

Development and Validation of a Psychological Empowerment Package for Family Caregivers of Older Adults: From Qualitative Findings to Intervention Design

Nahid. Ghanbarzadeh Alamdari¹, Mahdi. Zare Bahram Abadi^{2*}, Khadijeh. Abolmaali Al-Hosseini³

¹ Department of Family and Counseling, NT.C, Islamic Azad University, Tehran, Iran

² Department of Counseling, Allameh Tabataba'i University, Tehran, Iran

³ Department of Educational Psychology, NT.C, Islamic Azad University, Tehran, Iran

* Corresponding author email address: mahdi.zare@atu.ac.ir

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ABSTRACT

Given that the healthcare system relies substantially on family caregivers as the backbone of care provision, preserving caregivers' health is of considerable importance. Considering the Iranian and Islamic cultural context, family-centered strategies are required to support family caregivers of older adults. Accordingly, the primary objective of developing the psychological empowerment package was to create an intervention program capable of strengthening family caregivers of older adults across the psychological dimensions required for caregiving and thereby promoting continuity of care for older adults. The intervention package in the present study was developed based on the Medical Research Council (MRC) framework. Accordingly, caregivers' needs were identified through a systematic review of the literature and the collection of qualitative data from family caregivers of older adults; subsequently, the intervention protocol was developed and validated by an eight-member expert panel. The overall content validity of the package, assessed using the S-CVI/Ave, was 0.945, indicating a high level of content validity. The package consisted of five main modules and 11 submodules delivered over 15 weekly 90-minute sessions in a hybrid format, including face-to-face sessions for intervention delivery and virtual follow-up for assignments. The package was designed not merely as a simple educational program but as an intervention with the potential to evolve into an indigenous model for caregiver empowerment. Given its simultaneous emphasis on multiple dimensions, including the body, cognition, emotion, meaning, relationships, and behavior, the package can be conceptualized as a multilayered empowerment model.

Keywords: family caregiver empowerment, challenges of family caregivers of older adults, family caregiver needs, caregiver empowerment packages

1. Introduction

Population aging has become one of the most consequential demographic transformations affecting health and social care systems, with direct implications for the organization, financing, and sustainability of long-term care. As longevity increases and the prevalence of chronic disease, multimorbidity, functional dependency, cognitive impairment, and disability rises, a substantial proportion of care is transferred from formal institutions to households, where spouses, adult children, and other relatives assume responsibility for continuous assistance. In many societies, family caregivers constitute the principal source of support for older adults, frequently providing personal care, medication management, mobility assistance, supervision, emotional support, transportation, coordination with health services, and financial or household management. The aging trajectory in Iran has intensified the importance of this issue because demographic projections indicate a rapid increase in the proportion of older adults and, consequently, greater demand for sustained formal and informal caregiving resources (Dehghan-Banadaki et al., 2023). Older adults may also experience falls, frailty, chronic illness, and functional limitations that increase their dependence on others and expand the practical responsibilities imposed on families (Jamebozorgi et al., 2013). Within this context, family caregiving should not be understood merely as an informal interpersonal activity but as an essential component of the healthcare and social-support infrastructure. At the same time, reliance on families without adequate psychological, educational, social, and systemic support can expose caregivers to cumulative burden, emotional exhaustion, physical strain, and disruption of their personal lives. Evidence from Iran has demonstrated a relationship between caregiving burden and adverse care-related outcomes, including situations in which excessive strain may compromise the quality and safety of care provided to older adults (Zandieh et al., 2022). Therefore, supporting family caregivers is increasingly recognized not only as a matter of caregiver well-being but also as an important strategy for maintaining continuity, quality, and sustainability of care for aging populations.

Family caregiving is inherently multidimensional because its consequences emerge simultaneously across physical, psychological, relational, occupational, social, and economic domains. Caregivers frequently face sleep disturbance, fatigue, bodily pain, reduced opportunities for exercise and self-care, financial pressures, restrictions in

employment, diminished leisure activities, social isolation, and uncertainty regarding the older adult's future condition. These pressures may intensify when care recipients have dementia, cognitive impairment, severe physical disability, behavioral disturbances, or progressive chronic illness. Reviews of caregivers of older adults with chronic disease have shown that caregiving burden is affected by a complex interaction of care-recipient characteristics, caregiver resources, family relationships, duration and intensity of caregiving, and the availability of social support (Sebzali Pour et al., 2021). Mobility restrictions and the need to continually supervise cognitively impaired older adults may further constrain caregivers' participation outside the home and diminish their autonomy in everyday life (Werner & Shoval, 2012). Qualitative evidence has similarly shown that caring for a parent with dementia can become an indefinite and deeply intertwined process in which the caregiver's own life course, identity, and future planning become progressively integrated with the trajectory of the care recipient (Hwang et al., 2017). More recent investigations have identified persistent psychological needs among caregivers, including the need for knowledge, emotional regulation, coping support, and assistance in responding to demanding home-care situations (Sun et al., 2024). These findings indicate that caregiver burden cannot be adequately addressed through isolated educational messages or disease-specific information alone because the caregiving experience reshapes the caregiver's functioning at multiple interconnected levels.

The psychological consequences of caregiving are especially important because emotional burden may directly influence both caregiver health and the continuity of home-based care. Caregivers may experience chronic stress, anxiety, sadness, guilt, anger, helplessness, emotional ambivalence, hypervigilance, and fear regarding deterioration in the older adult's condition. When such reactions accumulate without appropriate coping resources, they may progress toward emotional exhaustion and burnout. Psychological characteristics of caregivers have been shown to predict discontinuation of home care for older adults with disabilities, suggesting that caregiver psychological functioning is a determinant of whether caregiving can be sustained over time (Okamoto et al., 2007). Contemporary evidence further demonstrates that compassion fatigue, burnout, and compassion satisfaction are dynamically related among family caregivers of older adults with disabilities, while social support can modify these relationships and operate as an important protective

resource (Yang et al., 2025). Caregivers' distress is therefore not simply an individual emotional reaction but is embedded within a wider relational and support environment. Studies of family caregivers in other chronic-care contexts have similarly highlighted the importance of competencies, adaptive strategies, and the capacity to manage prolonged caregiving demands (Eghtedar et al., 2023). Educational support has also been associated with reductions in caregiver anxiety, indicating that structured assistance can modify at least some psychological consequences of demanding care situations (Dalirirad et al., 2018). These observations support a shift from narrowly burden-focused approaches toward empowerment-oriented interventions that strengthen caregivers' psychological resources, agency, self-regulation, coping capacity, and ability to mobilize support.

Empowerment is particularly relevant in family caregiving because it emphasizes strengthening individuals' perceived control, competence, knowledge, decision-making ability, access to resources, and capacity to respond effectively to demanding circumstances. Conceptual analyses of caregiver empowerment emphasize that empowerment is not limited to the acquisition of information; rather, it involves an evolving process through which caregivers become more capable of recognizing their needs, mobilizing internal and external resources, participating in decisions, and managing caregiving demands with greater autonomy and confidence (Sakanashi & Fujita, 2017). Family-centered empowerment approaches have consequently been used to improve self-efficacy, resilience, and adaptation among caregivers and care recipients (Kiani et al., 2022; Rabei et al., 2012). The importance of self-control and self-management has also been highlighted within family-centered empowerment models, particularly where caregivers must balance their own emotional responses with the continuous demands of chronic illness (Nikrouz et al., 2020). More broadly, health-promoting educational approaches can strengthen psychological resources such as self-compassion, emotional-behavioral regulation, and psychological hardiness, suggesting that empowerment interventions should include capacities that extend beyond technical caregiving skills (Edalat et al., 2022). An effective empowerment package for family caregivers of older adults should therefore address knowledge and practical caregiving abilities while also strengthening emotional regulation, self-awareness, self-care, problem solving, boundary setting, meaning-making, social connectedness, resilience, and the ability to seek and accept support.

A growing body of intervention research confirms that caregiver outcomes can improve when interventions are structured, psychologically informed, and responsive to caregivers' multidimensional needs. Psychoeducational group interventions have demonstrated beneficial effects on caregiver burden by combining information with psychological support and skills training (Navidian et al., 2012). Stress-management interventions have also been used to improve quality of life among caregivers of older adults with disabilities (Haffari et al., 2014), while mindfulness-based programs have been associated with reductions in caregiver burden among family caregivers of older adults with Alzheimer's disease (Hosseini et al., 2016). Internet-based cognitive behavioral therapy has further shown that psychological support may be delivered through digital formats, thereby increasing accessibility for caregivers who cannot easily attend face-to-face services because of caregiving responsibilities (Biliunaite et al., 2021). Similarly, programs combining education with telephone follow-up suggest that continued contact after educational sessions may improve the practical application of acquired skills and provide sustained support (Bani-Ardalan et al., 2022). Mobile-based psychosocial empowerment programs have extended this principle by integrating technology into caregiver support and demonstrating potential benefits for caregivers' quality of life (Lahrasabi et al., 2024). Collectively, these studies suggest that caregiver interventions are most likely to be useful when they combine psychological techniques, structured education, opportunities for practice, follow-up mechanisms, and delivery formats compatible with the realities of caregivers' daily lives.

Intervention research has also moved toward more specialized approaches addressing cognition, emotion, coping, interpersonal processes, and resourcefulness. The SOURCE program, for example, was designed around learned resourcefulness and included components such as problem solving, self-regulation, management of daily activities, and modification of maladaptive thinking patterns; pilot and subsequent applications have indicated its potential to reduce caregiver burden and improve quality of life among older family caregivers (Chen et al., 2024; Chen et al., 2021). Mentalizing imagery interventions have focused on increasing caregivers' capacity to understand mental states, reflect on emotional experience, and modify responses to stressful interactions (Cheng et al., 2022; Jain et al., 2022). Project ANSWERS similarly emphasized strengthening existing caregiver capacities while teaching

dementia-related knowledge, communication skills, memory management, emotional recognition, and adaptive behavioral responses (Judge et al., 2013). Empowerment interventions specifically developed for caregivers of people with dementia have also demonstrated the value of structured programs designed to enhance adaptation and effective coping (Yoon & Kim, 2020). These findings reinforce the argument that psychological empowerment should be conceptualized as a multidimensional construct rather than as a single skill. Caregivers must often regulate their own emotions, interpret challenging behaviors, communicate effectively with the older adult and other family members, restructure expectations, solve practical problems, maintain a sense of competence, and preserve personal meaning under conditions of long-term uncertainty.

At the same time, effective caregiver interventions cannot be designed solely around individual-level psychological skills because family caregiving takes place within social networks, cultural systems, and service structures. Community-based care and case-management programs demonstrate the importance of coordinated professional and social support for families facing prolonged caregiving demands (Warkentin et al., 2022). Family group conferences and similar structured approaches seek to mobilize wider family resources, distribute responsibility, and improve collective problem solving rather than leaving the burden concentrated on a single caregiver (Hillebregt et al., 2018). Virtual communities of practice also provide opportunities for caregivers to exchange experiences, obtain practical information, reduce isolation, and build peer support, with evidence indicating potential improvements in quality of life (Romero-Mas et al., 2021). The need for such multidimensional support is particularly relevant in Iran, where strategic analyses have emphasized the necessity of developing more coherent systems for supporting family caregivers as population aging accelerates (Hezarjaribi et al., 2020). In settings where family responsibility for older relatives is strongly embedded in cultural expectations, support programs must therefore consider not only individual coping deficits but also caregiving norms, family expectations, gendered responsibilities, barriers to requesting assistance, and the limited availability or acceptability of respite and formal care services.

Cultural context is particularly important because caregiving may be simultaneously experienced as burdensome and deeply meaningful. Research on the lived experiences of caring for older parents in Tehran has indicated that family caregiving is intertwined with

emotional bonds, moral responsibility, intergenerational obligation, and personal identity (Majidi Khameneh & Mahdavi, 2018). Similar findings have been reported in other collectivist contexts, where caregivers may describe caregiving as extremely difficult while resisting its characterization solely as a burden because it is understood through family duty, gratitude, affection, and moral commitment (Nguyen et al., 2021). Iranian caregivers of older adults with dementia have likewise reported positive experiences arising from caregiving, including personal growth, strengthened relationships, increased patience, spiritual development, and a greater sense of responsibility (Farhadi et al., 2018). Satisfaction with caregiving may therefore coexist with strain, particularly when caregivers can interpret their experience through salutogenic processes such as meaningfulness, comprehensibility, and manageability (Sarabia-Cobo & Sarriá, 2021). Empowerment interventions that focus exclusively on reducing negative symptoms may consequently fail to engage with the motivational and meaning-related resources that help caregivers sustain care. A culturally responsive intervention should acknowledge suffering and burden while simultaneously strengthening caregivers' capacity to recognize personal values, spiritual motivations, relational commitments, positive growth, and character strengths emerging from caregiving.

Previous empowerment programs have produced promising findings, but the intervention literature remains fragmented. Some interventions primarily target education and knowledge, others focus on stress management, mindfulness, cognitive-behavioral skills, resourcefulness, social support, or resilience, and many have been developed for specific diagnostic groups. For example, empowerment programs have improved health-related quality of life and reduced burden among caregivers of older adults with Alzheimer's disease (Yazdanmanesh et al., 2023), while family-centered empowerment has enhanced resilience among caregivers in other chronic-care contexts (Kiani et al., 2022). Nevertheless, caregivers' needs frequently span several domains at once, including bodily exhaustion, emotional ambivalence, disrupted personal identity, role overload, interpersonal conflict, social withdrawal, financial concerns, cultural expectations, and existential questions about the meaning of caregiving. Consequently, combining complementary intervention components may be more appropriate than focusing on a single psychological mechanism. Moreover, intervention components should not simply be assembled from previously published programs

without examining whether they correspond to the actual lived experiences and priorities of the intended population. The development of a locally grounded package therefore requires systematic integration of international evidence with qualitative data obtained directly from caregivers within the cultural setting in which the intervention will eventually be implemented.

This requirement is consistent with contemporary guidance for complex intervention development. The updated Medical Research Council framework emphasizes that complex interventions should be developed through theoretically informed, context-sensitive, iterative processes in which evidence, stakeholder perspectives, mechanisms, implementation conditions, and contextual influences are examined together (Skivington et al., 2024). Under this perspective, intervention development is not a simple linear progression from identifying a problem to prescribing a standardized solution. Rather, it requires repeated movement between existing evidence, theoretical explanation, stakeholder experience, intervention design, feasibility assessment, and refinement. Such an approach is particularly suitable for psychological empowerment of family caregivers because caregiving itself is a complex phenomenon shaped by individual psychological characteristics, care-recipient needs, family structure, cultural expectations, socioeconomic circumstances, health-service accessibility, and interpersonal dynamics. A package intended for Iranian family caregivers of older adults should therefore emerge from an explicit developmental process that integrates empirical literature, qualitative evidence, theoretical mechanisms, and expert evaluation rather than relying on the uncritical adaptation of a single pre-existing intervention.

The available evidence consequently points to several interrelated needs: family caregivers require support that can reduce psychological and physical strain, enhance emotion regulation and self-care, strengthen agency and coping, improve family and interpersonal functioning, facilitate access to social and professional support, and preserve the motivations and meanings that sustain caregiving. Although previous educational, cognitive-behavioral, mindfulness-based, family-centered, digital, social-support, resourcefulness, and mentalization-oriented interventions each contribute important components, the literature does not provide a sufficiently integrated and culturally grounded psychological empowerment package designed specifically around the multidimensional experiences of Iranian family caregivers of older adults. Such an intervention should be

grounded simultaneously in evidence synthesis, caregivers' lived experiences, local sociocultural realities, established psychological theories, and systematic expert validation, while remaining sufficiently structured to allow subsequent feasibility testing and outcome evaluation. Accordingly, the aim of the present study was to develop and validate a culturally grounded, theory-based, multilayered psychological empowerment package for family caregivers of older adults by integrating evidence from the literature, qualitative findings, and expert evaluation.

2. Methods and Materials

Developing a psychological empowerment protocol or intervention package is a systematic and evidence-based process commonly employed in applied psychology and behavioral interventions. This process may be guided by established frameworks such as the National Institutes of Health (NIH) model for behavioral intervention development or the Medical Research Council (MRC) guidance for complex interventions. The MRC framework focuses on complex interventions in psychological, social, and health-related domains. Its structure is cyclical and nonlinear, emphasizing repetition, refinement, and continuous modification. It is explicitly theory-driven and is particularly appropriate for highly complex interventions consisting of multiple interacting components.

Because a better understanding of locally situated experiences of caring for older adults can facilitate the design and implementation of interventions that are compatible with cultural values and specific caregiver needs, locally grounded evidence was considered essential. Moreover, multicomponent interventions may be safer and more effective, and combining different complementary intervention modalities is particularly important when attempting to modify a multidimensional construct such as caregiver burden. In addition, studies of complex interventions should incorporate a qualitative component to explore intervention mechanisms and explain the processes contributing to change. Because the package developed in the present study comprised multiple components and was intended for implementation within complex social and cultural contexts, the MRC framework was selected as the methodological basis for intervention development.

3. Findings and Results

1. Development phase. The objective of this phase is to design the intervention using available evidence and relevant

theoretical foundations. Activities undertaken during this phase included a systematic review of the literature to identify similar interventions and conduct a needs assessment, as well as the collection of qualitative data from key stakeholders, namely family caregivers of older adults. The outputs of this phase were the identification of caregiver needs and the design and development of the preliminary intervention protocol.

2. Feasibility or pilot phase. The objective of this phase is to examine the feasibility, implementability, and validity of the intervention. Activities at this stage may include small-scale pilot implementation and/or modification of the intervention protocol on the basis of feedback provided by

an expert panel. The output of this phase is a revised version of the intervention and a pilot protocol.

3. Evaluation phase. The purpose of this phase is to evaluate intervention effectiveness. Activities include conducting randomized controlled trials or quasi-experimental studies and assessing relevant intervention outcomes.

In the first phase, a systematic review of domestic and international psychological empowerment interventions conducted during the preceding 15 years was performed. A summary of the identified interventions is presented in Table 1.

Table 1

Studies on Empowerment Interventions for Family Caregivers

No.	Domestic Source	Objective of the Empowerment/Educational Intervention
1	Navidian et al. (2012)	Systematic educational interventions based on a cognitive-behavioral therapy (CBT) approach
2	Rabiei et al. (2012)	Increasing self-efficacy, awareness, and knowledge
3	Haffari et al. (2014)	Stress-management training
4	Hosseini et al. (2016)	Mindfulness training
5	Dalirirad et al. (2018)	Educational support
6	Nikrouz et al. (2020)	Training in empowering self-control and emotional regulation
7	Kiani et al. (2022)	Training in problem-solving ability, self-reliance, and self-confidence
8	Bani-Ardalan et al. (2022)	Training in adaptive and positive behaviors
9	Majidi Khameneh and Mahdavi (2018)	Health-promoting lifestyle education
10	Lahrasabi et al. (2024)	Education regarding the nature of illness and methods of patient care
No.	International Source	
1	Boise (2005)	Training in relaxation techniques such as deep breathing through the Powerful Tools for Caregiving (PTC) program
2	Jain et al. (2022)	Four-week mentalizing imagery therapy for family caregivers of older adults with dementia
3	Judge et al. (2013)	Development of new skills while strengthening existing capacities through Project ANSWERS for caregivers and older adults with dementia, including education about dementia, memory management, effective communication, remaining active, and recognizing emotions and behaviors
4	Williams et al. (2016)	Psychoeducation, coping-strategy training, emotional-support training, and group CBT aimed at meaning-related change
5	Hillebrecht et al. (2018)	Family group sessions emphasizing problem solving through Family Group Conferences (FGC)
6	Yoon and Kim (2020)	Training in positive adaptation and effective coping
7	Warkentin et al. (2022)	Continuous care within a regional network and provision of formal social support through the RubiN model
8	Chen et al. (2021)	Training in problem solving, daily schedule management, self-regulation, identification of negative thoughts, and development of new thoughts through the SOURCE program
9	Cheng et al. (2022)	Mentalization-based intervention
10	Chen et al. (2024)	Learned resourcefulness intervention through the SOURCE program

Subsequently, qualitative domestic and international studies published during the preceding 15 years concerning the challenges, needs, and lived experiences of family caregivers of older adults were reviewed, and a meta-synthesis was conducted. To extract themes, after data collection, the three-stage thematic synthesis method proposed by Thomas and Harden (2008) was used to analyze

and synthesize themes across the selected studies. During the first stage, line-by-line coding of 13 selected articles yielded more than 350 initial codes. Analysis and synthesis of the extracted themes subsequently generated eight overarching themes and 54 organizing themes. After evaluation by six family caregivers of older adults and four specialists, several themes were removed because of insufficient validity or

merged because of overlap with other themes. Ultimately, 47 organizing themes remained, with an overall content validity ratio of 0.83. According to Lawshe's criteria for 10

evaluators, this value was considered acceptable. The themes are presented in Table 2.

Table 2

Themes Extracted From the Meta-Synthesis of the Reviewed Articles

Overarching Themes	Organizing Themes
The collapsing self	Physical exhaustion
	Emotional depletion
	Psychological breakdown
	Social and relational disconnection
Psychological challenges	Negative emotions
	Guilt, resentment, shame, and emotional ambivalence
	Need for professional assistance
A shrinking world	Social confinement
	Occupational and financial deprivation
	Suspension of pleasurable activities
Resilience	Moral and emotional obligation
	Strengthening capabilities
	Meaning-making
Need for support networks	Informational and educational support
	Emotional and psychological support
	Financial support
	Practical and instrumental support
	Social and family support
Caregiver agency	Professional and systemic support
	Adaptive communication with the older adult
	Self-care and coping skills
	Self-reliance
	Cultural resilience
Erosive pressures	Advocacy
	Financial management
	Behavioral and cognitive challenges of the older adult
	Physical deterioration and dependency of the older adult
	Uncertainty regarding the older adult's condition
	Excessive workload and time constraints
	Balancing multiple roles
	Physical strain
	Feeling trapped and unprepared
	Self-neglect
	Challenges in the marital relationship
	Family and sibling conflicts
	Stigma and judgment
The alchemy of caregiving	Cultural expectations and gender roles
	Financial burden
	Maturation and increased awareness
	Learning and development of new skills
	Deepening interpersonal bonds
	Development of positive character attributes
	Improvement in self-efficacy beliefs
	Social recognition and validation
	Spiritual growth and deeper faith
	Fulfillment of ethical and family commitments
	Enactment of personal values

To investigate stakeholder needs through a local study, semi-structured interviews were conducted using a qualitative design, and the data were analyzed through thematic analysis based on Braun and Clarke's (2006) six-phase framework. A total of 468 statements extracted from the interview transcripts were categorized into 72 basic themes, 21 organizing themes, and five overarching themes. To validate the themes, the content validity ratio (CVR) was

calculated based on ratings provided by three family caregivers who had participated in the interviews and seven specialists. Because the panel consisted of 10 evaluators, a value of 0.60 was adopted as the critical value according to Lawshe's table. The mean content validity ratio across all themes was 0.75, which was substantially higher than the critical value. The findings are presented in Table 3.

Table 3

Overarching and Organizing Themes Derived From the Qualitative Study

Overarching Themes	Organizing Themes
Multidimensional erosion of the caregiver	Physical harm
	Emotional strain and exhaustion
	Diminished social life
	Self-neglect
	Depletion of economic resources
Relational dynamics of caregiving	Stagnation of one's life trajectory
	Interpersonal conflict
	Emotional enmeshment
	Extensive and highly interdependent family relationships
	Gender stereotypes surrounding caregiving
Coping strategies	Caregiving as a nontransferable duty
	Cognitive strategies
	Expansion of interpersonal relationships
	Behavioral strategies
	Emotion regulation
Resilience and continuity of caregiving	Spirituality-based adaptation
	Spiritual motivations
	Family motivations
	Ethical commitments and values
	Growth in virtues and character strengths
Gifts of caregiving	Cognitive openness and flexibility

Ultimately, by integrating the themes derived from the meta-synthesis and the qualitative study, the principal components of the package were identified and the preliminary psychological empowerment package was developed. Following repeated revisions, the package was evaluated by an eight-member expert panel. The package consisted of five principal modules and 11 submodules delivered in 15 weekly 90-minute sessions, with face-to-face sessions used for implementation of the intervention and virtual contact used for assignment follow-up.

An attempt was made to ensure that the intervention would not merely constitute a simple educational package but could eventually evolve into an indigenous model of

caregiver empowerment. Scientifically, the package is grounded in qualitative data derived from the meta-synthesis and semi-structured interviews, theory-driven because every designed module has an explicit theoretical foundation, and multilevel because it simultaneously addresses the body, cognition, emotion, meaning, relationships, and behavior. Accordingly, it may be conceptualized as a multilayered empowerment model. The modules and a summary of the package content are presented in Table 4. It should be noted that the worksheets, short educational videos, and detailed lesson plans for each session are fully described and are available in the first author's doctoral dissertation.

Table 4

Objectives and Content of the Psychological Empowerment Package

Integrated Overarching and Organizing Themes	Corresponding Objectives of the Educational Package	Educational Content	Sessions and Duration
Multidimensional erosion of the caregiver: 1. Psychosomatic problems; 2. Emotional exhaustion; 3. Diminished social life; 4. Self-neglect; 5. Depletion of economic resources; 6. Stagnation of life trajectory	1. Reducing psychosomatic problems: Reduce chronic physical pain through body-focused attention and body-based mindfulness exercises; increase awareness of signs of physical and psychological exhaustion and encourage action to reduce such exhaustion	Somatic yoga exercises; body-based mindfulness; awareness of the mind-body connection; body-scan exercises to identify tension before it develops into physical injury; deep and diaphragmatic breathing; identification of warning signs of psychological burnout, including mood changes, sleep problems, appetite changes, reduced concentration, isolation, guilt, and physical symptoms; introduction to appropriate strategies for reducing psychological exhaustion	2 sessions, 90 minutes each
	2. Emotion regulation and management of complex emotions and emotional ambivalence: Identify bodily manifestations of emotions; label different emotions and recognize and validate conflicting and complex emotions; regulate anxiety, anger, persistent worry, hypervigilance, shame, sadness, helplessness, hopelessness, and guilt by increasing reflective capacity regarding one's own emotions and those of the older adult	Education regarding facts and misconceptions about the function and nature of emotions; increasing awareness of bodily warning signs preceding emotional activation; exercises in labeling and accepting one's own emotions; identifying emotional triggers such as environment, behavior, and speech, together with associated meanings and action tendencies using the TEMPO framework; differentiation, processing, and regulation of emotions; validation of one's own emotions and those of the older adult; increasing emotional tolerance through the "window of tolerance"; emotional co-regulation with the older adult; self-compassion exercises for reducing guilt	2 sessions, 90 minutes each
	3. Restoring dynamism to the life trajectory: Learn to cope with multiple roles, time restrictions, accumulated unfinished tasks, and suspended personal goals without interpreting such difficulties as personal failure, inefficiency, or incapacity; restore control over time and personal life planning and reconstruct priorities based on the caregiver's value system	Designing a daily activity schedule, prioritizing personal goals, and strengthening agency and effectiveness; setting achievable SMART goals in educational, occupational, and personal-life domains; "time-analysis" exercises to identify wasted time or tasks that can be delegated, thereby creating time for rest and personal interests; exercises aimed at building trust in potential supporters, relinquishing excessive control, and confronting emotional barriers to temporarily delegating caregiving responsibilities	2 sessions, 90 minutes each
	4. Social-relational connectedness and mobilization of support: Become familiar with the importance and role of social and relational connectedness in mental health; learn strategies for improving and strengthening social relationships; identify and connect with in-person and virtual groups sharing similar caregiving experiences; identify cognitive, emotional, and behavioral barriers to seeking emotional and practical support from family members, friends, relatives, and neighbors and take steps to overcome them	Education regarding humans as inherently social beings and the evolutionary significance of the social brain; identification of family and nonfamily supporters and use of available resources to distribute caregiving responsibilities; awareness of factors contributing to social connectedness and emotional support, including tone of voice, active listening, nonverbal communication, eye contact, sympathy, empathy, and expression of emotions; identifying cognitive-emotional barriers to requesting emotional and practical support; communication with other family caregivers to reduce isolation and loneliness and exchange practical strategies and successful experiences; provision of contact information for support centers, respite-care services, specialist psychologists, and support groups; development of a personal support system; examination of the consequences of failing to delegate caregiving tasks or seek assistance	1 session, 90 minutes
Relational dynamics of caregiving: 1. Emotional enmeshment; 2. Interpersonal conflict; 3. Extensive and highly interdependent family relationships; 4. Gender stereotypes in caregiving; 5.	1. Self-care through recognition of needs, self-differentiation, and boundary setting: Learn how to assert oneself and communicate needs without guilt or conflict; establish healthy and clear boundaries, particularly with the older adult and family members; develop skills in role differentiation and validation of personal needs;	"Wheel of Life" exercise in which caregivers visually assess different domains of their lives, including occupation, family, recreation, health, and spirituality, to understand how parental caregiving has restricted other domains; exercises separating the self from the caregiving role; differentiating the caregiver's emotions from those of the older adult; effective "saying no" exercises	2 sessions, 90 minutes each

Caregiving as a nontransferable duty	learn and implement strategies for improving role management and reducing multiple-role strain	involving communication skills for establishing boundaries and refusing additional requests that increase responsibility; self-compassionate letter-writing to reduce internal criticism and guilt associated with expressing one's needs; modeling assertive behavior through short educational videos and role-playing	
	2. Resolving interpersonal conflicts: Modify interaction patterns with the older adult and reduce recurring conflict cycles; identify and address automatic thoughts associated with triggers at the beginning of conflict cycles and the resulting behavioral tendencies	Exercises focusing on triggers, emotions, meaning, and protective behaviors involved in conflict cycles; introduction to attachment, attachment needs, and viewing relational cycles through an attachment lens; validating one's own emotions and those of the older adult during conflict; examining the effects of conflict on emotions, relationships, mental health, and willingness to continue caregiving; identifying conflict cycles, practicing safe and empathic responses, and providing positive feedback through role-playing	1 session, 90 minutes
	3. Reviewing and reconstructing sociocultural stereotypes: Recognize sociocultural and gender stereotypes related to caregiving; increase awareness of how stereotypes influence emotions and behavior and revise maladaptive stereotypes	"Magnifying glass on caregiving beliefs" exercise; liberation-from-beliefs exercises involving logical challenging and group-based cognitive restructuring; identification and modification of irrational cultural labels associated with caregiving; construction of positive stereotypes	1 session, 90 minutes
Coping strategies: 1. Cognitive strategies; 2. Expansion of relationships; 3. Behavioral strategies; 4. Emotion regulation; 5. Spirituality-based adaptation	Examine and evaluate existing coping strategies; strengthen appropriate and effective strategies; modify ineffective strategies	Reviewing current coping strategies; introduction to strategies reported by interview participants with comparable caregiving experiences; group-based assessment of the effectiveness of existing strategies; comparison of current strategies with strategies learned during the intervention sessions; group discussion of proposed modifications and incorporation of effective strategies into the caregiver's coping repertoire; introduction to and practice of spirituality-based coping	1 session, 90 minutes
Resilience and continuity of caregiving: 1. Spiritual motivations; 2. Family motivations; 3. Ethical commitments and values	1. Identify, value, and strengthen spiritual, family, and ethical motivations for continuing care; become familiar with characteristics of resilient individuals and actively develop these attributes	Education in resilience-related skills, including self-awareness, self-care, emotion regulation, hope, realistic optimism, acceptance of uncontrollable realities, self-efficacy, effective communication, social-support mobilization, goal orientation, and meaning in life; writing about one's own caregiving experiences, listening to other caregivers' experiences, and identifying sources of self-efficacy within caregiving experiences; exercises in realistic positive thinking	1 session, 90 minutes
	2. Develop new meaning in caregiving	Meaning-making education enabling caregivers to move beyond conceptualizing caregiving solely as an obligation or burden and to redefine it as a personally meaningful and growth-promoting experience; exercises involving redefinition, reframing, and development of a positive perspective toward caregiving; exploration of internal, familial, cultural, and religious values that facilitate continuation of caregiving; exercises recalling the older adult's previous services, sacrifices, and contributions	1 session, 90 minutes
Gifts of caregiving: 1. Growth in virtues and character strengths; 2. Cognitive openness and flexibility	Develop insight into personal virtues and character strengths and recognize how the caregiving experience has contributed to the emergence or reinforcement of these strengths	Identifying virtues and character strengths through completion of Seligman's character strengths questionnaire; comparing perceived strengths before and after the caregiving experience by plotting them along a continuum and gaining insight into the role of caregiving in developing or strengthening character strengths; learning about the experiences of other caregivers in the group	1 session, 90 minutes

The content and implementation validity of the package was evaluated by an eight-member expert panel. The experts assessed each module according to six criteria: the necessity of the module; alignment between module objectives and

themes extracted from the qualitative phase of the study; correspondence between educational content and objectives; effectiveness of the exercises and educational content; consistency of session content with relevant theories; and

adequacy of the time allocated to the module. The criterion concerning module necessity was analyzed separately to calculate the Content Validity Ratio (CVR). The remaining five criteria were used to calculate the Item-Level Content Validity Index (I-CVI), the Scale-Level Content Validity Index based on the average method (S-CVI/Ave), and descriptive statistics.

For data analysis, ratings of 4 and 5 were considered indicative of expert agreement, whereas ratings from 1 to 3 were interpreted as disagreement or insufficient adequacy.

For the calculation of the CVR, ratings of 4 and 5 on the necessity criterion were classified as "essential," whereas ratings below 4 were classified as "nonessential."

To assess the necessity of the package modules, the CVR was calculated. The number of experts who considered each module essential was entered into the CVR formula. Given the participation of eight experts, a CVR value of 0.75 or higher was regarded as acceptable. The CVR findings are presented in Table 5.

Table 5

Content Validity Ratio for the Package Modules

Module	Number of Experts	Number Agreeing on Module Necessity	CVR	Decision
1	8	7	0.750	Acceptable
2	8	8	1.000	Acceptable
3	8	7	0.750	Acceptable
4	8	8	1.000	Acceptable
5	8	8	1.000	Acceptable
6	8	8	1.000	Acceptable
7	8	8	1.000	Acceptable
8	8	6	0.500	Requires revision
9	8	8	1.000	Acceptable
10	8	7	0.750	Acceptable
11	8	8	1.000	Acceptable

As shown in Table 5, only Module 8, with a CVR of 0.50, was identified as requiring revision. Because the overall mean CVR for the package was 0.886, indicating a desirable level of expert agreement regarding the overall necessity of the modules, Module 8 was retained for the pilot phase after incorporating the modifications proposed by experts who had rated it less favorably.

To assess the content validity of individual modules, the I-CVI was calculated. In the present study, each module was

treated as a separate content unit or item. Accordingly, the I-CVI indicates the proportion of experts who evaluated each module as appropriate and acceptable according to the specified evaluation criteria. Ratings of 4 and 5 were interpreted as expert agreement regarding content adequacy or relevance, whereas ratings from 1 to 3 indicated disagreement. The mean I-CVI across the five evaluation criteria was subsequently calculated for each module. The results are presented in Table 6.

Table 6

Item-Level Content Validity Index for the Package Modules

Module	Mean I-CVI
1	0.875
2	1.000
3	1.000
4	1.000
5	0.950
6	0.925
7	0.775
8	0.875
9	1.000
10	1.000
11	1.000

As shown in Table 6, the I-CVI values of the package modules ranged from 0.775 to 1.000, indicating generally favorable expert evaluations of their content-related characteristics. The lowest I-CVI was obtained for Module 7, with a value of 0.775. This value lies near the threshold of acceptability and indicates that the module approached an acceptable level of content validity, although minor revisions based on specialist feedback may further improve it.

To assess the content validity of the package as a whole, the S-CVI/Ave was calculated. This index is obtained by

averaging the I-CVI values and was 0.945 in the present study, indicating favorable content validity at the overall instrument/package level. To provide a descriptive evaluation of expert ratings, the mean, standard deviation, minimum, and maximum scores were calculated for each module. In this analysis, the total module score was calculated from the sum of the five evaluation criteria, excluding the necessity criterion. Accordingly, the possible total score assigned by each evaluator to each module ranged from 5 to 25. The results are presented in Table 7.

Table 7

Descriptive Statistics and Ranking of the Package Modules

Rank	Module	Mean	Standard Deviation	Minimum	Maximum
1	2	24.875	0.354	24	25
2	9	24.500	0.535	24	25
3	11	24.375	0.916	23	25
4	10	24.250	0.707	23	25
5	3	23.500	1.604	20	25
6	6	23.500	2.673	17	25
7	1	23.250	3.412	15	25
8	4	22.875	1.356	20	24
9	8	22.625	3.335	15	25
10	5	22.250	2.375	19	25
11	7	21.000	3.381	15	24

As shown in Table 7, Module 2 achieved the highest ranking, with a mean score of 24.875, whereas Module 7 obtained the lowest mean score, at 21.000. Nevertheless, even the lowest mean was relatively high, given that the maximum possible score was 25. This finding indicates that, overall, the experts evaluated the package modules positively. However, the relatively larger standard deviations observed for several modules, particularly Modules 1, 6, 7, and 8, indicate greater variability in expert judgments regarding these modules compared with the others. Accordingly, these modules may warrant particular attention during implementation and final refinement of the package.

4. Discussion

The present study aimed to develop and validate a culturally grounded, theory-based psychological empowerment package for family caregivers of older adults by integrating evidence from a systematic review, meta-synthesis of qualitative studies, a local qualitative needs assessment, and expert evaluation. The final intervention comprised five main modules and 11 submodules delivered

in 15 weekly 90-minute sessions through a combined face-to-face and virtual format. The package addressed multiple domains of caregiver functioning, including psychosomatic strain, emotional regulation, life-course disruption, social connectedness and support seeking, differentiation and boundary setting, interpersonal conflict, sociocultural caregiving beliefs, coping strategies, resilience, meaning-making, and recognition of personal growth and character strengths. Expert assessment indicated a high level of overall content validity, with an S-CVI/Ave of 0.945 and a mean CVR of 0.886. Most modules were judged necessary and appropriate, while only one module initially required revision based on its CVR, and the lowest I-CVI was observed for Module 7. Nevertheless, expert ratings were favorable across the package, indicating that the developed intervention achieved an acceptable level of theoretical coherence, content relevance, and practical adequacy. These findings are consistent with contemporary approaches to complex intervention development, which emphasize iterative design, stakeholder involvement, theoretical grounding, contextual sensitivity, and systematic refinement

rather than reliance on a single pre-existing intervention model (Skivington et al., 2024).

One of the most important findings of the present study was that caregiver empowerment could not be reduced to the provision of information or disease-management education. The qualitative and meta-synthetic findings indicated that caregivers experience simultaneous physical, psychological, social, relational, and existential pressures, and the intervention was therefore designed as a multilayered model rather than a conventional educational package. This structure is supported by previous evidence demonstrating that family caregiver burden emerges from multiple interacting sources, including chronic exposure to caregiving demands, physical exhaustion, restricted mobility, competing family responsibilities, emotional strain, and insufficient support (Sebzali Pour et al., 2021; Werner & Shoval, 2012). The inclusion of psychosomatic self-care, body-based mindfulness, burnout awareness, and emotional regulation in the package also corresponds with findings showing that psychological distress and caregiver characteristics can influence the continuation of home-based care (Okamoto et al., 2007). More recent evidence has further shown that burnout and compassion fatigue are closely intertwined with family caregiver well-being, while social support may buffer their adverse effects (Yang et al., 2025). These findings support the inclusion of components that increase caregiver awareness of early signs of exhaustion, promote emotion regulation, and strengthen access to interpersonal support before psychological strain becomes severe enough to undermine caregiving continuity.

The emotional-regulation component was another central element of the intervention. Caregivers in the qualitative phase described complex and sometimes contradictory emotions, including guilt, anger, sadness, resentment, anxiety, shame, helplessness, and emotional ambivalence. Accordingly, the package included training in recognizing bodily signs of emotion, labeling and validating emotional states, identifying triggers, increasing tolerance of difficult affect, co-regulation with the older adult, and self-compassion. This design is aligned with previous interventions showing that psychological techniques can reduce caregiver distress when they extend beyond basic education. Mindfulness training has been associated with reductions in caregiver burden among caregivers of older adults with Alzheimer's disease (Hosseini et al., 2016), while internet-based cognitive behavioral interventions have demonstrated the feasibility of strengthening caregivers' coping and emotional adjustment through structured

psychological treatment (Biliunaite et al., 2021). Stress-management training has likewise improved caregiver quality of life (Haffari et al., 2014), and educational support has been associated with lower anxiety among family caregivers in demanding medical contexts (Dalirirad et al., 2018). The emphasis on mentalization and reflective understanding of emotional states is additionally consistent with mentalizing imagery approaches that have been developed specifically for dementia caregivers (Cheng et al., 2022; Jain et al., 2022). Together, these studies support the assumption underlying the present package that effective caregiver empowerment requires the development of emotional awareness, reflective capacity, and adaptive regulation rather than simple transmission of information.

A further important result concerned the inclusion of social connectedness, support mobilization, role redistribution, and boundary setting. The qualitative findings indicated that many caregivers experienced shrinking social worlds, diminished participation in pleasurable activities, excessive responsibility, difficulty asking for help, and a belief that caregiving duties could not be delegated. The intervention therefore included identification of family and nonfamily supporters, training in requesting practical and emotional assistance, development of a personal support system, analysis of barriers to help seeking, and exercises in assertiveness and boundary setting. This component is strongly supported by previous research demonstrating that caregiver well-being is shaped not only by individual coping but also by the availability, quality, and accessibility of formal and informal support. Community-based care and case-management interventions have emphasized the importance of coordinated social and professional support in reducing isolation and improving caregivers' ability to manage complex care situations (Warkentin et al., 2022). Family group conference approaches similarly recognize that caregiving responsibilities should be addressed within the broader family system and that collective problem solving may reduce excessive concentration of care on a single individual (Hillebrecht et al., 2018). Virtual communities of practice can also improve caregiver quality of life by facilitating peer connection, experiential learning, and exchange of practical strategies (Romero-Mas et al., 2021). The present findings are also consistent with Iranian evidence emphasizing the need for more systematic and strategic support structures for family caregivers as population aging intensifies (Hezarjaribi et al., 2020). Thus, the social-support component of the present package appears

well aligned with both empirical evidence and the contextual realities of family caregiving.

The package also incorporated modules addressing self-differentiation, interpersonal conflict, sociocultural stereotypes, and gendered caregiving expectations. This reflects an important result of the local qualitative phase: caregiver distress was frequently embedded in family relationships rather than occurring solely within the individual. Emotional enmeshment, role ambiguity, difficulty distinguishing one's own needs from those of the older adult, conflict with siblings or spouses, and perceived moral obligations all contributed to caregiver strain. Previous qualitative research on caring for older parents has similarly shown that caregiving becomes intertwined with family identity, responsibility, and the caregiver's broader life trajectory (Hwang et al., 2017; Majidi Khameneh & Mahdavi, 2018). Research from other collectivist settings further indicates that caregiving may be experienced as highly demanding while still being framed as a moral, familial, or relational responsibility rather than merely as a burden (Nguyen et al., 2021). These findings help explain why the present package included exercises on separating the self from the caregiving role, establishing boundaries, saying no, recognizing cultural beliefs, and reframing rigid caregiving expectations. The intervention therefore moves beyond burden reduction and addresses the family and cultural mechanisms through which caregiving responsibilities may become psychologically overextended.

The inclusion of coping, resilience, meaning-making, spirituality, and positive growth represents another distinctive aspect of the intervention. The qualitative findings demonstrated that caregivers did not experience caregiving only in negative terms; many also identified increased maturity, strengthened relationships, greater self-efficacy, spiritual growth, fulfillment of ethical obligations, and development of positive character qualities. These findings are consistent with previous Iranian research describing positive caregiving experiences among family caregivers of older adults with dementia, including growth, strengthened relationships, increased patience, and deeper appreciation of personal and family values (Farhadi et al., 2018). Research based on salutogenic perspectives likewise suggests that caregiving satisfaction can coexist with strain when caregivers experience their role as meaningful and manageable (Sarabia-Cobo & Sarriá, 2021). For this reason, the present intervention included meaning-making, realistic optimism, identification of spiritual and family motivations, self-efficacy, and recognition of character strengths. Similar

empowerment-oriented studies have demonstrated benefits from strengthening resilience and adaptive capacities rather than concentrating exclusively on symptom reduction (Kiani et al., 2022; Yoon & Kim, 2020). In addition, family-centered empowerment approaches emphasize the development of control, self-reliance, and adaptive functioning (Nikrouz et al., 2020; Rabei et al., 2012). The current package therefore reflects a strengths-based understanding of caregiving in which psychological empowerment involves both reducing harmful strain and identifying internal resources that support sustained care.

The intervention's multicomponent structure is also consistent with earlier caregiver programs that combined educational and psychological methods. Project ANSWERS, for example, incorporated knowledge about dementia, communication, memory management, emotional recognition, and behavioral skills, and demonstrated improvements in caregiver strain and psychosocial outcomes (Judge et al., 2013). The SOURCE program similarly integrates problem solving, self-regulation, daily activity management, and modification of maladaptive thinking patterns, with evidence suggesting improvements in caregiver burden and quality of life (Chen et al., 2024; Chen et al., 2021). Educational and telephone-based follow-up has also been used to reduce burden and reinforce intervention gains (Bani-Ardalan et al., 2022), while mobile-based psychosocial empowerment has shown the feasibility of extending support beyond face-to-face sessions (Lahrasabi et al., 2024). The hybrid format adopted in the present package, with face-to-face intervention sessions and virtual follow-up of assignments, is therefore consistent with the emerging direction of caregiver support toward blended and flexible service delivery. Such flexibility is especially relevant because caregivers frequently face time restrictions, mobility limitations, and competing responsibilities that can interfere with attendance at conventional services.

The expert-validation findings further support the initial adequacy of the intervention structure. The S-CVI/Ave of 0.945 indicated strong agreement regarding the overall content relevance of the package, while the mean CVR of 0.886 suggested a favorable level of consensus regarding the necessity of the modules. The fact that most modules received high I-CVI values also suggests that the intervention content was broadly consistent with the qualitative findings, theoretical foundations, and intended objectives. At the same time, the lower ratings for Modules 7 and 8 are informative because they identify components that may require closer scrutiny during pilot implementation.

Rather than representing a weakness of the developmental process, this variation is consistent with the iterative nature of complex intervention design, in which disagreement among experts is used as a source of refinement rather than treated as evidence for rejecting the intervention as a whole (Skivington et al., 2024). This is particularly important in culturally sensitive intervention development because modules dealing with beliefs, coping styles, meaning, or family norms may generate more heterogeneous judgments than modules focused on clearly defined skills or symptoms.

5. Conclusion

The findings support the broader proposition that caregiver interventions should be locally grounded and culturally responsive. Iran is experiencing substantial demographic aging, and the growing number of older adults will place increasing pressure on families and existing support systems (Dehghan-Banadaki et al., 2023). The consequences of caregiving burden may become particularly important when families are expected to provide extensive care without adequate formal respite, psychological services, or social support. Previous Iranian studies have shown that empowerment, education, mindfulness, psychosocial intervention, and health-promotion strategies can improve caregiver-related outcomes (Edalat et al., 2022; Hosseini et al., 2016; Navidian et al., 2012; Yazdanmanesh et al., 2023). However, many previous interventions have focused on isolated outcomes or single mechanisms. The present package attempts to address this gap by integrating psychological, interpersonal, behavioral, existential, and culturally relevant dimensions within one structured intervention. This integrative design is also consistent with evidence that caregivers' experiences and competencies are heterogeneous and require flexible strategies rather than uniform educational prescriptions (Eghtedar et al., 2023). Therefore, the principal contribution of this study is not merely the production of another caregiver education program, but the development of an empirically informed and theoretically organized multilayered empowerment model that can be subjected to subsequent feasibility and effectiveness testing.

The study has several limitations. First, although the package was developed through multiple evidence sources and underwent expert validation, the present phase did not evaluate its clinical effectiveness, feasibility under routine service conditions, participant adherence, or durability of effects. Second, the local qualitative component and expert

panel were necessarily limited in size and may not capture the full heterogeneity of Iranian family caregivers across geographic regions, socioeconomic groups, ethnic communities, caregiving relationships, and levels of care-recipient dependency. Third, some modules received lower expert agreement than others, indicating that the wording, sequencing, or intensity of specific intervention components may still require refinement. Fourth, although the package was designed to be culturally grounded, cultural acceptability was inferred primarily from qualitative findings and expert judgment rather than tested through large-scale implementation. Finally, the 15-session format may present practical challenges for caregivers experiencing severe time constraints, high care intensity, or limited access to face-to-face services.

Future research should proceed through sequential feasibility, pilot, and effectiveness phases. Initial pilot studies should examine recruitment, retention, session attendance, homework completion, treatment acceptability, participant burden, facilitator fidelity, and the practical usability of the hybrid delivery format. Subsequent randomized controlled trials should evaluate the effects of the package on caregiver burden, psychological distress, burnout, emotional regulation, self-efficacy, resilience, social support, quality of life, and continuity of caregiving, with assessments extending into medium- and long-term follow-up periods. Future studies should also investigate potential mediators and moderators of treatment response, including caregiver age, gender, relationship to the older adult, socioeconomic status, caregiving intensity, social support, spirituality, and care-recipient cognitive or functional status. Comparative research could further determine whether all 11 submodules are necessary or whether a shorter modular version can retain effectiveness while improving accessibility. Cross-cultural adaptation and validation in other cultural contexts would also help determine which components are universally relevant and which are specifically dependent on Iranian family and cultural structures.

In practice, the package may be useful for psychologists, nurses, social workers, geriatric care teams, community health centers, caregiver support organizations, and home-care services seeking a structured framework for supporting family caregivers of older adults. Implementation should preferably involve trained facilitators capable of integrating psychoeducation, experiential exercises, group discussion, emotional-regulation skills, family communication, and culturally sensitive meaning-based work. Health services

may also consider incorporating screening for caregiver strain, burnout, self-neglect, social isolation, and difficulty requesting support into routine geriatric care so that caregivers at elevated risk can be referred to structured interventions before severe psychological deterioration occurs. The hybrid delivery model may improve accessibility by retaining the relational advantages of face-to-face sessions while using virtual contact for assignment monitoring and reinforcement. In addition, service providers should treat family caregivers as active partners in the care system rather than as invisible extensions of the patient, and organizational policies should recognize that sustaining high-quality care for older adults requires systematic investment in the psychological empowerment, resilience, and well-being of those who provide that care.

Authors' Contributions

Authors equally contributed to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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