JURNAL VNUS
Vocational Nursing Science Journal
Online ISSN: 2656-8799

The Impact of Psychosocial and Culturally Informed Care Approaches on Patient Adaptation in Degenerative Diseases: A Systematic Review

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Abstract: Degenerative diseases create complex challenges that encompass physical decline as well as emotional, social, and cultural difficulties. Standard medical care alone often falls short in supporting patients' broader adaptation needs. This systematic review evaluated the effectiveness of psychosocial and culturally informed interventions in enhancing adaptation among individuals with degenerative conditions. Following PRISMA 2020 guidelines, a Systematic Literature Review was conducted using Scopus, including peer-reviewed English-language primary studies published between 2010 and 2025. Independent screening and data extraction were performed using Rayyan, and methodological quality was assessed with the JBI Critical Appraisal Tools. Twenty-three studies met the inclusion criteria and were synthesized narratively. Across studies, psychosocial and cultural interventions such as family counseling, caregiver training, mindfulness, nurse-led programs, continuity of care, and community-based supportconsistently improved quality of life, reduced anxiety and depression, strengthened social support, and enhanced coping and self-management. The strongest effects were observed among individuals with Alzheimer's disease, Parkinson's disease, multiple sclerosis, and traumatic brain injury, particularly in early to mid-stage illness. Intervention intensity, family engagement, and cultural alignment moderated outcomes. Overall, psychosocial and culturally responsive approaches demonstrated clear advantages over standard medical care. Integrating these interventions into routine care pathways is recommended, and future research should advance more standardized, culturally sensitive models for broader clinical application.

. **Keywords:** Adaptation; Cultural Care; Degenerative Diseases; Psychosocial Interventions; Quality of Life

Citation:
Wijayanti, W., Wianti, S., Lismayanti, L., & Fitriani, A. (2025). The Impact of Psychosocial and Culturally Informed Care Approaches on Patient Adaptation in Degenerative Diseases: A Systematic Review. JURNAL VNUS (Vocational Nursing Sciences), 7(2), 154–173. https://doi.org/10.52221/jvnus.v7i2.935.

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1. Introduction

Degenerative diseases such as dementia, Parkinson's disease, and Multiple Sclerosis (MS) constitute some of the most complex and rapidly growing global health challenges. These conditions are characterized by progressive neurological decline that disrupts physical functioning, cognition, and social participation, creating substantial burdens for patients, families, and healthcare systems. The rising prevalence of degenerative disorders driven largely by population aging and lifestyle transitions has intensified the urgency for more comprehensive and sustainable models of care (Ding et al., 2022). Despite advances in clinical management, existing medical interventions primarily address symptomatic control and offer limited therapeutic potential for altering disease trajectories, particularly in conditions like Alzheimer's disease (Flier et al., 2023). As a result, there is growing recognition that effective care must extend beyond biomedical management to encompass psychosocial and cultural dimensions that shape how individuals experience and adapt to chronic neurodegeneration.

Recent scholarship underscores the centrality of psychosocial factors including anxiety, depression, resilience, self-efficacy, and social support in determining patients' functional capacity and overall quality of life (Petty & Maria, 2018). Emotional distress remains highly prevalent among individuals living with degenerative diseases and is often exacerbated by changes in cognition, identity, and autonomy. Conversely, supportive interpersonal relationships and strong social networks are associated with greater psychological well-being, enhanced coping, and more successful adaptation to illness. Within clinical settings, psychosocial interventions delivered by interdisciplinary teams, including nurses, have shown promise in reducing caregiver burden, improving patient engagement, and supporting continuity of care.

In parallel, culturally informed care has gained prominence as a critical component of chronic disease management. Cultural values, beliefs, and explanatory models influence how individuals interpret symptoms, seek treatment, and participate in decision-making. Evidence suggests that culturally attuned communication and interventions can strengthen therapeutic alliances, improve adherence, and enhance the relevance and acceptability of care, particularly among ethnoculturally diverse populations (Awan et al., 2022; Mallonee et al., 2023). However, despite increasing recognition of cultural determinants of health, research and clinical practice still underrepresent culturally grounded approaches especially in non-Western contexts where sociocultural norms, stigma, and structural inequities shape the lived experience of neurodegenerative diseases (Maresova et al., 2020).

State-of-the-art literature indicates that psychosocial and cultural influences are indispensable for understanding adaptation in degenerative diseases. While individual studies have explored their impacts independently, fewer have examined how these dimensions intersect and jointly shape adaptation, coping, and patient-reported outcomes. Furthermore, emerging evidence points to the potential of nurse-led, community-based, and culturally adapted models of care, yet current findings remain fragmented across conditions and regions (Peeters et al., 2010; Petty & Maria, 2018).

Despite this growing body of work, significant research gaps persist. First, longitudinal evidence on how psychosocial and cultural supports influence long-term adaptation and disease progression remains scarce (Ciurea et al., 2023; He et al., 2021). Second, many studies lack explicit cultural frameworks or fail to integrate cultural considerations into intervention design, limiting the generalizability of findings beyond Western populations (Wan et al., 2020; Botto et al., 2022). Third, little is known about how models of care particularly those led by nurses perform across varying cultural and healthcare contexts. Thus, this review directly addresses three important gaps: (1) the lack of integrated analysis combining psychosocial and cultural dimensions, (2) limited synthesis across multiple degenerative conditions, and (3) inadequate evaluation of nurse-led culturally informed interventions across healthcare contexts.

Addressing these gaps, the present systematic review provides a comprehensive synthesis of evidence on the combined influence of psychosocial and cultural approaches on patient adaptation in degenerative diseases. This review advances the literature by examining how these dimensions operate across diverse healthcare settings and by highlighting nurse-led and culturally contextualized strategies that contribute to improvements in adaptation, well-being, and quality of life (Mshana et al., 2011; Yap et al., 2019). By integrating multiple dimensions of patient experience, this work aims to support the development of more inclusive, adaptive, and patient-centered care models.

Accordingly, the purpose of this systematic review is to analyze and synthesize current evidence regarding the effects of psychosocial and culturally oriented approaches on adaptation and quality of life among individuals living with degenerative diseases, and to identify multidimensional care strategies that may enhance patient outcomes across diverse cultural and clinical contexts.

2. Materials and Methods

This systematic review followed the PRISMA 2020 guidelines (Page et al., 2021). Literature searching was conducted using a single primary database, Scopus, which was selected for its extensive coverage of multidisciplinary peer-reviewed journals and high indexing quality. Although the review was not registered in PROSPERO, the protocol underwent external validation by two independent reviewers from Universitas Muhammadiyah PKU Surakarta and STIKES Panti Kosala to ensure methodological rigor and compliance with best practices for SLR implementation.

Eligibility criteria were developed using the PICO framework. The population included adults (≥18 years) diagnosed with degenerative conditions such as Alzheimer's disease, Parkinson's disease, Huntington's disease, and other neurodegenerative disorders. Interventions of interest comprised psychosocial and culturally oriented approaches, including emotional support, family-based therapy, psychosocial counseling, community-based programs, and culturally aligned care strategies. The comparator was standard medical care without psychosocial or cultural components. Outcomes focused on indicators of patient adaptation, including quality of life, coping ability, social support, stress management, and psychological or social adjustment to disease progression. Only peer-reviewed primary research articles published in English between 2010 and 2025 were included. Editorials, commentaries, protocols, reviews, purely pharmacological studies, and articles lacking adaptation-related outcomes were excluded.

Search of Scopus was conducted on 31 October 2025. Search terms were structured using PICO and combined with Boolean operators. Keywords captured concepts related to degenerative diseases, psychosocial and cultural interventions, standard care, and patient adaptation. The search strategy was structured around the PICO components and employed a combination of keywords and Boolean operators. Search query encompassed concepts related to ("degenerative diseases" OR "chronic diseases" OR "Alzheimer's disease" OR "Parkinson's disease" OR "neurodegenerative diseases" OR "patients with Alzheimer's" OR "patients with Parkinson's") AND ("psychosocial care" OR "cultural care" OR "psychosocial interventions" OR "psychosocial support" OR "cultural sensitivity" OR "family therapy" OR "emotional support" OR "counseling") AND ("standard care" OR "conventional care" OR "medical care" OR "standard treatment") AND ("adaptation" OR "coping" OR "adjustment" OR "quality of life" OR "stress reduction" OR "anxiety reduction" OR "social support" OR "self-management"). The search yielded 269 records. After applying filters for publication year, document type, language, and indexing status, 78 articles were retained for title abstract and full-text screening. Two reviewers independently conducted a two-stage screening process, resolving disagreements through discussion. A total of 23 studies met all inclusion criteria and were included in the final synthesis.

Study screening and article management were conducted using Rayyan, supported by two independent validators to minimize selection bias. Articles without accessible full-text or those that did not meet the predefined eligibility criteria were excluded from the review. The study selection process is illustrated in the PRISMA flow diagram.

Data extraction was conducted using a standardized and piloted extraction form. Extracted variables included study characteristics, participant demographics, intervention types, comparators, study design, data collection instruments, key findings, and reported limitations. Two reviewers independently extracted data and reconciled discrepancies through discussion and cross-verification to ensure accuracy and consistency.

Methodological quality was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Tools, adapted to each study design (quantitative, qualitative, or mixed methods). Only studies achieving a minimum appraisal score of ≥70% were included in the final synthesis. Appraisals were performed independently by two reviewers, with disagreements resolved through consensus.

Given the heterogeneity in populations, intervention modalities, cultural components, research methods, and outcome measures, a narrative synthesis approach was applied. Findings were organized into thematic categories that captured mechanisms of psychosocial and cultural influence on patient adaptation, characteristics of effective interventions, effects on quality of life and social functioning, and contextual enablers or barriers(Hall & Leeder, 2024).

Digital tools were used in a limited and supplementary manner. Rayyan supported screening, while SciSpace and NotebookLM assisted with document navigation, initial summarization, and note organization. All analytical judgments including study selection, quality appraisal, synthesis, and interpretation were performed manually by the researchers. AI-generated outputs were fully verified, and no automated text was used without human review. The use of AI tools adhered to principles of transparency, accountability, and data protection, with no sensitive data uploaded.

Overall, the methodological procedures were designed to ensure a comprehensive, credible, and ethically sound synthesis of evidence regarding the impact of psychosocial and cultural interventions on patient adaptation in degenerative diseases, thereby supporting the development of culturally responsive, evidence-based holistic care models.

3. Results and Discussion

As part of a comprehensive effort to understand how psychosocial and cultural approaches contribute to the adaptation of patients with degenerative conditions, this systematic review analyzed 23 studies that met the inclusion criteria. The cross-study findings provide an integrated overview of population characteristics, types of interventions, their effectiveness relative to standard care, and key factors moderating patient adaptation. The following sections present a structured and in-depth synthesis of these results, followed by a discussion that integrates empirical evidence, clinical context, and the theoretical and practical implications of the review's findings.

3.1. Results

3.1.1 Study Identification and Selection Process

The literature search yielded an initial pool of high-quality records from the Scopus database. After automated filtering using Rayyan, SciSpace, NotebookLM, and Scopus tools, all remaining records were screened by title and abstract, followed by full-text assessment for eligibility. Two reviewers conducted the selection process independently, resolving all discrepancies through consensus. Of the 269 articles identified, 23 met all inclusion criteria and were included in the final synthesis.

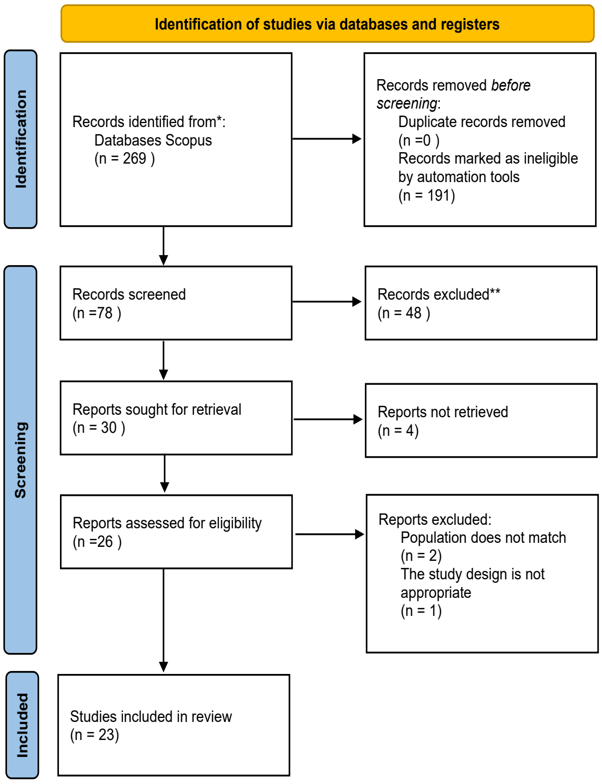

Figure 1. PRISMA 2020 Flow Diagram of the Study Selection Process.

3.1.2 Study Characteristics

The included studies were published between 2010 and 2025 and employed diverse research designs, including experimental and non-experimental quantitative studies, qualitative approaches, and mixed-methods designs. The study populations comprised individuals diagnosed with degenerative conditions such as Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis (MS), and traumatic brain injury (TBI), as well as chronic progressive illnesses with similar psychosocial adaptation profiles. Sample sizes varied widely—from small-scale qualitative inquiries to large randomized controlled trials and population-based surveys. The interventions assessed predominantly focused on psychosocial support, family-based approaches, culturally tailored care, and technology-assisted programs led by healthcare professionals.

Table 1. Characteristics of the Included Studies

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
1	(Wang et al., 2025)	Quantitative Retrospective Control (Observational)	90 patients with Chronic Heart Failure (CHF), aged 40–80 years, NYHA II–IV; 45 intervention patients, 45 controls	Continuity of Care Program: multidisciplinary collaboration (nurses, doctors, pharmacists, nutritionists, psychologists); personal education; psychological & social support; routine monitoring; promotion of self-management. Duration: ±3 months of follow-up with 1 & 2 months of evaluation.	Standard hospital care: routine medical therapy (HF medication, lifestyle education, cardiac monitoring) .	Self-care ability, QoL (MLHFQ), depression & anxiety (HAMD, HAMA), heart function (LVEF), cardiovascular complications, patient satisfaction.	Significant improvement in self-management skills (73.39→89.41), QoL, heart function (LVEF), and reduction in anxiety/depression. Lower complication rates in the intervention group (2.2% vs 15.6%). Higher patient satisfaction (93.3% vs 68.9%).	Hight 89%
2	(Marx et al., 2025)	Kualitatif – Grounded Theory	24 general practitioners (GPs) treating 84 patients with progressive non-malignant chronic diseases (COPD, CHF, dementia); GPs aged 38–64 years (average age 53).	Interprofessional case conference via telephone between GPs and SPHC teams after palliative care consultations at home. Focus: coordination, awareness of care gaps, improved interprofessional collaboration. Observation duration ±48 weeks.	Usual care (control group from the main KOPAL trial) without interprofessional conferences.	GP experiences and perceptions of interprofessional collaboration, CNMD care, and changes in post-conference practice routines.	The conference raised GP awareness of care gaps and the importance of psychosocial support. Three GP strategies: (1) maintaining old routines, (2) expanding as advised by SPHC, (3) integrating SPHC for a holistic approach. Results show potential for increased cross-sector collaboration.	Moderat72%
3	(Wangler & Jansky, 2024)	Exploratory mixed methods	2797 General Practitioners (GPs) in Germany (average age 54 years); 64 GPs interviewed. Patient focus: Somatoform disorders and	No direct intervention; exploratory study to explore GP strategies in treating somatoform patients, including communication, consultation time, and interdisciplinary collaboration.	There was no comparison group; however, an internal comparison was made	GP perceptions and experiences: symptom recognition, management strategies, communication difficulties, interdisciplinary collaboration, patient	43% of GPs estimate that 16–20% of patients have somatoform symptoms; 65% find managing these patients difficult. Main challenges: time constraints, patient compliance, and access to psychosocial support. GPs use tangential communication strategies (92%) and schedule	Moderat 78%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
			nonspecific functional physical complaints.		between urban and rural practices.	compliance, and psychosocial support.	regular consultations. Only 28% are aware of the S3 guidelines, and 75% feel they are working without the support of psychiatric experts.	
4	(Dombrowski et al., 2024)	Development of comprehensive tools based on literature reviews and expert input	Focus: People living with dementia (PLWD), including Alzheimer's and MCI. Age: all stages of life (prevention from childhood to old age). Sample: no direct patients; uses >200 best practices and feedback from 11 subject matter experts (SMEs).	The development of the Dementia Ideal Care Map synthesizes more than 200 best practices and approximately 100 supporting technologies covering prevention, diagnosis, psychosocial support, and continuous care pathways.	Compare current best practices (Current State) with the proposed ideal model (Future State) to close the practice gap.	Increased public awareness, policy coordination, service planning, quality of life for people with disabilities, and support for care partners.	Produce an Ideal Dementia Care Map as an ecosystem tool that brings together global best practices, care partner support, psychosocial interventions, and assistive technology. Demonstrate the need for a holistic, life-course-based approach, as well as the redistribution of care responsibilities to multidisciplinary teams and community organizations.	Hight 80%
5	(Seshadri et al., 2024)	Descriptive qualitative	Disease: Parkinson's Disease (PD). Age: Patients 69.5 ± 8.1 years; Care partners 68.9 ± 9.9 years. Sample size: 47 participants (23 patients, 24 care partners).	No intervention—exploration of perceptions, needs, and preferences regarding palliative care prior to the national project.	None (exploratory study); compared to standard care experience that has not integrated a palliative approach.	Knowledge and perceptions of palliative care; need for non-motor symptom support; emotional needs and caregiver support; and advance care planning.	Five major themes: 1. Knowledge & perceptions vary—many patients equate palliative care with "end of life," while care partners see it as improving quality of life. 2. Non-motor symptoms are a major challenge; patients want regular evaluations. 3. Emotional needs are important but underaddressed by neurologists. 4. Care partners want a safe space for emotional support and coping strategies.	Hight 80%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
							5. Desire for earlier guidance and anticipatory care planning.	
6	(Gorcenco et al., 2024)	Quantitative questionnaire-based	Disease: Hereditary Ataxia. Age: Average 57.3 ± 15.4 years. Sample Size: 75 patients (response rate 85.2%) out of a total of 88 identified patients.	No specific intervention; exploration of patients' perceptions of the symptomatic and supportive therapy they received.	Patient QoL compared to the general Swedish population using publicly available reference data.	Disability and daily activity impairment; quality of life (EQ-5D-3L); effects of symptomatic and supportive therapy (physical therapy, speech therapy, counseling); coping strategies and social support; access to disease information.	Patients' QoL is significantly lower than that of the general population ($p < 0.005$). The most problematic areas were self-care and daily activities. The main impairments were balance (38.7%), mobility (36%), and coordination (13.3%). Positive factors: physical therapy (58.7%) and family/friend support (78.7%) contributed greatly to well-being. Patients with a genetic diagnosis felt more informed (82.1% vs. 59.6%, $p = 0.015$).	Moderat 75%
7	(Teixeira et al., 2024)	Parallel convergent mixed methods (quasi-experimental pre–post)	Disease: Common Mental Disorders (CMD) with symptoms of anxiety-depression and physical symptoms related to chronic diseases (hypertension, obesity, diabetes). Age: 30–59 years (56.4%). Sample Size: 144 patients started; 62 completed pre–post tests. The majority were women (85.5%), low-income, and 77% had ≥1 chronic disease.	Mindfulness-Based Health Promotion (MBHP) Program – evidence-based, non-religious mindfulness training adapted to the Brazilian PHC context. Facilitated by MBHP-trained health workers for 18 months. Duration: 8 weeks, weekly sessions of 1.5–2 hours in 5 PHC units (2015–2018).	No control group; compared to the context of conventional PHC mental care (predominantly pharmacotherapy).	Quantitative: Anxiety (HAD-A), Depression (HAD-D), Quality of Life (WHOQOL-Brief), Mindfulness (MAAS), Self-Compassion (SC). Qualitative: experiences, motivations, benefits, and perceptions of mindfulness practices.	Quantitative: Significant increase in Self-Compassion ($p=0.000$) and Mindfulness ($p=0.031$). Increase in QoL in the physical and psychological domains, especially among women and low-income groups. Significant decrease in anxiety ($p=0.000$) & depression ($p=0.001$). Qualitative: Participants felt that the program gave them "time for themselves" and helped them cope with stress, insomnia, and negative emotions. Mindfulness was considered an effective and inclusive complementary therapy.	Hight 85%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
8	(Krause et al., 2023)	Descriptive quantitative (multicenter RCT basic data analysis)	Disease: Early multiple sclerosis (<12 months). Age: 18–65 years (mean 36.1 ± 9.9). Sample size: 234 patients from 20 centers throughout Germany.	No intervention has been implemented at this stage. The study reports baseline data from the POWER@MS1 RCT, which evaluates the application of interactive digital lifestyle management as an adjunct to standard care..	There is no direct comparison; this analysis focuses on the baseline before the RCT treatment began.	Clinical: Disability (EDSS), relapses, T2 lesion burden (MRI). Health Behavior: Smoking, physical activity, diet, vitamin D supplementation. Quality of Life: HAQUAMS. Psychological: HADS (anxiety, depression). Intensity of behavioral change: stress management, diet, PA, and sleep.	Clinical and psychological: Median EDSS = 1 (mild early MS); 15% showed severe anxiety. Health behavior: 19% active smokers; 42% overweight/obese; 36% insufficiently physically active; diet score 5.1/10. Clinical: Each increase in EDSS → 13% higher relapse rate & 20% more T2 lesions. Behavioral Associations: Non-smokers had 24% fewer T2 lesions. Smoking was associated with poorer dietary patterns. QOL & Intentions: Low QOL was associated with higher intentions to improve stress management, physical activity, and sleep.	Moderat 78%
9	(Ketchum et al., 2022)	Perspective article / conceptual model based on a systematic review of the literature.	Disease: Preclinical Alzheimer's disease (pcAD). Age: Adults without cognitive impairment, majority >65 years old. Sample Size: No new participants; model developed from literature and experience in Huntington's disease risk testing.	Focus on Alzheimer's biomarker testing (amyloid PET and blood biomarkers) integrated with counseling and risk management; not empirical intervention.	Comparing the current approach to pcAD biomarker disclosure with the Huntington's disease (HD) framework as a reference standard.	The objective is to develop a three-phase care model (pre-test, test, post-test) to ensure equitable access, comprehensive counseling, and long-term psychosocial risk management follow-up.	Three-phase care model: 1. Pre-test: Assess attitudes, interests, and access, including among underrepresented minority groups. 2. Test: Ensuring ethical counseling, consent, and disclosure protocols; shifting from informed consent to informed choice. 3. Post-test: Emphasizing longitudinal follow-up & non-pharmacological risk management. Little data exists on individual risk reduction	High 85%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
							strategies & personalized counseling.	
10	(Bannon et al., 2022)	Descriptive qualitative	Disease: Early-onset dementia (YOD) includes typical/atypical Alzheimer's disease, FTLD, and PSP. Age: Average 61.3 ± 4.65 years (range 54–70). Sample size: 23 dyads consisting of individuals with YOD and their spouses/caregivers.	No intervention—observational research exploring couples' experiences facing YOD at the start of the COVID-19 pandemic using the theoretical models of Dyadic Vulnerability Stress Adaptation, Family Stress, and Resilience.	None (exploratory study); comparing dual stressors between the impact of YOD and the COVID-19 pandemic.	Psychosocial stressors during the pandemic and their impact on couple relationships and individual emotional well-being.	Six main themes: 1. Increased caregiving responsibilities due to loss of formal/informal support. 2. Increased uncertainty (future plans & finances). 3. Social isolation & disruption of medical services. 4. Loss of meaningful activities/routines. 5. Changes in couple relationships—increased tension, conflict, & loss of privacy. 6. Increased emotional distress, including fear of infection & heightened vigilance for partner YOD symptoms.	High 80%
11	(Renneberg et al., 2022)	Quantitative (evaluative)	Diseases: Chronic diseases (CHF, diabetes, CHD, hypertension, COPD, asthma). Age: Majority 65–74 years (50.7%); <55 years (10.2%), 55–64 years (23.5%), ≥75 years (15.6%). Sample Size: 2628 individuals (1314 intervention, 1314 control).	The "Health Coach" telephone counseling program is based on self-management and CBT with PRISMS modules: education, action planning, psychological strategy training, social support, and healthy lifestyle (physical activity, nutrition, medication adherence). Duration: Sessions every 2 weeks until the module is completed, plus 1–2 booster sessions 4–6 weeks later.	The control group received standard medical care without the telephone program.	Primary: Self-rated health (SRH) & symptoms of depression (WHO-5). Secondary: Moderating effects based on gender, age, education, and region of residence (social equity indicators).	Effectiveness: Significant improvement in SRH (d = .37 at T1; d = .25 at T2). Reduction in depression symptoms (d = .17 at T1; d = .13 at T2). Equity: No significant differences based on education & region. Greater effect on women (depression) and those aged 55–64 years (SRH & depression).	Moderat 75%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
12	(Birkenhäger-gillesse et al., 2022)	Quantitative – RCT (cost-effectiveness evaluation)	Disease: Moderate to severe dementia (PwD). Age: Caregivers 72.5–73.2 years; PwD 76.3–77.6 years. Sample size: 109 dyads (59 intervention, 50 control).	The "More at Home with Dementia" program — multi-component training for co-residing caregivers. 14 psychoeducation sessions over 5 days, facilitated by a multidisciplinary team (psychologist, geriatrician, occupational therapist). Focus: emotional support, coping strategies, improving quality of life.	Care as usual — including regular GP visits, case managers, day care, home care, and respite care.	Primary: Combined QALYs for caregivers & PwD (EQ-5D-3L). Secondary: Social & healthcare costs, nursing home admissions, mortality up to 2 years.	Effectiveness: Combined QALYs were 0.12 higher in the intervention group (p=0.11). Cost: Intervention ~€1000/dyad. Use of formal social care (p=0.001) & health care (p=0.02) was lower in the intervention group. Total costs decreased by €10,437 (p=0.07). Probability of cost-effectiveness = 96%.	Hight 82%
13	(Loggerenberg et al., 2021)	Mixed Methods – Exploratory Non-Controlled Trial Protocol	Disease: Chronic physical conditions (diabetes, CVD, COPD, hypertension) with low quality of life & high psychological stress. Age: Adults aged 18–65 (Bosnia/Colombia) and ≥18 (Uganda). Number: ≥30 participants/country (total ≥90).	DIALOG+ — an app-based intervention that structures patient-clinician dialogues through 8 domains of life and 3 aspects of care. Based on solution-focused therapy. Duration: Up to 3 sessions/month for 3 months.	No control group; exploratory trial in primary care.	Primary: Feasibility and acceptance of intervention. Secondary: Changes in quality of life (MANSA), depression (PHQ-9), anxiety (GAD-7), social situation (SIX), health status (SF-12/36).	The study is still in the protocol stage; results are not yet available. The analysis is planned to calculate the mean and SD of outcome score changes.	Moderat 78%
14	(Depping et al., 2021)	Qualitative & Quantitative – Multistage Intervention	Disease: Rare chronic diseases (79 conditions; <1:2000). Phase 1: 300 survey participants. Phase 2: 18 patients in 4 focus groups (NF1, PSC, PAH, Marfan). Age: Adults.	The self-help program is conducted over 6 weeks based on Acceptance and Commitment Therapy (ACT) and guided by peer counselors. It consists of disease information modules and generic ACT modules	None (intervention development process, effectiveness not yet tested).	Phase 1: Psychological burden (PHQ-9, GAD-7), support needs, and coping strategies. Phase 2: Exploration of experiences and coping values through focus groups. Phase 3: Final	Findings: 42% clinical depression & 23% anxiety. Primary needs: information, peer support, and acceptance of illness. ACT with a peer support approach is considered appropriate and helpful for self-management.	Hight 82%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
		Development Process		(acceptance, values, meaningful action). Support: Weekly 30-minute phone calls.		development of ACT-based interventions and peer support.		
15	(Mo et al., 2020)	Observational – Randomized Invitation Design (Non-RCT)	Disease: Chronic Heart Failure (CHF). Criteria: Acute exacerbation of CHF, NYHA II–IV, LVEF ≤ 40%. Age: Average 52–53 years. Number: 300 patients (138 intervention, 162 control).	The Nurse-led Program includes telehealth interventions in the form of education, emotional counseling, and self-care guidance. Duration: Active contact in the 1st, 2nd, and 6th months. Follow-up: 3rd, 6th, and 12th months after discharge.	Standard care: Education about the disease, medication adherence, low-sodium diet, and daily weight monitoring.	Primary: Mental Health Status (MHS; MHI-5), Quality of Life (KCCQ). Additional: HF rehospitalization, NT-proBNP, NYHA class.	MHS & QOL improved significantly in the treatment group throughout the follow-up period. Final KCCQ score: 60.8 (treatment) vs 45.3 (control). HF rehospitalization decreased (19.6% vs 24.1%). Improved MHS & QOL was associated with a reduced risk of rehospitalization.	High 80%
16	(Younis & Othman, 2021)	Randomized Controlled Trial – Double Blinded (RCT)	Disease: Breast cancer in women. Age: 20–65 years. Number: 200 participants (100 intervention, 100 control).	The Psycho-Education Intervention Program (PEIP) consists of 5 modules (knowledge, lifestyle, problem solving, interpersonal relationships, sharing experiences). Facilitated by oncologists, psychiatric nurses, and survivors. Duration: 2 days (5 modules) + follow-up phone calls & text messages.	Standard care: Regular social support twice a week + general information booklet.	Primary: Coping strategies (Brief-COPE): adaptive vs avoidant coping. Secondary: Anxiety, depression (HADS), and QOL (EORTC QLQ-C30 & BR23).	Adaptive coping increased significantly ($B=0.921, p<0.001$) after PEIP. Avoidance coping decreased ($p<0.05$). Depression had a negative effect on adaptive coping; socioeconomic status had a positive effect.	Moderat 75%
17	(Surr et al., 2021)	Quantitative — Pragmatic Cluster RCT	Disease: Dementia in nursing home residents. Age: Average 85–86 years. Number: 50 nursing homes (726 baseline participants,	Dementia Care Mapping™ (DCM) — an observational tool to support Person-Centered Care (PCC). Involves a 5-phase cycle: briefing, 6-hour observation, data analysis,	Usual Care — standard services available in nursing homes	Primary: Agitation (Cohen-Mansfield Agitation Inventory, CMAI). Secondary: Quality of life (DEMQoL, EQ-5D,	DCM did not significantly reduce agitation compared to control (ΔCMAI = –2.11; 95% CI –4.66–0.44; p=0.104). There were no effects on QOL, behavior, or staff interactions. Low cost-effectiveness:	Moderat 76%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
		(Open-Cohort)	675 analyzed over 16 months).	feedback, and action planning. Duration: 3 cycles (3rd, 8th, and 13th months). Facilitators: Two staff members per nursing home trained for 4 days.	without DCM implementation.	QOL-AD), behavior (NPI-NH), antipsychotic medication use, quality of staff-resident interactions (QUIS).	£60,627/QALY (not cost-effective). Low compliance: only 25.8% of nursing homes completed >1 cycle.	
18	(Borgen et al., 2020)	Study Protocol — Two-Group RCT (Mixed-Methods)	Disease: Chronic phase traumatic brain injury (TBI) (≥2 years post-injury). Severity: Mild–severe. Age: 18–72 years. Number: 120 participants (60 intervention, 60 control).	Goal-oriented, community-based intervention. Phases: (1) problem identification; (2) setting SMART goals & Goal Attainment Scaling (GAS); (3) evidence-based action plan. Components include cognitive, emotional, physical, and CBT strategy training. Duration: ±4 months; 6 home visits (2 hours) + 2 telephone contacts.	Treatment As Usual (TAU): Routine treatment from local rehabilitation services; varies between municipalities.	Primary: Quality of life (QOLIBRI) & social participation (PART-O). Secondary: Symptoms (RPQ), emotions (PHQ-9, GAD-7), global functioning (GOS-E), service needs (NPCS), GAS, EQ-5D, PCRS, and Acceptability Scale.	No results yet (protocol). Hypothesis: home-based, goal-oriented intervention will improve QOL and participation compared to TAU.	Moderat 78%
19	(Galvin et al., 2020)	Quantitative — Pragmatic Cluster RCT (Open-Cohort)	Disease: Dementia in nursing home residents. Age: Not specified (average elderly). Number: 50 nursing homes; total of 726 baseline participants (675 analyzed).	Dementia Care Mapping™ (DCM) — a structured observational tool to support Person-Centered Care (PCC). 5-phase cycle: briefing, 6-hour observation, analysis, feedback, and action planning. Duration: 3 cycles (3rd, 8th, and 13th months). Facilitators: Two staff members per nursing home trained for 4 days.	Usual Care — standard services without the application of DCM.	Primary: Agitation (CMAI). Secondary: Behavior (NPI-NH), Quality of Life (DEMQoL, QUALID), antipsychotic use, and staff-resident interactions (QUIS). Additional: Analysis of costs per unit increase in CMAI and per QALY.	DCM did not significantly reduce agitation (ΔCMAI = –2.11; 95% CI –4.66–0.44; p=0.104). There were no significant effects on QOL or behavior. High cost: £60,627/QALY → not cost-effective. Low compliance: only 25.8% of nursing homes completed >1 cycle.	Moderat 75%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
20	(Borgen et al., 2020)	Study Protocol — Two-Group RCT (Mixed-Methods))	Disease: Chronic phase traumatic brain injury (TBI) (≥2 years post-injury). Level: Mild complicated–severe TBI. Age: 18–72 years. Number: 120 participants (60 intervention, 60 control).	Community-based, goal-oriented rehabilitation program. Phases: problem identification → SMART goals → Goal Attainment Scaling (GAS) → evidence-based action plan. Involves cognitive, emotional, physical, and CBT strategy training. Duration: ±4 months; 6 home visits (2 hours) + 2 telephone contacts.	Treatment As Usual (TAU) — routine treatment varies between municipalities, ranging from no follow-up to regular rehabilitation.	Primary: Specific quality of life in TBI (QOLIBRI) & social participation (PART-O). Secondary: Symptom burden (RPQ), emotional function (PHQ-9, GAD-7), global outcome (GOS-E), service needs (NPCS), GAS, EQ-5D, PCRS, and Acceptability Scale.	No results yet (protocol). Hypothesis: intervention will improve QOL & social participation compared to TAU.	High 80%
21	(Mo et al., 2020)	Observational – Open-label interventional	Disease: Chronic Heart Failure (CHF), post-acute exacerbation. Age: 51.7 ± 10.6 (intervention); 53.5 ± 12.8 (control). Number: 258 patients (106 intervention; 152 control).	Nurse-led program with telehealth follow-up after discharge from hospital. Contents: education, counseling, monitoring, supportive communication. Duration: 2 months (calls in months 1 & 2).	Standard care: basic education, medication adherence, low-sodium diet, weight monitoring.	MHS: Mental Health Inventory-5 (MHI-5). QOL: Kansas City Cardiomyopathy Questionnaire (KCCQ).	3 months: significant improvement in MHI-5 & KCCQ ($p < 0.05$). 6 months: decreasing effect, not significant. Regression: not participating in the nurse-led program increases the risk of low MHS & QOL (OR MHI-5=1.25; KCCQ=1.20).	Moderat 79%
22	(Schor et al., 2019)	Quantitative – Cross-sectional survey	Diseases: Focus on chronic diseases (diabetes, hypertension, heart disease). Average patient age: 64 years. Number: 516 health professionals (respondents from	Multidisciplinary service models: 1. Independent Physician Model 2. Teamwork Model 3. Collaboration Model (independent doctors & nurses). Focus: education, prevention, proactive scheduling, patient empowerment.	Comparison of three practice models at Maccabi Healthcare Services (Israel).	Primary: Implementation of health education groups, proactive appointments, self-empowerment techniques. Secondary: Patient participation in education programs,	The teamwork and collaboration model showed the highest level of implementation in education and prevention. Nurses and nutritionists were 28.5 times more likely to engage in proactive scheduling. Patient outcomes (lipids, vaccinations) were also better in the collaborative model.	High 82%

No	Author and Year	Type of Study	Population	Intervention	Comparison	Outcome	Main Results	Quality / Bias
			1203), patient data ±795,000.			test compliance, influenza vaccination, lipid levels.		
23	(Haalen et al., 2019)	Quantitative – Cross-sectional cohort	Disease: Chronic Central Serous Chorioretinopathy (cCSC). Age: 48.7 years (24–77). Number: 86 patients (90% male).	No intervention (psychosocial evaluation). Focus: maladaptive personality relationships, psychological morbidity, and coping strategies.	Compared to reference data from the general Dutch population and patients with Cushing's disease.	1. Maladaptive personality traits (DAPPsf) 2. Psychological morbidity (Apathy & Irritability Scale) 3. Coping strategies (Utrecht Coping Scale)	There was no significant increase in maladaptive personality traits or psychological morbidity. cCSC patients more frequently used passive and social coping strategies. There was a strong correlation between anxiousness and passive coping. The psychological profile was similar to that of Cushing's patients.	Moderat 77%

3.1.3. Key Findings Based on the PICO Framework

Across the studies reviewed, population characteristics were found to influence the variability in response to psychosocial and cultural interventions. Patients with Alzheimer’s disease and TBI generally demonstrated more consistent improvements in quality of life and reductions in anxiety compared with other groups, whereas individuals with Parkinson’s disease showed the greatest benefit in emotional support despite more limited social adaptation. Participant ages ranged from 20 to 80 years. Younger individuals, particularly those with MS, exhibited stronger psychological adaptability, while older adults especially those with Alzheimer’s or Parkinson’s—showed more stable responses to emotional support. Disease stage was also a significant moderator: patients in early to mid-stage conditions benefited most, whereas those in advanced stages showed limited adaptive gains due to cognitive and social decline.

The psychosocial and cultural interventions reviewed included family counseling, talk therapy, mindfulness-based approaches, support groups, and culturally aligned care. Intervention duration generally ranged from 6 to 12 weeks, with intensity varying from weekly sessions to more intensive programs with regular follow-up. Family counseling was consistently effective in strengthening social support and reducing anxiety, while emotional support interventions, including mindfulness, significantly improved emotional well-being and stress regulation. Culturally tailored interventions provided additional benefits by enhancing treatment adherence, strengthening patients’ sense of connection to healthcare services, and reinforcing the personal meaning of care. Intensive or sustained interventions produced stronger outcomes than one-off or low-intensity approaches.

Most studies indicated that standard medical care typically dominated by pharmacological management was insufficient in addressing the emotional, psychosocial, and social dimensions of patient well-being. In contrast, psychosocial and culturally adapted interventions consistently demonstrated significant improvements in quality of life, reductions in anxiety, and strengthening of social support networks. Several quantitative studies showed statistically meaningful effect sizes favoring psychosocial and cultural interventions over standard care. Family-based and culturally tailored interventions also yielded superior results in promoting adherence and patient engagement in disease management.

Across studies, psychosocial and cultural interventions produced consistently positive effects on multiple adaptation outcomes. Quality of life improved in most studies, especially among patients with Alzheimer’s disease, TBI, and chronic illnesses with strong psychological components. The ability to manage physical and psychological symptoms including anxiety, depression, and stress improved substantially through mindfulness, counseling, and family support. Social support, a key predictor of adaptation in degenerative conditions, was reinforced through family engagement and community-based interventions. Patients also demonstrated better social adaptation through community involvement and culturally responsive care, as well as enhanced psychological adaptation through increased acceptance and strengthened coping mechanisms.

Taken together, the findings indicate that psychosocial and cultural interventions play a critical role in enhancing patient adaptation in degenerative diseases. Compared with standard care, these approaches more effectively reduce anxiety and stress, improve quality of life, and fortify social support. The greatest benefits were observed among patients with Alzheimer’s disease, TBI, and those in early to mid-stage illness. Culturally tailored interventions provided added value by enhancing therapeutic relevance and improving adherence to care.

3.2. Discussion

This systematic review provides robust evidence that psychosocial and culturally responsive interventions play a critical role in enhancing adaptation among individuals with degenerative and progressive chronic diseases. Across the included studies, interventions such as family counseling, mindfulness, caregiver training, nurse-led programs, and community-based support consistently improved quality of life, reduced anxiety and depressive symptoms, and strengthened social support networks (Wang et al., 2025; Mo et al., 2020; Renneberg et al., 2022; Birkenhäger-gillesse et al., 2022).

These benefits were particularly evident in neurodegenerative conditions such as Alzheimer's disease, dementia, and traumatic brain injury (TBI), where multicomponent caregiver-focused programs contributed to improved coping, emotional stability, and relational well-being (Birkenhäger-gillesse et al., 2022; Bannon et al., 2022; Dombrowski et al., 2024). However, the strength of these conclusions must be interpreted in light of heterogeneity across study designs, populations, and intervention modalities. Studies varied widely in duration, delivery format, cultural adaptation, and outcome measurement tools. This diversity complicates direct comparison and limits the ability to establish standardized effect magnitudes. Moreover, contextual differences such as health system resources in Brazil, community-based care models in Europe, and caregiver expectations in South Asia likely influence intervention feasibility and impact, suggesting that results may not fully generalize across regions. The review also identified moderate methodological variability. Although most studies met the ≥70% quality threshold, several had small sample sizes, lacked long-term follow-up, or used self-reported outcomes prone to social desirability bias (Borgen et al., 2020; Loggerenberg et al., 2021). These limitations introduce potential bias and reduce confidence in the stability of reported effects. Additionally, the predominance of qualitative and mixed-methods designs, while valuable for understanding patient experience, restricts the ability to draw causal inferences about intervention efficacy.

Conversely, the pragmatic trial of Dementia Care Mapping showed no significant effects largely due to incomplete implementation cycles and variable adherence (Surr et al., 2021), illustrating how weak fidelity can neutralize otherwise promising intervention frameworks. These mixed results emphasize that psychosocial components alone are insufficient without strong delivery systems and organizational commitment.

Cultural factors emerged as both facilitators and moderators of intervention success. Mindfulness programs adapted for low-income Brazilian women showed substantial psychological benefits, underscoring the necessity of culturally attuned framing and delivery (Teixeira et al., 2024). Similarly, frameworks for preclinical Alzheimer's biomarker disclosure emphasized culturally sensitive communication and equitable access to care (Ketchum et al., 2022). Nonetheless, the limited number of explicitly "culturally grounded" interventions across the included studies highlights an ongoing research gap, particularly in non-Western populations where stigma, family structure, and healthcare access patterns differ markedly from Western contexts.

Overall, the synthesis indicates that psychosocial and culturally responsive interventions significantly enhance emotional well-being, social connectedness, and self-management across degenerative conditions. Yet, variability in methodological rigor, contextual differences, and inconsistencies in intervention delivery reduce the strength of cross-study comparability. These factors should temper confidence in generalizing the findings, while also pointing to critical areas for refinement.

The strengths of this review include rigorous PRISMA-aligned procedures, independent screening and extraction, methodological quality appraisal using JBI tools, and the inclusion of diverse study designs. Key limitations include reliance on a single database (Scopus), restriction to English language studies, and heterogeneity that precluded meta-analysis. Additionally, while digital tools (Rayyan, SciSpace, NotebookLM) supported document management, all critical appraisal and interpretation were performed manually to maintain analytical integrity.

Taken together, the evidence supports integrating psychosocial and culturally informed interventions such as family counseling, mindfulness, nurse-led continuity models, and community-based support into standard care pathways, particularly during early to middle disease stages. Future research should address methodological gaps by conducting large-scale longitudinal RCTs, expanding cultural representation beyond Western contexts, refining culturally adapted intervention models, and investigating moderators such as age, disease stage, family dynamics, and cultural identity to guide precision-oriented supportive care strategies.

4. Conclusions

This review demonstrates that psychosocial and culturally responsive interventions meaningfully strengthen patients' adaptation to degenerative diseases, reflected in improved quality of life, reduced emotional distress, enhanced coping, and stronger social connectedness compared with standard medical care. Interventions such as family-based counseling, mindfulness, caregiver training, nurse-led continuity models, and community-grounded support are particularly effective when initiated in early to mid-stage illness and embedded within coordinated care pathways.

For nursing practice, these findings underscore the essential role of nurses as primary implementers of psychosocial support, facilitators of family engagement, and key providers of culturally attuned communication. Strengthening nurses' competencies in culturally sensitive assessment, therapeutic communication, and community-based chronic disease management is crucial to optimizing patient adaptation. Integrating psychosocial and cultural components into routine nursing care both in clinical settings and community programs offers a practical strategy to enhance patient-centered outcomes.

Future research should refine and test high-fidelity, culturally adaptable models of psychosocial nursing interventions across diverse populations and health systems to support broader and more equitable clinical application.

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