that they *improved their caregiving skills and self-perceptions* by learning critical skills of self-care and self-compassion. They described that WOOP gave them the opportunity to focus on themselves and their needs, which ultimately helped them to become better care partners, as acknowledged by one participant:

Caregivers have to really think about themselves... [WOOP] helped me to focus more on me - Just like mediation, 'How am I feeling right now, how am I going to handle it?' And I can only be a good caregiver if I'm good to myself.

By caring for and focusing on themselves, care partners benefited from the renewed independence that WOOP gave them. WOOP transformed one participant's perceptions of caregiving, from once believing she had no freedom to have personal time, to believing she could be independent while still caring for her spouse. She felt empowered from seeing herself as an independent adult like she once was, "It has given me an outlet to become more peaceful with myself and tranquil...I was reluctant to do things on my own before and now, if I want to do something by myself, I go ahead and do it."

### 3.2 | Meta-theme 2: Learning from experience

Participants' perspectives on *the rewards and challenges of involving people living with dementia* in WOOP exercises evolved across 2 weeks of engaging with this practice. Some participants were unfazed by their spouses' minimal involvement with this practice and accepted that their spouse could encourage them to use it without participating themselves, as described by one participant, "My [spouse] was not particularly [involved]... I just said [to her] 'I'm thinking of doing it' and I asked her how she felt about it and she [said] 'yeah go for it.' There was certainly no objection."

Other participants described wishing their partner would be more involved with WOOP, because they believed their spouses' involvement may be the key to the practice's success. One participant reported that she thought that her spouse would have been more involved in the exercises, especially since her wishes were centered around his changing emotions and behaviors. She was disappointed that she completed these exercises by herself, as shared, "I envisioned [WOOP] being... a couple process... it would be more successful and more helpful if... both partners were doing the WOOP. Then [they] would be sharing and working through that [together]... that would help especially for stress reduction." In other cases, although participants told their spouses about WOOP, they were hesitant to involve their spouses more in the exercises. They shared that it would be too difficult to include them because they may not understand due to cognitive limitations, as described by one participant:

[My spouse] really didn't understand much of [WOOP]. And when I did tell him at the beginning, he said, 'Oh yeah, alright that's good.' But then of course he would forget... I really didn't go into much detail because the less [I] talk to [my spouse] the better off [I am]...that's at this stage [of dementia].

In contrast, some participants did find effective ways to involve their spouses in WOOP, which facilitated positive experiences. For example, one participant shared that he was afraid of leaving his spouse at home alone, which limited his ability to exercise by himself at his own leisure. By visit 2, he involved his spouse in his WOOP practice for maintaining physical fitness, facilitating his physical health while also bolstering his interconnectedness with his spouse:

It was the day before I was gonna take my bike ride, which is one of [my wishes]... My obstacle was 'I'll miss [my spouse]'s company'-and I told [my spouse] this... but I then told her how important it is for me to be doing this and that I'd take a few photos... When I got home, I showed [the pictures] to her... and she really loves the fact that I took them... She just got up out of her chair, came over and gave me a kiss, almost like 'thank you for doing all of this.'

By visit 2, many care partners had developed an appreciation for WOOP as an opportunity to *become in tune with emotions and actions* of themselves and their spouses. For some, WOOP increased their awareness of how emotional reactions could trigger negative interactions with their spouse. The practice helped them fine-tune their responses in a way that became automatic, as indicated by one participant:

I didn't even really have to think about [doing WOOP exercises]... I just automatically went into that mode... You become more aware of your yelling, your rolling your eyes, your answering in a negative way—coming across negative. So, with that, this program in my opinion has definitely made me aware of what I do that may trigger [my spouse]... not saying I'm 100%, but I am aware.

The WOOP process also required participants to pause and reflect on why they were feeling the way they did and how to effectively respond in those situations. In this way, participants described the practice as a relaxing and stress-reducing exercise. One participant appreciated WOOP as a "pause button," as it helped her to take stock of how she and her spouse were feeling during a difficult moment, sharing, "I just... pause before I react... and say 'is this the worst thing, that [my spouse] tracked mud in the house?' That pause button has become kind of like my safe haven, to... say 'How's [my spouse] feeling? How should I feel?'" Another participant shared that thinking about her behaviors in a meditative way, by following along with the instructional content, reduced her stress and anger and motivated her to continue setting feasible wishes:

[The exercises] reduced some [of my] stress and anger because [my spouse] is very challenging at times... I found listening to online [instructions...enhanced the experience]. And so I'm just gonna keep going back to that and listen to it. And then it sort of sets me up in very relaxed situation where I just want [to] keep pushing myself and setting goals that are within my reach for exercise [and] for better health, and [to] work with my husband as his dementia progresses.

Some participants who felt satisfied with WOOP and its usefulness felt compelled to share the exercise with their support groups, friends, and family. They gave tutorials of WOOP to those within their own social circles, hoping they would find the exercise just as valuable.

After using WOOP for 90 days, participants described that they were even further *in tune with their emotions and actions*. Participants felt comforted that they could better recognize what emotions they were feeling in any moment and why. For this reason, one participant referred to WOOP as a "healthy crutch," saying:

On the last [WOOP card], I had written down about how I have a much better sense now of how I'm doing at any given time... and I'm much more satisfied about the way I'm feeling... even when I get ticked off... I'm more aware of what I'm feeling... figuring that, 'Okay, this is the moment now, but it won't be the moment for a really extended time.'

Together, a proactive mindset and an understanding of emotions also helped participants to lessen conflicts with spouses. By visit 3, participants had often become more in-tune with unpleasant responses like anger and common anger triggers, with one participant sharing, "We had an incident this week. And WOOP—it comes back to me... I think about WOOP when I realize I have to change what I'm doing." WOOP exercises also cultivated a proactive mindset, helping participants anticipate difficult events with their spouse. Using WOOP in advance of partners' forgetfulness, for example, lessened disruptions to life and instilled a sense of control, as one participant described:

The one thing I have noticed is regarding appointments. My wife could never remember [that] we're gonna do something...So now all I do is leave her a note...Life is easy, (Laughs), really. So I do use [WOOP] frequently...it makes me feel okay, makes me feel like I've resolved [an issue].

### 3.3 | Meta-theme 3: Fine-tuning and sustaining WOOP

By visit 2 or 3, participants were able to describe two promising ways to *adapt the WOOP design* to fit their needs and lifestyles. First, many participants no longer used the WOOP cards provided to them during the study, or their personal journals, to write down their wishes, outcomes, obstacles, and plans; instead, they completed the WOOP exercise mentally. Second, although participants were instructed to try WOOP exercises once per day, many participants reported that they did not compose a new wish every day. Instead, they used the exercises as needed; sometimes more than once a day, and sometimes not at all each day. By visit 3, WOOP became "automatic" to their thought process, so it was easier to use this practice mentally while attending to their care role, with one participant describing, "Being so busy, I think [the exercise] is just automatic at this point in my life...[I] don't need to read and constantly write things down because [WOOP] is just like an automatic reflex." Another participant felt overwhelmed completing a new wish on a new WOOP card every day, so she took breaks every couple of days. By altering the frequency with which the written WOOP card was used, she was able to consistently accomplish the health goals that were important to her, stating:

I didn't come up with any new [wishes]... I thought it was, for me a bit much... I almost needed a break of a day or two in between before [I] started [a new WOOP]...but what it did do was, it did...keep me focused on [the] things I want to do, like drinking water, taking a deep breath... taking my meds more regularly in the morning, taking my blood pressure...

Some participants expressed feeling burdened by their caregiving responsibilities, their worries about their spouse's health, and their anticipation of decline, leading them to give up attempts to participate in WOOP exercises through writing. This freed them of the feeling of an additional task to complete. One participant described, "It got to be tedious. So, I just kind of did it... in my own head, instead of actually writing things down." Although many participants adapted WOOP into a mental-based exercise, others valued the writing process. One participant attributed her success with accomplishing her wishes to writing down her wishes in her WOOP journal, saying, "In very mundane ways, like 'I'm gonna clean out a drawer...' if I write it down, then it gets done...[WOOP] is very simple – a simple idea, but it works...when you write something down."

Feedback about WOOP refinement during visits 2 and 3 also centered on *improving the delivery of WOOP* by weighing the pros and cons of delivering the intervention in a one-on-one versus group setting. Some participants shared that it was difficult for them to come up with wishes and plans on their own and felt that they may benefit from engaging with support networks. One participant suggested for WOOP to include examples of other dementia care spouses' thoughts and feelings as they navigated similar challenges and stressors. He thought that knowing how these care partners applied this practice to their personal lives would guide him to use the exercise on his own, saying, "I think more examples of other people that are in this study and what they felt... rather than asking me to come up with a problem and come up with a solution... would be an asset to the program."

Finally, after engaging in the practice for several weeks, many participants found that *problem solving through action*, specifically by finding an obstacle and then identifying an action to overcome the obstacle, was the most important and effective aspect of the exercise. One participant, who was initially skeptical about the simplicity of WOOP, felt that the process of finding an obstacle and considering how to overcome it gave her the opportunity to think deeply about the problems in her life, sharing:

When you gave me that I was like, '[You] must be kidding me.' [laughter] I'm not in school, ...what I thought was, 'This is freakin' homework! I don't know if I can do it.' It takes training. And if you really want to get something out of it, you must put effort into it... At the beginning I was like, 'Okay, [WOOP is] simple.' But it's not, it's quite the opposite. But then the results were quite the opposite too... I think most of us find a problem— it's obvious. To find a solution that's gonna

actually...fix that [problem]? That's totally in a different spectrum.

Participants also liked that they created and shared their obstacles and actions with the facilitator, which added accountability. The facilitator checked in with participants periodically to review their progress, and this motivated them to follow through with their actions and stay focused on achieving their wishes. One participant said:

Nothing compares to actually focusing in on a goal with someone else involved. So I find that [WOOP] made me keep some goals in front of me—really daily... when someone else is involved and you're striving to really understand this concept, it stays in front of you... and I'm hoping it won't ever really leave, because the way I was working with goals before, it wasn't as deep. I gave myself permission to get away from [my goals] too frequently, rather than sticking to the tasks.

Participants appreciated that the facilitator took the time to understand their personal circumstances and empathize with their struggles. While using WOOP, participants felt that they could rely on and trust the facilitator to help them identify actions to overcome obstacles.

## 4 | DISCUSSION

This study qualitatively evaluated the feasibility of WOOP, identifying factors that support or hinder its utility for addressing unmet needs of care partners of people living with dementia. Our findings can be used to translate WOOP into an accessible support strategy for care partners of people living with dementia early in the illness trajectory.<sup>29</sup> Our results showed that WOOP helped care partners discover personalized ways to become more patient, understanding, proactive, and balanced during caregiving, while increasing attention to self-care. In some cases, it was initially challenging for care partners to come up with wishes and obstacles within their control, but with the support of a facilitator, the 90-day delivery of WOOP was sufficient for their mastery of and satisfaction with the exercise.

While some care partners would have preferred to use WOOP with their spouse or in a group setting with other care partners, WOOP was still a satisfying exercise for many if completed alone. Once care partners practiced completing written WOOPs, using mental WOOPs when needed, was considered helpful and decreased the stress of multiple competing demands. By shifting from writing WOOPs to thinking of WOOPs, it was feasible for many care partners to integrate the activity into their busy schedules. These results, together with the quantitative results of our RCT, suggest that this brief self-regulation approach helps care partners respond constructively in challenging situations (e.g., responding to dementia

symptoms, managing stress), and it provides a promising direction for broader implementation in dementia caregiving.

### 4.1 | The role of acceptance of the spouses' dementia in the delivery of WOOP

We found that care partners sometimes struggled to accept that their spouse had dementia and that it would not go away; these care partners described initial difficulty seeing the benefit of WOOP and at first faced more difficulties with the steps of this practice. Our study showed that WOOP was effective in helping some care partners with this process of acceptance. Over time, many care partners generated realistic wishes, indicating that they developed a new understanding about compartmentalizing uncontrollable and controllable wishes. In doing so, they began to accept their new normal, incorporating the pursuit of attainable wishes into the process of dementia caregiving. We recommend that WOOP facilitators provide added support to dementia care partners to promote acceptance of the diagnosis as they assist with WOOP instructions. It is crucial for facilitators to consider, for example, the role of hope in care partners' goal-directed behaviors. Mentally contrasting feasible wishes in the context of hope, or positive images about the uncontrollable, facilitates both the development of acceptance and the pursuit of realistic wishes in the face of disease progression.<sup>30</sup> Facilitators should direct care partners to focus on ways to accept the dementia diagnosis while addressing realistic wishes.

In addition, changes in acceptances of dementia over time may be one component of evolving anticipatory grief symptoms, or intense feelings of loss that occur prior to a death.<sup>31,32</sup> Anticipatory grief is associated with care partners' development of burden.<sup>33,34</sup> Some spouses may expect that a behavioral intervention would help them to navigate their anticipatory grief.<sup>35</sup> Embedding support into WOOP to address care partners' anticipatory grief may prevent complex grief responses across time.

### 4.2 | Implementation successes promoted by education on dementia and attention to self

Prior to using WOOP, some care partners reacted to their spouses' behaviors without sensitivity to their spouses' diseases, which often culminated in feelings of frustration and inadequacy. Throughout the study, however, care partners described honing skills to constructively react to their spouses' challenging behaviors. In the early stages, dementia care partners are eager for education about symptom development,<sup>36-38</sup> and educational programs may reduce burden.<sup>39</sup> With education and understanding, care partners can set realistic expectations, develop coping skills, and improve their confidence, emotional wellbeing, and relationships.<sup>40-42</sup> While WOOP already appears to be a platform for developing this understanding, we assert that facilitators can play a vital role in guiding care partners



to respond well to their spouses' emerging symptoms of dementia by emphasizing the utility of the intervention's four steps as symptoms progress.

WOOP also gave care partners the opportunity to better understand themselves. When anticipating how to overcome their obstacles on the way to achieve their wishes, care partners became more in tune with their emotions, understanding how and why they felt the way they did during the difficult interactions. They used this newfound understanding to curb their affective response when behavior problems arose, which strengthened emotional intimacy. By focusing on themselves, care partners accounted for the role of self-care in their own happiness and autonomy, as well as their ability to appropriately care for their spouse. Care partners of people living with dementia have described the importance of developing skills to support self-care across the span of caregiving,<sup>43</sup> but have indicated that burdens of caregiving detract from opportunities to learn self-care strategies.<sup>44</sup> Our study suggests that WOOP may offer a unique opportunity to develop and practice self-care strategies, possibly doing so earlier in the course of caregiving than what commonly occurs.

### 4.3 | Implementation challenges and possible improvements

Although WOOP was generally accepted, some care partners wanted to use WOOP together with people living with dementia, especially when their wishes were related to their marriage. Though this practice was not designed with a focus on dyads, a dyadic model of WOOP may be suitable for couples. We recommend that facilitators leave the involvement of people living with dementia open when teaching this practice to care partners, suggesting that the decision to involve the people living with dementia is up to the care partner. High expectations of involving the spouse may leave care partners feeling disappointed with WOOP and frustrated with their spouse. Low expectations may leave care partners feeling unmotivated to try using these exercises to improve spousal interactions. Facilitators should listen to the care partner, and they may review the benefits and drawbacks of trying to involve one's spouse and encourage the care partner to decide based on their experiences with the people living with dementia.

A support group approach to administering WOOP should be considered. Some care partners struggled to identify wishes that were relevant to their care partner role and adapt the practice to accommodate their busy schedules. In a support group, care partners may work together to generate creative plans to address obstacles. Care partners may also feel less disappointed when their spouses are not involved in WOOP if they are part of a dementia caregiver network. Considering that support groups reduce psychological burden and improve social support, resilience, and well-being,<sup>45–48</sup> we recommend that future studies evaluate the effectiveness and implementation success of a WOOP-based care partner support group.

### 4.4 | Study limitations

Most of the participants were female, white, educated, and retired, and we did not collect information regarding financial strain. Our study thus captures a specific cohort of care partners and their dementia-caregiving experiences and does not characterize all background characteristics that may be relevant for data interpretation. Populations not captured in this study may be at greater risk of burden and have different barriers to self-care and wellbeing.<sup>44</sup> As such, they may have different reactions to, or derive different benefits from, this intervention. A strength of this study is its demonstration that this intervention is useful to participants when delivered by a non-clinically trained facilitator, providing some evidence for greater dissemination capability. However, the primary facilitator for this study still had other background characteristics (e.g., experience with nursing training) that may have contributed to intervention success. Future work should consider ways that this intervention can be effectively adapted to be guided by a range of facilitators. In addition, the interviews and interventions were both administered by the facilitator. While the facilitator may have built useful rapport with some participants that could enrich their responses to interview questions, it is also possible that this study design discouraged some participants from answering honestly about their perspectives on this intervention. As the application of WOOP in populations of care partners of people living with dementia continues to be tested, better measures should be taken to differentiate between research team members' roles to ensure participants feel comfortable providing honest feedback.

## 5 | CONCLUSION

WOOP appears to be a practical, feasible, and desirable intervention for spouses at the early stages of dementia. This intervention has far-reaching benefits across adult populations and, with further refinement, may serve an important role for addressing care partners' emotional, wellbeing, and acceptance needs early in the course of dementia caregiving. With the support of a facilitator, care partners quickly learned to use the exercise on their own. Care partners made WOOP easy to incorporate in their everyday lives by adapting the design into a mental-based exercise as needed. Suggestions for increasing sustainable implementation include offering guidance for involving people living with dementia in WOOP and encouraging care partners to come up with wishes that are within their control. WOOP in a support group setting may be a good way to accomplish even more effective implementation.

### AUTHOR CONTRIBUTIONS

Joan K. Monin, Gabriele Oettingen, Daniel David, and Richard Marottoli conceived the study design and rationale. Gabriele Oettingen developed the WOOP exercise. Joan K. Monin, Gabriele Oettingen, and Richard Marottoli developed the interview guides used to collect data. Joan K. Monin collected data. Anna E. Schwartz and Sarah Valeika

analyzed and interpreted the data and drafted the manuscript. Emily L. Mroz, Joan K. Monin, and Gabriele Oettingen wrote and edited the manuscript. All authors read and approved the final manuscript.

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## CONFLICT OF INTEREST STATEMENT

The authors declare that they have no competing interests to disclose.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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