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Support interventions for families of people with terminal cancer in palliative care

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Abstract

Objective. The terminal phase of cancer represents a major crisis for the family system. Regardless of the caregiving role they undertake, family members are forced to address multiple impacts when facing the approaching death of their terminally ill loved one. International guidelines recognize the importance of integrating the family into a care plan. However, more needs to be known about how to deliver optimal family support. The purpose of this study is to review the current state of the art in family/caregiver-focused interventions of people with terminal cancer in palliative care.

Method. For this purpose, an overview of the literature's systematic reviews on the topic was conducted to select Randomized Controlled Trials (RCTs) on family/caregiver-focused interventions.

Results. Nine interventions were found in the systematic reviews of literature and meta-analysis. These family/caregiver-focused interventions were then thoroughly and critically analyzed. Despite the heterogeneity with regard to their characteristics, the interventions commonly focused on caregiving matters, were brief in duration, and delivered by non-mental health experts. The efficacy of such interventions was seen as modest.

Significance of results. Family/caregiver-focused interventions in palliative care remain a matter of concern and more research is needed to identify adequate and effective ways of helping families that face the crisis of terminal illness in the system.

Introduction

Cancer is considered a "we-disease" (Kayser et al., 2007) given that it affects not only the patient but also the whole family system and its members (Rolland, 2005; Areia et al., 2017). The terminal phase of a cancer is particularly demanding for the family as a whole (Walsh and McGoldrick, 2004), and for individual family caregivers in particular, who may experience an emotional impact, psychological morbidity, and poor social, financial, spiritual, and physical well-being (Hudson et al., 2012).

In this field, recent studies show that family members of people with terminal cancer are susceptible to increased levels of burden, which may be related to a significant deterioration in quality of life (QoL) (Rha et al., 2015) and to diminished mental health (Chua et al., 2016). It is also worth noting that family members, regardless of their caregiving role (Areia et al., 2019), are likely to show equal or higher levels of psychological morbidity (e.g., depression) when compared with patients (Nipp et al., 2016), and this may be influenced by poorer family functioning (Nissen et al., 2016; Areia et al., 2019).

Recognizing the challenges faced by families in the context of end-of-life and palliative care, the World Health Organization (WHO, 2002) advocates that patient and family should be considered a unit of care, and thus, a goal of palliative care must be identified as the improvement of QoL for families and its respective members. However, more than a decade after the establishment of palliative care guidelines (WHO, 2002), how to offer an optimal support to families in palliative care (Hudson et al., 2012) still remains unclear. Thus, the development and improvement of family/caregiver-focused interventions has become a research priority in palliative care (Hudson and Payne, 2011; Hudson et al., 2011).

Based on this evidence, the present study aims to review the current family/caregiver-focused interventions of people with terminal cancer in palliative care. As a specific goal, we sought to discover, describe and critically analyze these kinds of interventions as they are presented in the recent research literature. To attain this goal, systematic reviews of literature on palliative care psychosocial interventions were conducted, from which we retrieved the most significant family/caregiver-focused examples based on a pre-established criteria described in the next section.

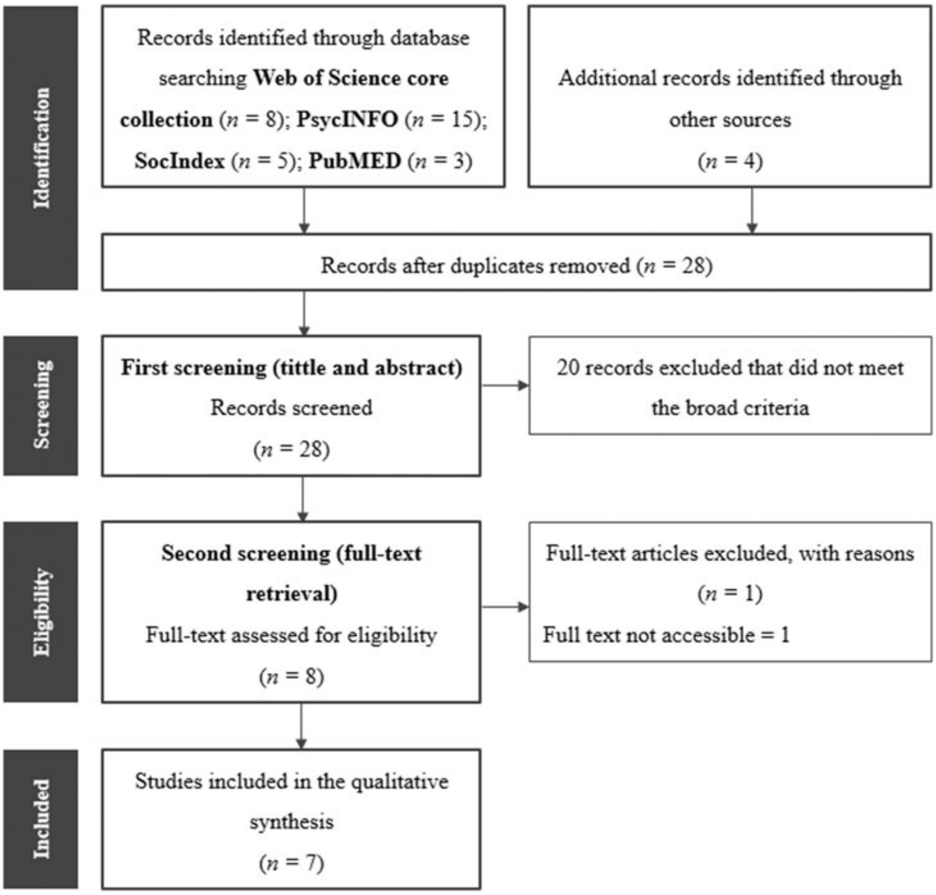

Fig. 1. Flowchart of the systematic reviews of literature studies selection process.

Methods

This study contained three main steps: (1) an overview of systematic reviews of family/caregiver-focused psychosocial interventions in oncology contexts, (2) selection of family/caregiver-focused psychosocial interventions on the palliative care, and (3) analysis of the selected intervention programs. Each step is described below.

Step 1: Overview of systematic reviews

Step 1 consisted of an overview of systematic reviews of family/caregiver-focused psychosocial interventions in oncology contexts. Specifically, it was conducted systematic reviews of literature, considering specific guidelines to properly conduct and report overviews of systematic reviews (see Smith et al., 2011; Li et al., 2012; Lunny et al., 2016) and the PRISMA statement (Moher et al., 2009) (see Supplementary Material).

The systematic review of literature search was conducted in four databases: Web of Science core collection, PsycINFO, SocIndex, and PubMED. The research strategy focused specifically on systematic reviews of literature of family/caregiver-focused psychosocial interventions in oncology contexts, through a combination of the following keywords: [(“systematic review of literature” OR “systematic review”) AND (“psychosocial interventions” OR “support interventions” OR “intervention programs”) AND (family OR caregiver) AND (“palliative care” OR “end-of-life care”)]. Other sources were considered, particularly additional systematic reviews of literature that were cited in other studies.

Following the database searches, duplicated records were identified and removed electronically, through EndNote (Thomson Reuters, USA). A total of 28 non-duplicated records were identified, of which 20 were excluded as clearly did not follow the broad goal of this study. The inclusion criteria for the selected studies were as follows: (a) empirical studies following a systematic review of literature design, conducted according PRISMA guidelines, (b) studies focused on family/caregiver-focused interventions, (c) studies focused on interventions developed for adult-cancer contexts, (d) studies that were published between 2008 and 2018, and (e) studies written in English. From the eight eligible studies for full-text examination, only one was excluded as its full text was not accessible. Therefore, seven systematic reviews of literature were included for further detailed analysis. Figure 1 displays a flowchart of the studies selection process.

Step 2: Selection of family/caregiver-focused psychosocial interventions programs in palliative care

The seven selected systematic reviews of literature were examined in detail to properly identify and select the family/caregiver-focused psychosocial interventions programs that would be analyzed in Step 3. The following inclusion criteria for intervention programs’ selection were taken into account: (1) being a family/caregiver-focused intervention, (2) being delivered in palliative care contexts (home-based and/or hospice), (3) being delivered to caregivers/families of people with advanced/terminal cancer, and (4) interventions whose efficacy was tested through randomized controlled trials.

Step 3: Analysis of the selected family/caregiver-focused psychosocial interventions programs

Step 3 consisted of the analysis of the selected family/caregiver-focused interventions considering the following topics: (1) framework (e.g., psycho-educational, family-centered); (2) format: target, dosage, setting, professionals responsible for delivering the intervention, and the intervention's key elements (e.g., caregiver skills education); and (3) efficacy: outcomes, post-intervention assessment, and overall efficacy.

The topics selected for analysis were defined by two senior members (J.N.G. and A.P.R.) of the research team with relevant clinical expertise in the field. Topics more frequently appearing in the literature which present and evaluate the quality of psychosocial intervention programs were also addressed.

Each intervention was analyzed based on its author's original publication describing the program and evaluating its efficacy.

Results

Overview of systematic reviews and selection of intervention programs

From the systematic reviews of literature, seven studies were identified (Hudson et al., 2010; Northouse et al., 2010; Harding et al., 2011; Applebaum and Breitbart, 2013; Waldron et al., 2013; Chi et al., 2016; Fu et al., 2017) and were indicated by asterisks in the References section.

Nine intervention models met the inclusion criteria for further analysis in the third step of this study (Hudson et al., 2005, 2013; McMillan et al., 2005; Kissane et al., 2006; Walsh et al., 2007; McLean et al., 2013; Mitchell et al., 2013; Northouse et al., 2013; Dionne-Odom et al., 2015).

Table 1 displays the main characteristics of the systematic reviews (e.g., aims, main conclusions) and in which were identified the family/caregiver-focused interventions intervention programs.

Analysis of selected intervention programs

A detailed description of the selected psychosocial interventions is presented in Table 2.

Investigation into the literature yielded the following intervention frameworks: two psycho-educational (Hudson et al., 2005, 2013); one cognitive-behavioral (McMillan et al., 2005); one family-centered, Family-Focused Grief Therapy (FFGT) (Kissane et al., 2006), two dyadic-based, Emotionally Focused Therapy (EFT) (McLean et al., 2013), and FOCUS (Family involvement, Optimistic attitude, Coping effectiveness, Uncertainty reduction, Symptoms management) (Northouse et al., 2013); and three undefined (Walsh et al., 2007; Mitchell et al., 2013; Dionne-Odom et al., 2015).

Regarding the format of the intervention programs, only FFGT (Kissane et al., 2006) targeted the whole family system, whereas all other interventions targeted the individual primary caregivers (Hudson et al., 2005, 2013; McMillan et al., 2005; Walsh et al., 2007; Mitchell et al., 2013; Dionne-Odom et al., 2015) or the dyad patient-caregiver (McLean et al., 2013; Northouse et al., 2013). Most of the interventions were brief in duration, specifically less than six sessions (Hudson et al., 2005, 2013; McMillan et al., 2005; Walsh et al., 2007; Mitchell et al., 2013; Northouse et al., 2013; Dionne-Odom et al., 2015), home-based (Hudson et al., 2005, 2013; Walsh et al., 2007; Northouse et al., 2013) and delivered by nurses (Hudson et al., 2005, 2013; McMillan et al., 2005; Walsh et al., 2007; Northouse et al., 2013; Dionne-Odom et al., 2015). Key elements of intervention models were very heterogeneous. Support, in terms of information (e.g., education for caregiving) was emphasized by Hudson et al. (2005) and Hudson et al. (2013). Coping skills training was the main consideration of McMillan et al. (2005). The intervention model proposed by Walsh et al. (2007) aimed at offering support in several areas (e.g., financial and future planning, information on patient care) without a centralized focus. Mitchell et al. (2013) offered routinely consultations to address and discuss unmet needs. The FFGT (Kissane et al., 2006) focused on family functioning, more specifically, on family cohesion, communication, and conflict resolution. The EFT (McLean et al., 2013) targeted the couple's dynamics. The FOCUS (Northouse et al., 2013) contemplated both information and emotional support. Finally, the ENABLE (Dionne-Odom et al., 2015) privileged problem-solving, communication, decision-making, and advance care planning in its telephone sessions.

Regarding the indicators to evaluate the efficacy, the variables selected to measure the efficacy were not the same across the studies (Figure 2). Caregiving-related outcomes were more frequently evaluated in the selected studies.

All studies assessed the outcomes through questionnaires (e.g., General Health Questionnaire) that aimed to evaluate the investigated constructs (e.g., psychological distress). The data collection time was different for each study. For instance, the shortest follow-up assessment period was one to two weeks of post-intervention in McMillan et al. (2005). The longest post-intervention follow-up assessment was the 13-month period after intervention or patient's death seen in Kissane et al. (2006). Other follow-up assessments lasted no longer than 6 months (Hudson et al., 2005, 2013; McMillan et al., 2005; Walsh et al., 2007; McLean et al., 2013; Mitchell et al., 2013; Northouse et al., 2013; Dionne-Odom et al., 2015).

Regarding the results of the efficacy study, the psycho-educational intervention proposed by Hudson et al. (2005) only proved to be effective in improving caregivers' rewards. FFGT (Kissane et al., 2006) proved to be modestly efficient by reducing distress and depression. The intervention proposed by McMillan et al. (2005) was efficient in improving caregiver QoL and reducing the burden associated with the patient's symptomatology and caregiving tasks. The Walsh et al. (2007) intervention was moderately efficient in reducing only the psychological distress. The psycho-educational intervention proposed by Hudson et al. (2013) showed itself to be effective in increasing caregivers' sense of preparedness and competence. The need-based intervention (Mitchell et al., 2013) demonstrated itself as inefficient in reducing the number and intensity of needs. The EFT showed efficacy in improving marital functioning (McLean et al., 2013). The FOCUS was efficient in improving dyads' coping, self-efficacy, and social QoL and in improving caregivers' emotional QoL (Northouse et al., 2013). Although failing in improving its primary outcome (QoL), the ENABLE proved to be efficient in reducing depression and burden (Dionne-Odom et al., 2015).

Discussion

The terminal phase of a cancer and thus the approaching death of a relative is a major crisis for the family system and its elements (Walsh and McGoldrick, 2004; Rolland, 2005), with disturbing effects on family members (Costa-Requena et al., 2012; Nielsen

Table 1. Summary table of the reviews accounted for the study

Authors (year), Journal, Country	Aim (time frame^a)	Main conclusions	Identified intervention programs
Applebaum and Breitbart (2013), Palliative & Supportive Care, USA	To characterize the state of art of psychosocial interventions for informal cancer caregivers (1980–2011)	Integrative, structured, goal-oriented, and time-limited interventions appear to offer the greatest benefits for informal caregivers	Kissane et al. (2006), McMillan et al. (2005), Walsh et al. (2007)
Chi et al. (2016), American Journal of Hospice and Palliative Medicine, USA	To synthesize behavioral and educational interventions that support family caregivers in end-of-life care (2004–2014)	More RCTs are needed and more tools to assess caregivers' needs. It stresses finding the most efficient intervention format and method	Hudson et al. (2005), McMillan et al. (2005), Hudson et al. (2013)
Fu et al. (2017), Frontiers in Psychology, China	To systematically review the effect of psychosocial interventions on improving QoL, depression, and anxiety of informal caregivers (2011–2016)	Interventions targeting self-care and interpersonal connections of caregivers and symptom management of patients are effective in improving QoL and reducing depression levels in informal caregivers	McLean et al. (2013), Mitchell et al. (2013), Northouse et al. (2013), Dionne-Odom et al. (2015)
Harding et al. (2011), Palliative Medicine, UK	To update the original review of literature (Harding and Higginson, 2003) (2001–2011)	Although an increased number of studies is seen, they are still narrow in scope, only regarding caregiver's needs	Hudson et al. (2005), Walsh et al. (2007)
Hudson et al. (2010), BMC Palliative Care, Australia	To identify developments in family carer support that have occurred in the previous decade (2000–2009)	Psychosocial interventions slightly increased in quality and quantity. More research is required to meet caregivers' needs	Hudson et al. (2005), McMillan et al. (2005), Walsh et al. (2007)
Northouse et al. (2010), CA: A Cancer Journal for Clinicians, USA	To analyze the types of interventions offered to family caregivers of cancer patients (illness phase). To determine the effect of the interventions on caregivers' outcomes (1983–2009)	Interventions reduced caregiver burden and improved positive aspects (e.g., QoL). Clinicians need to deliver valid interventions to help caregivers/patients to cope and to maintain QoL	Hudson et al. (2005), Kissane et al. (2006), McMillan et al. (2005), Walsh et al. (2007)
Waldron et al. (2013), Psycho-Oncology, USA	To estimate the effect of psychosocial interventions on improving QoL of informal caregivers (1947–2011)	Interventions targeting problem-solving and communication skills may reduce burdens and improve caregiver's QoL	McMillan et al. (2005), Walsh et al. (2007)

[a] Period between which studies were selected for systematic/meta-analysis reviews.

et al., 2016; Nipp et al., 2016; Areia et al., 2019). The importance of providing support to families who are facing the imminent death of a family member is unquestionable. Thus, the present study has desired to carry out a close examination of the current state of family/caregiver-focused interventions in both oncological and end-of-life care contexts.

Although international guidelines (WHO, 2002) advocate that palliative care should be family-centered (Hudson and Payne, 2011; WHO, 2002), results of the present study show that family support is still an issue that the literature fails to address, as only nine family/caregiver-focused intervention programs (Hudson et al., 2005, 2013; McMillan et al., 2005; Kissane et al., 2006; Walsh et al., 2007; McLean et al., 2013; Mitchell et al., 2013; Northouse et al., 2013; Dionne-Odom et al., 2015) met the inclusion criteria (cf. Methods section) for the present critical review. Noting which countries have developed and tested interventions, in our study the majority of the interventions were developed and tested in Australia and USA, it becomes important to expand the research on this topic to other nations (e.g., Europe, Latin America), as cultural, racial, and economic diversities (Northouse et al., 2010) may influence the emergence of different challenges placed upon the families of individuals in the terminal stages of cancer.

Although the literature clearly states that cancer and the impending death of a loved one is indeed a family affair, which affects not only the patient but also all his/her relatives (Kissane and Bloch, 2002; Rolland, 2005), from the nine interventions programs studied, only one third showed a relational perspective (Kissane et al., 2006; McLean et al., 2013; Northouse et al., 2013), while the others were caregiver-focused (Hudson et al., 2005, 2013; McMillan et al., 2005; Walsh et al., 2007; Mitchell et al., 2013; Dionne-Odom et al., 2015).

As for the duration of the interventions, most were brief, consisting of few sessions over a specified period of time (Hudson et al., 2005, 2013; McMillan et al., 2005; Walsh et al., 2007; Mitchell et al., 2013; Dionne-Odom et al., 2015). Also, they were delivered by non-mental health experts (Hudson et al., 2005, 2013; McMillan et al., 2005; Walsh et al., 2007; Mitchell et al., 2013; Northouse et al., 2013; Dionne-Odom et al., 2015) and were mainly focused on caregiver-specific problems (e.g., increasing competences, caregiver education) (Hudson et al., 2005, 2013; Walsh et al., 2007; Mitchell et al., 2013; Dionne-Odom et al., 2015). This general panorama may be somewhat sparse. As Walsh and McGoldrick (2004) note, of all human experiences, the death of a loved one, or its imminent arrival, is the most painful challenge for both families and their individual members and may be trauma-producing with manifestations of psychological morbidity (e.g., post-traumatic stress disorder, depression) appearing in one or more family members (Bonanno and Mancini, 2006; Everstine and Everstine, 2006). The end-of-life context appears too challenging for interventions that are too restricted in terms of their format (e.g., dosage, goals). We believe that other neglected issues (e.g., anticipatory grief) and other formats (e.g., longer interventions, greater involvement on the part of mental-health professionals) should be considered in the family intervention equation to address the family's most important needs and thus prevent morbid trauma responses (Romito et al., 2013; Areia et al., 2019).

Table 2. Characteristics of family or caregiver-focused interventions

		Format			Efficacy		
Authors (year), Country	Framework	Target	Dosage/Setting/Professionals	Key elements	Outcomes	Post-intervention follow-up assessment	Overall efficacy[a]
Hudson et al. (2005), Australia	Psycho-educational	Family caregivers	Two home visits + follow-up phone call (between visits); Complementary caregiver guidebook and audiotape/ Home-based/Nurses	Supportive/informative-focused: (1) information about aspects associated with caregiving role; (2) skills guidance and education; (3) support; (4) meaning-making of caregiving experience; (5) promotion of caregiver self-care; and (6) future planning (e.g., goals, caregiver rights)	Preparedness for caregiving Caregiver competence Rewards of caregiving Anxiety Mastery Self-efficacy	Five weeks Eight weeks post-patient's death	Effective in increasing positive caregiving experience (rewards)
Kissane et al. (2006), Australia	Family-centered	At-risk families	4–8 sessions (90 min) across 9–18 months/Hospice and home care/Family therapists (social workers)	Exploration of family cohesion, communication and handling of conflict, through three phases: (1) assessment: identify issues and concerns relevant to the family and devise a plan to deal with them (one to two weekly sessions) (2) intervention: focused on the agreed concerns on the previous phase (2–4 sessions) (3) termination (1–2 sessions): consolidates gains	Distress Depression Social adjustment Family functioning	6, 13 months post-intervention or, if occurred, post-patient's death	Modestly efficient in decreasing distress and depression
McMillan et al. (2005), USA	Cognitive-behavioral	Family caregivers	Three sessions/Hospice/ Nurses	Problem-solving (assess and manage patient symptoms) and coping intervention (structured instruction in coping skills), derived from Family COPE model that comprises four domains: (a) creativity, (b) optimism, (c) planning, and (d) expert	QoL Symptom burden Caregiving task burden Mastery	One and two weeks/steps	Effective in improving caregiver QoL and reducing burden both related to patient's symptoms and caregiver's task
Walsh et al. (2007), UK	Not defined	Family caregivers (one-to-one)	Six weekly visits/ Home-based/Trained advisor (nurses and social workers)	Advice, information and emotional support, regarding (a) patient care, (b) physical health needs, (c) need for time away from the patient in the short- and longer-term, (d) need to plan for the future, (e) psychological health, relationships and social networks, (f) relationships with health and social service providers, and (g) finances	Psychological distress Strain Quality of life Satisfaction with care Bereavement	4, 9, and 12 weeks 4 months after patient's death	Low

Hudson et al. (2013), Australia	Psycho-educational	Family caregivers (one-to-one)	Four weeks/steps; Two versions: Intervention 1: one visit and three phone calls Intervention 2: two visits and two phone calls/ Home-based/Nurses	To increase the number of resources, including: (a) feelings of preparedness, (b) competence, (c) having adequate information, (d) fewer unmet needs, and (e) focusing on positive aspects of the role	Psychological distress Needs fulfillment Preparedness Competence Positive emotions	One week Eight weeks post-patient's death	Efficient in increasing family caregivers' sense of preparedness and competence Inefficient in decreasing psychological distress, unmet needs and improving positive emotions
McLean et al. (2013), Canada	Couple-centered	Couples (patient and spouse)	Eight weekly sessions/ Undifferentiated/ Psychologists	Mainly focused on couple relationship: (a) facilitate the marital relationship, (b) increase mutual understanding, (c) increase emotional engagement, and (d) strengthen the marital bond	Marital functioning Psychological morbidity Empathic caregiving (patient) Burden (caregiver)	Immediately post-intervention and 3 months	Efficient in improving marital functioning and patients' experience of caregiver empathic care
Mitchell et al. (2013), Australia	Not defined	Family caregivers	Assessment with the Needs Assessment Tool — Carers (NAT-C) and NAT-C-guided consultation at a baseline of 3 months/Outpatient setting/ General Practitioners	Needs assessment and further consultation	Unmet needs Anxiety Depression Quality of life	1, 3, and 6 months	Inefficient in reducing the number and intensity of needs Limited impact on people with pre-existing anxiety and depression
Northouse et al. (2013), USA	Dyadic/ couple-centered	Patient-caregiver dyads	Three (brief) or six (extensive) sessions/Home-based/ Trained Nurses	Information and emotional support, considering: (a) family involvement, (b) optimistic attitude, (c) coping effectiveness, (d) uncertainty reduction, and (e) symptom management	QoL Appraisal of illness/ caregiving Uncertainty Hopelessness Coping Interpersonal relationships Self-efficacy	3 and 6 months	Efficient in improving dyads' coping, self-efficacy and social QoL and in caregivers' emotional QoL
Dionne-Odom et al. (2015), USA	Not defined	Family caregivers	Three telephone sessions (once per week), considering the delivered of earlier palliative care/Not applicable/Trained Nurses	Problem-solving Communication Decision-making Advance care planning	QoL Depression Burden	1.5 and 3 months	Efficient in reducing depression levels and burden

[a] Outcomes that showed no intervention effects are not displayed.

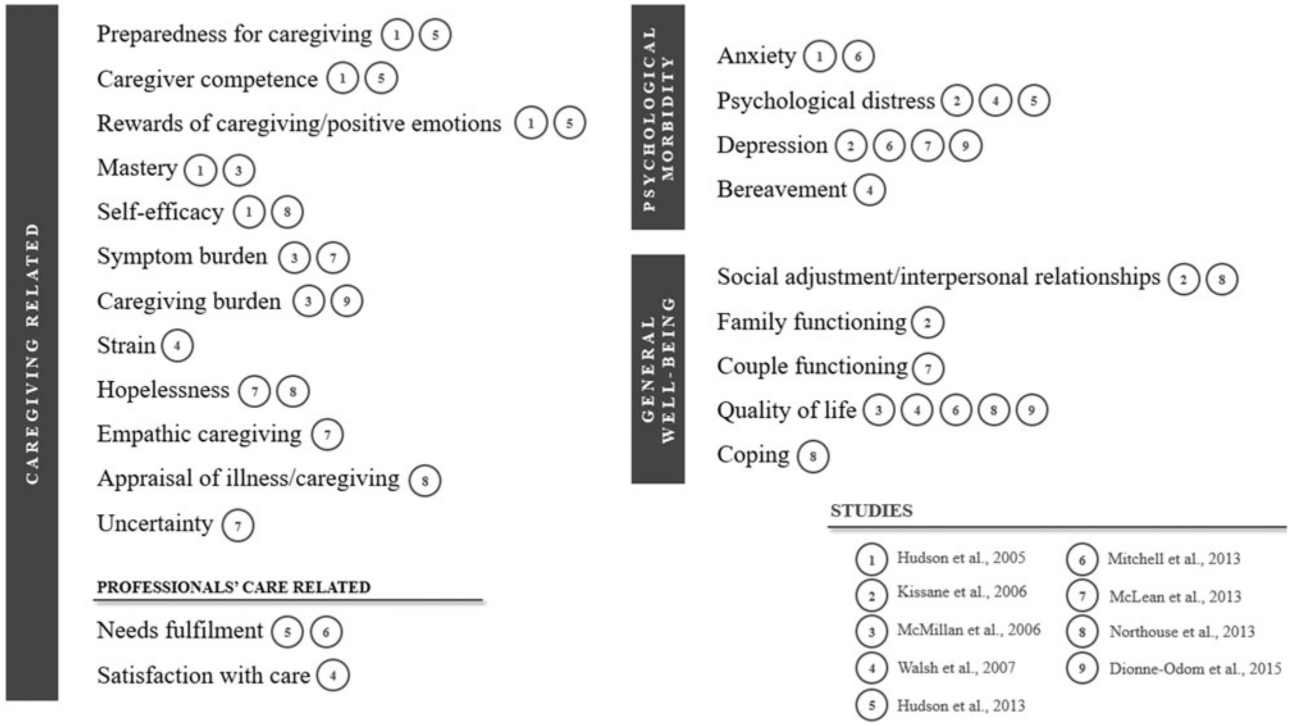

Fig. 2. Evaluated outcomes in interventions efficacy studies.

Regarding the effectiveness of the intervention programs analyzed, results showed an overall modest efficacy. On the one hand, it is undeniable that the approaching death of a family member is extremely demanding and stressful (Walsh and McGoldrick, 2004; Walsh et al., 2007), and psychosocial support may not improve the situation when the moment of crisis finally arrives (Walsh et al., 2007). This corroborates the hypothesis that support from extended family in time may improve the psychosocial adjustment of the family at the end of the patient's life. On the other hand, we argue that a family intervention in palliative care should aim at preventing abnormal responses over the long term, such as complicated grief during bereavement, rather than reducing present psychological symptomatology (e.g., anticipatory grief) in the terminal phase as this is somewhat expected and, in due terms, functional. More prophylactic intervention programs, such as FFGT (Kissane et al., 2006), should be considered and implemented in palliative care contexts.

At this point, it is worth noting that it an important gap still remains between the implementation of intervention programs in clinical practice and what is advocated in research and policy (Hudson et al., 2010). As far as we know, and similar to the assumption made by Northouse et al. (2010), none of the analyzed intervention programs have been translated into other languages nor have been applied as a routine procedure in other different countries — such as non-English speaking countries — than the ones in which have been developed. We must, therefore, agree that an articulated collaboration between researchers, clinicians and funding agencies is a pressing need, as this will undoubtedly facilitate the implementation of these empirically tested interventions in clinical settings (Northouse et al., 2010).

The present study has obvious limitations, mainly related to its methodology. Limiting the review to other systematic reviews of literature (Step 1), to further select family/caregiver-focused interventions (Step 2), may have not abled the selection of recent RCT studies on the topic. Additionally, the selection of family/caregiver-focused interventions was somewhat strict, which may not offer a realistic overview of the actual state of family/caregiver-focused interventions in palliative care (e.g., RCTs eventually published after 2016), given the limits of the literature reviews. Additionally, this study was limited to the context of terminal cancer. What is being done for families of individuals suffering from dementias, organ failure, or infectious disease, which are also diseases with recourse to palliative care (WHO, 2002), remains unclear.

Despite these limitations, we consider that including studies with methodological reliability (RCTs) is an important strength of this critical review, as it has enabled a close examination of the content and efficacy of each intervention and a good description of a general panorama of the most significant family/caregiver-focused interventions. Additionally, this study seeks to reinforce the view that the development and improvement of family support in palliative care remains a research priority in the field and highlights the urgent need to include families in the patient's care plan by offering them high-quality psychosocial support.

Conclusion

Few family/caregiver-focused interventions have been validated through broad and rigorous methodologies. At present, interventions still mainly focus on caregiving matters, are brief in duration and delivered by non-mental health professionals, and show modest efficacy. More family interventions programs which consider different formats should be developed in order to identify a more effective way to support families that are facing the death of a loved one.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S1478951520000127.

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