International Journal of Social Impact
ISSN: 2455-670X
Volume 11, Issue 2, DIP: 18.02.044/20261102
DOI: 10.25215/2455/1102044
www.ijsi.in |April-June, 2026

International Journal of Social Impact

Research Paper

A Study of Spirituality among Chronic Disease Patients

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ABSTRACT

The research was conducted to investigate the differences in spirituality among patients with various chronic diseases, taking into account the importance of psychological elements. The research also sought to determine how people with various chronic illnesses differed in their spirituality. The degree of spirituality among three distinct categories of individuals with chronic illnesses would vary. The study was conducted on two hundred six (206) chronic disease patients. The participants were taken from different public and private hospitals of Delhi NCR. Out of 206 participants, 109 were male chronic disease patients and remaining 97 were female chronic disease patients. The age of the participants ranges 25-60 years. All participants were selected for the study from the hospital's OPD department, various wards, or discharge rooms. The intensity of the challenges mentioned by the patients or their caretakers was used to divide them into three groups. The patients collected from the OPD were assigned to Group I since the majority of them were observed attending hospitals for routine check-ups just to consult with doctors for updates. Those who were contacted from discharge rooms were placed in group II; these patients reported frequent hospital admissions as a result of exacerbating their condition. Individuals in Group III had been hospitalised in the past few weeks. In group I (Diabetics/Hypertension) consisted eighty male and female both. The group II (Cardiovascular/Asthma) consists of sixty-five (65) male and female participants. and group III (Chronic kidney disease/Arthritis) was consist of sixty-one (61) male and female participates from private and public hospital among the groups. Spirituality Coping Scale was used to see level of spirituality of chronic disease patients. The obtained data were analysed with the help of SPSS using various statistical technique like mean, standard deviation (SD), ANOVA, and Post hoc analysisetc. The obtained results were interpreted and discussed in the light of hypotheses. The study was presuming difference in the level of spirituality in the patients suffering from different types of chronic diseases. From the result it was obvious that patients belonging to three different groups were significantly differed with each other.

Keywords: *Spirituality, Diabetics, Hypertension, Cardiovascular, Asthma, Chronic kidney disease, Arthritis & Chronic Diseases*

Chronic Disease:

The word "chronic illness" University of Michigan Center for Managing Chronic Disease (UMCMCD) define as "a long-term ailment that can be managed but not cured" (2011). A

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Received: March 7, 2026; Revision Received: June 18, 2026; Accepted: June 22, 2026

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chronic condition, according to the National Center for Health Statistics, is one that lasts longer than three months. Chronic diseases, in general, cannot be prevented or cured by vaccines, and they do not simply disappear. Chronic diseases are non-communicable diseases with a slow progression. Cancers, cardiovascular diseases, diabetes, chronic obstructive pulmonary disease, cerebrovascular diseases, hepatitis C, arthritis, asthma, and HIV/AIDS are the most common (World Health Organization (WHO), 2015). A chronic disease is frequently caused by genetics or environmental factors such as poor nutrition and living standards, smoking or other harmful substances, or adopting a sedentary lifestyle. Since most chronic diseases are not produced by infection, a person suffering from one is difficult to pass it on to someone else.

Chronic diseases vary greatly in terms of severity, signs, and the extent to which they impose constraints on their victims. Some are moderate "lived-with" disorders that need lifestyle adjustments and/or adherence to medication regimens, whereas others are severe, life-threatening, and/or degenerative. A chronic disease diagnosis can cause severe emotional suffering in individuals and their families. In most situations, these sentiments fade as people accept the diagnosis and begin to deal with its consequences.

Living with a chronic disease can be highly problematic, depending on the nature and seriousness of the illness. People with chronic conditions have a variety of worries, including the fear of losing their body and self-esteem, of losing love, relationships, and other people's acceptance, and of pain and discomfort.

The term (chronic physical diseases) CPD, according to Sprangers et al. (2000), refers to a group of illnesses that have long-term effects on subjective well-being / quality of life.

According to Martino, Catalano, Bellone, Russo, Vicario, Lasco et al. (2019), this study emphasizes the direct correlation between these conditions. The most prevalent severe illnesses (arthritis, osteoporosis, neoplastic diseases, diabetes and asthma) are commonly accompanied with psychiatric illnesses or emotional/psychological disorder.

Many researchers have already been performed to explore the influence of signs and symptoms associated with psychological disorders on the most frequent chronic diseases, using a subjective assessment of wellbeing and QoL as a measure (Megari, 2013). Alexithymia, anxiety, sadness, emotional stress, sleep patterns, and emotional dysfunction have been thoroughly examined in patients suffering with diabetes type II, psoriasis,fibromyalgia, and osteoporosis, in particular (Cristina, C. N., Mario, F., and Paolo, A. 2019)

Spirituality:

Spirituality and religion are popular coping techniques for both physical and mental illness. Religion and spirituality are important parts of many patients' lives and may help them cope with their symptoms. Personal beliefs of patients may be crucial to their feeling of well-being and may support them in coping with negative elements of illness or treatment. Incorporating spirituality into clinical practices, on the other hand, continues to provide several obstacles. Spirituality is frequently seen as a private and subjective domain that exists outside of the therapeutic setting, although patients' beliefs can have a significant influence on the formation of the meaning of disease, coping behaviour, and treatment choices. Positive religious/spiritual coping reflects a helpful religious way of understanding and dealing with life challenges, whereas negative religious/spiritual coping reflects religious struggle in

coping. Empirical investigations have revealed a clear link between stressful life situations and various types of religious/spiritual activity (Bjork & Cohen, 1993; Ellison & Taylor, 1996)

Most studies concentrate on the positive aspects of spirituality, such as a solid relationship with God and belief in a broader, benign purpose for life. Spiritual challenges, on the other hand, are the outcome of a more tenuous relationship with God, a more ominous vision of life, and a sense of detachment from the spiritual community.

Tanyi (2002) defines spirituality as a multifaceted, subjective, intangible, and multidimensional concept that is difficult to describe. The Oxford Dictionary defines it as "related to or influencing the human spirit or soul as opposed to material or physical objects," while Merriam-Dictionary Webster's defines it as "supernatural creatures or phenomena." It is connected to notions such as spirituality, religion, religiosity, and faith. Some have conflated spirituality and religion. This is because spirituality signifies "sensitive or connection to religious ideals" (Merriam-Collegiate Webster's Dictionary) and is concerned or linked to religion or religious belief or values (Oxford Dictionary; Merriam-Dictionary, Webster's). But, despite their closeness, the two are different. Spirituality covers a larger range of concepts than religion.

Spirituality, on the other hand, extends beyond religious borders. According to Rowe and Allen (2004), one can be spiritual without being religious. Finally, spirituality may be associated with religion for some people, but not for others (for example, atheists) (Tanyi, 2002).

Spirituality influences patients' capacity to cope with the disease. Spiritual beliefs and activities are a source of comfort for many people, insight to help make sense of what appears to be meaningless, and a ritual method for addressing the fundamental spiritual problems of purpose, value, & relationship (Sulmasy, 2009).

Spiritual beliefs can give people a sense of control when recognizing, coping with and interpreting events or experiences. Previous research has found that people with religious beliefs might minimize their stressful reactions to uncontrolled situations by reframing or reinterpreting them, potentially getting a new meaning and understanding (McCulloch, 2009). A sense of purpose or meaning in life is essential. An illness reduces this sense of meaning. This loss, and the related recovery were necessary for both depression and spirituality. The emphasis on liturgy, worship, and prayer seen in the main religious traditions may offer such a feeling of significance (Dein, 2009). Adverse life events can be rated in several ways. Religion gives a perspective for understanding misfortune by providing a meaningful context. Aspects of spirituality may positively impact several physiological pathways associated with health. Spirituality's emphasis on happiness, forgiveness, hope, and love, in particular, may positively impact a person's physical well-being. Furthermore, spirituality has been shown to reduce negative emotions such as anger, fear, and revenge and reduce anxiety levels (McColl et al., 2000).

Several research findings have emphasized the significance of spirituality in coping with HIV-related stressors such as the loss of loved ones to AIDS (Richards, Acree, and Folkman, 1999), overcoming shame and guilt for engaging in risky behaviours (Kaldjian, Jekel, and Friedland, 1998), and finding a sense of meaning and purpose (Tarakeshwar, Swank,

Pargament, and Mahoney, 2001). Higher levels of spirituality have also been linked to long-term HIV survival (Ironson & Kremer, 2009; Ironson, Stuetzle, & Fletcher, 2006).

McClain, Rosenfeld, and Breitbart (2003) conducted a study to examine the correlation between sadness, end-of-life despair in terminally ill cancer patients and spiritual well-being.

Meanwhile, in people who identified with the lowest spiritual well-being, depression was substantially connected with a desire for death. Participants higher in spiritual well-being had a lower association with depression and a shorter life span. The interpretation of the data demonstrated that good spiritual health provides some protection against sadness in people who are facing death.

Pearce et al., (2012) learn more about spiritual well-being. According to the author, spiritual care offered by health care providers to patients promotes spiritual well-being. During their time as hospitalized patients at a southern medical institution, they Polled 150 patients with advanced cancer. "Examined the associations between obtaining lower spiritual care than expected and patient outcomes." Ninety-one per cent of patients have spiritual requirements, and the vast majority have gotten the specific care. They require religious community (78 per cent; 73 per cent), healthcare professionals (67 per cent; 68 per cent), and hospital chaplains to be available (45 per cent; 36 per cent). However, a small proportion of the sample, 42 out of 150 respondents, reported receiving considerably less spiritual care from their healthcare professionals (17 per cent), religious community (11 per cent) and chaplains (40 per cent). A focus on spiritual care in health care demonstrates increased patient satisfaction with hospital services. Patients who received less spiritual care than expected had more depressive symptoms, a loss of meaning, and tranquility. It indicates that spiritual care provided to patients results in spiritual well-being, which decreases sadness and increases the level of serenity."

Rationale of the study

People began to disregard their health in this fast-paced society, which led to them being ensnared by a variety of ailments. At our time, chronic diseases are neither able to be cured by medicine, nor do they just vanish on their own. When it comes to treating chronic illnesses that have an impact on an individual's personality, resilience, cognition, and emotions, as well as bring about change in an individual's life, it is essential to get treatment throughout one's whole life and to practice self-care. Every person will, without a doubt, be confronted with a variety of circumstances in which they will be required to portray themselves. Engage in conversation with other people, exchange thoughts and perspectives, and also work in a variety of environments. As a result of the fact, the organ dysfunction and deformity have a tendency to inhibit and damage persons' self-esteem, self-confidence, social and emotional competence, and make them psychologically susceptible as a whole. People who are in this condition need to build psychological toughness so that they can confront the hardships of life on the one hand and combat sickness on the other. This is true in all circumstances and in the day-to-day events of their lives. There is a good association between spirituality and resilience among patients who are coping with chronic diseases, according to the findings of a number of research. On the other hand, there is not enough data to establish that there is a difference in spirituality among people who are suffering from chronic diseases. As a result, researchers are interested in determining whether or not there is any diversity in spirituality among individuals who suffer from chronic diseases.

Objective:
In view of the above, the study is planned with the following objectives:

- To examine difference in the level of spirituality among patients suffering from three different categories of chronic disease.

Hypothesis:
On the basis of the above objectives, the following hypotheses are formulated:

- Three different categories of chronic disease patients would differ on the level of spirituality.

Sample:
Participants for the research consisted of a total of 206 people who were suffering from chronic diseases. The participants came from a variety of public and private hospitals outside of Delhi and the National Capital Region (NCR), as well as from inside Delhi and the NCR. Among the total of 206 participants, 109 were male patients suffering from chronic diseases, while the remaining 97 were female patients suffering from chronic diseases. In an effort to maintain consistency, the socioeconomic statuses of all groups were not altered. Those who took part in the study varied in age from 25 to 60 years old. All of the patients were chosen at random according to the inclusion and exclusion criteria that were established.

This research used purposive sampling to collect a sample of individuals with chronic diseases, including Arthritis, Asthma, Chronic Kidney Disease, COPD, Cardiovascular Disease, Hypertension, and Type II Diabetes. Only individuals who satisfied the sample's inclusion requirements were included. Patients with various chronic diseases were selected from multiple public and private hospitals in the Delhi/NCR region, including Fortis Escort Hospital, Holy Family Hospital, Alshifa Multispeciality Hospital, Apollo Hospital, Max Hospital, All India Institute of Medical Sciences, Safdarjung Hospital, and Moolchand Hospital. All participants were informed about the research at the outset. Informed, written permission was obtained from them. The Spiritual Coping Scale and personal information sheets were administered in individual settings. A break was offered for the comfort and convenience of the participant as needed.

Design:
In this study different group design was used. All participants were selected for the study from the hospital's OPD department, various wards, or discharge rooms. The intensity of the challenges mentioned by the patients or their caretakers was used to divide them into three groups. The patients collected from the OPD were assigned to Group I since the majority of them were observed attending hospitals for routine check-ups just to consult with doctors for updates. Those who were contacted from discharge rooms were placed in group II; these patients reported frequent hospital admissions as a result of exacerbating their condition. Individuals in Group III had been hospitalised in the past few weeks. In group I (Diabetics/Hypertension) consisted eighty male and female both. The group II (Cardiovascular/Asthma) consists of sixty-five (65) male and female participants. and group III (Chronic Kidney Disease/Arthritis) was consisting of sixty-one (61) male and female participates from private and public hospital among the groups.

Tools:

- **Socio-demographic Data Sheet**: A self-made semi structured socio-demographic sheet especially designed for the study to collect information regarding patient’s age, gender, marital status, religious affiliation, education, occupation, family type and

monthly family income, also clinical details would be collected as diagnosis, duration of illness and type of treatment.

- **Spiritual Coping Scale (SCS) (Khatoon F. and Husain A., 2016)**: The scale has been developed by **Khatoon** and **Husain** in the year 2016. This scale consisted of 16 items with four factors, namely, spiritual practices, God's support, spiritual resource, and spiritual transformation. The overall reliability obtained for the scale was 0.797 with factorial validity 56.48.

Table A: Items representing to the factors of SCS are as follows:

	No. of Items	**Reliability**	**Factorial Validity**
Spiritual Practices	1,5,6,7,8,9,12	0.797	56.48
God's Support	**13,14,15,16**	0.752	
Spiritual Resources	**2,3**	0.779	
Spiritual Transformation	**4,10,11**	0.628	
Spiritual Coping Scale		0.572	

It should be noted that the Cronbach's alpha values for the SCS show an acceptable alpha values ranging from 0.572 to 0.752. Nunnally and Berstein (1994) pointed out that the value of Cronbach's Alpha should exceed 0.5 in practical participation. Based on this argument, the low value for process-oriented coping is acceptable to be used in this current study. Thus, the Cronbach's Alpha proved that the spiritual coping scales and their dimensions identified in this study are acceptable.

Data Collection

Data was collected via the use of questionnaires, interviews, and surveys in this particular research. For the purpose of acquainting the potential respondents with the overarching idea of the study, the researcher made first contact with them. During the period that we were in touch with one another, it was made abundantly apparent that this study had nothing to do with management and that the researcher carried out the research on their own. As a result of the researcher's personal interactions with a few of the executives working in the human resources department of the hospital, it had become important to make sure that this was the case. The researcher got the impression that this sentiment may be present in the thoughts of some of the responders. Subsequently, letters were sent to the individuals who participated in the study, in which they were explained the overarching objective of the research and asked for their assistance. For the purpose of conducting the questionnaire, subsequent contact was made with the responders. After obtaining their agreement, our data collection process consisted of conducting interviews with them in person. This action was taken due to the fact that the majority of the participants were illiterate. In order to better accommodate the convenience of the participants, several questionnaires were delivered in an offline format. Following the date that was specified by the responder, the questionnaires that were filled out were collected.

RESULT AND DISCUSSION

Hypotheses: There would be difference among three different categories of chronic disease patients with regard to their spirituality.

Table 1: Showing mean and standard deviation of the dimension wise spirituality scores of the three groups of chronic disease patients

	Group 1 (Diabetics + Hypertension) (N=80)		Group II (Cardio + Asthma) (N=65)		Group III (Kidney + Arthritis) (N=61)	
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**
Spirituality Practices	22.81	4.097	24.52	3.401	25.66	3.188
God's Support	13.31	3.200	14.51	2.278	14.79	2.130
Spirituality Resource	7.23	1.889	7.57	1.704	7.57	1.147
Spiritual transformation	10.73	2.614	10.65	2.534	11.54	1.747
Spirituality	54.08	9.437	57.25	7.714	59.56	6.554

Table 2: Showing ANOVA dimension wise spirituality score of the three different groups of chronic disease patients

		Sum of Squares	Df	Mean Square	F	Sig
Spirituality Practices	**Between Groups**	290.06	2	145.030	11.001	.000
	Within Groups	2676.17	203	13.183		
	Total	2966.23	205			
God's Support	**Between Groups**	89.05	2	44.528	6.394	.002
	Within Groups	1413.66	203	6.964		
	Total	1502.72	205			
Spirituality Resource	**Between Groups**	5.873	2	2.937	1.090	.338
	Within Groups	546.80	203	2.694		
	Total	552.68	205			
Spiritual transformation	**Between Groups**	31.342	2	15.671	2.805	.063
	Within Groups	1133.96	203	5.586		
	Total	1165.30	205			
Spirituality as a whole	**Between Groups**	1068.68	2	534.340	8.082	.000
	Within Groups	13420.66	203	66.112		
	Total	14489.34	205			

Table 3: Showing the difference between the possible pairs of groups.

	Diagnosis Group (I)	Diagnosis Group (J)	Mean Difference (I-J)	Std. Error	Sig
Spirituality Practices	Group I	Group II	1.711*	.606	.014
		Group III	2.843*	.617	.000
	Group II	Group III	1.133	.647	.189
Spirituality	Group I	Group II	3.171	1.358	.053
		Group III	5.482*	1.382	.000
	Group II	Group III	2.311	1.449	.250

The above-mentioned hypothesis was also tested by computing mean and SD of spirituality scores it appears on looking at the table of results separately for three different categories of chronic disease patients that the overall spirituality was higher among three different categories. The difference among the three categories was appeared to be small but found statistically significant. From the results given in the table 1, it was obvious that although it was obvious that kidney/arthritis category was slighter higher on the sense of spirituality as whole than other two categories of chronic disease patients as the mean and the standard deviation score on the overall spirituality of the three different categories differed. Similarly, the mean and the standard deviation of the first category of chronic disease patients were 54.08, and 9.437 respectively. For the second category of chronic disease patients mean and the standard deviation was 57.25 and 7.714 respectively. For the third category of chronic disease patients mean and the standard deviation was 59.56 and 6.554 respectively. Table 2 of ANOVA indicates that the main effect of the groups (F=8.082, p=.000<.001) was found highly statistically significant. The post hoc analysis table 3 shows that people living with chronic diseases differed. Mean differences between categories I and II was 3.171, and was not found significant (P= .053>.005). Similarly, mean difference between categories II and III was 2.311, and was not found (p=1.449>0.05) statistically significant. Whereas, mean differences between categories I and III was 5.482, and was found significant at (p=.000<0.001). These findings suggest that people living with different chronic diseases in the different groups have worked spirituality differently.

Table3, it was clearly showing dimension-wise analyses of the mean and the standard deviation of the spirituality of the different groups of chronic disease patients. For Spirituality Practices dimension, the mean and the standard deviation score of the three different groups differed. Similarly, the mean and the standard deviation of the first group of chronic disease patients were 22.81, and 4.097 respectively. For the second group of chronic disease patients mean and the standard deviation was 24.52 and 3.401 respectively. For the third group of chronic disease patients mean and the standard deviation was 25.66 and 3.188 respectively. Table (2) of ANOVA indicates that the main effect of the groups (F= 11.001, p=.000<.001) was found highly statistically significant. The post hoc analysis (Table 3) shows that people living with chronic diseases differed. Mean differences between group I and group II was 1.711, and was found significant (P= .014<.05). Similarly, mean difference between group I and group III was 2.843, and was found (p=.000<0.001) statistically significant. Whereas, mean differences between group II and group III was 1.133, and was not found significant at (p=.189>0.05). These findings suggest that people living with different chronic diseases in the different groups have maintained spirituality practice differently. Similarly, on the On the **God's support** dimension the mean and the standard deviation score of the three different groups differed. For the mean and the standard deviation of the first group of chronic disease patients were 13.31, and 3.200 respectively. For the second group of chronic disease patients mean and the standard deviation was 14.51 and 2.278 respectively. For the third group of chronic disease patients mean and the standard deviation was 14.79 and 2.130 respectively. Table 2 of ANOVA indicates that the main effect of the groups (F= 6.394, p=.002<.01) was found statistically significant. Whereas, the difference of the mean and standard deviation score of remain dimension of spirituality as spirituality resource and spiritual transformation were not found statistically significant at any level.

The differences in spirituality, spirituality practice and God's support two diseases with great differences in their characteristics: kideny/Arthritis category patients lifestyle modification is essential for the treatment. Therefore, this pathology requires a high capacity for adaptation and the modification of habits. Spirituality can be used as a coping strategy for critical

situations of people's lives, since it can increase the sense of purpose and meaning of life, which are associated with greater resistance to stress, which is related to diseases. Kideny/arthritis category of patient's life more complicated than other type of chronic disease patients. They felt always hopeless, loneliness and facing many challenges in their life. Kidney disease more serious illness in the category of chronic disease, more life threatens and treatment also more expensive. Patients who suffer from chronic renal disease face problems in many aspects of their life; problems such as physical and social as well as mental such as stress, anxiety, depression. They exhibit an amount of spiritual needs and practice which relate and influence the psychological adaptation to the illness. On the other hand, diabetic, hypertension, asthma patients have low life threaten than chronic kidney disease. Patient not very serious about modify their life style, not take medicine properly, not always conscious about routine check up on timely and less amount of coping strategies were used.

According to Fradelos, E et al, (2015) assessing and addressing chronic kidney disease patient's spirituality and spiritual needs is necessary and it can have a positive outcome in health-related quality of life, mental health and life expectancy.

According to Pham, T.V., Beasley, C.M., Gagliardi, J.P. et al. (2020) examined the effects of spirituality on chronic kidney disease (CKD) maintenance in the rural community of Robeson County, North Carolina. they conducted nine focus group discussions and 16 interviews involving 80 diverse key informants impacted by CKD. As disenfranchised patients, they locally engaged in spirituality which mobilized personal and social resources and elicited support from a transcendent authority.

According to Valcanti CC, Chaves EC, Mesquita AC, Nogueira DA, Carvalho EC, (2012) use of religious/spiritual coping in patients who undergo hemodialysis treatment was verified as a way of facing the health condition, where patients who consider religion/spirituality as important in their lives presented high scores of religious/spiritual coping.

Ariane Moysés Bravin , Armando dos Santos Trettene, Luis Gustavo Modelli de Andrade, Regina Célia Popim 2019 a Thai qualitative study involving 20 patients with Chronic Kidney Disease under hemodialysis, whose objective was to investigate the influence of religion and spirituality in coping with the disease, pointed to religious and spiritual practices as a modality of coping, including religious and spiritual for the development of disease, karmic disease, merit, prayer and praises, and the act of bargaining with the gods through promises. Finally, the authors associated the results with the religiosity and spirituality of the Thai people.

CONCLUSION

Present study attempted to examine the spirituality of three different groups of chronic disease patients. In this study spirituality difference among three groups of chronic disease were differed and enough to be significant.

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Acknowledgment

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Rahman, M.M. (2026). A Study of Spirituality among Chronic Disease Patients. *International Journal of Social Impact*, *11*(2), 467-477. DIP: 18.02.044/20261102, DOI: 10.25215/2455/1102044