DOI: 10.71317/jgst.2.8.2026.306
Journal of Global Social Transformation
Journal homepage: https://rjsaonline.org/index.php/JGST

Existential Loneliness and Spiritual Well-being as Predictor of Hope among Patient with Chronic Illness

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ARTICLE INFO

Submission:
June 18, 2026
Revised:
July 02, 2026
Accepted:
July 16, 2026
Available Online:
August 01, 2026

Keywords:
Chronic Illness, Existential Loneliness, Spiritual Well-being, Hope, Pakistan.

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ABSTRACT

Not only do chronic diseases impact a person physically, but they can also take a toll on one's psychological state and spirituality. In this study, the researcher looked into the connections between existential loneliness, spiritual well-being, and hope in people with chronic diseases and tried to determine whether the level of spiritual well-being acted as a mediator for the correlation between existential loneliness and hope. For this research, a quantitative correlational cross-sectional design was utilized. The target group of 342 individuals with chronic diseases such as diabetes, hypertension, heart disease, kidney disease, and cancer was recruited from hospitals and medical centers in Gujrat, Pakistan. Three measurement tools were used, namely, the Brief Scale of Existential Loneliness (BSEL), the Spiritual Well-Being Scale (SWBS), and the Herth Hope Index (HHI). There was a significant negative correlation between existential loneliness and hope, while existential loneliness correlated positively yet weakly with spiritual well-being. Spiritual well-being negatively correlated with hope. There were significant differences in hope and spiritual wellbeing between various groups defined by marital status and type of illness. These results demonstrate the interconnection of multiple aspects such as existential, spiritual, and psychological within chronic illness treatment.

Introduction

Chronic diseases like diabetes, cancer, and cardiovascular diseases constitute some of the most common causes of mortality and morbidity (WHO, 2023). In addition to posing physical risks, chronic diseases also involve serious psychological and social threats, involving greater emotional stress and reduced life satisfaction when compared to healthy individuals (Livneh & Antonak, 2005). The traditional biomedical approach is now gradually superseded by biopsychosocial-spiritual paradigms, emphasizing the psychological and existential aspects of illnesses (Engel, 1977). Existential issues and conflicts associated with an illness might challenge one's identity, sense of purpose, and meaning of life and thus be more than just physical ailments (Charmaz, 1995; Yalom, 1980). Existential loneliness is different from social loneliness because it entails a feeling of emptiness and isolation associated with an understanding that no one else shares the same fear and pain as one feels and that the individual's suffering cannot be divided. The existence of existential loneliness is explained by the feeling of being alone with the experience of death, despite being surrounded by friends and relatives (Bolmsjö & Tengland, 2019).

McKenna-Plumley et al. (2023) conceptualize loneliness as multidimensional, encompassing social, emotional, and existential forms. The existential dimension though the most profound is frequently overlooked in clinical practice. Research confirms that individuals

with chronic illness are particularly vulnerable to this experience due to their altered health status, dependence on others, and confrontation with mortality (Lewis et al., 2024).

Spiritual well-being refers to the inner peace, harmony, and sense of connection with a higher power or transcendent source of meaning that enables an individual to cope with adversity. Paloutzian and Ellison (1982) distinguish two components: Religious Well-Being (a sense of relationship with God) and Existential Well-Being (a sense of meaning and purpose in life). Within the Islamic tradition that underpins the sociocultural context of this study, spiritual well-being is considered essential to leading a wholesome life. The Qur'an (Surah Al-Nahl: 97) affirms that those who believe and perform good deeds will be granted a good life. Research consistently shows that higher spiritual well-being is associated with better psychological adjustment and lower emotional distress in chronically ill patients (Koenig, 2012).

Hope Theory (Snyder, 2002) defines hope as a cognitive-motivational system comprising three interacting elements: Goals the valued outcomes individuals wish to achieve, Pathways Thinking the perceived ability to generate routes towards those goals, Agency Thinking the belief that one can initiate and sustain movement along those pathways. Hope is a powerful psychological resource that helps patients manage ongoing health challenges, maintain a positive orientation towards the future, and find meaning despite suffering. Higher hope has been linked to reduced anxiety, depression, and hopelessness in chronic illness populations (Katsimigos et al., 2021).

Existential loneliness has roots in Yalom's (1980) existential theory, which describes isolation as one of the four ultimate human concerns. Although humans are close socially and psychologically, an unbridgeable gap between individuals makes certain experiences particularly suffering and death fundamentally private. Ettema et al. (2020) found through systematic review that life-threatening illness significantly intensifies this form of loneliness; social contact alone cannot resolve it because its origin lies in the individual's confrontation with existence rather than mere social absence. M berg wager (2020) demonstrated that existential loneliness is a measurable, independent construct characterized by a deep sense of meaninglessness and alienation from life — distinct from social and emotional loneliness. Dahlberg et al. (2021) argued from a phenomenological perspective that it should be understood as an ontological state resulting from life disruptions (illness, ageing, personal crisis) rather than as a psychological disorder. The BMC Psychiatry study (2023) linked existential loneliness to anxiety, depression, and difficulty finding meaning underscoring the public health significance of this construct.

Ozaras and Abaan (2020) found a strong inverse correlation between existential loneliness and spiritual well-being in Turkish cancer patients who perceived meaning in their illness experience felt less detached from life and others. Chiang et al. (2021) demonstrated that existential spiritual well-being was the strongest single predictor of lower existential loneliness in older adults (31% variance explained). Cordero et al. (2024) confirmed that spirituality reduces inner loneliness even when social support is limited, by fostering the sense that one is not alone in suffering. Tirgari (2022) found that chronically ill patients with higher spiritual well-being scored significantly higher on the Herth Hope Index, with spiritual meaning and faith sustaining positive expectations despite chronic symptoms. Jafari et al. (2020) identified spiritual well-being as the strongest positive predictor of hope among young adults ($\beta = .61$, $p < .001$), arguing that spirituality imbues adversity with significance.

Hope is increasingly recognized as a vital psychological resource in chronic illness. Duggleby et al. (2021) identified social support, spirituality, healthy relationships, and positive clinician communication as the principal facilitators of hope, while uncertainty, disease progression, and social isolation were its greatest threats. Katsimigos et al. (2021) showed that higher hope was associated with better emotional functioning and pain outcomes even when symptoms persisted. Salamanca-Balen et al. (2021) demonstrated in a systematic review that dignity therapy, spiritual counselling, and cognitive-behavioral interventions significantly raised hope levels in chronic and terminal illness populations. Spiritual well-being has been identified as a significant buffer against existential distress. Patients who experience a sense of meaning, transcendence, and inner peace report lower levels of existential loneliness, even in the absence of strong social support (Cordero et al., 2024). Meeting unmet spiritual needs through supportive care has been shown to reduce existential suffering and enhance hope (Kalanidhi, 2019).

Aim of the study

The purpose of this research is to investigate the connection between existential loneliness, spiritual health, and hope in patients with long-term illness. The goal of the study is to determine whether spiritual well-being plays a mediating or supportive role in boosting hope and how existential loneliness affects the degree of hope in people with long-term medical conditions. Additionally, this study intends to explore the psychological and emotional experiences of patients with chronic illnesses, with a particular emphasis on how spiritual beliefs and a sense of purpose in life may assist them in managing the distress associated with their condition. The study aims to advance knowledge of the elements that support psychological resilience and enhance general well-being in patients with chronic illnesses by examining these variables.

Methods

A quantitative cross-sectional correlational research design was employed. This design allows for the simultaneous collection of data on multiple variables, examination of associations without experimental manipulation, and is well-suited to health and psychological research owing to its practicality and cost-effectiveness.

Sample

A purposive sample of 342 patients diagnosed with chronic illness was recruited from hospitals and clinics in Gujrat, Pakistan (including Ikram Hospital and Medico Roots Hospital). The sample included both males (44.7%) and females (55.0%) across all age groups. Table 1 presents the full demographic profile.

Instruments

Brief Scale of Existential Loneliness (BSEL) developed by McKenna-Plumley et al. (2024). Six items on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree). Higher scores indicate greater existential loneliness. Cronbach's α = .71.

Spiritual Well-Being Scale (SWBS) developed by Ellison and Paloutzian (1983). The Urdu version was used. Twenty items across two subscales: Religious Well-Being (RWB) and Existential Well-Being (EWB). Rated on a 6-point Likert scale. Cronbach's α = .64.

Herth Hope Index (HHI) developed by Herth (1992). Twelve items across three subscales: Interconnectedness, Positive Readiness and Expectancy, and Temporality and Future. Rated on a 4-point Likert scale (items 3 and 6 reverse-scored). Cronbach's α = .63.

Procedure

First of all, I requested permission from the respective author of the scales to use them in my research. After receiving approval, I obtained a permission letter from my chairperson for data collection. I collected the data from chronic illness patients. Before collecting the data, I explained the purpose of my study to the participants and assured them that the information they provide would be kept confidential and used only for research purposes. Data were collected from different places, including hospitals such as Ikram Hospital and Medico Roots Hospital, Gujrat. In addition, some participants were also approached from my village and surrounding areas. Three scales were distributed to the participants, including the Existential Loneliness scale, Spiritual Well-being scale, and Hope scale. Along with these, a demographic sheet was also provided. Participants were guided on how to fill out the questionnaires, and I remained available to answer any questions during the process. All the questionnaires were carefully checked after completion to ensure that they were properly filled.

Ethical Considerations

Permission to use all instruments was obtained from the original authors via email. Ethical approval and a data-collection permission letter were secured from the institutional chairperson. All participants provided written informed consent and were assured of confidentiality, voluntary participation, and the right to withdraw at any time without consequence. Data were collected in person; the researcher remained available to address queries during completion.

Results

Reliability Analysis

Table 1. Psychometric properties of study scales

Scale	M	SD	Range	α
Existential Loneliness Scale	16.10	4.24	6–26	.71
Spiritual Well-Being Scale	35.50	10.53	28–70	.64
Herth Hope Index	46.10	4.91	17–48	.63

Table 1 summarizes the psychometric properties of the three instruments. All scales demonstrated acceptable to moderate internal consistency, confirming their suitability for further statistical analysis

Correlation Analysis (Spearman's Rho)

Table 2. Correlation of Study Variables

Variable	1	2	3
1. Existential Loneliness	—		
2. Hope	−.36**	—	
3. Spiritual Well-Being	+.19**	−.42**	—

**p < .01.

Existential loneliness was significantly negatively correlated with hope (r = −.36), existential loneliness showed a weak but significant positive correlation with spiritual well-being (r = +.19). Spiritual well-being was significantly negatively correlated with hope (r = −.42).

Multiple Regression Analysis

Table 3. Regression Analysis of Study Variables

Variable	B	SE	t	p	95% CI
Existential Loneliness Scale	-0.30	0.05	-5.42	< .001	[-0.41, -0.19]
Spiritual Well-Being	-0.19	0.02	-8.13	< .001	[-0.22, -0.14]
Constant	48.74	1.22	39.79	< .001	[46.33, 51.25]

Note. B = unstandardized coefficient; SE = standard error; CI = confidence interval.

A multiple regression was conducted with existential loneliness and spiritual well-being as predictors of hope. The overall model was significant $F(2, 339) = 60.13$, $p < .001$ and explained 26% of the variance in hope ($R^2 = .26$). Both predictors were significant: existential loneliness ($\beta = -.26$, $p < .001$) and spiritual well-being ($\beta = -.39$, $p < .001$). These results shows that both predictors influencing hope, though the direction for spiritual well-being contrasts with theoretical expectations.

Discussion

The findings of the current study showed negative association between existential loneliness and hope. The empirical evidences support the current study as Bolmsjö et al. (2017), found that pessimism and despair among symptoms of existential loneliness in palliative patients, and Kao et al. (2025), who described decreased future perspectives associated with existential loneliness among chronic patients. The result showed that existential loneliness is not just social loneliness, must be taken into consideration in order to maintain hope in chronic conditions.

The counterintuitive direction of this relationship is worth discussing in more detail. One possible reason behind this pattern may be the fact that existential loneliness leads people to engage in spiritual practices, despite the intense suffering involved. The studies conducted by Puchalski et al. (2014), Büssing and Koenig (2010) show that suffering and death confrontations tend to increase spiritual searches. In the Islamic socio-cultural environment that this population represents, suffering is viewed as an experience where one can grow spiritually and become closer to Allah (Bensaid, 2018; Amiruddin et al., 2021). Thus, existential loneliness will not make people distance themselves from religion but, on the contrary, draw closer to it – creating a positive rather than negative association. It should be emphasized that the current results are contrary to those found by (Ozaras & Abaan, 2020; Chiang et al, 2021).

The inverse relation between spiritual well-being and hope stands in opposition to the majority of research conducted in both Western and Eastern settings (Tirgari, 2022; Jafari et al., 2020). A possible explanation here is that the SWBS scale used to measure spiritual well-being might actually be measuring spiritual distress such as God-directed anger, spiritual crisis, and doubt about divine will after becoming ill. Precisely this phenomenon was demonstrated by Balboni et al. (2007), where seriously ill patients experiencing spiritual needs not fulfilled or spiritual crisis reported having poorer psychological status and reduced levels of hope. According to Büssing and Koenig (2010), spiritual needs increase with suffering. This means that high SWBS scores can actually be a sign of higher spiritual burden and not spiritual satisfaction. The moderate internal consistency of the SWBS scale in the Urdu language may also be explained by problems with assessing spiritual experiences.

Both variables emerged as significant predictors of hope and independently explained 26% of its variance, thus confirming the usefulness of spiritual well-being as the mediating variable (H4), even though contrary to expectations. Based on the obtained results, it could be suggested that the mediating process takes place through spiritual burden rather than spiritual thriving, as suggested by Kalanidhi (2019): the more one feels existential loneliness, the more one suffers spiritually, leading to the loss of hope. Thus, the focus on unfulfilled spiritual needs as the means of protecting hope among chronically ill patients gains clinical significance.

Conclusion

This study provides empirical evidence that existential loneliness is a significant negative predictor of hope among patients with chronic illness in Pakistan, highlighting the importance of addressing existential dimensions of patient experience in clinical care. While the associations among spiritual well-being, existential loneliness, and hope emerged in unexpected directions reflecting the complex, culturally bound interplay of these constructs the overall findings support a biopsychosocial-spiritual model of chronic illness. Marital status and illness type were shown to differentially influence hope and spiritual well-being, pointing to the value of tailored, person-centered care approaches.

Limitations

The cross-sectional design precludes causal inference; longitudinal studies are needed to examine temporal relationships and variable stability. Purposive sampling from a single city (Gujrat) limits generalizability to other populations and regions. The moderate internal consistency of the Urdu SWBS and HHI may have introduced measurement error; culturally validated versions should be developed and tested. The validity of Western spiritual well-being instruments in Pakistani Muslim communities requires further psychometric investigation

Implications and Recommendations

The findings enrich the biopsychosocial-spiritual model by demonstrating, within an Islamic sociocultural context, that existential loneliness, spiritual well-being, and hope are interlocking constructs that cannot be studied in isolation. The existential-loneliness correlation with spirituality challenges universal assumptions about the direction of this relationship and calls for culturally sensitive theoretical frameworks. Clinicians working with chronic illness populations should routinely screen for existential loneliness and unmet spiritual needs alongside standard psychological assessments. Integrating spiritual care tailored to patients' religious and cultural backgrounds into treatment plans may bolster hope and psychological resilience. Psychologists, psychiatrists, and hospital chaplains should collaborate to deliver holistic care addressing emotional, spiritual, and physical dimensions simultaneously, with particular attention to highly vulnerable groups such as cancer patients and the bereaved. Longitudinal designs to track changes in existential loneliness, spiritual well-being, and hope across illness trajectories. Development and validation of culturally appropriate scales for Pakistani Muslim populations. Experimental studies evaluating spiritual interventions (e.g., spiritually integrated psychotherapy, meaning-centered therapy) on hope and existential loneliness. Multi-site studies with larger, more diverse samples from different provinces and illness contexts

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