EDICIONES COMPLUTENSE

Psicooncología
e-ISSN: 1988-8287

ARTÍCULOS

Impact of psychosocial support interventions for informal caregivers of palliative care patients: a systematic review

Elísabet Amorós Graciá[1], **María Rueda-Extremera**[2], **María Cantero García**[3*]

https://dx.doi.org/10.5209/psic.108432 Recibido: 30 de septiembre de 2025 / Aceptado: el 1 de marzo de 2026

Abstract: Background: Informal caregivers of patients in advanced or terminal stages of illness frequently experience high psychosocial burden, including anxiety, depressive symptoms, and reduced quality of life. Although family support is a core component of palliative care, psychosocial interventions specifically targeting informal caregivers remain limited. Aim: To systematically review the impact of psychosocial support interventions delivered to informal caregivers of adult palliative care patients on emotional outcomes, caregiver burden, and quality of life, and to synthesize caregivers' perceptions and experiences of the support received. Method: A systematic review was conducted in accordance with PRISMA 2020. Searches were performed in ProQuest, PubMed, Web of Science, and PubMed Central for studies published in English or Spanish between 2014 and 2024. Quantitative, qualitative, and mixed-methods studies evaluating psychosocial interventions for informal caregivers or providing them with structured access to psychosocial support were included. Results: Ten studies met inclusion criteria. Multicomponent interventions—particularly those addressing the patient–caregiver dyad or integrating caregivers into patient-centered programs—showed favorable effects on depressive symptoms, anxiety, caregiver burden, and/or quality of life. Caregivers reported emotional validation, improved coping strategies, and a sense of support. Remote delivery formats (telephone, online platforms) were feasible and acceptable. Conclusions: Psychosocial interventions that actively involve informal caregivers are associated with meaningful benefits and positive subjective experiences. Future research should prioritize methodologically robust designs and explicitly address grief and bereavement when relevant.

Keywords: Palliative care, caregivers, family members, psychosocial intervention, terminal care.

* Dirección de correspondencia: María CanteroGarcía. Facultad de Psicología y Ciencias de la Salud, Universidad a Distancia de Madrid (UDIMA). A6, 15, 28400 Collado Villalba, Madrid, España. E-mail: maria.canterogar@gmail.com

1 Elísabet Amorós Graciá. Facultad de Psicología y Ciencias de la Salud, Universidad a Distancia de Madrid (UDIMA), Collado Villalba, Madrid, España.
E-mail: elilijo@gmail.com

2 María Rueda-Extremera. Facultad de Psicología y Ciencias de la Salud, Universidad a Distancia de Madrid (UDIMA), Collado Villalba, Madrid, España. ORCID: 0000-0003-4682-6695
E-mail: maria.rueda@udima.es

3 María Cantero-García. Facultad de Psicología y Ciencias de la Salud, Universidad a Distancia de Madrid (UDIMA), Collado Villalba, Madrid, España. ORCID: 0000-0002-7716-2257
E-mail: maria.canterogar@gmail.com

ESP Impacto de las intervenciones de apoyo psicosocial en cuidadores informales de pacientes en cuidados paliativos: una revisión sistemática

ESP**Resumen:** Introducción: Los cuidadores informales de personas en fase avanzada o terminal suelen experimentar una elevada sobrecarga psicosocial, con síntomas de ansiedad, depresión y deterioro de la calidad de vida. A pesar de que los cuidados paliativos incluyen la atención familiar, las intervenciones psicosociales dirigidas específicamente al cuidador informal son todavía limitadas. Objetivo: analizar, mediante una revisión sistemática, el impacto de las intervenciones de apoyo psicosocial dirigidas a cuidadores informales de adultos en cuidados paliativos sobre variables emocionales, carga del cuidador y calidad de vida, y sintetizar las percepciones y experiencias de los cuidadores respecto al apoyo recibido. Método: Revisión sistemática conforme a PRISMA 2020. Se buscaron estudios en ProQuest, PubMed, Web of Science y PubMed Central (2014–2024) en español e inglés. Se incluyeron estudios cuantitativos, cualitativos y mixtos que evaluaran intervenciones psicosociales dirigidas a cuidadores o que les ofrecieran acceso estructurado a apoyo psicosocial en contexto paliativo. Resultados. Se incluyeron 10 estudios. Las intervenciones multicomponente —especialmente las dirigidas a la díada paciente–cuidador o que integraban activamente al cuidador en programas centrados en el paciente— mostraron efectos favorables en la reducción de síntomas depresivos y ansiosos, en la disminución de la carga del cuidador y/o en la mejora de la calidad de vida. Los cuidadores valoraron positivamente el apoyo recibido, destacando la validación emocional, el aprendizaje de estrategias de afrontamiento y la sensación de acompañamiento. Las modalidades a distancia (teléfono, plataformas online) resultaron factibles y aceptables. Conclusiones: Las intervenciones psicosociales que incorporan activamente al cuidador informal en cuidados paliativos se asocian a beneficios relevantes. Se recomienda mejorar la calidad metodológica de futuros estudios y definir explícitamente la inclusión del duelo y la atención al proceso de pérdida cuando proceda.
Palabras clave: Paliativos, cuidadores, familiares, intervención psicosocial, cuidados al final de la vida

Cómo citar: Amorós-Graciá E, Rueda-Extremera M, Cantero-García M. Impact of psychosocial support interventions for informal caregivers of palliative care patients: a systematic review. Psicooncología 2026; 23; 121-134. https://dx.doi.org/10.5209/psic.108432

1. Introduction

Palliative care encompasses a range of interventions aimed at providing comprehensive support to individuals with terminal illnesses, focusing on enhancing their physical, psychological, and spiritual well-being while alleviating suffering and improving quality of life for both patients and their families[1,2]. Globally, around 40 million people require such care each year, a number exe pected to rise with population aging and the growing prevalence of non-communicable diseases[1]. Cardiovascular diseases and cancer account for most adult cases, although many chronic and neurological conditions also necessitate palliative services[1]. It is crucial to adopt a holistic approach to palliative care that extends beyond the individual patient, recognizing the impact of illness on families and incorporating psychological and spiritual support as essential components of care, rather than solely addressing physical symptoms.

Family members frequently act as primary caregivers, assuming emotional, practical, and financial responsibilities[3]. This role is associated with psychosocial strain—denial, anger, frustration, ambivalence[4,5]—and adverse outcomes such as fatigue, sleep disturbances, emotional

distress, anxiety, and depression[6–9]. Caregiving may also generate dysfunctional dynamics, including overprotection, caregiver burden, and silence around illness[10]. Moreover, families often lack preparation to cope with end-of-life uncertainty and anticipatory grief, despite bereavement support being a core component of palliative care[11–15].

Consequently, addressing caregivers' needs is essential. Psychosocial support and information provision are recognized as key elements of palliative care[16]. Interventions typically combine psychoeducation, skills training, and therapeutic counseling targeting coping, communication, relational issues, and bereavement[17]. Evidence indicates that multi-component, self-care-oriented programs improve psychosocial outcomes and reduce depressive symptoms[8,18–20]. Third-generation therapies—such as Acceptance and Commitment Therapy, mindfulness, and attentional training—also show promise in reducing psychological distress[13–15,21].

This systematic review examines psychosocial interventions for informal caregivers in palliative care, evaluates their effectiveness, and analyzes their impact on depression, anxiety, quality of life, caregiver burden, and grief. Additional indicators of emotional well-being are considered. Through a systematic, evidence-based approach[22], the review aims to derive recommendations to guide the development of tailored interventions that mitigate caregiver distress during end-of-life care.

2. Method

Information Sources

As part of the study planning, the search strategy was prospectively registered in the Open Science Framework (OSF)[23]. A systematic literature search was conducted in the databases ProQuest, PubMed, Web of Science, and PubMed Central (PMC). The search included peer-reviewed articles published in English and Spanish between 2014 and 2024, with the last search carried out on November 16, 2024. The review process was conducted in accordance with the PRISMA 2020 guidelines[24].

Search Strategy

The search strategy was developed using the PICO(s) framework (Population, Intervention/Exposure, Comparison, Outcomes, Study design) to ensure conceptual and methodological coherence (Table 1). Controlled vocabulary (e.g., MeSH terms) and free-text keywords were combined. Search terms included Spanish descriptors (*cuidados paliativos, cuidadores, apoyo psicosocial, ansiedad, depresión, duelo*) and their English equivalents *(palliative care, hospice care, caregivers, psychosocial support, psychosocial intervention, anxiety, depression, grief*). Boolean operators (AND, OR, NOT) were applied to refine the search. The complete search equations used for each database are presented in Table 3.

Table 1. Description of the PICO(s) Strategy

P *Patient*	Informal caregivers of adult patients in palliative care.
I *Intervention*	Interventions that include psychosocial support.
C *Comparison*	Absence of psychosocial support interventions for informal caregivers.
O *Outcome*	Subjective improvement in caregivers' emotional well-being, quality of life, or "*sense of preparedness*" Reduction in depressive symptoms, anxiety, stress, and/or caregiver burden.
(S) *Study*	Empirical studies (quantitative, qualitative, or mixed-methods).

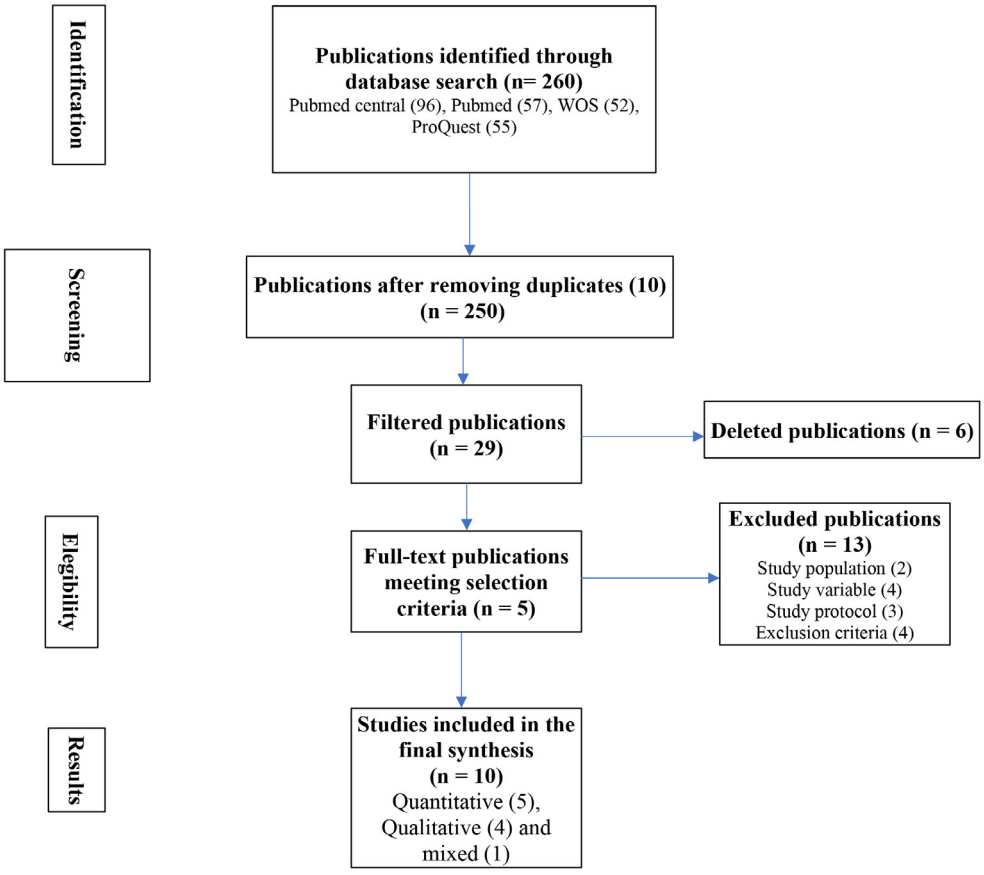
Selection Process

The search yielded 260 records across all databases. After duplicate removal, 10 unique studies remained for screening. Titles and abstracts were independently reviewed according to

predefined inclusion and exclusion criteria (Table 2). Full-text assessment was subsequently performed to confirm eligibility. Discrepancies during the selection process were resolved through discussion and consensus among the reviewers. The study selection process is illustrated in the PRISMA flow diagram (Figure 1).

Table 2. Selection Criteria

Inclusion Criteria	Exclusion Criteria
Studies conducted between 2014 and 2024.	Interventions that do not include psychosocial support.
The intervention includes the informal caregiver of individuals in palliative care or with severe illness.	Family members did not have access to psychosocial support.
Both caregiver and patient were over 18 years old.	Interventions targeting families of children in pediatric palliative care.
Psychosocial support intervention for a family member or caregiver.	Systematic reviews or opinion articles.
Quantitative, qualitative, or mixed-method studies.	Samples not related to palliative care or terminal severe illness.



From: Moher et al.[25]

Figure 1. PRISMA-based Systematic Review Process Flowchart)[25]

Data Extraction Process

Data extraction was conducted using a standardized and piloted extraction form developed specifically for this review. Two reviewers independently extracted data from each included study. Extracted variables included: author(s), year of publication, country, study design, sample characteristics, psychosocial variables assessed, measurement instruments, key findings, and reported limitations. Any inconsistencies in extracted data were discussed and resolved through consensus to ensure accuracy and methodological rigor.

Risk of Bias Assessment

The methodological quality and risk of bias of the included studies were assessed using tools appropriate to the study design. Qualitative studies were evaluated using standardized qualitative appraisal criteria, while mixed-methods studies were assessed using corresponding mixed-methods quality assessment frameworks. Risk of bias was considered in the interpretation of findings but did not constitute grounds for exclusion, in line with PRISMA recommendations.

Table 3. Sources and Search Strategies

Database	Search Equation	Number of references found
Web of Science	*palliative care* (Topic) AND *caregivers* (Topic) AND *psychosocial support* (Topic) AND (*depression* OR *anxiety* OR *grief*) (Topic) NOT *child* (Topic) Filters**:** 2014-2024, Open Acces, Article, Exclude Review Article, Spanish and English	52
Proquest	*cuidados paliativos* AND *cuidadores* AND *apoyo psicosocial* AND (*ansiedad* OR *depresión* OR *duelo*) Filters**:** 2014-2024, Article, Spanish and English	55
Pubmed	(“*palliative care*” OR “*hospice care*”) AND (*caregivers* OR *family*) AND (“*psychosocial support*” OR “*psychosocial intervention*”) Filters**:** In the last 10 years, Free full text, English, Spanish, Adult: 19+years	57
Pubmed Central	(“*palliative care*”) AND (*caregivers*) AND (“*psychosocial support*”) AND (*anxiety* OR *depression* OR *grief*) NOT (*child*) NOT (*systematic review*) Filters: 2014-2024, Open Access	96

3. Results

Study characteristics

A total of 10 studies were included in this systematic review. Eligible studies were those in which informal caregivers of patients receiving palliative care were either the primary recipients of a psychosocial intervention or had structured access to psychosocial support as part of an intervention primarily targeting the patient. Interventions were included provided that caregiver-related outcomes or experiences were explicitly assessed and reported.

Of the included studies, eight focused directly on caregivers as primary recipients of the intervention, whereas two implemented patient-centered interventions in which caregivers had formal access to psychosocial, emotional, or spiritual support. Regarding study design, five studies employed quantitative methodologies, four used qualitative approaches, and one applied a mixed-methods design (Table 4). Table 5 presents the characteristics of the studies and the intervention outcomes.

Table 4. General Classification of Studies

Study Type	Authors (ref)	Type of Psychosocial Intervention / Professional Applying It	Targeted at	Patient Diagnosis in Palliative Care
Quantitative	DionneOdom et al.[26]	ENABLE telephone-based support / Nurses	Only Caregiver	Advanced Heart Failure
Quantitative	Mosher et al.[27]	Acceptance and Commitment Therapy (ACT) / Psychologists	Patient & Caregiver	Lung Cancer
Quantitative	Badr et al.[28]	Telephone problem-solving and coping support / Mental health professionals	Patient & Caregiver	Advanced Lung Cancer
Quantitative	Milbury et al.[29]	Couplesbased meditation vs expressive support / Psychologist	Patient & Caregiver	Lung Cancer
Quantitative	Ibrahim et al. [30]	Holistic palliative rehabilitation (exercise, psychoeducation, spiritual) / Trained counselors	Patient & Caregiver	Terminal Cancer
Qualitative	Olesen et al.[31]	EMBRACE group (psychoeducation, mindfulness) / Nurse & family therapist	Only Caregiver	ALS
Qualitative	De Wit et al.[32]	Multicomponent caregiver program (group + psychoeducation) / Psychologist	Only Caregiver	ALS
Qualitative	Lion et al.[33]	TeleMAST online support / Unspecified professionals	Patient & Caregiver	HighGrade Glioma
Qualitative	Zomerdijk et al.[34]	Early palliative care with caregiver access to psychosocial support / Palliative care team	Caregiver access	Thoracic Cancer
Mixed	Borelli et al.[35]	Early palliative care with periodic psychosocial support / Physician, fellow, nurse	Caregiver access	Cancer

Note: **ACT:** Acceptance and Commitment Therapy; **PC:** Palliative Care; **ALS**: Amyotrophic Lateral Sclerosis; **CI**: Cognitive and Behavioral Impairment; **PMA**: Progressive Muscular Atrophy

Table 5. Intervention outcomes

DionneOdom et al.[26]	Quasiexperimental / quantitative	ENABLE telephone / Nursing team	Only caregivers	No significant QoL changes; focus on selfcare and stress management
Mosher et al.[27]	Randomized trial	ACT (Acceptance and Commitment Therapy) / Psychologists	Patient + caregiver	Moderate effect on illness acceptance; mixed anxiety/distress results
Badr et al.[28]	Randomized trial	Telephone problem-solving and coping support / Mental health professionals	Patient + caregiver	Significant reductions in depression and caregiver burden

Milbury et al.[29]	Randomized trial	Couples meditation vs expressive support / Psychologist	Patient + caregiver (couples)	Significant reduction in depressive symptoms; improved spiritual well-being
Ibrahim et al.[30]	Quasiexperimental	Holistic palliative rehabilitation (exercise, psychoeducation, spiritual) / Trained counselors	Patient + caregiver	Reduced depression and anxiety; improved quality of life
Olesen et al.[31]	Qualitative	EMBRACE group (psychoeducation, mindfulness) / Nurse & family therapist	Only caregivers (ALS)	Emotional validation; coping strategies; sense of accompaniment
De Wit et al.[32]	Qualitative	Multicomponent caregiver program (groups + psychoeducation) / Psychologist	Only caregivers (ALS)	Caregiver-centred space; improved emotional management and communication
Lion et al.[33]	Qualitative	TeleMAST online support / Unspecified professionals	Patient + caregiver	Remote support acceptable; practical and emotional aid for glioma caregivers
Zomerdijk et al.[34]	Qualitative	Early palliative care with psychosocial support / Palliative care team	Caregiver access to support	Informational clarity and perceived support; emotional relief linked to patient stabilization
Borelli et al.[35]	Mixed	Early palliative care with periodic psychosocial support / Physician, fellow, nurse	Caregiver access to support	Temporal shifts in emotional representations; narratives reflecting emotional support and meaning

Note: **N**=Sample size; **W**=Female participants; **M**=Male participants; **PROMIS**=Patient-Reported Outcomes Measurement Information System; **ACT**=Acceptance and Commitment Therapy; **GE**=Experimental Group; **GC**=Control Group; **CV**=Quality of Life; **HADS**=Hospital Anxiety and Depression Scale; **SF-36**=Health Survey Scale; **CBI**=Caregiver Burden Inventory; **BAI**=Beck Anxiety Inventory; **PC**=Palliative Care; **UMC**=Usual Medical Care; **BCOS**=Bakas Caregiving Outcome Scale; **MBCB**=Montgomery-Borgatta Caregiving Burden; **TFA**=Theoretical Framework of Acceptability; **ALS**=Amyotrophic Lateral Sclerosis; **DS**=Depressive Symptoms; **BE**=Emotional Well-being; **ZBI**=Zarit Burden Interview; **MOSS**=Medical Outcomes Study Social Support Survey; **CBM**=Couple-Based Meditation; **CES-D**=Center for Epidemiological Studies Depression Scale; **IES**=Impact of Events Scale; **PMA**=Progressive Muscular Atrophy; **CI**=Cognitive and/or Behavioral Impairment; **COREQ**=Consolidated Criteria for Reporting Qualitative Research; **PHQ-7**=Patient Health Questionnaire-7; **GAD-7**=Generalized Anxiety Disorder-7 Scale; **FARMCARE-2**=Family Carer Satisfaction with Palliative Care scale.

Among quantitative studies, depression (n = 5) and anxiety (n = 4) were the most frequently assessed outcomes. Quality of life and caregiver burden were each evaluated in three studies (n = 3). Additional outcome variables included illness acceptance, general distress, cancer-related stress, and spiritual well-being. Only one intervention exclusively targeted caregivers (26), while the remaining quantitative studies (n = 4) evaluated interventions delivered to both patients and caregivers.

The qualitative studies (n = 4) explored caregivers' experiences either with specific psychosocial interventions (n = 2) or with access to support during early palliative care for their relative (n = 2). Data were collected primarily through semi-structured interviews. Topics addressed included

awareness of the illness trajectory, perceived control or manageability, emotional validation, meaning-making related to the end-of-life process, quality of communication with patients and healthcare professionals, access to practical and psychosocial support, and coping strategies for the future, including bereavement-related processes. Two qualitative interventions were designed exclusively for caregivers[31,32], whereas the remaining studies focused primarily on patients while allowing caregivers access to psychosocial support.

One study[35] applied a mixed-methods design, conducting qualitative analyses of semi-structured interviews with caregivers and subsequently performing a quantitative analysis of word frequency within participants' narratives. The intervention was primarily patient-focused, with caregivers receiving periodic psychosocial, emotional, and spiritual support through interactions with the palliative care team.

Methodological Quality and Risk of Bias

Methodological quality of randomized controlled trials was assessed using the PEDro Scale. Four studies were evaluated using this tool[26–29]. One study obtained a score of 9[27], two studies scored 8[26,28], and one study scored 7[29]. None of the studies met Criterion 6 (blinding of therapists) (Table 6).

Table 6. Methodological Quality Results

	PEDro Scale											
Articles	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total score**
Dionne-Odom et al. [26]	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	8
Mosher et al. [27]	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	9
Badr et al. [28]	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	8
Milbury et al. [29]	Yes	Yes	Yes	Yes	-	No	No	No	Yes	Yes	Yes	7

Note. **1.** The selection criteria were specified; **2.** The subjects were randomly assigned to the groups; **3.** The allocation was concealed; **4.** The groups were similar at the start concerning the most important prognostic indicators; **5.** All subjects were blinded; **6.** All therapists who administered the therapy were blinded; **7.** All evaluators who measured at least one key outcome were blinded; **8.** Measures of at least one of the key outcomes were obtained from more than 85% of the subjects initially assigned to the groups; **9.** Results from all subjects who received treatment or were assigned to the control group were reported, or when this was not possible, data for at least one key outcome were analyzed by "intention to treat"; **10.** The results of statistical comparisons between groups were reported for at least one key outcome; **11.** The study provides point estimates and measures of variability for at least one key outcome.

The JBI Critical Appraisal Checklist was applied to the five studies using qualitative methodologies, including the mixed-methods study by Borelli et al.[35]. Three studies achieved the maximum quality score[32–34], while the remaining two scored 9[31] and 8[35], respectively. Two studies reported an underrepresentation of male caregivers[31,33]. In the remaining studies, participant samples were predominantly female. Two studies reported that the interval between intervention completion and qualitative interviews varied (Table 7). The study by Ibrahim et al.[30] was not included in previous assessments because it used a quasi-experimental design. According to the JBI checklist for quasi-experimental studies, four of nine criteria were clearly met: the causal relationship was defined, outcomes were measured reliably, follow-up was completed, and appropriate statistical analyses were used. Other criteria were not applicable due to the lack of a control group or comparable groups, or could not be assessed because repeated outcome measurements were not reported.

Table 7. Methodological Quality Results (JBI)

	Verification of critical appraisal for JBI										
Articles	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**To include**
Olesen et al.[31]	Yes	Yes	Yes	Yes	Yes	Not clear	Yes	Yes	Yes	Yes	Yes (9)
De Wit et al.[32]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (10)
Lion et al.[33]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (10)
Zomerdijk et al.[34]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (10)
Borelli et al.[35]	Yes	Yes	Yes	Yes	Yes	Not clear	Not clear	Yes	Yes	Yes	Yes (8)

Note: **1.** Consistency between the philosophical perspective and the research methodology. **2.** Consistency between the research methodology and the research question or objectives. **3.** Consistency between the research methodology and the methods used to collect data. **4.**Consistency between the research methodology and the representation and analysis of data. **5.** Consistency between the research methodology and the interpretation of the results. **6.** Is there a statement that situates the researcher culturally or theoretically? **7.** Does it address the influence of the researcher on the research, and vice versa? **8.** Are the participants and their voices appropriately represented? **9.**Is the research ethical, or is there evidence of ethical approval from an appropriate body? **10.** Do the conclusions arise from the analysis or interpretation of the data?

Types of Studies and Interventions

Quantitative Studies

Quantitative studies employed experimental or quasi-experimental designs to evaluate the effects of psychosocial interventions, including telehealth-based support, Acceptance and Commitment Therapy (ACT), mindfulness-based meditation, and holistic palliative rehabilitation programs.

Dionne-Odom et al.[26] and Badr et al.[28] evaluated telephone-based psychosocial interventions for caregivers of patients with heart failure and advanced lung cancer, respectively. Both interventions included structured sessions focused on problem-solving, stress management, coping strategies, and decision-making support.

Mosher et al.[27] examined an ACT-based intervention delivered to patients with lung cancer and their caregivers, focusing on psychological flexibility and acceptance processes. Milbury et al.[29] compared a couples-based meditation intervention with an expressive support group and standard care. Ibrahim et al.[30] implemented a holistic palliative rehabilitation program integrating physical exercise, psychoeducation, and spiritual support.

Qualitative Studies

Qualitative studies examined caregivers' experiences of psychosocial support programs delivered through digital platforms or professional interactions. Olesen et al.[31] and De Wit et al.[32] evaluated caregiver-focused interventions for individuals caring for patients with amyotrophic lateral sclerosis (ALS), incorporating group meetings, psychoeducation, mindfulness exercises, and professional guidance.

Lion et al [33] explored caregivers' experiences following participation in the Tele-MAST program, an online intervention for caregivers of patients with high-grade glioma. Zomerdijk et al.[34] examined caregivers' perceptions of early access to palliative care for patients with advanced thoracic cancer, focusing on informational clarity and support availability.

Mixed-Methods Study

Borelli et al.[35] conducted a mixed-methods study analyzing temporal changes in caregivers' emotional and cognitive representations of illness following early palliative care access. Quantitative

word-frequency analyses were used to complement qualitative findings. Although the intervene tion primarily targeted patients, caregivers received ongoing psychosocial, emotional, and spiritual support.

Effects of Interventions

Quantitative Outcomes

Depression or depressive symptoms. Significant reductions in depressive symptoms were observed in three studies: Ibrahim et al.[30] ($p < 0.05$), Badr et al.[28] ($p = 0.01$), and Milbury et al.[29] ($p < 0.01$).

Anxiety, general distress, or cancer-related stress.- Significant reductions in anxiety were reported by Ibrahim et al.[30] ($p < 0.05$) and Badr et al.[28] ($p = 0.02$; $d = –1.3$). No significant effects were found for cancer-related stress in Milbury et al.[29] ($p = 0.73$), nor for anxiety and general distress in Mosher et al.[27] (prs = 0.02–0.05) or Dionne-Odom et al.[26] ($p = 0.88$).

Quality of life.- Improvements in quality of life were reported by Ibrahim et al.[30] ($p < 0.05$), whereas no significant changes were observed in Dionne-Odom et al.[26] ($p = 0.88$).

Caregiver burden.- Badr et al.[28] reported significant reductions in caregiver burden ($p < 0.001$). No significant effects were observed in Dionne-Odom et al.[26] ($p > 0.99$).

Other outcomes.- Mosher et al.[27] reported a moderate effect on illness acceptance (prs = 0.38). Milbury et al.[29] reported a statistically significant difference in spiritual well-being between intervention and standard care groups ($p = .07$).

Qualitative Outcomes

Qualitative studies reported caregivers' accounts of their experiences with psychosocial interventions and access to support. Findings included descriptions related to emotional experiences, coping strategies, perceived support, communication, and illness-related understanding.

In caregiver-focused interventions[31,32], participants described experiences related to psychoeducation, peer interaction, professional support, emotional responses, and coping strategies. In studies involving digital interventions or early palliative care access[33,34], caregivers described experiences related to practical support, emotional support, and information provision. In the mixed-methods study[35], caregivers' narratives were characterized using qualitative themes and quantitative word-frequency analyses, including emotional and temporal language categories. Table 5 presents the characteristics of the studies and the intervention outcomes

4. Discussion and conclusions

Main Findings

The findings of this systematic review indicate that most psychosocial interventions (n = 7) primarily target the patient–caregiver dyad and report meaningful positive outcomes. These interventions were effective in reducing depressive symptoms[29], as well as depression, anxiety, and caregiver burden[28,30], and in promoting disease acceptance[27]. Several studies further highlight the reciprocal nature of patient and caregiver well-being. Specifically, Zomerdijk et al.[34] and Lion et al.[33] observed that caregivers experienced relief and emotional improvement when the patient's condition stabilized or improved. This interdependence between patient and caregiver quality of life has also been emphasized by Kim et al.[36], reinforcing the relevance of dyadic approaches in palliative care.

At the same time, qualitative findings from group-based interventions such as EMBRACE[31] and the program developed by De Wit et al.[32] underscore the importance of providing caregivers with spaces exclusively focused on their own needs. These interventions, involving caregivers of individuals with amyotrophic lateral sclerosis (ALS), highlight how progressive and degenerative conditions generate specific psychosocial demands. Similarly, Lion et al.[33] note that caregivers of

patients with high-grade gliomas present distinct support needs. Taken together, these findings suggest that interventions combining dyadic and individual caregiver-focused components may be particularly appropriate.

Comparison with Previous Literature

The effectiveness of multi-component interventions observed in this review aligns with previous evidence. Programs incorporating multiple psychosocial components (26,28,30) yielded significant improvements in depression, anxiety, quality of life, and caregiver burden, or enhanced perceived control and acceptance[32]. These results are consistent with earlier reviews highlighting the benefits of comprehensive psychosocial interventions for caregivers (8,18,19).

Across the studies reviewed, intervention content clustered around five core domains: (1) development of self-care strategies and resource mobilization skills[26,28,31,32]; (2) enhancement of communication and emotional expression skills[28–32,34,35]; (3) mindfulness-based practices[27,29,31,32]; (4) exploration of personal values to facilitate acceptance and decision-making[26,27,29,32]; and (5) access to spiritual and existential support[26,29,30,33–35]. These domains reflect a growing consensus in the literature that caregiver interventions should move beyond purely informational approaches and address deeper emotional and existential dimensions of caregiving.

Despite the centrality of grief in palliative care, this review identified a notable gap: although grief-related processes were indirectly addressed through values clarification and spiritual support (domains 4 and 5), none of the interventions explicitly targeted grief or extended support beyond the patient's death. This finding contrasts with existing recommendations that identify bereavement support as a core element of palliative care for families[37].

Clinical Implications

The results of this review suggest several implications for clinical practice. First, psychosocial interventions that involve both patients and caregivers appear particularly beneficial, given the reciprocal influence of their well-being. However, exclusive caregiver-focused interventions remain essential, especially in conditions characterized by rapid deterioration or prolonged dependency. Second, multi-component interventions addressing emotional regulation, mindfulness, values, and existential concerns seem especially promising and should be prioritized in clinical settings.

The positive evaluation of remote intervention formats (telephone or online delivery) across studies highlights their feasibility and suitability for caregivers, who often face significant time constraints. This modality may facilitate broader implementation and improve access to psychoe social support within palliative care services.

Strengths and Limitations

A key strength of this systematic review lies in its specific focus on interventions that prioritize caregivers' psychosocial needs, an area that remains underrepresented in palliative care research[26]. Additionally, the emphasis on emotional and psychological dimensions—rather than solely educational or instructional components commonly found in other interventions[39]—highlights the importance of integrating psychological well-being into caregiver support programs.

However, several limitations must be acknowledged. The restricted number of databases consulted and the specific search strategy employed limit the representativeness of the sample, resulting in partial and non-generalizable findings. Furthermore, the inclusion of caregivers supporting patients with heterogeneous diagnoses introduces variability in caregiver needs and experiences. Only four of the included studies were randomized controlled trials[26–29], limiting the ability to draw firm conclusions regarding intervention efficacy. Other studies, such as those by Borelli et al.[35] and Zomerdijk et al.[34], provide valuable descriptive insights but lack robust outcome data.

Implications for Future Research

Future research should prioritize the development and evaluation of rigorously designed randomized controlled trials focusing explicitly on caregivers in palliative care. Greater diagnostic

homogeneity would allow for more precise identification of caregiver needs and intervention effects. Additionally, the systematic integration of grief-focused components—both before and after the patient's death—represents a critical gap to be addressed. Further exploration of hybrid intervention models combining dyadic and individual caregiver components is warranted. Finally, the continued refinement of remote and personalized interventions may enhance feasibility, scalability, and responsiveness to caregivers' evolving needs throughout the palliative care trajectory

5. References

1. World Health Organization (WHO). Cuidados paliativos. (Accessed October 26, 2024]. Available from: https://www.who.int/es/news-room/fact-sheets/detail/palliative-care. 2020.
2. Sociedad Española de Cuidados Paliativos. SECPAL. 2024 (Accessed October 26, 2024] Available from: https://www.secpal.org/
3. Adejoh SO, Boele F, Akeju D, Dandadzi A, Nabirye E, Namisango E, Namukwaya E, Ebenso B, Nkhoma K, Allsop MJ. The role, impact, and support of informal caregivers in the delivery of palliative care for patients with advanced cancer: A multi-country qualitative study. Palliat Med 2021;35:552-62. https://doi.org/10.1177/0269216320974925.
4. Northouse L, Williams AL, Given B, McCorkle R, Netter FH. Psychosocial care for family caregivers of patients with cancer. J Clinic Oncol 2012;30:1227-34. https://doi.org/10.1200/JCO.2011.39.5798.
5. Muñoz Cobos F, Espinosa Almendro J, Portillo Strempell J, Benítez del Rosario, JM. Atención a la familia. Aten Prim 2002;30:576 https://doi.org/10.1016/s0212-6567(02)79109-9
6. Haun MW, Sklenarova H, Brechtel A, Herzog W, Hartmann M. Distress in cancer patients and their caregivers and association with the caregivers' perception of dyadic communication. Oncol Res Treat 2014;37:384-8. https://doi.org/10.1159/000364885.
7. Hernández-Zambrano SM, Melo ML, Tello SS, García IJ, Rozo KDS, Algarra AJC, Valero KAR. Necesidades de cuidado paliativo en hemodiálisis percibidas por pacientes, cuidadores principales informales y profesionales de enfermería. Enf Nefrol 2019;22:141-9. https://doi.org/10.4321/s2254-28842019000200005.
8. Hudson PL, Remedios C, Thomas K. A systematic review of psychosocial interventions for family carers of palliative care patients. BMC Palliat Care. 2010;9:17. https://doi.org/10.1186/1472-684X-9-17
9. Kim Y, Duberstein PR, Sörensen S, Larson MR. Levels of depressive symptoms in spouses of people with lung cancer: effects of personality, social support, and caregiving burden. Psychosom 2005;46:123-30. https://doi.org/10.1176/appi.psy.46.2.123.
10. Cuesta M. Abordaje familiar en los Cuidados Paliativos Family approach in Palliative Care. Family approach in Palliative Care. Rev Dig Med Psicosom Psicot 2021;11:13-6.11.
11. Bambague G, Chavarro BCD, Arenas DV, Oliveros SG. Anticipatory grief in relatives of palliative care patients. Gac Méd de Caracas 2023;131:501-8. https://doi.org/10.47307/GMC.2023.131.3.3.
12. Zhu Y, Pei X, Chen X, Li T. Family caregivers' experiences of caring for advanced cancer patients: a qualitative systematic review and meta-synthesis. Cancer Nursing 2023;46:270-83. https://doi.org/10.1097/NCC.0000000000001104.
13. Đorđević D, Garnier J, van Mackelenbergh T, Seitz S, Mundhenke C. The impact of online yoga on sleep and quality of life in women with breast cancer: a randomized trial. Arch Gynec Obst 2024;310:571-5. https://doi.org/10.1007/s00404-024-07563-6.
14. Kroemeke A, Dudek J, Kijowska M, Owen R, Sobczyk-Kruszelnicka M. The effect of an online acceptance and commitment intervention on the meaning-making process in cancer patients following hematopoietic cell transplantation: Study protocol for a randomized controlled trial enhanced with single-case experimental design. Trials. 2024;25(1). https://doi.org/10.1186/s13063-024-08235-1.
15. Trindade IA, Soares A, Skvarc D, Carreiras D, Pereira J, Lourenço Ó, et al. Efficacy and cost-effectiveness of an ACT and compassion-based intervention for women with breast cancer: study protocol of two randomised controlled trials. Trials 2025;26(1):5. https://doi.org/10.1186/s13063-024-08626-4.

16. Soikkeli-Jalonen A, Mishina K, Virtanen H, Charalambous A, Haavisto E. Healthcare professionals' perceptions of psychosocial support for family members in palliative care inpatient units—A qualitative descriptive study. Nurs Op 2023;10:3018-27. https://doi.org/10.1002/nop2.1548.
17. Northouse LL, Katapodi MC, Song L, Zhang L, Mood DW. Interventions with family caregivers of cancer patients: Meta-analysis of randomized trials. CA: Canc J Clinic 2010;60:317. https://doi.org/10.3322/CAAC.20081.
18. Becqué YN, van der Wel M, Aktan-Arslan M, Driel AG van, Rietjens JAC, van der Heide A, Witkamp E. Supportive interventions for family caregivers of patients with advanced cancer: A systematic review. Psychooncology 2023;32:663-81. https://doi.org/10.1002/pon.6126.
19. Fu F, Zhao H, Tong F, Chi I. A systematic review of psychosocial interventions to cancer caregivers. Front Psychol 2017;8. https://doi.org/10.3389/fpsyg.2017.00834.
20. Glajchen M, Goehring A, Johns H, Portenoy RK. Family meetings in palliative care: benefits and barriers. Curr Treat Opt Oncol 2022;23:658-67. https://doi.org/10.1007/s11864-022-00957-1.
21. Rosique MT. Avances en técnicas de intervención psicológica. CEF-Udima. 2021
22. Perestelo-Pérez L. Standards on how to develop and report systematic reviews in Psychology and Health. Int J Clin Health Psychol 2013;13:49-57 https://doi.org/10.1016/S1697-2600(13)70007-3
23. Authors. Impact of support interventions on informal caregivers of palliative care patients: A systematic review. 2025. Retrieved from osf.io/m5esr
24. Yepes-Nuñez JJ, Urrútia G, Romero-García M, Fernández SA. Declaración PRISMA 2020: una guía actualizada para la publicación de revisiones sistemáticas. Rev Esp Cardiol 2021;74:790-9. https://doi.org/10.1016/j.recesp.2021.06.016.
25. Moher D, Liberati A, Tetzlaff, J, Altman, DG. The PRISMA group. Preferred reporting ítems for systematic reviews and meta-analyses: The PRISMA statement. PloS Med 2009;6(7): e1000097. https://doi.org/10.1371/journal.pmed1000097
26. *Dionne-Odom JN, Ejem DB, Wells R, Azuero A, Stockdill ML, Keebler K, et al. Effects of a telehealth early palliative care intervention for family caregivers of persons with advanced heart failure the ENABLE CHF-PC randomized clinical trial. JAMA Netw Op 2020;3(4). https://doi.org/10.1001/jamanetworkopen.2020.2583.
27. *Mosher CE, Secinti E, Hirsh AT, Hanna N, Einhorn LH, Jalal SI, Durm G, Champion VL, Johns SA. Acceptance and Commitment Therapy for symptom interference in advanced lung cancer and caregiver distress: A pilot randomized trial. J Pain Symp Manag 2019;58:632-44. https://doi.org/10.1016/j.jpainsymman.2019.06.021.
28. *Badr H, Smith CB, Goldstein NE, Gomez JE, Redd WH. Dyadit psychosocial intervention for advanced lung cancer patients and their family caregivers: results of a randomized pilot trial. Cancer 2015;121:150-8. https://doi.org/10.1002/cncr.29009.
29. *Milbury K, Li Y, Durrani S, Liao Z, Tsao AS, Carmack C, Cohen L, Bruera E. A mindfulness-based intervention as a supportive care strategy for patients with metastatic non-small cell lung cancer and their spouses: Results of a three-arm pilot randomized controlled trial. Oncolog 2020;25(11):E1794-E1802. https://doi.org/10.1634/theoncologist.2020-0125.
30. *Ibrahim AM, Wahba NMI, Zaghamir DEF, Mersal NA, Mersal FA, Ali RAES, Eltaib FA, Mohamed HAH. Impact of a comprehensive rehabilitation palliative care program on the quality of life of patients with terminal cancer and their informal caregivers: A quasi-experimental study. BMC Nurs 2024;23(1). https://doi.org/10.1186/s12912-024-02028-2.
31. *Olesen LK, la Cour K, With H, Mahoney AF, Handberg C. A cross-sectional evaluation of acceptability of an online palliative rehabilitation program for family caregivers of people with amyotrophic lateral sclerosis and cognitive and behavioral impairments. BMC Health Serv Res 2022;22(1). https://doi.org/10.1186/s12913-022-07986-4.
32. *De Wit J, Vervoort SCJM, Van Eerden E, Van Den Berg LH, Visser-Meily JMA, Beelen A, et al. User perspectives on a psychosocial blended support program for partners of patients with

amyotrophic lateral sclerosis and progressive muscular atrophy: A qualitative study. BMC Psych 2019;7(1). https://doi.org/10.1186/S40359-019-0308-X.

33. *Lion KM, Jamieson A, Billin A, Jones S, Pinkham MB, Ownsworth T. 'It was never about me': A qualitative inquiry into the experiences of psychological support and perceived support needs of family caregivers of people with high-grade glioma. Palliat Med 2024; 38:874-83. https://doi.org/10.1177/02692163241261211.
34. *Zomerdijk N, Panozzo S, Mileshkin L, Yoong J, Nowak AK, Stockler MR, Philip J. Palliative care facilitates the preparedness of caregivers for thoracic cancer patients. Eur J Canc Care 2022; 31(6):e13716. https://doi.org/10.1111/ecc.13716.
35 *Borelli E, Bigi S, Potenza L, Eliardo S, Artioli F, Mucciarini C, et al. Changes in cancer patients' and caregivers' disease perceptions while receiving early palliative care: A qualitative and quantitative analysis. Oncolog 2021;26(12):E2274-E2287. https://doi.org/10.1002/onco.13974.
36. Kim Y, Carver CS, Cannady RS. Caregiving motivation predicts long-term spirituality and quality of life of the caregivers. Ann Beh Med 2015;49:500-9. https://doi.org/10.1007/s12160-014-9674-z.
37. Harrop E, Scott H, Sivell S, Seddon K, Fitzgibbon J, Morgan F, et al. Coping and wellbeing in bereavement: Two core outcomes for evaluating bereavement support in palliative care. BMC Palliat Care. 2020;19(1). https://doi.org/10.1186/s12904-020-0532-4.
38. Miklos AC, Li C, Sorrell CD, Lyon LA, Pielak GJ. An upper limit for macromolecular crowding effects. BMC Biophy. 2011;4(1). https://doi.org/10.1186/2046-1682-4-13.
39. Halkett GKB, Lobb EA, Phillips JL, McDougall E, Clarke J, Campbell R, et al. Carer preparedness improved by providing a supportive educational intervention for carers of patients with high-grade glioma: RCT results. J Neuro-Oncol 2023;161:501-13. https://doi.org/10.1007/s11060-023-04239-0.