

Research Progress on Spiritual Care for Patients with Chronic Diseases

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Abstract. With the shift in medical models from the traditional biomedical model to the bio-psycho-social medical model, spiritual care for patients with chronic diseases, as an important component of palliative care, is increasingly recognized by scholars for its critical role in improving patients' quality of life. However, in China, spiritual care in chronic disease management still faces challenges, such as an underdeveloped theoretical system, insufficient localization of assessment tools, and a lack of standardized intervention measures. Therefore, this study provides a review of the current status of spiritual care, research tools, influencing factors, and intervention measures, aiming to provide theoretical support for clinical healthcare professionals in formulating relevant intervention strategies.

Keywords: Chronic Diseases, Spiritual Care, Research Tools, Influencing Factors, Nursing

1. Introduction

With the development of social economy and the acceleration of life pace, the incidence of chronic non-communicable diseases (NCDs) has been continuously rising, becoming one of the major challenges in global public health. Data show that these diseases account for 71% of total global deaths and are currently the primary source of the global disease burden [1]. Previous studies have confirmed that patients with chronic diseases generally experience reduced physical reserves, decreased quality of life, and significantly increased psychological stress [2]. Spiritual care [3] is a professional practice in which nurses, guided by the values of spiritual nursing, help patients regain life meaning, goals, and personal value through companionship, listening, communication, and other care measures. At critical stages, such as the end of life, spiritual care is a core component of holistic care, fully reflecting attention to patients' overall needs. However, current research on spiritual care for patients with chronic diseases in China mainly focuses on cancer patients, while explorations targeting other chronic diseases, such as cardiovascular diseases^[4,5] and chronic obstructive pulmonary disease^[6,7], remain insufficient. Therefore, it is necessary to comprehensively and in-depth investigate spiritual care for patients with chronic non-communicable diseases. Based on this, this paper reviews the current research status, assessment tools, and intervention measures for spiritual care in chronic NCDs, aiming to provide reference for clinical nursing research.

2. Current status of spiritual care in different populations

The current status of spiritual care among patients with different chronic non-communicable diseases (NCDs) shows significant variation, which is closely related to disease characteristics, stages of illness, and patients' physical and mental conditions. In the field of cardiovascular diseases, Wang, Zhang, and Yi [8] conducted a survey of 157 patients with chronic heart failure and found that their spiritual care needs were at a moderate level. This may be related to the fact that patients focus more on physiological indicators, such as improvements in cardiac function, during disease progression, and perceive relatively less need for spiritual support. A similar situation was observed among breast cancer patients. Luo, Qing, and Yue [9] conducted a survey of 413 patients and found that their spiritual health levels were also at a moderate level, possibly because concerns about changes in appearance and the risk of recurrence during treatment diverted attention from spiritual needs. Among patients with malignant tumors, differences are more pronounced. An analysis of spiritual needs in patients with gynecologic malignancies showed a moderate-to-high level, which may be related to the impact of the disease on female reproductive function and bodily integrity, prompting existential reflection [10]. Li, Long, and Xiang [11] surveyed 89 patients with advanced liver cancer and further noted that due to the difficulty of treatment and poor prognosis, patients often experience a strong sense of low self-worth and lack of treatment motivation. This existential dilemma leads to relatively higher spiritual care needs.

3. Assessment tools for spiritual care

3.1. Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale (FACIT-Sp-12)

This scale was developed by Brady et al. [12] and revised by Liu, Xiangyu, et al. [13]. It includes three dimensions and a total of 12 items. Each item is scored using a 5-point Likert scale, ranging from “Not at all” to “Very much,” corresponding to 0–4 points, with a total score of 0–48. Higher scores indicate higher levels of spiritual well-being. The scale's Cronbach's α coefficient is 0.922.

3.2. Spiritual Need Scale (SNS)

The revised version was developed by Yong [14] and includes five dimensions: relationship with God, meaning and purpose, acceptance of death, hope and peace, and love and connection. Its Cronbach's α coefficient is 0.92, with good reliability and validity, and it can be used to assess patients with specific religious beliefs.

3.3. Spiritual Needs Assessment for Patients (SNAP)

This scale [15] evaluates needs from three aspects: psychosocial, spiritual, and religious. Its testing population includes patients from multiple cultural backgrounds, such as Hispanic and Asian groups. The scale's Cronbach's α coefficient is 0.95, showing good reliability and validity.

3.4. Spiritual Health Assessment Scale (SHAS)

This scale was developed by Gaur et al. and includes dimensions of self-development, self-actualization, and self-awareness. Its Cronbach's α coefficient is 0.82, and test–retest reliability is 0.81. Although this scale has been validated in elderly populations, its assessment content is limited

to self-related aspects and life meaning, failing to comprehensively reflect the rich connotations of spiritual health, which constitutes a certain limitation.

4. Factors affecting the demand for spiritual care

4.1. Individual factors

Disease course, gender, and educational level are major factors influencing the spiritual care needs of patients with chronic diseases. A meta-analysis by Huang, Peiwen, et al. [16] showed that there was no significant difference in spiritual needs between early-to-mid-stage and late-stage cancer patients; however, these needs were closely related to disease duration. Patients with a disease course ≥ 12 months exhibited significantly higher spiritual needs than those with a course < 12 months. In addition, gender differences also significantly affect spiritual needs, with female patients generally showing higher demand [17]. Compared with males, females are more prone to negative emotions such as anxiety and depression when facing illness. Combined with deeper concerns and attachments to family members, they are more eager to obtain emotional comfort through spiritual care, resulting in stronger spiritual care needs. Educational level also influences patients' spiritual care needs. Advanced liver cancer patients with a high school or technical secondary education or above have approximately twice the spiritual care needs of patients with lower educational levels. Patients with higher education generally have stronger health awareness and can access health information through multiple channels [11]. Conversely, patients with lower educational levels often cannot correctly identify their spiritual needs and experience higher disease-related fear, preventing them from actively managing negative emotions. As a result, their spiritual care needs are relatively high.

4.2. Socio-psychological factors

Social support and psychological resilience are important factors influencing patients' spiritual care. Patients with lower psychological resilience have difficulty effectively coping with treatment-related pain and emotional stress caused by illness, which leads to lower levels of spiritual well-being and more urgent demand for spiritual care [9]. In contrast, patients with higher psychological resilience can adopt an optimistic mindset to face the pressures and challenges brought by disease, effectively alleviating feelings of helplessness and disease burden, and thus exhibit relatively higher levels of spiritual well-being. The strength of social support affects spiritual care through tangible resources and emotional support. Ren, Chaohong, et al. [18] conducted a survey of 104 patients with chronic obstructive pulmonary disease (COPD) and confirmed this: elderly patients with lower per capita monthly family income, due to the heavy economic burden of long-term treatment, are prone to negative emotions such as self-blame and guilt. Their spiritual well-being is relatively low, and their need for spiritual care is correspondingly higher. Similarly, COPD patients with low social support, lacking companionship and emotional backing from family and friends, are more likely to develop pessimistic attitudes and lose hope for the future, resulting in lower spiritual well-being and increased demand for spiritual care. Thus, both intrinsic psychological coping ability (psychological resilience) and external social support networks influence patients' spiritual well-being and care needs by affecting their emotional state, stress response, and life expectations.

5. Intervention measures for spiritual care in patients with chronic diseases

5.1. Systematic spiritual care model

The systematic care model demonstrates unique advantages and features in spiritual interventions for patients with chronic diseases. Centered on the core concept of “holistic–continuous–team-based” care, this model establishes an intervention system encompassing four dimensions: Assessment dimension: Standardized spiritual needs assessment tools (e.g., FACIT-Sp-12) are used for regular screening, and dynamic spiritual health records are maintained. Team dimension: A core team composed of specialist physicians, psychotherapists, religious advisors, and social workers is formed, with weekly case discussion meetings. Intervention dimension: A stepped spiritual support program is implemented, including basic support (daily 15-minute listening and companionship), developmental interventions (weekly life-meaning exploration groups), and specialized care (support for religious rituals). Evaluation dimension: A multidimensional evaluation system is established, including subjective measures (patient self-assessment) and objective indicators (quality-of-life scales). Cai, Huimin, et al. [12] conducted a study on spiritual care interventions using the systematic care model. They established a professional spiritual care team, implemented a standardized spiritual needs assessment process, and designed a targeted spiritual curriculum system. This model particularly emphasizes the integration of religious care resources. The intervention significantly improved patients’ spiritual well-being while also enhancing overall quality-of-life indicators. This systematic and structured intervention approach provides a replicable practical framework for spiritual care in chronic disease patients. In the future, this system model is expected to further integrate artificial intelligence technology to analyze patterns in patients’ spiritual needs and achieve more precise, personalized interventions.

5.2. Traditional Chinese Medicine–based integrated nursing pathway

Domestic scholars have conducted innovative explorations in spiritual care with distinctive Chinese characteristics, organically integrating Traditional Chinese Medicine (TCM) theories with modern spiritual care concepts to develop a series of localized spiritual intervention programs. For example, Wu, Yan, et al. [19] innovatively combined TCM theories with spiritual care and developed a TCM-based integrated nursing pathway. This pathway includes three core modules: TCM pain management (using TCM-guided cancer pain protocols, external application of Xiaoyao packs, and other characteristic therapies), application of TCM nursing techniques (such as acupoint massage and moxibustion), and collaborative spiritual care team support. Research has shown that this pathway produces significant mind–body integration effects, effectively relieving patients’ physical symptoms and, through the TCM concept of “unity of body and spirit,” promoting overall rehabilitation in physical, psychological, social, and spiritual domains. This study not only demonstrates the unique advantages of integrating Chinese and Western medicine but also provides a new intervention pathway for improving the overall health of patients with chronic diseases.

5.3. Theory-based spiritual intervention program

Theory-based intervention programs refer to interventions guided by specific behavioral science or psychological theories, designed and implemented within a systematic theoretical framework. Zhou, Yijuan [20] developed an individualized intervention program based on Hope Theory, emphasizing precise interventions tailored to the psychological characteristics of breast cancer patients. This

program adopts a three-level intervention strategy: at the basic level, acceptance training helps patients face reality; at the intermediate level, art therapy (calligraphy, painting, music) is used to alleviate emotional distress; at the advanced level, meaning reconstruction guides patients to achieve self-value. A controlled study of 157 patients showed that the intervention group had significantly higher scores on key indicators such as well-being and self-efficacy compared with the control group. The successful implementation of this program confirms that integrating psychological theory with spiritual care can effectively meet the deeper needs of patients with chronic diseases.

6. Strategies and recommendations

6.1. Improve theoretical framework and develop localized spiritual care models

Currently, research on spiritual care for patients with chronic diseases in China lacks a systematic theoretical framework, particularly regarding the relationship between disease characteristics (e.g., disease progression, symptom burden) and spiritual needs. Recommendations include: ① Integrate multidisciplinary theories from medicine, psychology, and religious studies. ② Develop chronic disease spiritual care models that align with Chinese cultural contexts, incorporating traditional philosophical concepts such as “unity of heaven and human” and “family continuity.” ③ Conduct cross-disease comparative studies to clarify differences in spiritual needs and intervention priorities among patients with cardiovascular diseases, COPD, malignant tumors, and other chronic conditions. ④ Explore the synergistic mechanisms between spiritual care, palliative care, and psychological care to form an integrated “body–mind–social–spiritual” chronic disease management model.

6.2. Optimize assessment tools and establish dynamic monitoring systems

Existing spiritual needs assessment tools have cultural adaptation limitations and lack dynamic monitoring of long-term spiritual changes in chronic disease patients. Recommendations include: ① Localize internationally used scales (e.g., FACIT-Sp-12) by adding dimensions relevant to Chinese patients, such as “family harmony” and “fulfillment of social roles.” ② Develop disease-stage-specific assessment tools, such as a “Sense of Life Meaning Scale” for end-of-life patients. ③ Combine with electronic health records (EHRs) to establish a dynamic database of spiritual needs, using artificial intelligence to analyze trends in patients’ spiritual health and provide evidence for personalized interventions.

6.3. Innovate intervention strategies to enhance clinical practice

Current spiritual care interventions remain fragmented and experience-based, lacking standardized protocols and evidence support. Recommendations include: ① Develop evidence-based clinical pathways for spiritual care, following a four-step approach: assessment → stratified needs → personalized intervention → outcome evaluation. ② Promote multidisciplinary team (MDT) collaboration, forming spiritual care teams including nurses, psychologists, religious personnel (if applicable), and social workers. ③ Integrate digital health technologies to develop spiritual health management apps, providing modular interventions such as mindfulness meditation, life narrative exercises, and online spiritual support groups. ④ Pay special attention to the spiritual needs of rural patients, adolescent chronic disease patients, and caregivers, exploring interventions adapted to their cultural contexts.

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