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Spirituality as a Care Tool for Hospitalized Patients with Cardiovascular Events

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Abstract

Cardiovascular events are among the leading public health problems worldwide and, in Brazil, they head the mortality statistics, frequently associated with prolonged hospital stays and significant emotional and existential repercussions. This paper discusses spirituality and religiosity (S/R) as a tool of care and as a modulator of coping in patients hospitalized for cardiac events, as well as the place of the psychologist in this setting. This is an integrative literature review of studies published between 2020 and 2026 in PubMed/MEDLINE, SciELO and Google Scholar, using the descriptor Cardiovascular Disease combined with the terms Spirituality, Religiosity, Religious Coping and Psychology. After the search and eligibility criteria had been applied, 36 studies made up the sample, and the synthesis of the data was discussed along three axes: S/R in coping with cardiovascular disease; S/R as a tool of care for hospitalized patients with cardiac events; and the perspective of clinical psychology on S/R in cardiovascular health and illness processes. The evidence points to an association between S/R and higher levels of hope, better treatment adherence and more active participation in shared decision-making, as well as, in some of the studies, physiological outcomes such as reduced systolic blood pressure and improved endothelial function, highlighting the need for careful attention to the possibility of negative religious coping. It is concluded that S/R constitutes a relevant resource in the comprehensive care of the hospitalized cardiac patient and should be assessed in an individualized and ethical manner, supported by validated instruments, without replacing conventional medical and psychological treatment.

Keywords: *Spirituality; Religiosity; Cardiovascular Events; Clinical Psychology*

Introduction

Cardiovascular events have for many years been among the leading public health problems worldwide. In Brazil, cardiovascular diseases (CVD) head the mortality statistics, accounting for almost one third of registered deaths according to recent data from the Ministry of

Health [1]. Against this backdrop, cardiac patients may experience prolonged hospital stays, which produces significant impacts on their personal, emotional and professional lives.

As research on health and quality of life advances, there is growing recognition of spirituality as a relevant supportive element in the face of illness and of the hospital experience [2,3]. It is a subjective and existential dimension that can strengthen the patient at moments of vulnerability. In this sense, spirituality may be understood as the personal search for meaning and purpose and for a relationship with the sacred or transcendent, being understood as the way in which people relate to themselves, to the environment in which they live and to aspects that go beyond the concrete world [4], whereas religiosity corresponds to the degree to which individuals believe in, follow and practice a religion, whether in an organizational or a non-organizational form [5]. They are often observed in association, as Spirituality/Religiosity (S/R), and are even taken by the patient to be something single and inseparable.

With regard to mental health, resilience within the health-illness process represents a valuable psychological resource. This capacity to reshape oneself through recognition of the current state and through self-encounter can help the patient assimilate the diagnosis, encourage commitment to treatment and favor regularity in the use of medication, positively impacting both recovery and the well-being of family members [6]. Thus, the presence of resilience and of spirituality may represent a significant differential in the way the patient faces the challenges imposed by hospitalization.

The hospital context in itself may represent an aggravating factor in the illness process. It is therefore necessary for health professionals to break with the reductionist tendency to view the human being solely through the lens of pathology. According to research [4], it is essential to recognize the active role of patients in their own treatment, so that care must go beyond the clinical aspect, integrating the social, emotional and spiritual dimensions of the individual.

In this sense, it is important to deepen studies in this setting by linking theory, hitherto suggested across several areas of the dimensions of health and illness processes, to the clinical approach within the hospital environment alongside patients with cardiovascular disease, in order to provide a tool for modulating resilience through spirituality in the hospital context. Since positive emotions such as joy, gratitude, love and hope not only provide immediate pleasure but also foster the development of skills that are essential to adaptation and personal growth [7,8], helping such emotions to broaden the behavioral repertoire and to influence directly the way individuals perceive reality may promote a greater capacity to cope with the adversities experienced by patients with cardiovascular events in the hospital setting.

Materials and Methods

This study is an integrative literature review addressing S/R as an instrument of emotional modulation and of coping with cardiovascular disease in patients in the hospital environment. A brief analysis from the psychologist's perspective on S/R in this setting was also developed.

The selection of articles took place between July and August 2026 in the Scientific Electronic Library Online (SciELO), in PubMed/MEDLINE, the freely accessible search tool of the US National Library of Medicine for the Medical Literature Analysis and Retrieval System Online database, and in Google Scholar. The following search strategy was applied, in English and in Portuguese: ("Cardiovascular Disease" AND "Spirituality") OR ("Cardiovascular Disease" AND "Religiosity") OR ("Cardiovascular Disease" AND "Religious Coping") OR ("Cardiovascular Disease" AND "Psychology"). A second, undated search combined three terms in order to encompass the psychologist in the setting of cardiac events associated with S/R modulation in hospital: ("Cardiac events" AND "Spirituality" AND "Clinical Psychology") OR ("Cardiac events" AND "Religiosity" AND "Clinical Psychology") OR ("Cardiac events" AND "Religious Coping" AND "Clinical Psychology"), searched under the same conditions. The terms Cardiovascular Diseases, Spirituality, Religion and Psychology, Clinical correspond to controlled descriptors of the Health Sciences Descriptors (DeCS/MeSH), whereas the expressions Religious Coping and Cardiac events were used as free text terms.

The study grouped, analyzed and synthesized the results of the studies retrieved in a systematic and orderly manner, in order to present, discuss and deepen knowledge on the proposed theme, following Mendes [9]. Inclusion criteria comprised articles that fitted the theme addressed, with full texts available, and published between 2020 and 2026, except for those found in the undated search, which combined all descriptors with the term Hospital Psychology. Grey literature, namely dissertations, theses and undergraduate final papers, was considered eligible whenever the full text was freely accessible, given the still limited volume of Brazilian publications on the theme. Incomplete texts were excluded, as were studies without free access, repetitions of the same article in more than one database, editorials and studies on S/R in diseases that were not exclusively cardiovascular. Selection proceeded through reading the article titles, followed by reading the abstracts and, after the removal of duplicates, by full-text reading, in order to extract the data for analysis and discussion.

The temporal criterion described above applies to the studies that made up the analytical sample (n = 36). Classical references on spirituality, positive psychology, resilience and review methodology, as well as guidelines and position statements of scientific societies, were used as theoretical and methodological grounding and were therefore not subject to the same time window.

Results and Discussion

According to the criteria of the methodology adopted, 74 studies were identified. After the titles and abstracts had been read and the inclusion criteria applied, 42 works were selected, of which 6 were duplicates in more than one database. The remaining 36 studies, 4 from PubMed, 7 from SciELO and 25 from Google Scholar, were sent for full-text reading and made up the final sample, as shown in figure 1. Based on the data collected, the present discussion was divided into three axes: i) S/R in coping with cardiovascular disease; ii) S/R as a tool of care for hospitalized patients with cardiac events; and, finally, iii) the perspective of clinical psychology on S/R in cardiovascular health and illness processes in hospital.

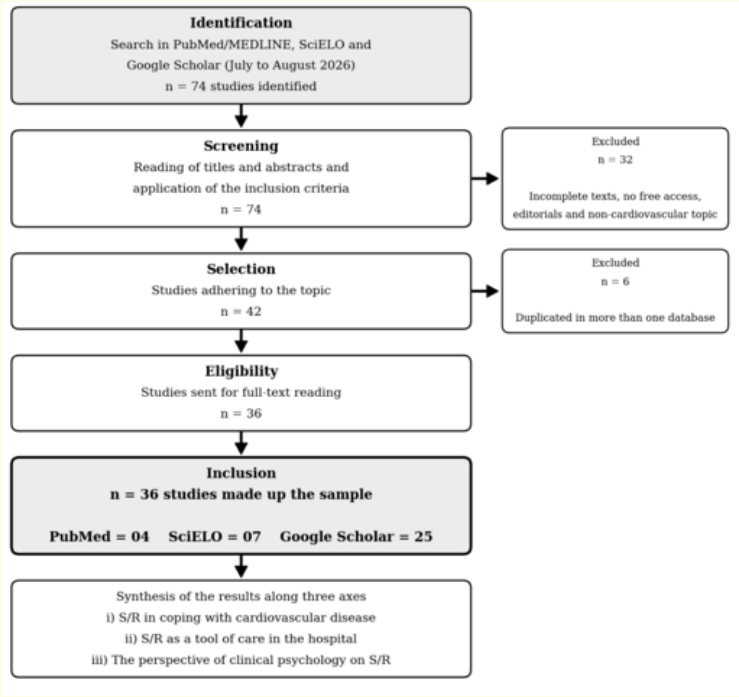

Figure 1: *Flowchart illustrating the stages of study selection.*

Source: Authors, 2026.

S/R in coping with cardiovascular disease

The relationship between S/R and the health-illness process has long been recognized, both in the hospital setting and in epidemiological research [10], and studies have demonstrated associations between S/R and cardiovascular disease, including greater survival, lower blood pressure levels and a lower incidence of postoperative complications [5,11]. Considering that cardiovascular diseases constitute the leading cause of morbidity and mortality worldwide and have a multifactorial etiology influenced by psychosocial risk factors such as stress, depression and social isolation [12], the spiritual dimension emerges as a potential tool for modulating the clinical course of these conditions [13], and is indeed addressed in official documents of the Brazilian Society of Cardiology [14].

With regard to coping with illness, S/R acts as an important internal resource. A study of outpatients with heart failure [15] found that 91.9% of the participants reported some religion or belief and that coping focused on religious practices was one of the most frequently used strategies; it did not, however, correlate with perceived social support, which suggests a predominantly internal resource that is relatively independent of the external environment.

From the standpoint of treatment adherence, the evidence is consistent. Researchers identified a clear association between spirituality and treatment adherence in outpatients with heart failure, although without establishing a causal relationship [16].

Corroborating these benefits, beyond the psychological sphere, there is evidence of measurable physiological effects. The influence of spiritual well-being on blood pressure, central hemodynamics and endothelial function was investigated [17] and, subsequently, in the FEEL trial, a single-centre pilot randomized clinical trial, a spirituality-based intervention encouraging forgiveness, gratitude, optimism and purpose in life reduced office systolic blood pressure and improved flow-mediated dilation in patients with mild to moderate hypertension, with no significant effect on home blood pressure monitoring [18]. Given the pilot design and the sample size, these findings require confirmation in larger multicentre trials.

In line with this, another study demonstrated, through a qualitative approach grounded in Viktor Frankl's existential analysis, that the spiritual dimension provides meaning and a sense of life, favoring the recovery of hope and of the will to live, which are manifested in self-care actions and treatment adherence [19]. Similarly, Camargo., *et al*. [20] showed, in a study of 237 hypertensive patients, that intrinsic religiosity and the capacity to forgive were positively and significantly associated with greater adherence to pharmacological and non-pharmacological treatment, with no significant association for the dimension of values and beliefs; the cross-sectional design, however, does not allow causal inference. Furthermore, literature reviews corroborate these findings by showing that spirituality is associated with better treatment adherence, greater resilience and even a reduction in inflammatory markers such as C-reactive protein [21]. Accordingly, Lucchetti [22] suggests that religious and spiritual beliefs should be assessed and incorporated into clinical practice, since they influence cardiovascular risk factors, outcomes and treatment adherence, favoring a culturally sensitive and therefore more inclusive medicine.

With regard to the care of cardiac patients, authors highlight the importance of uniting health and spirituality in clinical practice [23], especially in identifying the spiritual need and the source of coping and hope of each individual. Similarly, research argues that care for cardiac patients should be humanized, aiming to address emotional, social and spiritual aspects beyond the biomedical understanding [24].

Despite these benefits, inconclusive data were also found, which merit an innovative methodological perspective. A study that evaluated 57 patients in a cardiovascular rehabilitation program [25] detected no association between organizational, non-organizational or intrinsic religiosity and functional or quality-of-life gains. Commenting on these results, Silva [26] argues that the heterogeneity of the measurement instruments and of the populations studied still limits definitive conclusions about the role of S/R in cardiac rehabilitation. In contrast, the systematic review conducted by Souza [13], as an undergraduate final paper, identified a positive and statistically

significant association between S/R and quality of life in nine of fourteen studies, further reinforcing that, in most settings, the spiritual dimension acts favorably on multiple domains of the cardiac patient's life.

Therefore, the body of evidence suggests that S/R function as a modulating tool in cardiovascular disease through at least three complementary pathways: the strengthening of coping and of the attribution of meaning to illness; the increase in treatment adherence; and possible direct biological effects on blood pressure and endothelial function. Consequently, it is recommended that cardiologists incorporate spiritual history-taking into the consultation, by means of brief and validated instruments, in order to understand how the beliefs of patients influence their treatment and in what way those beliefs bring them comfort or suffering [5]. Finally, the need for larger randomized studies and for standardized instruments is emphasized, so as to consolidate the integration of this dimension into cardiovascular care in an ethical, ecumenical and patient-centered manner [14,22].

S/R as a tool of care for hospitalized patients with cardiac events

Hospitalization of the cardiac patient constitutes a moment of intense physical and existential vulnerability, in which illness of the heart, an organ symbolically associated with life itself, frequently raises questions about meaning, finitude and transcendence. In this context, comprehensive care presupposes attention not only to the biological, psychological and social dimensions, but also to the spiritual dimension of the individual. In analyzing the experience of hospital chaplaincy with hospitalized cardiac patients, Chiang [27] highlights that spirituality constitutes a relevant element in the recovery process, insofar as it offers acceptance, comfort and a re-signification of illness during the hospital stay. Complementarily, another study reports that medical training in health and spirituality, begun at university through academic leagues [23,28], has positive repercussions in clinical practice, enabling professionals to recognize and address the spiritual needs of patients in an ethical and respectful manner.

In the hospital environment, empirical evidence reinforces the relevance of this dimension. In a cross-sectional study of 70 adults in the immediate preoperative period of cardiac surgery [29], researchers found that having a religion and practicing it, regardless of denomination and of the time devoted to religious practices, was significantly associated with higher levels of hope ($p < 0.01$), concluding that the multiprofessional team should create conditions for the spiritual process of the patient to be viable during hospitalization.

In line with this, an investigation conducted with patients hospitalized for coronary angiography examined the relationships between S/R, anxiety, depression and subjective well-being, showing the relevance of considering such variables in the care of patients with cardiac events who undergo invasive procedures [30]. In that study, patients presented high intrinsic and non-organizational spirituality, together with psychological distress arising from the illness and hospitalization process, which calls for careful attention to support throughout treatment. Moreover, so that this dimension may be incorporated into care in a systematic and measurable way, Gomes and Bezerra [31] validated the Spiritual Well-Being Scale for hospitalized patients in the preoperative period at a university hospital specializing in cardiology, providing a psychometrically adequate instrument for the bedside assessment of spiritual well-being. In a subsequent study, the same authors examined religiosity, spiritual well-being and transpersonal care in the preoperative period of cardiac surgery [32].

Beyond emotional outcomes, spirituality has repercussions for the therapeutic relationship itself. In this direction, a cross-sectional study of patients with chronic heart failure showed that spirituality was directly and indirectly associated with shared decision-making, in a chain mediated by benefit finding and by decision self-efficacy, with the total indirect effect accounting for 69.1% of the association [33]; the cross-sectional design, however, does not allow causal inference. The authors therefore suggest that spiritual support services may promote patient engagement in clinical decisions and, consequently, favor medication adherence.

In parallel, structured interventions have also been tested, as in the PsicoCare pilot randomized clinical trial, which combined cognitive-behavioral therapy and positive psychology in patients with acute coronary syndrome. Magán., *et al*. [34] observed that the intervention

was associated with better maintenance of spiritual coping, social support and cognitive function throughout follow-up, whereas the control group showed deterioration in these domains.

It should also be noted that comprehensive care of the hospitalized patient with cardiac events extends to the advanced stages of the disease. In the case of the patient with chronic heart failure, for example, care requires the inclusion of palliative care, an approach that encompasses symptom control, family support and attention to the spiritual and existential needs of the patient [24]. In this scenario, the contribution of hospital chaplaincy described by Chiang [27] is taken up again, since the presence of a specialized spiritual care service, articulated with the multiprofessional team, broadens the possibilities of receiving suffering and of promoting comfort for the patient and their family, especially in the face of guarded prognoses.

With a similar view, researchers recommend that physicians, nurses and psychologists validate and expand the opportunities for patients to be in contact with their spirituality during hospitalization, setting aside moments for prayer, meditation and visits from religious leaders, in addition to ensuring effective communication with the patient and their family [30].

The perspective of clinical psychology on S/R in cardiovascular health and illness processes in hospital

Hospitalization for cardiovascular disease goes beyond organic impairment, since it mobilizes emotional, social and existential repercussions capable of interfering with adaptation to treatment and with recovery. Research highlights that cardiac illness involves stress, anxiety, depression and the symbolism attributed to the heart, which is frequently associated with life and with finitude [35]. In this scenario, spirituality may constitute a relevant dimension of the experience of the patient and should therefore be considered during psychological listening. Oliveira Neto [10] highlights the importance of spirituality in hospital care and points to gaps in the training and practice of psychology professionals for the management of this dimension.

In cardiology units, these reactions may be intensified by invasive procedures, disruption of routine and fear of death. Researchers point out that the presence of the psychologist in the cardiac intensive care unit (ICU) makes it possible to identify emotional factors that hinder adaptation to hospitalization [35,36], corroborating Finkler and Vivian [37], who emphasize the repercussion of a poor prognosis in the presence of disorders such as anxiety and depression in the management of heart failure. Cardiovascular therapeutics therefore requires a broader understanding of the patient, beyond the biomedical diagnosis, positioning the approach to spirituality not as presupposing the adoption of beliefs by the professional, but as enabling patients to express the meanings and resources they consider important in the face of illness.

In this context, the psychologist works on immediate suffering and on the ways in which patients understand and cope with illness. Studies describe interventions that include assessment of the understanding of disease and treatment, emotional support, investigation of risk and protective factors, support for family members and facilitation of communication with the team [35,37]. With a practical approach, researchers advocate work that is integrated into case discussions, so that psychoemotional and singular aspects are considered by the interdisciplinary team [35,38].

In keeping with this, in reporting care provided to patients undergoing cardiac surgery, a study reinforces this mediating function, showing that failures in the understanding of medical information may amplify distress and resistance to procedures [39]. To overcome these obstacles, tools such as active listening, psychoeducation and accessible communication become central resources. Scholars add that, in the preoperative and postoperative periods, psychological intervention favors the expression of fears and fantasies and helps to reduce anxiety [36].

In reporting internship experience in the hospital environment, authors have demonstrated the complexity of the psychological follow-up of patients undergoing cardiac care, highlighting the presence of emotional and spiritual aspects during this process [38,39]. These elements reinforce the importance of practice that considers the patient beyond the exclusively organic dimension, recognizing the interaction between physical, emotional, social and spiritual aspects.

Beyond emotional support and suffering, psychology can contribute to strengthening the participation of patients in their own treatment. Studies have identified that spirituality was positively related to shared decision-making in patients with heart failure, by means of decision-making self-efficacy [33]. Although that study did not directly investigate the work of the hospital psychologist, its results allow us to understand that subjective resources associated with spirituality may be related to more active patient participation in decisions concerning care.

In parallel, S/R appear as a relevant dimension in the face of serious and life-threatening diseases. Thus, the understanding of spirituality as a subjective dimension related to the search for meaning and purpose appears capable of taking part in coping with suffering [36]. Researchers show that S/R can be received in psychological listening as part of comprehensive and humanized care, provided that it is understood on the basis of the concrete experience of the patient [38].

In research with hospital psychologists, Sousa observed that spirituality frequently emerges during consultations, especially in ICUs, functioning as a source of comfort, hope and re-signification for patients and family members [40]. Other studies also emphasize that resources such as hope, courage and spirituality may contribute to treatment adherence and quality of life [35,40], and experience reports on the insertion of psychology into multiprofessional teams in cardiology services describe this practice as a path for consolidating such care [41].

Although the literature describes many resources through which S/R may provide emotional support to the patient during illness, the association between S/R and health outcomes should not automatically be interpreted as a protective factor. Carneiro [42], in evaluating patients in the preoperative period of myocardial revascularization, found depressive symptoms in 27.2% and anxiety symptoms in 45.3% of the sample. Although higher indicators of religiosity showed a trend toward fewer depressive symptoms, there was no statistically significant association between S/R, anxiety and depression, which reinforces the need for individualized assessment [42]. In the same direction, a study on religious-spiritual coping in the preoperative period of cardiac surgery describes the variability of these resources among patients and the need to assess them individually [43].

This observation is due to the fact that modulation by S/R may be positive (positive coping) or negative (negative coping), depending on the intrinsic beliefs of the patient or on prior histories involving religious contexts. In this sense, it may intensify guilt, a sense of divine abandonment, punishment, karma or resistance to treatment [40,44]. It is therefore up to the psychologist to investigate the function assumed by S/R for each patient, in a sense that protects against negative coping, in order to avoid a poor outcome in the prognosis of the patient.

This approach requires ethical rigor and technical preparation. The literature emphasizes that the professional should receive the spiritual dimension without suggesting religious practices or guiding the patient on the basis of the professional's own beliefs [36,45], and adds that it is necessary to respect the wish to address the subject or not and to recognize situations in which S/R amplifies suffering or impairs treatment adherence [40,45]. As obstacles to this view, recent research identified the absence of specific training, professional insecurity and the resistance of teams that are still strongly oriented by the biomedical model [40], factors that deserve to be revisited. Taken together, it is understood that managing S/R does not mean exercising religious practice in the hospital, but rather including, in a qualified way, a subjective dimension that may take part in how patients interpret their illness and make decisions.

Accordingly, psychological practice should also include evidence-based strategies for the management of emotional suffering. The PsicoCare pilot trial discussed above [34] illustrates this possibility, since the combination of Cognitive-Behavioral Therapy and Positive Psychology was associated with better maintenance of spiritual coping, social support and cognitive function in patients after acute coronary syndrome, whereas the control group deteriorated in these domains. Its results reinforce the importance of structured psychological interventions in cardiovascular care. Therefore, the perspective of the psychologist in the treatment of cardiovascular events in the hospital environment articulates clinical listening, biopsychosocial understanding, interdisciplinary mediation and attention to the sources of meaning mobilized by illness.

Conclusion

The body of evidence indicates that S/R are part of the care of the hospitalized patient through multiple pathways, sustaining hope and subjective well-being at critical moments. In addition, the studies point out how the preoperative period and invasive procedures qualify the therapeutic relationship by favoring shared decision-making and treatment adherence, highlighting the core of palliative care in advanced disease.

Consequently, the operationalization of this dimension, through validated assessment instruments, chaplaincy services, structured psychological interventions and professional training in health and spirituality, presents itself as a consistent path toward the realization of care that is truly comprehensive, humanized and person-centered.

The contributions of the studies discussed here converge toward work directed at emotional elaboration, communication, adherence and the re-signification of the cardiovascular experience, integrating S/R when these are meaningful for the individual, without replacing conventional medical or psychological treatment. Beyond this discussion and its reach among health professionals, further studies in the area are important in order to disseminate the theme and the hospital practice of S/R with the psychologist and other health professionals in favor of the care of patients and their families.

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Conflict of Interest

The authors declare that there is no conflict of interest.

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