Exploring the Role of Spiritual Care in Enhancing Quality of Life Among Hospice Patients

Dante Rivera, Zane Warren, Easton Bell

October 21, 2025

1 Introduction

The integration of spiritual care within hospice settings represents a critical yet understudied dimension of palliative medicine. While physical symptom management has dominated end-of-life care protocols, the existential, meaning-making, and transcendent aspects of the human experience during terminal illness remain inadequately addressed in clinical practice. This research emerges from the recognition that quality of life at life's conclusion encompasses dimensions beyond physical comfort, extending into the realms of purpose, connection, and existential resolution. Traditional medical models often approach spiritual care as an ancillary service rather than a core therapeutic component, resulting in fragmented approaches that fail to capture the holistic nature of the dying process.

Our investigation addresses this gap through a novel methodological framework that quantifies spiritual well-being as a measurable clinical outcome. The central research question examines how structured spiritual care interventions influence multidimensional quality of life indicators among hospice patients, with particular attention to existential distress, meaning reconstruction, and transcendent experiences. This study challenges conventional palliative care paradigms by positioning spiritual care as a primary rather than secondary intervention,

with measurable impacts on psychological, physiological, and existential well-being.

The theoretical foundation integrates concepts from existential psychology, transpersonal studies, and quality of life research to construct a comprehensive model of spiritual care efficacy. We propose that spiritual well-being functions as a moderating variable between physical suffering and quality of life perceptions, potentially transforming the experience of terminal illness from one of despair to opportunity for growth and completion. This perspective represents a significant departure from symptom-focused approaches and offers a more nuanced understanding of the dying process as a developmental stage with unique psychological and spiritual tasks.

2 Methodology

2.1 Participants and Setting

The study employed a multi-site randomized controlled trial design with 240 hospice patients recruited from three distinct healthcare facilities specializing in end-of-life care. Participants ranged in age from 48 to 92 years ($M = 72.4$, $SD = 11.3$) with diverse terminal diagnoses including advanced cancer, end-stage organ failure, and neurodegenerative diseases. Inclusion criteria required a life expectancy prognosis of six months or less, cognitive capacity to provide informed consent, and willingness to engage in spiritual care interventions. The sample reflected diverse spiritual and religious backgrounds, including various Christian denominations, Jewish, Muslim, Buddhist, Hindu, spiritual-but-not-religious, and non-affiliated participants.

2.2 Intervention Protocol

The experimental intervention consisted of a structured spiritual care program delivered by trained spiritual care specialists over an eight-week period. This protocol integrated multiple modalities including meaning-centered therapy, life review techniques, forgiveness

processes, legacy development, and contemplative practices adapted to individual spiritual orientations. Each session followed a standardized framework while allowing customization based on patient preferences, cultural background, and spiritual needs. The control group received standard hospice care, which included access to spiritual care upon request but without the structured intervention protocol.

2.3 Assessment Measures

We developed the Spiritual Care Assessment Matrix (SCAM) as the primary instrument for quantifying spiritual well-being across four dimensions: existential peace (sense of meaning and purpose despite suffering), meaning-making capacity (ability to integrate the dying experience into one's life narrative), transcendence experiences (moments of connection beyond the self), and relational connectedness (quality of relationships with self, others, and the transcendent). The SCAM demonstrated strong psychometric properties with Cronbach's alpha coefficients ranging from 0.84 to 0.92 across subscales.

Secondary measures included standardized instruments for quality of life (McGill Quality of Life Questionnaire), psychological distress (Hospital Anxiety and Depression Scale), pain intensity (Brief Pain Inventory), and spiritual well-being (Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being). Physiological markers including cortisol levels, heart rate variability, and inflammatory markers were collected to examine mind-body connections.

2.4 Data Analysis

Statistical analyses employed mixed-effects models to account for repeated measures and site variations. Primary outcomes examined changes in quality of life and spiritual well-being scores between baseline and post-intervention assessments. Mediation analyses explored whether spiritual well-being changes accounted for quality of life improvements, while moderation analyses investigated whether demographic, diagnostic, or spiritual background variables influenced intervention efficacy.

3 Results

3.1 Primary Outcomes

Patients receiving the structured spiritual care intervention demonstrated significant improvements in overall quality of life scores compared to the standard care control group ($F(1,238) = 18.47$, p ¡ 0.001). The intervention group showed a mean increase of 2.34 points (SD = 0.67) on the McGill Quality of Life Questionnaire, representing a clinically meaningful improvement. Particularly notable were enhancements in the existential domain, where intervention participants reported greater sense of meaning ($t(238) = 4.82$, p ¡ 0.001) and reduced existential distress ($t(238) = -5.13$, p ¡ 0.001).

Spiritual well-being, as measured by the SCAM, showed substantial gains across all four dimensions. Existential peace scores increased by 38

3.2 Secondary Outcomes

Psychological distress measures revealed significant reductions in both anxiety (HADS-A: $t(238) = -3.94$, p ¡ 0.001) and depression (HADS-D: $t(238) = -4.27$, p ¡ 0.001) among intervention participants. Pain tolerance measures indicated that while pain intensity ratings did not differ significantly between groups, intervention participants reported lower pain interference in daily activities (BPI interference subscale: $t(238) = -3.12$, p ¡ 0.01).

Physiological markers provided compelling evidence of mind-body connections. Intervention participants showed significantly reduced cortisol levels ($F(1,238) = 7.89$, p ¡ 0.01) and improved heart rate variability ($F(1,238) = 6.43$, p ¡ 0.05), suggesting reduced stress response system activation. Inflammatory markers including IL-6 and TNF-alpha showed modest but statistically significant reductions in the intervention group.

3.3 Moderating and Mediating Factors

Mediation analyses confirmed that improvements in spiritual well-being partially mediated the relationship between the intervention and quality of life outcomes, accounting for 42

Demographic variables including age, gender, and education did not significantly moderate intervention effects. Diagnostic category showed some moderating influence, with cancer patients demonstrating slightly larger effects than those with non-cancer diagnoses, though these differences did not reach statistical significance after multiple comparison corrections.

4 Conclusion

This research establishes spiritual care as a measurable, evidence-based intervention with significant impacts on quality of life for hospice patients. The findings challenge the conventional positioning of spiritual care as ancillary to medical treatment and instead support its integration as a core component of comprehensive end-of-life care. The development of the Spiritual Care Assessment Matrix provides clinicians with a validated tool for assessing spiritual needs and monitoring intervention effectiveness.

The substantial improvements in existential peace and meaning-making capacity suggest that addressing spiritual distress may be as critical as managing physical symptoms in the hospice context. The physiological correlates of spiritual well-being improvements further support the interconnectedness of spiritual, psychological, and physical dimensions of the human experience, particularly during life's final chapter.

This study contributes several original insights to the field of palliative care. First, it demonstrates that spiritual well-being can be systematically enhanced through structured interventions, even in the context of advanced terminal illness. Second, it establishes empirical connections between spiritual care and both psychological and physiological outcomes, moving beyond anecdotal evidence to quantitative validation. Third, it provides a replicable framework for integrating spiritual dimensions into standard care protocols.

Future research should explore the longitudinal sustainability of these effects, the potential for adapting these interventions to earlier stages of serious illness, and the development of training protocols for interdisciplinary team members. The translation of these findings into clinical practice guidelines represents an important next step for enhancing the quality of end-of-life care across diverse healthcare settings.

References

Adams, J. R., Coleman, P. G. (2023). Meaning reconstruction in terminal illness: A phenomenological study. Journal of Palliative Medicine, 26(4), 512-525.

Breitbart, W., Rosenfeld, B., Pessin, H., Applebaum, A. (2022). Meaning-centered group psychotherapy: An effective intervention for improving spiritual well-being. Psycho-Oncology, 31(3), 445-453.

Chochinov, H. M., Hack, T., Hassard, T., Kristjanson, L. J. (2023). Dignity therapy: A novel psychotherapeutic intervention. Palliative Medicine, 37(2), 178-189.

Edwards, M. J., Holden, R. R. (2022). Assessing spiritual well-being in palliative care. Journal of Pain and Symptom Management, 64(1), 89-97.

Fitchett, G., Murphy, P. E., Stein, E. M. (2023). Spiritual care in palliative settings. American Journal of Hospice and Palliative Medicine, 40(5), 523-531.

Kearney, M. K., Mount, B. M. (2022). Spiritual care of the dying patient. Journal of Palliative Care, 38(3), 215-222.

Puchalski, C. M., Vitillo, R., Hull, S. K. (2023). Improving the spiritual dimension of whole person care. Journal of Palliative Medicine, 26(7), 912-920.

Steinhauser, K. E., Voils, C. I., Tulsky, J. A. (2022). Spiritual needs of patients with serious illness. Quality of Life Research, 31(8), 2345-2355.

Sulmasy, D. P., Mueller, P. S. (2023). Ethics and the spiritual dimensions of healthcare. Hastings Center Report, 53(1), 28-37.

Vachon, M. L., Fillion, L. (2022). The spiritual needs of palliative care patients. Journal of Palliative Care, 39(2), 98-106.