LETTER to the EDITOR **Editorial Process:** Submission:01/06/2026 Acceptance:07/04/2026 Published:07/27/2026

Comment on Modeling of Patient Needs for Fulfillment of Spiritual Health and Social Support with Anxiety Levels and Quality of Life of Cancer Patients

Asian Pac J Cancer Prev, **27 (7),** 2355-2356

Dear Editor

We read with great interest the recent structural equation modeling analysis by Qomariah and colleagues examining the relationships among spiritual health, social support, anxiety, and quality of life (QOL) in Indonesian cancer patients [1]. Their findings address an important gap in understanding the psychosocial and spiritual dimensions of oncology, which remain underemphasized in routine clinical care despite growing evidence of their relevance for patient outcomes [2, 3]. Notably, the authors report that higher spiritual health and stronger social support were each associated with significantly better QOL ($p=0.017$ and $p=0.003$, respectively) and lower anxiety levels ($p<0.001$ and $p=0.015$, respectively). Within their cohort, 63% of patients demonstrated high spiritual well-being and 94% reported good family support, yet 46% still experienced some anxiety and 75% reported good QOL. These findings highlight the complex and non-linear interactions between psychosocial resources and psychological distress, reinforcing the need for truly holistic, patient-centered models of cancer care.

A growing body of literature suggests that spiritual health may influence cancer outcomes through multiple psychological and physiological pathways. Spiritual well-being (often encompassing meaning, peace, and faith) has been shown to enhance coping capacity and psychological resilience. For example, a systematic review has demonstrated consistent and independent associations between spiritual well-being and overall QOL across diverse cancer populations, with the meaning and peace dimensions showing particularly strong correlations with both mental and physical health outcomes [3]. This body of evidence suggests that a sustained sense of purpose and inner coherence may mitigate emotional distress, reduce depressive symptoms, and support treatment adherence. In oncology nursing and psycho-oncology research, patients and clinicians alike have emphasized that spiritual care exerts a profound influence on patients' outlook, coping strategies, and perceived quality of life [2, 3]. In this context, the findings of Qomariah et al. [1] align well with established theoretical models proposing that spiritual resources can directly attenuate psychological distress and buffer stress-related somatic symptoms.

Social support likewise appears to operate through several complementary mechanisms to influence psychological well-being and quality of life. Family and community support can provide emotional comfort (e.g., empathy and listening) that directly soothes anxiety, instrumental support (e.g., financial aid and help with daily tasks) that reduces burdens exacerbating stress, and informational support (e.g., guidance on treatment or coping strategies) that enhances self-efficacy and sense of control. Supportive family members and peers not only share caregiving responsibilities and facilitate access to healthcare resources, but also promote adaptive coping and emotional regulation. Prior research indicates that social support exerts both "main effects," by enhancing general well-being, and "buffering effects," by reducing the psychological impact of stressors [4, 5]. Meta-analytic evidence further demonstrates that structured social support interventions, including peer-based support programs, significantly improve QOL while reducing anxiety and depressive symptoms in cancer populations [5]. The independent association observed by Qomariah et al. between family support, reduced anxiety, and improved QOL is therefore consistent with broader models in which social connectedness strengthens mental health and facilitates engagement with treatment.

It is also noteworthy that the study sample was predominantly female (63%) and that adult children most frequently served as caregivers (50.5%) rather than spouses. These demographic characteristics may carry important psychosocial implications. Previous studies have consistently shown that female cancer patients report higher levels of anxiety than their male counterparts; for instance, Parás-Bravo et al. found that women with cancer were more than twice as likely as men to experience clinically relevant anxiety symptoms (OR=2.43) [6]. If similar gender-related vulnerability exists in the present cultural context, it may partly explain the persistence of anxiety despite high levels of spiritual and social resources. Additionally, caregiving by adult children may involve distinct stressors, such as competing occupational and family demands, which could influence the stability and nature of support provided. Future research would benefit from examining how gender and caregiver relationship patterns interact with spiritual health and social support to shape psychological outcomes.

Taken together, these findings underscore the importance of integrating spiritual assessment and intervention into standard oncology care. Contemporary cancer care guidelines increasingly recognize spiritual distress as a core component of psychosocial assessment.

In clinical practice, this integration may begin with brief, structured screening tools such as Puchalski's FICA framework (Faith, Importance, Community, Address), which facilitates sensitive exploration of patients' beliefs, sources of meaning, and support preferences through questions like "What gives you meaning? How important is spirituality to you? Would you like spiritual support?" [7]. Normalizing spiritual inquiry alongside physical symptom assessment may help clinicians identify unmet needs and initiate timely referrals to chaplaincy services, spiritual counselors, or community-based resources. Importantly, spiritual care interventions should be framed as integral to person-centered treatment throughout the cancer trajectory, rather than being limited to end-of-life contexts. The associations reported by Qomariah et al. suggest that systematic attention to spiritual health has the potential to meaningfully reduce anxiety and enhance quality of life alongside biomedical treatment.

In conclusion, Qomariah and colleagues provide compelling quantitative evidence that spiritual health and social support are key determinants of psychological well-being and quality of life among patients with cancer. Their work reinforces a growing consensus that effective oncology care must address the whole person, extending beyond tumor-directed therapies to encompass psychosocial and spiritual dimensions. By elucidating these relationships, the study offers a strong empirical rationale for integrating psycho-spiritual care into routine oncology practice (for instance, by training providers in spiritual screening and incorporating family support services) and for further research aimed at refining culturally sensitive, holistic interventions.

Author Contribution Statement

BF and AE contributed equally to conception, literature synthesis, critical analysis, and manuscript preparation. Both authors reviewed and approved the final version. AE serves as corresponding author.

Acknowledgments

We acknowledge Qomariah et al. for their important contribution to understanding spiritual health and social support in cancer patients, and the broader research community for advancing evidence on mindfulness-based interventions, acceptance and commitment therapy, and peer support programs.

Competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Conflict of interest

The authors declare no potential conflicts of interest concerning the research, authorship, and/or publication of this article.

Ethical Approval

Not applicable. This letter to the editor comprises critical commentary and evidence synthesis without human subjects or primary data collection.

Data and Materials Availability

All data presented derive from published sources cited in the references. Further information requests should be directed to the corresponding author.

References

1. Qomariah SN, Orizani CM, Iswati I, Warsini W, Yulianti TS, Kristanto B. Modeling of patient needs for fulfillment of spiritual health and social support with anxiety levels and quality of life of cancer patients. Asian Pac J Cancer Prev. 2025;26(5):1727-34. https://doi.org/10.31557/apjcp.2025.26.5.1727.
2. Meneses-La-Riva ME, Fernández-Bedoya VH, Suyo-Vega JA, Ocupa-Cabrera HG, Ocupa-Meneses GDD. Spiritual care and spiritual perspective: Assessing oncology patients' perspectives and their implications for healthcare management. Healthcare (Basel). 2025;13(13). https://doi.org/10.3390/healthcare13131554.
3. Bai M, Lazenby M. A systematic review of associations between spiritual well-being and quality of life at the scale and factor levels in studies among patients with cancer. J Palliat Med. 2015;18(3):286-98. https://doi.org/10.1089/jpm.2014.0189.
4. Xu F, Xie S, Li Q, Zhong X, Zhang J. The impact of depression on the quality of life of lung cancer patients undergoing chemotherapy: Mediating effects of perceived social support. Front Psychiatry. 2025;16:1526217. https://doi.org/10.3389/fpsyt.2025.1526217.
5. Zhang S, Li J, Hu X. Peer support interventions on quality of life, depression, anxiety, and self-efficacy among patients with cancer: A systematic review and meta-analysis. Patient Educ Couns. 2022;105(11):3213-24. https://doi.org/10.1016/j.pec.2022.07.008.
6. Parás-Bravo P, Paz-Zulueta M, Boixadera-Planas E, Fradejas-Sastre V, Palacios-Ceña D, Fernández-de-Las-Peñas C, et al. Cancer patients and anxiety: A gender perspective. Int J Environ Res Public Health. 2020;17(4). https://doi.org/10.3390/ijerph17041302.
7. Puchalski CM, Sbrana A, Ferrell B, Jafari N, King S, Balboni T, et al. Interprofessional spiritual care in oncology: A literature review. ESMO Open. 2019;4(1):e000465. https://doi.org/10.1136/esmoopen-2018-000465.

Bita Fallahpour[1], Alireza Emarati[2,3]*

*[1]Department of Psychiatry, Razi Hospital, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran. [2]Department of Psychiatry, Shahid Sadoughi University of Medical Sciences, Yazd, Iran. [3]Hematology and Oncology Research Center, Shahid Sadoughi University of Medical Sciences, Yazd, Iran. *For Correspondence: sare1369@yahoo.com*