AMERICAN PSYCHOLOGICAL ASSOCIATION

APA RESOLUTION **on Family Caregivers**

AUGUST 2026

INTRODUCTION

Family caregiving is an essential and growing focus in psychology. Psychologists have been major contributors to family caregiving science and practice since the publication of one of the first psychologically oriented empirical articles on caregiving burden (Zarit et al., 1980). This 2026 Resolution updates the 2011 APA Resolution on Family Caregivers (American Psychological Association [APA], 2011) incorporating contemporary psychological research, practice, education, and advocacy sought to meet the needs of today's family caregivers across their lifespan and various care settings.

This Resolution uses the term family caregiver (FCG) throughout to describe an unpaid "family member or other individual who has a significant relationship with and who provides a broad range of assistance to an individual with a chronic or other health condition, disability or functional limitation" (Administration of Community Living [ACL], 2022, p.7). These relationships include FCGs who provide care to families of origin as well as families of choice across diverse caregiving contexts. Consistent with other APA documents and the family caregiving landscape, the scope of this Resolution also includes FCGs who provide support to children and adults with various medical or mental health conditions (e.g., intellectual and developmental disabilities [ID/DD], serious psychological and substance use disorders, acute illness and injury, chronic conditions such as diabetes, and progressive and/or life- limiting illnesses, such as neurocognitive disorders and cancer). This Resolution also includes FCGs who are primary caregivers to their grandchildren who may have a medical or mental health condition (ACL, 2022; APA, 2011).

The annual cost to the economy of family caregiving is $522B in the United States according to the latest estimates (ACL, 2024). Although FCGs are, by definition, unpaid, some may receive a stipend through the Centers for Medicare & Medicaid Services (CMS) or the Veterans Health Administration (VA). However, such minimal financial support is not sufficient to meet the needs of all FCGs or those who receive their care. Financial access to support programs (e.g., stipend) also varies by state or type of caregivers (AARP and National Alliance for Caregiving, 2025b). The number of, and demands on, FCGs are increasing exponentially due to the rising cost of care. In addition, FCGs experience indirect but adverse financial impacts due to out-of-pocket expenses incurred when delivering care.

Complicating the financial situation is the fact that there is a growing shortage of paid caregivers and direct care workers in institutional settings due to burnout, health risks, and career changes since the COVID-19 pandemic (ACL, 2024), as well as recent changes in immigration policy and enforcement in the United States (Chidambram & Pillai, 2025). Globally, demands on care systems are increasing, although care work continues to disproportionately fall on women and especially older women (United Nations, 2024). Additional factors include the greater emphasis on managing serious illnesses in outpatient settings, partly reflecting the desire among older adults to "age in place." The time commitments of caregiving can force FCGs, especially women, to reduce their employment or leave the workforce completely to care for their family members, potentially leading to absenteeism, reduced productivity, employment instability, and career disruption. This is particularly true when FCGs lack employer support; do not have flexible schedules; have limited workplace benefits, especially as hourly workers (AARP & NAC, 2025b); or work in an environment where there may be stigma and discrimination towards one's caregiver status.

Limited time and financial resources can become barriers to FCGs' equitable access to and engagement in their own self-care, especially among caregivers with intersecting, marginalized identities (Cohen et al., 2022; Longacre et al., 2021). FCGs may forego both leisure opportunities and preventive medical care, which can have long-term implications for their own health. Older FCGs may experience their own serious medical issues or even death, disrupting the caregiving fabric and placing the care recipient in a vulnerable situation. Finally, it is common to have a network of FCGs that may have positive experiences as they share caregiving responsibilities and offset some caregiver burden. However, FCG networks may also lead to increased interpersonal stress as they communicate their own expectations, negotiate responsibilities, and deal with difficult family dynamics that may predate the caregiving context, sometimes resulting in complications with care coordination and care fragmentation (Tingey et al., 2020).

It is therefore crucial for psychologists to maintain an ongoing role in family caregiving research, practice, education, and advocacy to address the evolving stress, mental health concerns, and potentially unmet needs of FCGs, such as by supporting the U.S. National Strategy to Support Family Caregivers (2022).

NATURE AND CONTEXT OF FAMILY CAREGIVING

In 2025, an estimated 63 million Americans, or 24% of the U.S. population, served as FCGs (AARP & NAC, 2025a). The average age of FCGs is 51 years, and the average age of the care recipient is 69.8 years. An estimated 22% of FCGs are aged 65 years and older and 61% are women. Among FCGs, 65% identify as non-Hispanic White; 10% reported being lesbian, gay, bisexual, and/or transgender. While intended to be nationally representative, these data are limited by the underrepresentation of different racial/ethnic minority groups, as well as the lack of disaggregation of Asian, Native Hawaiian, and Pacific Islander groups. Furthermore, these surveys were conducted in English, thereby limiting the likelihood of capturing of the experiences of non-English speakers.

According to the same report, FCGs provide care to a wide variety of family members, including parents, children (both under 18 and adult), spouses/partners, siblings, grandparents, and "chosen families" including friends or other kinship groups. Approximately 24% of FCGs care for more than one family member. Half of all FCGs care for a parent (40%) or parent-in-law (7%), and 5.7% care for a child with an illness, injury, disability, or mental health problem. A substantial percentage also care for a spouse (15%), grandparent or grandparent-in-law (8%), or nonrelative (11%).

FCGs provide emotional support, help with activities of daily living (e.g., bathing and toileting), instrumental activities of daily living (e.g., managing finances and medications), self-management support (e.g., managing medications, preventive care), and coordination of healthcare and social services. FCGs are often responsible for communicating with medical and mental health professionals to coordinate care across care transitions (e.g., from hospital to nursing home) and to understand and advocate for the needs of the care recipient. Although family caregiving usually takes place at the care recipient's home in the community, it may also involve other healthcare and residential care settings (e.g., hospital ICU, skilled nursing facilities, hospice). FCGs may therefore be required to assist in coordinating the provision of services, including those provided by paid caregivers such as home-health nurses. Evolving responsibilities include digital health management (e.g., electronic medical records) and telehealth navigation.

The nature of caregiving varies substantially depending on the underlying condition. Caregiving in the context of serious mental illness (SMI) often involves managing symptom relapse, medication adherence, crisis episodes, and stigma, with caregivers frequently serving as informal care coordinators within fragmented systems (Perlick et al., 2016). In substance use disorders (SUD), families may navigate repeated relapse cycles, overdose risk, financial and legal stressors, and complex boundary setting, with recent research emphasizing the psychological toll on caregivers and the importance of family-inclusive interventions (Osilla et al., 2025). Caregivers of individuals with ID/DD often provide lifelong support that includes advocacy, service coordination, and future planning, particularly as parents age (Lindahl et al., 2019; Seltzer et al., 2011). In contrast, dementia caregiving typically includes progressive decline, increasing supervision needs, behavioral symptoms, and anticipatory grief, with well-documented risks for caregiver burden, depression, and health decline (Greene et al., 2026; Pinquart & Sörensen, 2003, 2005; Schulz & Sherwood, 2008). Across conditions, differences in predictability, crisis intensity, duration, and system navigation demands shape caregivers' emotional experiences and support needs.

Psychological research illustrates that the nature and history of the relationship between the FCG and recipient serve as key influences on the caregiving experience. FCGs may receive support from adult children, siblings, or even other relatives and chosen families (Mulcahy Symmons et al., 2023; Opsomer et al., 2022; Phillips et al., 2023; Wiegelmann et al., 2021). For spouses/ partners who serve as FCGs, there may be both higher positive and negative impacts of caregiving compared to nonspousal/ partner caregivers (Dang et al., 2022). The negative effects are especially pronounced for care recipients when caregiving is intensive, such as when the recipient has dementia (Lai et al., 2024). Research suggests that adult children caring for a parent, including Millennial caregivers and those who are middle-aged and older, may have different resources and needs based on their developmental stage (e.g., childcare needs, work advancement), which could result in having dual roles and added pressures; yet they may also report greater satisfaction due to role enhancement. A narrative review of literature from 2004 to 2019 cited the ongoing stress faced by custodial grandparents, including complex family relationships and the need for parent training (Hayslip et al., 2019). Thus there are important historical and generational influences on caregiving (Aaron et al., 2023; Brady et al., 2024).

Family and paid caregivers increasingly function as an intertwined workforce, and about one third of FCGs support someone who also receives paid home care from a direct care worker. Many paid workers first entered the field as unpaid family or friend caregivers themselves (PHI and NAC, 2024). As with FCG, paid caregivers report intensive physical and

emotional labor. However, unlike FCG, they struggle with unique challenges of role ambiguity, feelings of disrespect, and low wages, contributing to high turnover that can affect FCGs (Sterling et al., 2021). Since immigrants constitute 28%-32% of the direct care workforce, the current enforcement-oriented immigration policy and the rollback of protections for health facilities are expected to further destabilize staffing. These policies impact both paid caregivers and FCG, who must absorb gaps in paid care coverage and navigate even more underresourced care teams (Center for Medicare Advocacy, 2025).

To provide optimal support to FCGs, psychologists need to be familiar with the range of circumstances and challenges that face this large and growing segment of the population.

IDENTITY, INTERSECTIONALITY, AND FAMILY CAREGIVING

The family caregiving experience is further shaped by the FCG's various identities, including age, gender, sexual orientation, race and ethnicity, health and disability status, education, and socioeconomic status. Of course, no two FCGs from a demographic group will have identical caregiving needs, experiences, and supports due to other demographic (e.g., age, disability), cultural (e.g., racial/ethnic minority, indigenous identity, immigration status), and geographic (e.g., rurality, natural disasters, geographic isolation on reservations) factors. Historically, empirical evidence has reflected the experiences of FCGs who are non-Hispanic White, heterosexual, and part of nuclear families.

In most cultures, gender norms dictate that women are caregivers. As noted earlier, 61% of all FCGs in the United States are women, and research indicates that women are more likely than men to provide intensive care, emotional support, and longer-term care, thereby reducing their time in the workforce and even leaving it completely to become a FCG (Huertas-Domingo et al., 2023). Such decisions have a significant impact on the economic well-being and security of many women FCGs. Because gender norms also intersect with race, women FCGs of color may experience additional expectations to provide care while getting limited financial support. This may be particularly challenging for Black women FCGs who are dealing with their own perinatal health issues as the maternal mortality crisis disproportionately affects Black women (Hoyert, 2025).

Age is another characteristic that has been studied extensively in family caregiving research. An estimated 42% of all FCGs are age 65 or older (AARP & NAC, 2025a). Older spousal/partner caregivers are more likely to be solo caregivers with a disability or illness (Ornstein et al., 2019). Although no research to date has examined FCGs with disabilities, caregivers with disabilities may experience greater access issues when they and their care recipients both need varying types of accommodations and support (e.g., a Deaf FCG needs ASL interpreter services at the hospital where their adult child who is in a coma after a stroke; when a FCG who needs to use a wheelchair is flying with a spouse living with dementia and related behaviors). In addition, disabled parents may experience stigma and discrimination across the lifespan (APA, 2024b). In communities that are impacted by massive incarceration and/or substance use, including Black families, it is more likely for grandparents or older siblings to care for, or become foster or adoptive parents to, grandchildren and younger siblings (e.g., Turner et al., 2025; Xu et al., 2025). Although grandparents are generally resilient, they also experience notable financial stress, chronic physical health and psychological concerns, social isolation, stigma about their family circumstance, and difficulties accessing services and support (Hayslip et al., 2019).

There is growing attention to youth caregivers (i.e., FCGs who are under the age of 18 years old). Over 5.4 million children under age 18 provide care for older, ill, or disabled adult family members, with Latinx and Black youth providing higher levels of family caregiving due to systemic inequities and not only cultural factors. Adolescents and youths who care for a parent diagnosed with young-onset dementia may experience interruptions to their educational goals and other developmental needs (Sobers et al., 2025). Youth caregivers experience more emotional challenges, peer difficulties, lower school grades; and there are also poorer health habits among older youths and among White non-Latinx youth caregivers (Armstrong-Carter et al., 2025). Very young children aged six and younger are more likely to provide caregiving (e.g., assisting with household tasks, providing social contact, translating) in households of lower socioeconomic status. According to reports by parents, very young children experience fulfillment in their role as FCGs; however, they also experience lost sleep, increased emotional distress, and interference with school and social life.

Over the past few decades, there has been growing attention devoted to understanding the caregiving experiences of different minoritized communities. Minoritized FCGs share commonalities such as more intensive caregiving, juggling multiple caregiving roles, greater economic, educational, legal, and healthcare barriers; less access to caregiving resources; greater discrimination, marginalization, and stigma (e.g. Mage et al., 2024). For example, historical context (e.g., slavery, Jim Crow, medical experimentation), as well as generational, historical, and contemporary trauma (e.g., the Holocaust, internment camps, genocide, forced assimilation and boarding schools, involvement with the criminal justice system, law enforcement-related violence) may influence caregiving patterns, help-seeking behaviors, and needs in Black, Indigenous, and other minoritized families because these experiences may impact trust in

healthcare, mental health care, and other social systems. Immigration and migration history may further impact FCGs' caregiving resources and stress, namely language barriers, unfamiliarity with different healthcare systems, increased uncertainties about their legal status considering recent immigration policy changes, and potential for work exploitation. Furthermore, for FCGs who also work in long-term care settings (Chidambaram & Pillai, 2025), there may be "double caregiving burden" as unpaid caregivers at home. In addition, racial/ethnic minoritized groups often espouse collectivism compared to the individualism prevalent among non-Hispanic white groups, with a focus on familism, filial piety, and filial obligations (Knight & Sayegh, 2010). This may result in a reluctance to seek support outside of the family.

Sexual/gender minoritized groups continue to experience limited support in their caregiving experience. In the 2025 Caregiving in the United States study, LGBTQ+ caregivers were less likely to have paid or unpaid assistance, more likely to face negative financial consequences, more likely to be working while caregiving, experiencing more isolation and poorer health, and being less likely to be included in care conversations when their care recipient is in the hospital (AARP & National Alliance for Caregiving, 2025). Research on LGBTQ+ older adult dementia caregivers suggested that minority stress intersected with caregiver stress to impact health, highlighting the importance of considering LGBTQ+ FCGs with intersecting identities, namely those from racial and ethnic minority groups (Lampe et al., 2025). FCG who identify as LGBTQ+ have also historically experienced barriers to social and legal recognition of their relationship status, amplifying the stress on these FCG while also making the act of caregiving uniquely challenging.

As this field continues to evolve, contemporary and future areas for psychological research about FCGs should examine more carefully intersectionality as a conceptual framework to better appreciate the nuances of family caregiving (Brady et al., 2024; Hepburn et al., 2025). In addition, there is an urgent need to improve the data infrastructure to capture the diverse experiences of FCG who have historically not been adequately studied, including but not limited to FCGs in rural communities, FCGs from racial/ethnic minority groups, households with multiple FCGs, FCGs who also work as professional caregivers, and non-English-speaking FCGs.

STRESS IN FAMILY CAREGIVING

The impact of family caregiving is multidimensional, complex, and variable and can be influenced by demographic variables and health status of the FCG, the intensity of care provided, relationship to the care recipient, diagnosis or condition of the care recipient, symptom severity of the care recipient, and personal and cultural characteristics (Larkin et al., 2019; Schulz et al., 2020; Spiers et al., 2021; van den Kieboom et al., 2024; Walbaum et al., 2024).

Captured by the term "caregiver burden," there is a long history on the combination of challenges faced by FCGs, including caregiving stress, depression and anxiety, quality of life, limited educational opportunities, financial strain, social isolation, and cognitive decline (Al Maqbali et al., 2025; Allen et al., 2017; Daley et al., 2019; Ervin et al., 2022; Haley et al., 2020; Kaddour & Kishita, 2020; King et al., 2024; Larkin et al., 2019; Walbaum et al., 2024). Family caregiving has been found to be associated with increased depressive symptoms (Gallagher & Wetherell, 2020; Liu et al., 2021). FCGs of people with dementia are more likely to experience symptoms of depression and anxiety than nondementia caregivers (Huang, 2022; Sheehan et al., 2021). A heightened risk of depression among FCGs is influenced by various factors, such as caregiver guilt (Han et al., 2025), individual coping mechanisms, hours spent in caregiving, and the caregiving context (Walbaum et al., 2024). Anxiety has also been found to be a prevalent difficulty experienced by dementia FCGs (Kaddour & Kishita, 2020), with caregivers of individuals with Alzheimer's disease reporting higher anxiety and depression scores compared to those assisting with care for persons with other types of dementia (Deli et al., 2024).

The FCG's physical health can also be influenced by substantial and sustained caregiving (Haley et al., 2020). For example, caregiving is associated with higher risk of diseases of the spine, hypertension, diabetes, and reduced quality of life (Janson et al., 2022). FCGs are also found to experience higher rates of dementia risk factors such as excess alcohol consumption, obesity, smoking, depression, social isolation, physical inactivity, air pollution, and LDL cholesterol. FCGs are also less likely than non-FCGs to have health coverage, and have increased risk of inadequate health care coverage, often due to cost (Kilmer, 2024; Tingey et al., 2020). Psychologists, researchers, and those who provide services to FCGs should be aware of the potential strains associated with family caregiving and the impact these can have on mental and physical health. Routine screening of FCG for burden, stress, and depressive symptoms has been shown to be clinically feasible in waiting rooms (Suresh et al., 2023) and primary care (Riffin et al., 2019, 2020, 2021) Conceptualizing caregiving as a chronic stressor should be used to advocate for routine measurement of stress-related physical and physiological measurements.

RESILIENCE IN FAMILY CAREGIVING

Early psychological research on caregiving emphasized caregiver burden and stress rather than the positive benefits of caregiving, such as personal growth and positive affect. However, psychological science on stress and coping (Lawton et al., 1989; Lazarus & Folkman, 1984) has facilitated a

paradigm shift in caregiving research since the early 2000s, moving the focus from reducing caregiver stress and burden to optimizing positive family caregiving experiences. A concept analysis of the term "resilience" revealed key aspects that include acceptance, coping strategies, social support, self-appraisal, and spirituality (Poe et al., 2023).

Research supports the existence of resilience and its conceptual convergence among a variety of caregiving contexts, including FCGs caring for those with neurocognitive disorders (Lee & Li, 2022; McKenna et al., 2022) such as dementia (Poe et al., 2023; Quinn & Toms, 2019; Yu et al., 2018), as well as those in palliative care settings (Palacio et al., 2020). A systematic review of 41 published studies identified four key domains of resilience: a sense of personal accomplishment, a sense of mutuality, an increase in family cohesion and functionality, and derivation of meaning and a sense of purpose (Yu et al., 2018). A narrative synthesis of dementia caregiving across 53 studies found that FCGs' identification of positive aspects of family caregiving was associated with lower self-reported symptoms of depression and burden, better mental health, greater life satisfaction and quality of life, and greater self-efficacy (Quinn & Toms, 2019).

In the only English-published study that has examined older adult FCGs of autistic adults, researchers found that this population is at risk for chronic stress, poor mental health, and decreased quality of life. However, despite such challenges, these FCGs also show evidence of resilience, particularly as facilitated by positive social support, self-efficacy, and problem- and meaning-focused coping styles (Chakurian & Popejoy, 2024).

Resilience also exists among grandparents who serve as FCGs of young children, although there is a need for more evidence on how cultural, sociointerpersonal and policy-related considerations shape this (Hayslip et al., 2019). Resilience also fosters improved mental health in caregivers of persons with late-stage dementia who are using hospice or other palliative care services (Han et al., 2025). Community support and spirituality function as resilience factors in Black FCGs (Idorenyin Imoh & Charity, 2023).

Given the extensive evidence supporting the existence of resilience among FCGs, a reframing of caregiver well-being is needed to foster a more balanced view of the caregiving experience and to provide a basis for interventions (Marino et al., 2017). Although many FCGs from racial, ethnic, sexual, and gender minority groups demonstrate remarkable resilience, clinicians, researchers, and advocates shall strive to dispel stereotypes (e.g., Strong Black Woman schema; Thomas et al., 2022) that may delay efforts to address systemic barriers and to advocate for better caregiver resources, as resilience may coexist with suffering. Advances in psychological science and practice will rely on incorporating culturally grounded resilience models that include collectivism, spirituality, community coping strategies, while also focusing on positive caregiver outcomes, such as meaning making, advocacy skills development, and posttraumatic growth.

FAMILY CAREGIVING INTERVENTIONS

Psychological research on family caregiving cuts across age groups from children and adolescents as caregivers (Armstrong-Carter et al., 2025) to older FCGs caring for adult children with disabilities (Chakurian & Popejoy, 2024). Such information helps inform and tailor the delivery of psychological interventions for other family caregiving relationships. While much of the intervention research has focused on FCGs of people living with dementia, there is a growing evidence base of behavioral interventions that support FCGs of other chronic conditions such as cancer, diabetes, and heart failure (Applebaum et al., 2024; Dionne-Odom et al., 2022; Piette, 2009; Rosland et al., 2022; Trivedi et al., 2023) as well as interventions to support FCGs of those with serious mental illnesses and substance use disorders (Osilla et al., 2025).

Psychologists have taken a leadership role in creating, implementing, evaluating, and disseminating evidence-based interventions in applied research to reduce distress and improve the well-being of FCGs and care recipients, including individual psychotherapy, self-care and relaxation training, skills training (e.g. behavioral management strategies and interventions), psychoeducation (e.g. education about the disease, stress management, resources), support groups, and caregiver family therapy (Burgio & Wynn, 2021; Cheng et al., 2022; Qualls, 2016; Schulz et al., 2020). Cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), and mindfulness-based interventions for parents caring for children with serious illness and disabilities, stroke caregivers, and dementia caregivers across racial, ethnic, and cultural groups have demonstrated efficacy and effectiveness (Atefi et al., 2023; Han, 2021; Holmberg Bergman et al., 2023; Risch et al., 2025). A recent clinical handbook summarizes assessment and intervention tools for clinical psychologists treating patients with FCG distress (Gallagher-Thompson et al., 2023).

Psychoeducational programs for family caregivers are widely used to reduce caregiver strain by combining information (e.g., what to expect as the illness progresses, how to interpret behavioral symptoms) with skills training (e.g., problem-solving, communication strategies, behavior management, risk assessment, stress management, and self-care planning), often paired with coaching or peer support. Reviews focused on dementia (Cheng et al., 2022), advanced cancer (Chow et al., 2010), and schizophrenia (Okafor & Monahan, 2023) showed that these interventions have small-to-moderate benefits for key caregiver outcomes, including reductions in

depressive symptoms, caregiver burden, and distress, and improvements in coping and confidence in handling behavior concerns (e.g., Amin Abdelhalim et al., 2025; Burgio & Wynn, 2021; Sikora Kessler et al., 2021), particularly when programs are structured, multicomponent, and skills-based, and include active practice rather than information only (Meyer et al., 2018; Rouch et al., 2021; Schulz et al., 2003, 2009; Yu et al., 2018). Efficacious multicomponent interventions also improve FCGs' knowledge, reduce care recipient symptoms, and delay long-term care placement of care recipients (Cheng et al., 2022; Cheng & Zhang, 2020; Chow et al., 2010; Khiewchaum & Chase, 2021; Pinquart & Sörensen, 2005; Shin et al., 2026; Wiegelmann et al., 2021). For example, REACH II was a large, randomized trial of 642 diverse dementia FCGs that tested a 12-session skills-based intervention (Belle et al., 2006). The program reduced depressive symptoms across all racial/ethnic groups and improved quality of life for Hispanic and White caregivers. Adaptations have been made by community-based agencies (e.g., 4-session REACH OUT), the U.S. Department of Veterans Affairs (REACH VA; Nichols et al., 2016), cultural adaptions to American Indian and Alaska Native Tribal communities, and the online Caregiver TLC: Thrive, Learn, Connect (Montoro-Rodriguez et al., 2025).

Family caregivers frequently experience multiple forms of grief across the caregiving trajectory. Anticipatory grief may arise as caregivers confront progressive changes in a loved one's health, functioning, or identity. Recent studies confirm that higher caregiver burden, illness uncertainty, lack of informativeness, and income level is significantly associated with greater anticipatory grief, and that resilience and strong family functioning can help mitigate these effects (e.g., Li, C., et al., 2023; Li, J., et al., 2022; Wang et al., 2022). Prolonged caregiving stress also places caregivers at risk for compassion fatigue and psychological distress, with research showing links between chronic caregiving demands, emotional exhaustion, and mental health outcomes such as anxiety and depressive symptoms (Applebaum & Sannes, 2025). Some caregivers, particularly those navigating repeated medical crises or crisis care situations, may experience emotional distress and trauma responses, underscoring the value of trauma-informed care approaches that prioritize safety, empowerment, validation, collaboration, empowerment, and holistic support (Meng et al., 2025). Grief-informed and trauma-informed support, including psychoeducation, peer groups, counseling, and respite services, are therefore critical to sustaining caregiver well-being across both caregiving and bereavement phases.

Recent research supported the usefulness of telehealth in improving the mental wellbeing of FCGs of children with neurodevelopmental disorders (Kelson & Dorstyn, 2025) and dementia FCGs whose care recipient transitioned to long-term care settings (Gaugler et al., 2024). Web-based programs, often with facilitator support, can reduce caregiver distress and improve quality-of-life-related outcomes. WHO's iSupport is a prominent example, with growing trial evidence in multiple settings (Brijnath & Antoniades, 2025; Windle et al., 2025; Zhao et al., 2019). In addition, online health communities may support FCGs to flexibly access information and support based on their own schedule, and overcome barriers of distance, mobility, or travel costs (Kamalpour et al., 2021). Interventions with a virtual component, either live or through study-specific software, have been found to be efficacious and effective in specific clinical population such as depression (Aikens, Trivedi, Heapy, et al., 2015), cancer (Badr et al., 2016), diabetes (Aikens, Trivedi, Aron, et al., 2015; Rosland et al., 2015), and heart failure (Piette, 2009), as well as for patient-caregiver dyads managing multiple conditions (Trivedi et al., 2023). However, FCGs from marginalized and minoritized groups such as racial and ethnic minority FCGs and FCGs in rural communities may not have reliable access to broadband internet infrastructure often necessary to access these interventions (Wang et al., 2025).

Despite psychology's contributions in basic and applied caregiving research, there is insufficient research-practice collaboration to translate evidence-based practices into community-based, culturally appropriate family caregiver interventions and services (National Academies of State Health Policy, 2022). There is a strong need to either culturally adapt evidence-based programs or codesign programs in collaboration with cultural groups to ensure that the programs meet the needs of the community. Faith-based communities with Black churches are a strong example of such programs (Epps et al., 2022). Accumulating evidence shows that for Black dementia caregivers, programs embedded in faith settings and championed by faith leaders improve caregiving outcomes such as increased knowledge of dementia and improved coping skills (Fields et al., 2025). In general, FCGs may lack equitable access to and engagement in interventions, due in part to the extensive demands of their caregiving responsibilities, particularly FCGs with significant work obligations, regional variability in caregiving resources, limited time, and limited financial resources (Cohen et al., 2022; Longacre et al., 2021). More research is needed to maximize the potential contributions of these interventions in reducing caregiver burden and maximizing resilience.

EDUCATION, TRAINING, AND ADVOCACY

APA has developed guidelines and resolutions on practice with diverse populations that hold relevance for psychological practice with FCGs, including *Guidelines for Psychological Practice With Older Adults* (APA, 2024a), *Guidelines for Assessment of and Intervention With Persons With Disabilities* (APA, 2022), *Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* (APA, 2021), and the *Resolution on Parents With Disabilities* (APA, 2024b). Currently, there

are no professional guidelines for working with FCGs. More information is needed for psychologists and caregivers to increase knowledge and skills in this area beyond static online material. In addition, there are few culturally relevant and personalized education and training opportunities based on variations in preferences, needs, and experiences among FCGs across different disease/caregiving contexts.

To support FCGs, APA continues to train psychologists and facilitate opportunities to advocate for policies supporting FCGs at the local, state, and federal levels. For example, APA encourages the use of the Recognize, Include, Support, and Engage (RAISE) Act (ACL, n.d.) to support FCGs of older adults, as well as grandparents who are caregivers. Additionally, APA supports the mission of the National Institute on Aging to provide vital funding support for caregiving research and training programs across disease contexts. Even when policies are enacted, they may be inequitably implemented in diverse and minoritized groups due to structural barriers, systemic racism, and inequitable distribution of resources.

APA can support all FCG communities by engaging with a variety of policy and advocacy groups, including those that focus on the needs of cultural/minority groups, including but not limited to Diverse Elders Coalition, National Caucus & Center on Black Aging, and Services and Advocacy for GLBT Elders (SAGE). APA supports efforts to enhance the health and well-being of family caregivers as exemplified by updates to the 2010 *Family Caregiver Briefcase for Psychologists* (updated in 2015; 2020; 2026 pending) and the adoption of the 2011 *Resolution on Family Caregivers*, as well as partnerships with the National Alliance for Caregiving and others to advocate for the rights of and support for FCGs. In addition, APA submitted written comments to the ACL regarding the National Strategy to Support Family Caregivers (2022) and to the U.S. Congress's Special Committee on Aging regarding the mental health impact of family caregiving (2024) and published a *Caregiving Policy Statement* (2025) to inform policy at the federal level.

Consistent with APA's commitment to promote a global perspective in psychology, it is important to amplify models of family caregiving around the world, especially for family-centered care (FCC) to be supported across the lifespan (Kokorelias et al., 2019). In the World Health Organization (WHO)'s various guidelines and policy recommendations (e.g., *Integrated Care for Older People; Supporting Informal Long-term Caregivers for Older People; Caregiving Interventions for Early Child Development*), accessible training and support programs for FCGs are key. Countries such as Australia, Germany, and the United Kingdom have implemented more comprehensive caregiver support systems, including caregiver allowances, statutory rights to assessment, and integration of caregiver needs into healthcare planning. Some of these strategies are already part of the U.S. National Strategy to Support Family Caregivers (2022). However, without a strong commitment to providing financial and social support to FCGs, caregiver support may remain inadequate, and adherence to FCC principles may be difficult to achieve. At its worst, this could result in FCGs being involved in hospital care only as unpaid labor when hospital staff is unavailable (Gwaza & Msiska, 2022).

IN SUMMARY

WHEREAS psychologists are key in advancing the science and practice to promote resilience across the scope of chronic illness trajectories through their involvement in content development in education and training to healthcare professionals and family caregivers, as well as in the refinement of psychological assessment tools of burden, resilience, abuse/neglect, and capacity; and WHEREAS the FCG empirical evidence has been historically defined based on single identities such as gender, age, race/ethnicity, health and disability status, and sexual and gender identity; and

WHEREAS much of the scientific basis of our insights into FCGs and caregiver intervention is based on family caregiving experiences of non-Hispanic White communities and the experiences of women; and

WHEREAS caregiving expectations and experiences of racial/ethnic, LGBTQ+, and other minoritized communities are often influenced by cultural mores, generational trauma, and the historical exploitation of women of color as caregivers, and such communities also usually face the specific challenges related to structural racism, implicit bias in healthcare, and economic disparities; and

WHEREAS psychologists have significantly contributed to the design and implementation of evidence-based interventions for FCGs, delivered in person, virtually, over the phone, and asynchronously; and

WHEREAS existing evidence-based approaches to support FGCs are disease and/or age specific; typically focused on dementia, cancer, other chronic health conditions, and children with ID/DD; and have varying degree of cultural relevance and ease of engagement; and

WHEREAS family caregiving is a rich and complex experience involving uplifts and resilience, but also caregiver burden, physical, and economic strain; and

WHEREAS APA has developed relevant practice guidelines for working with older adults, people with disabilities, people with cognitive disorders, and disabled parents, but not with FCGs; and

WHEREAS online health communities may be powerful tools in support of FCG resilience as a space to share and receive social support, and experience self and moral empowerment by promoting self-care, independence, altruism, and connectedness; and

WHEREAS the number of FCGs in the United States continues to rise with the aging population while resources and support remain limited; and

WHEREAS FCGs' needs vary based on the nature, intensity, duration, stage, and setting of caregiving, including being caregivers to multiple people simultaneously or in long-term care and/or palliative and end-of-life care settings; and

WHEREAS FCGs' needs vary by characteristics of the care recipient including diagnoses, functional abilities, availability of home and community support, geographical proximity to care recipient, and there is limited research on specific populations such as older adults caring for autistic adult children, and caregivers of adults with ID/DD; and

WHEREAS FCGs' experiences and well-being may vary based on the type of relationship with the care recipient; quality of that relationship; and social mores and norms; and

WHEREAS nationally there has been limited recognition and implementation of the National Strategy to Support Family Caregivers, the RAISE Family Caregivers Act, the CARE Act, other programs that provide direct financial and social support to FCGs compared to other countries, and laws that are actionable to protect against workplace discrimination based on caregiver status; and

WHEREAS APA continues to train psychologists and facilitate opportunities to advocate for policies supporting FCGs at the local, state, and federal levels;

THEREFORE, BE IT RESOLVED that the APA supports the use of psychological science to further develop, identify, and incorporate meaningful and accessible caregiving outcome measures in research and practice to facilitate ongoing funding and coverage of needed services for family caregivers.

THEREFORE, BE IT RESOLVED that the APA supports FCG research that involves culturally diverse caregiving experiences by increasing recruitment and retention of racial/ethnic minorities, rural contexts, non-English speakers, and those who live in households with multiple caregiving relationships.

THEREFORE, BE IT RESOLVED that the APA supports FCG research that involves patient-FCG dyads, the wider caregiver network, and the complex dynamics between patient, FCGs, and healthcare teams across the lifespan through an intersectional lens that consider the unique needs of FCGs across the lifespan.

THEREFORE, BE IT RESOLVED that the APA supports improvement in data infrastructure to capture cross-sectional and longitudinal experiences of FCG who have historically been excluded in caregiving science, including developing national epidemiological datasets that can be used to monitor caregiving as a measure of public health.

THEREFORE, BE IT RESOLVED that the APA supports the exploration of design and implementation of evidence-based interventions for caregivers that take into consideration their individual preferences, needs, experiences, and the accessibility, feasibility, and sustainability of such interventions, including psychological interventions such as individual, dyadic, and group psychotherapy, integration of I/O psychology principles and artificial intelligence to improve caregiving-related products and care delivery (e.g., smart homes).

THEREFORE, BE IT RESOLVED that the APA encourages the development of a training curriculum to ensure competency-based and trauma-informed caregiver training in doctoral-level, master's-level, and continuing education programs and to expand ethical guidance for psychologists treating caregivers and care recipients concurrently.

THEREFORE, BE IT RESOLVED that the APA encourages psychologists to familiarize themselves with evidence-based practice and educational content on different FCGs and their needs, the various dynamics and nuances of relationships with care recipients, impact of caregiving, types of programs/supports, types of illness or disability that call for family caregiving, and strategies to address the impact of racism and other structural inequities on FCGs.

THEREFORE, BE IT RESOLVED that the APA supports the promotion of theoretically and culturally grounded conceptual and operational definitions of resilience among FCGs across the lifespan and all care settings.

THEREFORE, BE IT RESOLVED that the APA explores the development of APA Guidelines for Psychological Practice With FCGs, the development of which could include establishing a taskforce of psychologists or interprofessional workgroups to advance family caregiving research and practice.

THEREFORE, BE IT RESOLVED that the APA supports culturally adapting evidence-based programs, including those that address design, implementation, and evaluation of interventions in partnership with caregivers from racial/ethnic minority groups, rural communities, LGBTQ+

communities, male caregivers, and other groups that may be underrepresented in research.

THEREFORE, BE IT RESOLVED that the APA supports the development of 24/7 online health communities and caregiver learning and support platforms, especially for those who experience barriers to accessing in-person programs such as those with mobility, financial, geographical, and time constraints.

THEREFORE, BE IT RESOLVED that the APA supports the development of alternate modes of program delivery beyond telehealth to address the needs of FCGs, including from racial/ethnic minority groups and those living in rural areas, who may have limited access to broadband internet.

THEREFORE, BE IT RESOLVED that the APA supports the provision of emotional and psychological support to family caregivers through different types of best practices, including individual psychotherapy, dyadic or family therapy, support and groups, as well as education of the public (including the media) about the need for reducing caregiver burden, improving stress management, promoting self-care, maintaining positive caregiver-care recipient relationships, and supporting resilience.

THEREFORE, BE IT RESOLVED that the APA calls on psychologists to routinely monitor and assess, in person and through telehealth, key indicators of psychological and physical well-being and resilience among FCGs and their care recipients, such as meaning in life, self-efficacy, compassion satisfaction, traumatic growth, and positive aspects of caregiving in addition to anxiety, depression, compassion fatigue, cognitive function, social isolation and loneliness, grief, physical health and health behaviors, abuse, and neglect.

THEREFORE, BE IT RESOLVED that the APA encourages psychologists to maintain active engagement with community organizations, such as local Area Agencies on Aging, to facilitate family caregivers' access to resources like caregiver education, respite care, and transportation assistance, home health and other care navigation, as well as legal, medical, financial, and insurance assistance.

THEREFORE, BE IT RESOLVED that the APA encourages clinical and educational programs to promote culturally responsive care and personalized approaches based on individual needs.

THEREFORE, BE IT RESOLVED that the APA contributes to policy changes that support family caregivers across the lifespan and address root causes of disparities in healthcare access to caregivers, such as enhancing economic and employment policies to make the process of requesting paid leave and caregiver allowance or stipend less burdensome and more accessible; enacting policy to protect caregivers from workplace discrimination; and enhancing caregiver programs especially in rural communities, for disabled caregivers, and youth caregivers in schools.

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