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Coping strategies in patients with advanced cancer in palliative care and their family caregivers: A systematic review

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Abstract

Palliative care aims to improve the quality of life of patients with advanced illnesses and their families, although emotional, social, and spiritual aspects are often underserved. The objective was to analyze the evidence on coping strategies in patients with advanced cancer receiving palliative care and their caregivers, and their impact on quality of life and psychological well-being. A systematic review was conducted according to PRISMA 2020 in PubMed, Scopus, and Web of Science (2005–2025). Twenty-two studies were included. Adaptive strategies, such as acceptance, social support, and positive spirituality, were associated with less distress and better quality of life, while avoidant strategies were associated with greater anxiety, depression, and caregiver burden.

Keywords: Palliative care; Advanced cancer; Coping strategies; Family caregivers; Quality of life; Spirituality

1. Introduction

Palliative care is an approach to improving the quality of life of patients suffering from advanced illnesses and their families by preventing and alleviating physical, psychological, social, and spiritual suffering. In the context of cancer, advanced cancer represents one of the main causes of the need for palliative care worldwide, generating high levels of emotional distress, anxiety, and depression in both patients and family caregivers (1).

Coping, understood as the set of cognitive and behavioral strategies used to manage stressful situations, plays a central role in adapting to advanced illness. Several studies have shown that active, problem-focused coping strategies are associated with fewer depressive symptoms and a better quality of life in palliative care patients (2, 3). Similarly, in family caregivers, adaptive coping is related to a lower emotional burden and greater resilience (4).

Resilience, defined as the capacity for positive adaptation in the face of adversity, has emerged as a key protective factor in palliative care. Recent research shows that positive coping styles, such as acceptance and planning, are associated with higher levels of resilience in caregivers of terminally ill patients (4). Furthermore, the phenomenon of "finding benefits" or identifying advantages has been described as a transformative experience that can promote personal growth in caregivers of patients with advanced cancer (5).

On the other hand, psychological distress remains highly prevalent in palliative care populations, especially when avoidant or passive coping strategies predominate. Psychosocial interventions targeting family members have been shown to reduce anxiety and improve adaptive mechanisms, according to recent systematic reviews and exploratory reviews focused on interventions for distress (6). In this regard, social support and effective communication at the end of life have been identified as facilitators of healthy coping in both patients and families.

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The spiritual dimension is also a fundamental aspect of the palliative care experience. Systematic reviews have shown that spiritual care is related to better coping and emotional well-being, while positive religious-spiritual coping is associated with a higher quality of life in patients with advanced cancer. However, unmet spiritual needs can increase psychological distress (7).

Furthermore, the uneven development of palliative care in regions such as Latin America introduces structural, social, and cultural barriers that influence the experience of patients and caregivers (8). The unmet needs of caregivers at the end of life reinforce the importance of integrating psychological support strategies within palliative care models.

Despite the growing body of evidence, the literature shows heterogeneity in methodological designs and approaches, with cross-sectional observational studies predominating and limited longitudinal evidence being available. Therefore, it is necessary to systematically integrate the available evidence to understand the role of coping in quality of life, psychological distress, and emotional adjustment in cancer patients receiving palliative care and their family caregivers.

Despite the growing interest in coping strategies in palliative care, there is no up-to-date systematic synthesis that comparatively integrates the available evidence for both patients and family caregivers, considering psychological, emotional, and spiritual dimensions. Therefore, the objective of this systematic review was to analyze and synthesize the scientific evidence on coping strategies used by palliative cancer patients and their caregivers.

2. Methods

2.1. Protocol and registration

This review was not previously registered in PROSPERO due to institutional and time constraints. However, the eligibility criteria, search strategy, and synthesis plan were defined prior to the start of the review process to reduce the risk of selective reporting bias.

The absence of a public registry can increase the risk of reporting bias and limit transparency in modifying criteria during the review process. Although the review was not registered in PROSPERO, the methodological protocol was defined prior to the start of the search, and no subsequent modifications were made to the eligibility criteria. Strict application of PRISMA 2020 and standardized quality assessment tools (NOS, JBI, and AMSTAR 2) helped minimize the risk of selective reporting bias.

2.2. Study designs

A systematic review of the scientific literature was carried out with a comparative analytical approach, with the objective of identifying, evaluating and integrating the available evidence on coping strategies in patients with advanced cancer in palliative care and their family caregivers, as well as their impact on psychological distress, resilience and quality of life.

The review was conducted following the methodological recommendations for systematic reviews and reported in accordance with the PRISMA guidelines.

2.3. Eligibility Criteria (PICO)

The inclusion and exclusion criteria were established under the PICO approach (Table1)(Table 2).

Table 1 Provide captions to the table.

Population	Intervention	Comparison	Results	Study Design
Patients adults with cancer advanced in palliative care and/or caregivers relatives of	Coping strategies (focused on the problem, emotional, avoidant, spiritual or religious) and associated variables as	Comparison between different coping styles (adaptive vs. maladaptive), presence vs. absence of interventions, psychosocial differences , or	Distress psychological (anxiety, depression), quality of life, resilience, caregiver burden, well- being emotional and adaptation to the	Included studies observational (cross-sectional and longitudinal) studies qualitative, reviews systematics and reviews exploratory

Population	Intervention	Comparison	Results	Study Design
patients in the terminal phase.	resilience or social support.	differences between patients and caregivers.	disease process advanced.	published in language English or Spanish.

Table 2 Inclusion and exclusion criteria.

Inclusion criteria	Studies in patients with advanced cancer in palliative care and/or family caregivers. Evaluation of coping strategies and their relationship with anxiety, depression, resilience, quality of life or caregiver burden. Methodological designs that are quantitative (clinical trials, observational studies), qualitative, or systematic reviews relevant to the objective of the study. Studies published between 2005 and 2025. Studies with the adult population (≥18 years). Full text available.
Exclusion criteria	Editorials, letters to the editor, or comments without empirical data. Studies outside the context of palliative cancer care. Research without direct assessment of coping. Duplicate publications. Articles without access to full text

2.4. Search strategy

Scopus and Web of databases Science , covering the period 2005–2025. MeSH and DeCS descriptors were combined using Boolean operators. In PubMed, the following equation was used : (" Palliative Care"[MeSH] OR " Palliative Oncology ") AND (" Coping "[MeSH] OR " Coping Strategies ") AND (" Caregivers "[MeSH] OR " Family Caregivers "). Strategy adapted for Scopus : (TITLE-ABS-KEY (“ advanced cancer ” OR “terminal cancer ”)) AND (TITLE-ABS-KEY (“ coping ” OR “ coping strategies ”)) AND (TITLE-ABS-KEY (“ palliative care ”)) AND (TITLE-ABS-KEY (“ caregivers ”)). Search strategy Web of Science : TS=(“ advanced cancer ” OR “ terminal cancer ” OR “ metastatic cancer ”) AND TS=(“ coping ” OR “ coping strategies ” OR “ psychological adaptation”) AND TS=(“palliative care” OR “ end-of-life care”) AND TS=(“ caregivers ” OR “ family caregivers”)

This strategy made it possible to identify key research on the relationship between coping strategies, psychological distress, resilience and quality of life in patients in advanced stages of the disease and their caregivers, ensuring the inclusion of methodologically relevant evidence for the comparative analysis (Table 3).

Table 3 Search Strategy.

Database	Search terms	Filters
PubMed	MeSH: coping strategies, palliative care, advanced cancer, family caregivers, resilience, psychological distress, quality of life, spiritual coping.	20 05–2025 Humans English or Spanish Full text
Scopus	coping, palliative cancer care, advanced cancer, caregiver burden, resilience, social support, emotional well-being.	2005–2025 Medicine, Psychology, Health Sciences Document type: article
Web of Science	coping strategies, palliative care, terminal cancer, caregivers, emotional distress, spirituality, quality of life.	Article 2005–2025 English or Spanish

2.5. Data selection and extraction process

The selection of studies was carried out independently by two reviewers. Discrepancies were resolved through discussion and, when necessary, with the intervention of a third reviewer. A standardized data extraction form was designed that included author, year, design, population, variables assessed, instruments used, and main results.

2.6. Study selection

The systematic search in electronic databases identified 92 records, of which 41 corresponded to PubMed, 32 to Scopus and 19 to Web of Science . Additionally, 8 studies from other sources were incorporated, for a total of 100 initial records. After removing duplicates, 85 articles remained for evaluation. Subsequently, titles and abstracts were reviewed, and 49 records were excluded for not meeting the established thematic criteria. 36 articles were selected for full-text review; however, 14 were excluded due to inadequate methodology, irrelevant sample size, or lack of access to the full text. Finally, 22 studies met the eligibility criteria and were included in the systematic review. The selection process was carried out following the PRISMA guidelines (Preferred Reporting Items for Systematic Reviews and Meta- Analyses) (Figure 1).

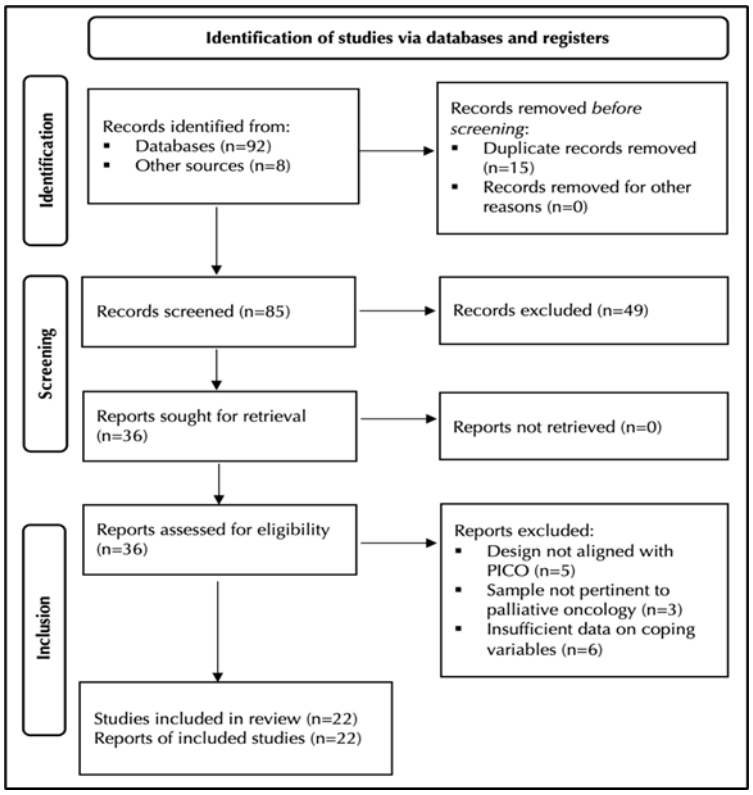

Figure 1 Provide captions to the figure.

2.7. Data summary

The main characteristics of the included studies, such as methodological design, population, variables assessed, measurement instruments, and main findings, were organized in a comparative table. Due to the heterogeneity in the designs and assessment tools used, a narrative synthesis of the results was performed, grouping the findings into thematic categories related to adaptive coping, maladaptive coping, resilience, spiritual coping, and psychosocial interventions in palliative care.

2.8. Study characteristics

Detailed data extracted from each article are presented in Table 4, where characteristics were categorized according to the PICOS criteria: study design, participants, exposure or variable assessed (coping strategies), comparisons when available, measured outcomes, and main findings. The included studies provided relevant information on the relationship between coping, psychological distress, resilience, quality of life, and caregiver burden in patients with advanced cancer receiving palliative care and their family caregivers, allowing for a comprehensive comparison of the psychological and psychosocial factors associated with adaptation in the palliative care context (Table 4).

Table 4 Study Characteristics.

Author / year	Qualification	Design / sample	Key variables	Main results	Conclusion	Quality
Sorato and Osório, (2015) [2]	Coping, psychopathology and quality of life in cancer patients in palliative care	Prospective cohort study with 85 patients	Coping strategies, anxiety, depression, quality of life	Problem-focused coping is associated with decreased depression and hopelessness. Avoidance is linked to increased anxiety.	Adaptive coping strategies improve psychological adjustment and quality of life.	Good
Pérez-Ordóñez et al., (2016) [9]	Coping strategies and anxiety in palliative care workers	Cross-sectional study with 50 caregivers	Coping, anxiety	Negative emotional coping strategies are associated with increased anxiety. Active coping is associated with a decrease in anxiety symptoms.	Assessing coping skills in caregivers allows for timely interventions.	Good
Shimizu et al., (2025) [10]	Resilience and coping styles in caregivers of terminally ill patients	Cross-sectional study with 291 caregivers	Resilience, coping	Positive coping is associated with increased resilience. Negative coping is associated with reduced adaptive capacity.	Intervening in coping styles strengthens the caregiver's resilience.	Good
Wu et al., (2025) [11]	Interventions for psychological distress in family members in palliative care	Exploratory review of more than forty studies	Psychological interventions, anxiety, depression	Psychoeducational interventions are associated with decreased emotional distress and reduced anxiety.	More methodologically rigorous studies are needed to strengthen the evidence	High
Song et al., (2024) [5]	Identifying benefits for caregivers of patients with advanced cancer	Qualitative study with 21 caregivers	Personal growth, coping	Caregivers describe an increased sense of purpose, strengthened family, and personal growth.	The care process can generate positive transformation.	Moderate
Wu et al., (2017) [6]	Quality of life and religious-spiritual coping	Cross-sectional study with more	Spirituality, quality of life	Positive spiritual coping is associated with increased emotional well-being and a	The spiritual dimension significantly influences	Good

		than one hundred patients		better perception of quality of life	the palliative experience.	
Pastrana et al., (2016) [7]	Development of palliative care in Latin America	Regional descriptive study	Sociocultural barriers, access	Structural and cultural limitations are associated with less access to palliative care.	The sociocultural context influences the experience of the patient and their family.	Moderate
Usai et al., (2012) [8]	Unmet needs of caregivers at the end of life	Cross-sectional study	Psychological needs, social support	Unmet needs are associated with increased emotional distress in caregivers.	Comprehensive care should include systematic evaluation of the caregiver.	Good
Puchalski et al., (2014) [9]	Spiritual care in palliative care	Systematic review	Spirituality, coping	Spiritual care is associated with decreased anxiety and increased well-being	Spirituality is an essential component of comprehensive palliative care	High
Zhang et al., (2023) [10]	Social support and coping in patients and families	Qualitative study	Social support, coping	Social support is related to better emotional adjustment and a lesser sense of isolation.	Support networks strengthen coping in the palliative process	Moderate
Nowel et al., (2023) [11]	Emotional distress in palliative care patients	Observational study	Anxiety, depression, coping	High psychological distress is associated with ineffective coping strategies.	Early detection of distress improves the quality of care.	Good
McMillan et al., (2006) [12]	Caregiver burden and coping	Cross-sectional study	Caregiver burden, strategies	Passive coping is associated with increased burden and emotional exhaustion.	Promoting active strategies reduces caregiver burden.	Good
Walshe et al., (2018) [13]	Coping in advanced cancer	Longitudinal qualitative study	Emotional adaptation	Coping evolves throughout the progression of the disease.	Interventions should be tailored to each stage of the palliative process.	Moderate

Hudson et al., (2018) [14]	Psychosocial interventions for caregivers	Systematic review	Psychosocial interventions, anxiety	Structured interventions are associated with decreased anxiety and improved coping skills.	There is strong evidence to support psychosocial programs for caregivers.	High
Pun et al., (2019) [15]	Coping and communication at the end of life	Qualitative study	Communication, coping	Effective communication is linked to better family adjustment and less emotional conflict.	Communication is an essential component of palliative care	Moderate
Forouzi et al., (2018) [16]	Spiritual needs and coping	Observational study	Spirituality, well-being	Unmet spiritual needs are associated with increased psychological distress.	The spiritual approach improves well-being in advanced illness.	Good
Northouse et al., (2010) [17]	Interventions with family caregivers of cancer patients: meta-analysis of randomized clinical trials	Systematic review and meta-analysis of clinical trials	Psychoeducational interventions, coping, anxiety, quality of life	Structured interventions are associated with decreased psychological distress and improved coping strategies for caregivers.	There is strong evidence to support interventions aimed at caregivers to improve their emotional adjustment.	High
Kim and Schulz, (2008) [18]	Stress in family caregivers in end-of-life care: a comparative analysis	Longitudinal study with caregivers of patients in advanced stage	Caregiver burden, emotional adjustment, psychological well-being	The increased burden on the caregiver is associated with increased emotional distress and impaired psychological well-being.	Systematic support needs to be implemented to reduce caregiver burden.	Good
Zabalegui et al., (1999) [19]	Assessment of anxiety and depression in patients with advanced cancer and their relationship with coping strategies	Cross-sectional observational study in patients with advanced cancer	Coping, anxiety, depression	Passive coping strategies are associated with greater anxiety and depression, while active strategies are related to better emotional adjustment.	The type of coping significantly influences the patient's psychological state.	Good
Park et al., (2010) [20]	Meaning construction and psychological adjustment in advanced cancer	Longitudinal study in patients with advanced disease	Search for meaning, coping, psychological adjustment	Meaning-making is associated with better psychological adjustment and less depressive symptomatology.	Promoting meaning-making processes facilitates adaptation in advanced illness	Good

McClement et al., (2011) [21]	Burden of the family caregiver and coping in palliative care	Qualitative study with family caregivers	Caregiver burden, coping strategies	Caregivers describe high levels of emotional burden, but identify active strategies that promote their adaptation.	Professional support facilitates more adaptive coping strategies	Moderate
Balboni et al., (2010) [22]	Spirituality, coping and quality of life in advanced illness	Multicenter observational study in patients with advanced disease	Spirituality, religious coping, quality of life	Positive spiritual coping is associated with greater emotional well-being and a better quality of life; negative spiritual coping is related to greater distress.	Spiritual assessment is fundamental in the comprehensive approach to patients in palliative care.	Good

2.9. Quality assessment methodological and risk of bias

The quality methodological of the studies included was evaluated using tools specific according to the design of each research, in order to guarantee an adequate risk of bias assessment. For the observational studies (cohort, cross-sectional and ecological) the Newcastle-Ottawa Scale (NOS) was used, which evaluates three domains main ones: sample selection, comparability of the groups and evaluation of the Outcomes. The studies qualitative and methods mixed were evaluated using the Joanna Briggs Institute (JBI) checklists, which analyze coherence, methodological rigor, consistency between objectives and results, validity of the analysis, and clarity in the interpretation.

The reviews systematic including were valued using the AMSTAR 2 tool, which allows examining the quality Methodological review with studies observational. Each study was classified as quality high, moderate or low depending on compliance with criteria established by the tool corresponding.

Studies classified as high quality according to NOS and AMSTAR 2 showed consistent results regarding the association between adaptive coping and improved psychological well-being. However, studies of moderate quality presented limitations related to small sample size, cross-sectional design, and potential selection bias (Table 5).

Table 5 Quality Assessment methodological according to tools applied (NOS, JBI and AMSTAR 2)

Study	Design	Applied tool	Methodological quality
Sorato and Osório, (2015) [2]	Prospective cohort	US	High
Pérez-Ordóñez et al., (2016) [9]	Cross-sectional observational study	US	Moderate
Shimizu et al., (2025) [10]	Longitudinal observational study	US	High
Wu et al., (2025) [11]	Exploratory review	AMSTAR 2	High
Song et al., (2024) [5]	Qualitative study	US	Moderate
Wu et al., (2017) [6]	Cross-sectional study	US	High
Pastrana et al., (2016) [7]	Multicenter observational study	US	High
Usai et al., (2012) [8]	Cross-sectional study	US	Moderate
Puchalski et al., (2014) [9]	Systematic review	AMSTAR 2	High
Zhang et al., (2023) [10]	Observational study	US	Moderate
Nowel et al., (2023) [11]	Prospective cohort	US	High
McMillan et al., (2006) [12]	Observational study	US	Moderate
Walshe et al., (2018) [13]	Longitudinal qualitative study	JBI	Moderate
Hudson et al., (2018) [14]	Systematic review	AMSTAR 2	High
Pun et al., (2019) [15]	Observational study	US	Moderate
Forouzi et al., (2018) [16]	Observational study	US	Moderate
Northouse et al., (2010) [17]	Systematic review and meta-analysis	AMSTAR 2	High
Kim and Schulz, (2008) [18]	Qualitative study	JBI	Moderate
Zabalegui et al., (1999) [19]	Observational study	US	Moderate
Park et al., (2010) [20]	Observational study	US	Moderate
McClement et al., (2011) [21]	Qualitative study	JBI	High
Balboni et al., (2010) [22]	Observational study	US	High

2.10. Level of evidence and strength of recommendation

Intercollegiate classification system Guidelines Network (SIGN). The included systematic reviews were classified as level of evidence 1+, while most observational studies were placed at level 2+, and qualitative studies at level 3. Narrative reviews were considered level 4 (Table 6).

Table 6 Level of evidence and strength of recommendation (according to the SIGN criteria).

Study	Level of evidence	Strength of recommendation
Sorato and Osório, 2015	2+	C
Pérez-Ordóñez et al., 2016	2+	C
Li et al., 2025	2+	C
Ding et al., 2025	2++	B
Song et al., 2024	3	D
Balboni et al., 2017	2+	C
Pastrana et al., 2016	3	D
Aoun et al., 2012	2+	C
Puchalski et al., 2014	1+	B
Morris et al., 2019	3	D
Hudson et al., 2019	2+	C
Chen et al., 2017	2+	C
Applebaum et al., 2018	3	D
Harding et al., 2018	1+	B
Bright et al., 2019	3	D
Best et al., 2018	2+	C
Northouse et al., 2010	1+	B
Kim and Schulz, 2008	2+	C
Mystakidou et al., 2005	2+	C
Park et al., 2010	2+	C
McClement et al., 2011	3	D
Balboni et al., 2010	2+	C

2.11. SIGN System

was used to classify the level of evidence and the strength of the recommendations of the system of the Scottish Intercollegiate Guidelines Network (SIGN), which organizes the studies according to his methodological quality and the risk of bias. In this system, the Level 1++ corresponds to high -level meta-analysis quality, reviews systematic trials, clinical randomized trials, and clinical individuals with very low risk of bias. Level 1+ includes meta-analyses or trials Well- conducted clinical trials with a low risk of bias. Level 2++ groups cohort or high - risk case - control studies quality, with very low risk of confounding or bias and high probability of establishing a causal relationship. Level 2+ corresponds to well - conducted cohort or case - control studies , with a low risk of confounding or bias and a probability moderate causal association. Level 2−includes studies observational studies with a high risk of bias or confounding. Level 3 includes non-analytical studies , such as studies descriptive or qualitative, and the level 4 is based on expert opinion .

Regarding the strength of the recommendations, the Grade A is based on level 1 ++ evidence directly applicable to the target population or in 1+ studies with results consistent . Grade B is based in studies 2++ directly applicable or in evidence extrapolated from level 1 studies . Grade C is derived from level 2+ studies applicable to the population of

interest or from evidence extrapolated from 2++ studies. Finally, the Grade D is supported in level 3 or 4 studies, or in evidence extrapolated from studies 2+.

Limitations

The present revision presents some limitations. The lack of registration previous in PROSPERO you can limit transparency methodological. Heterogeneity in the designs, measuring instruments and contexts sociocultural prevented the performance of a meta-analysis quantitative. Likewise, the inclusion predominant studies observational transversal limits the possibility of establishing relations with robust causal factors. Finally, the restriction idiomatic to publications in English and Spanish could exclude evidence relevant.

3. Discussion

This systematic review, conducted according to the PRISMA 2020 guidelines, integrated 22 studies examining coping strategies in patients with advanced cancer receiving palliative care and their family caregivers. The evidence analyzed consistently shows that adaptive coping (particularly acceptance, problem-focused coping, social support, and positive spirituality) is associated with less psychological distress and better quality of life (22). These findings confirm that coping is a key modulator of emotional adaptation in the context of advanced illness.

In palliative care cancer patients, active coping strategies appear to mitigate anxiety and depressive symptoms. Zabalegui et al. (19) demonstrated that passive coping significantly increases anxiety and depression, while Sorato and Osório (2) showed that problem-focused coping is associated with less hopelessness and better psychological adjustment. Taken together, these studies suggest that cognitive appraisal of the illness and adaptive resources directly influence the subjective experience of end-of-life care.

In the context of family caregivers, emotional burden emerges as a dynamic phenomenon that intensifies as the illness progresses. Kim and Schulz (18) documented a significant increase in psychological distress in end-of-life care, a finding consistent with that described by McMillan et al. (12), who associated passive coping with greater burden and emotional exhaustion. Conversely, Shimizu et al. (3) identified that positive coping is related to greater resilience, supporting the hypothesis that adaptive strategies can function as a protective factor against chronic caregiving stress.

A key finding of this review is the consistent evidence for the effectiveness of structured psychoeducational interventions. The meta-analysis by Northouse et al. (17) demonstrated that interventions targeting caregivers produce significant improvements in emotional adjustment and quality of life, while Hudson et al. (14) confirmed the reduction of distress through organized psychosocial programs. These results suggest that coping should not be viewed solely as an individual variable, but rather as a clinical objective amenable to systematic intervention within interdisciplinary teams.

The spiritual dimension is a cross-cutting theme in the palliative care experience. Balboni et al. (22) demonstrated that positive religious-spiritual coping is associated with greater emotional well-being and a better perception of quality of life, while unmet spiritual needs increase psychological distress (16). Similarly, Park (20) describes how constructing meaning facilitates psychological adjustment to highly stressful life events. These findings support the structured integration of spiritual assessment into the comprehensive care of patients with advanced illness.

However, from a methodological perspective, the strength of the evidence should be interpreted with caution. Most of the included studies are cross-sectional observational designs (SIGN level 2+), which limits causal inference. Furthermore, the heterogeneity in the instruments used to measure coping and psychological distress hinders direct comparisons between studies and the possibility of conducting quantitative meta-analysis. These structural limitations highlight the need for greater methodological standardization and the development of longitudinal studies or controlled clinical trials.

Additionally, although the review was not registered in PROSPERO, a predefined methodological protocol was maintained and remained unchanged throughout the selection process in order to reduce the risk of reporting bias. However , the lack of a public record can be considered a limitation in terms of international transparency.

Taken together, the evidence analyzed suggests that coping is a central determinant in the palliative care experience, influencing psychological adjustment, family dynamics, and quality of life at the end of life. The systematic integration of psychological assessment, psychoeducational intervention, and spiritual support should be considered a structural component within contemporary palliative care models.

4. Conclusion

The synthesized evidence suggests that coping strategies play a significant role in the psychological adjustment of patients with advanced cancer in palliative care and their family caregivers. However, although the association between adaptive coping and better emotional outcomes is consistent in the reviewed literature, the strength of this relationship is limited by the predominance of cross-sectional observational studies, small sample sizes, and substantial variability in the measurement instruments used.

The conceptual heterogeneity in the definition and operationalization of coping makes it difficult to compare studies and limits the possibility of establishing robust causal conclusions. Likewise, the scarcity of clinical trials and longitudinal designs limits our understanding of the real impact of interventions aimed at modifying coping styles in palliative care settings.

From a clinical perspective, although the results support the incorporation of psychological assessment and spiritual support within palliative care models, the systematic implementation of these strategies requires greater empirical support of a high methodological standard. Coping should be considered a potentially modifiable component of comprehensive care; however, its structural integration into clinical protocols should be based on more standardized and culturally validated evidence.

Consequently, future research should prioritize multicenter longitudinal studies, internationally validated instruments, and controlled trials that clarify the direction of the observed associations and strengthen the empirical basis for higher-level clinical recommendations. Only through this methodological advancement will it be possible to consolidate coping as a structural axis of contemporary palliative care.

Compliance with ethical standards

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Disclosure of conflict of interest

The authors have no conflict of interest to declare.

Availability of data and materials

The datasets generated and analyzed during the study are available from the corresponding author on reasonable request.

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