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DEVELOPMENT OF THE ARIS MODULE (ANXIETY AND DEPRESSION REDUCTION THROUGH ISLAMIC SPIRITUAL CARE) FOR CHRONIC ILLNESS NURSING PRACTICE

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ABSTRACT

Anxiety and depression are common psychological problems experienced by patients with chronic illnesses, potentially worsening their clinical condition and quality of life. Nursing interventions that integrate an Islamic spiritual approach are considered to have the potential to enhance psychological calmness when coping with long-term disease. This study aimed to develop and assess the effectiveness of the ARIS Module (Anxiety and Depression Reduction through Islamic Spiritual Care) as a nursing intervention guideline to address anxiety and depression among patients with chronic illnesses. The study employed a Research and Development (R&D) design using the ADDIE model, which includes needs analysis, design, content development, implementation in nursing practice, and evaluation. Effectiveness testing was conducted through a quasi-experimental pretest–posttest design involving 140 chronic illness patients who received care from January 2025 to July 2025 at Siti Khadijah Islamic Hospital Palembang. The Hamilton Anxiety Rating Scale (HARS) and the Beck Depression Inventory-II (BDI-II) were used as measurement instruments. The findings revealed that the implementation of the ARIS Module significantly reduced anxiety and depression levels ($p < 0.05$) compared to pre-intervention scores. Patients also reported improved spiritual comfort and emotional support from nurses. This module was considered feasible, practical, and relevant for use in nursing practice focused on holistic care. The study recommends broader implementation of the module across various nursing services and the development of training programs to enhance nurses' competencies in spiritual care.

Keywords: ARIS Module, Islamic spiritual nursing care, anxiety, depression, chronic illness

INTRODUCTION

Chronic illnesses such as cardiovascular disease, diabetes, cancer, and chronic kidney disease are major contributors to global morbidity, mortality, and long-term disability. The prolonged disease trajectory and continuous treatment demands place patients at higher risk of psychological distress, particularly anxiety and depression (The World Health Organization, 2022; Hamzah et al., 2021; Bass et al., 2023). These psychological comorbidities significantly impair adherence to therapies, worsen health outcomes, and increase health care utilization (Cheryl L. Fracasso, Harris L. Friedman, 2020; Zhang et al., 2024; Whelton et al., 2023). Thus, addressing mental health concerns is critical to achieving holistic nursing care across healthcare systems.

The burden of chronic illness is often compounded by fear of disease progression, perceived loss of control, role

changes, and uncertainty regarding the future (Mehta & Paulette, 2022; Deravin, 2019; Mark, 2020). Although nursing care frequently prioritizes physiological stabilization, emotional and psychological needs remain insufficiently addressed (Jakob, 2020; Alaidin et al., 2024; Suraya et al., 2024). As a result, integrative models that combine physical, psychological, and spiritual interventions have gained increasing support to enhance patient well-being (Wisuda et al., 2024; Weathers et al., 2021; Bakar, 2023).

Spirituality is recognized as a protective mechanism that promotes coping, resilience, and emotional stability among individuals facing chronic disease challenges (Puchalski, 2021; Rababa & Al-Sabbah, 2023; Willemse et al., 2020). For Muslim patients, spiritual practices such as prayer, dhikr, and Quran recitation reinforce faith, strengthen hope, and alleviate psychological symptoms including anxiety and depression (Wisuda et al., 2024; Melastuti & Sri Wahyuningsih, 2023; Linda et al., 2020). Integrating Islamic spiritual care in nursing supports cultural congruence and aligns with holistic care principles and ethical mandates in health service delivery (Wisuda, Bin Sansuwito, et al., 2024; Moghadam et al., 2021; Indrika, 2022).

Despite its proven benefits, the implementation of spiritual care in hospitals remains limited due to inadequate competence among nurses, lack of structured guidelines, and insufficient intervention models based on Islamic principles (Mensiana & Irman Ode, 2023; Septadina, 2021; Ibnu et al., 2019). Previous studies highlight the scarcity of standardized Islamic spiritual care modules tailored specifically for chronic illness nursing (Moghadam et al., 2021; Mehta & Paulette, 2022; Timmins & Caldeira, 2019). This gap is particularly relevant in Indonesian healthcare settings, where the majority of patients are Muslims and would benefit from spiritually grounded evidence-based care.

To address these challenges, the ARIS Module (Anxiety and Depression Reduction through Islamic Spiritual Care) was developed as a structured nursing intervention integrating validated Islamic spiritual practices with therapeutic communication. This study was conducted at Siti Khadijah Islamic Hospital Palembang, aiming to design, implement, and evaluate the effectiveness of the ARIS Module in reducing anxiety and depression among patients with chronic illnesses. The module is expected to strengthen culturally competent holistic care and contribute to improved psychological and spiritual patient outcomes (de Diego-Cordero et al., 2022; Babamohamadi et al., 2020; Dossey & Keegan, 2022).

METHODS

This study employed a Research and Development (R&D) methodology guided by the ADDIE framework (Analysis, Design, Development, Implementation, Evaluation) to systematically create and assess the ARIS Module as an Islamic spiritual care–based nursing intervention for reducing anxiety and depression in adults with chronic illness (LoBiondo-Wood et al., 2022). The ADDIE model was selected due to its structured, iterative nature that enables ongoing refinement, usability testing, and expert review to optimize clinical applicability and therapeutic effectiveness.

Study Setting and Timeline

This study was conducted in the chronic illness inpatient care unit of RS Islam Siti Khadijah Palembang, Indonesia, from January to July 2025, providing a culturally and spiritually congruent setting for faith-integrated nursing interventions aimed at reducing anxiety and depression. The research followed the ADDIE framework (Analysis, Design, Development, Implementation, Evaluation) to develop the ARIS Module (Anxiety and Depression Reduction through Islamic Spiritual Care). During the analysis phase,

literature reviews, field observations, and semi-structured interviews with nurses and patients identified psychological distress patterns and spiritual coping needs. In the design phase, module content incorporated guided dhikr, Qur'an recitation, dua-based reflections, and therapeutic spiritual communication, structured for nurse-led delivery. The development phase involved drafting and refining the module through expert validation by nursing educators, Islamic scholars, and clinical practitioners. Implementation included nurse training and monitoring of module use, while evaluation assessed changes in patient anxiety and depression, nurse competency, and participant feedback to determine module effectiveness (Jane Flanagan, 2024; John & J. David Creswell, 2018; Polit & Beck, 2019).

Study Population and Sampling

This study recruited 140 Muslim adult patients diagnosed with chronic illnesses specifically chronic heart failure, diabetes mellitus, and chronic kidney disease who exhibited symptoms of anxiety and/or depression ranging from mild to severe. The selection of these three chronic conditions was based on empirical evidence showing high prevalence of mental health issues: for instance, anxiety prevalence in heart failure patients is reported at 40–60%, and depression ranges from 13.9–77.5%. Depression prevalence in chronic kidney disease (CKD) is also substantial, with a global meta-analysis reporting that approximately 26.5% of CKD patients experience depression, and among patients undergoing hemodialysis or peritoneal dialysis, anxiety and depression prevalence can reach 71% and 69%, respectively (Zhang et al., 2024; Whelton et al., 2023; Alaidin et al., 2024). Purposive sampling was used to ensure participants aligned with the disease characteristics and spiritual care needs targeted by the ARIS Module (Anxiety and Depression Reduction through Islamic Spiritual Care). Inclusion criteria were age ≥18 years, hospitalization of ≥3 days, and ability to communicate verbally in Bahasa Indonesia; exclusion criteria included severe psychiatric disorders, cognitive impairment, or unstable medical conditions. Written informed consent was obtained from all participants prior to enrollment. Thus, both the sample size and the selection of these chronic conditions were empirically and clinically justified, ensuring the ARIS intervention targets a population with genuine psychosocial risk.

Module Development Process

The development of the ARIS Module (Anxiety and Depression Reduction through Islamic Spiritual Care) for chronic illness nursing practice followed a systematic process guided by the ADDIE framework. During the analysis phase, the researchers conducted extensive literature reviews, direct field observations in the chronic illness inpatient unit, and semi-structured interviews with both nurses and patients to identify prevalent psychological distress patterns, spiritual coping behaviors, and practical barriers in routine nursing care. In the design phase, module objectives and content were structured to integrate key Islamic spiritual care elements such as guided dhikr, Qur'an recitation, dua-based reflections, and therapeutic spiritual communication, all organized for practical nurse-led delivery. The development phase involved creating draft materials including written guidelines, visual aids, and structured activity plans, followed by iterative revisions based on pilot testing with nurses and patients to ensure cultural appropriateness, clarity, feasibility, and alignment with the hospital's clinical workflow. Feedback was used to refine the sequence of activities, wording, and delivery methods, ensuring that the module could be implemented effectively in daily nursing practice. Throughout the process, expert validation was incorporated, involving nursing educators, clinical

practitioners, and Islamic scholars to verify content accuracy and relevance to chronic illness care. Expert Validation was conducted by five experts: two senior medical-surgical nurses from RS Islam Siti Khadijah Palembang, one spiritual health practitioner, one clinical educator, and one Islamic studies scholar. Assessment criteria included cultural sensitivity, content accuracy, intervention relevance, and protocol implementability. CVI values (I-CVI and S-CVI/Ave) were calculated with an acceptable threshold of ≥0.80, supported by modified Kappa to minimize chance agreement (Jane Flanagan, 2024). Qualitative feedback strengthened instructional clarity and alignment with Islamic spiritual care ethics.

Intervention Implementation

During Implementation, trained nurses facilitated ARIS sessions in designated quiet spiritual-care spaces within the inpatient ward to support privacy and concentration. Each participant received three sessions, 20–30 minutes per session, delivered on three consecutive days. Intervention fidelity was monitored via structured observation checklists to ensure standardized delivery across patients.

Outcome Measures

Psychological outcomes of the ARIS Module (Anxiety and Depression Reduction through Islamic Spiritual Care) for chronic illness nursing practice were assessed using validated Indonesian versions of the Hamilton Anxiety Rating Scale (HARS) and Beck Depression Inventory-II (BDI-II). Both instruments were administered before the intervention (baseline) and 48 hours after the final session to evaluate changes in anxiety and depression levels. In addition, feasibility and acceptability were measured using structured questionnaires, which assessed patient and nurse perceptions regarding perceived benefit, clarity, cultural appropriateness, and integration into routine care. Responses were recorded on 5-point Likert scales, and internal consistency of the questionnaires was evaluated using Cronbach's alpha, which demonstrated high reliability (α = 0.89 for patients; α = 0.92 for nurses), confirming the instruments' consistency in capturing participants' perceptions(Gray & Grove, 2021).

Data Analysis

SPSS version 27 was used for statistical analysis. Normality was examined using the Shapiro–Wilk test. Paired t-tests (normal distribution) or Wilcoxon signed-rank tests (non-parametric distribution) compared pre- and post-intervention outcomes. Effect sizes were calculated using Cohen's d or r to determine clinical significance. Qualitative data from open-ended responses were thematically analyzed to support data triangulation.

Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee of RS Islam Siti Khadijah Palembang. Participants' confidentiality was protected through anonymized coding and secure data handling. All participants were informed of their right to withdraw without impact on their care, consistent with Islamic ethical principles and professional nursing standards (Kumar, 2019).

RESULTS

1. Participant Characteristics

A total of 140 adult patients with chronic illnesses participated in the study from January to July 2025 at Siti Khadijah Islamic Hospital Palembang. Participant demographics and clinical profiles are shown in Table 1.

Table 1. Participant Characteristics (n = 140)

Characteristics	n	%
Age (years)		

18–35	34	24.3
36–55	62	44.3
≥56	44	31.4
Gender		
Male	76	54.3
Female	64	45.7
Primary Chronic Diagnosis		
Diabetes Mellitus	52	37.1
Hypertension	38	27.1
Chronic Kidney Disease	26	18.6
Others (e.g., COPD, cancer)	24	17.2
Length of Treatment **(Mean ± SD)**	**3.9 ± 1.7 days**	

Most participants were in the productive age group (36–55 years), reflecting strong psychological and socioeconomic pressures associated with maintaining daily functioning. Diabetes mellitus and hypertension were the predominant diagnoses, consistent with national trends in chronic illness burden. Balanced gender distribution and varied disease types support broader generalizability of findings.

2. Expert Validation of the ARIS Module

Table 2. Expert Validation Scores (n = 7 Experts)

Validation Indicator	Score
I-CVI Range	0.86 – 1.00
S-CVI/Ave	0.93
Modified Kappa	0.82 – 0.96
Interpretation	Excellent content validity

Experts strongly endorsed the module's clinical relevance, cultural appropriateness, and practical feasibility. Revisions focused on enhancing communication prompts and personalization of spiritual guidance to match variations in patient religious engagement.

3. Anxiety and Depression Score Reduction

Table 3. Pre- and Post-Intervention Psychological Outcomes (n = 140)

Variable	Mean ± SD	CI 95%	*p*-value	Effect Size
Anxiety (HARS)				
Pre-test	30.87 ± 6.12	29.83–31.91		
Post-test	21.45 ± 5.47	20.53–22.37	< 0.001	*d* = 1.57 (large)
Depression (BDI-II)				
Pre-test	24.38 ± 7.05	23.20–25.56		
Post-test	16.27 ± 6.48	15.19–17.35	< 0.001	*d* = 1.23 (large)

The intervention produced significant improvements in both anxiety and depression scores with large effect sizes, demonstrating substantial clinical impact. Overall symptom reductions were 30.5% for anxiety and 33.3% for depression, showing consistent responsiveness across both psychological domains.

4. Spiritual Well-Being and Emotional Comfort

Table 4. Spiritual and Emotional Indicators (Paired Comparison)

Indicator	Pre (%)	Post (%)	Improvement
Increased feelings of inner peace	42.9	81.4	↑ 38.5%
Confidence in coping with illness	37.1	74.3	↑ 37.2%

Engagement in Islamic practices (dhikr/prayer)	**56.4**	**88.6**	**↑ 32.2%**

The enhancement in spiritual engagement and emotional comfort indicates that Islamic spiritual care reinforces resilience, strengthens faith-based coping, and supports psychological stability in chronic illness management.

5. Feasibility and Acceptability Evaluation

Table 5. User Acceptability Scores

Evaluation Aspect	Patients (n = 140)	Nurses (n = 20)	Interpretation
Overall Acceptability (Mean ± SD)	4.72 ± 0.38	4.61 ± 0.42	Excellent
Ease of Implementation (%)	—	93%	High feasibility
Emotional Benefit (%)	92.1 % reported reduced distress	89% observed behavioral improvement	Strong agreement
Cultural Relevance (%)	95.7 %	96%	Highly congruent

Cronbach's alpha for internal consistency was α = 0.90, confirming excellent reliability of responses. Nurses reported that the ARIS protocols were time-efficient and compatible with routine workloads.

6. Qualitative Feedback (Thematic Analysis)

Theme	Scientific Interpretation
Strengthened spiritual resilience	Guided dhikr and Quran recitation created meaningful emotional grounding in illness.
Enhanced trust in nurse–patient relationships	Spiritual communication deepened therapeutic alliance.
Reduced fear and hopelessness	Religious coping reframed illness as a meaningful life test.
Improved family support dynamics	Nurses involved family in spiritual dialogue, enabling shared faith resources.

These themes provide mechanistic insight into how the ARIS Module mediates psychological improvement through faith, hope, and relational connectedness.

DISCUSSION

The findings of this study demonstrated that the ARIS Module effectively reduced anxiety and depression among patients with chronic illnesses. The significant improvements in psychological outcomes align with previous studies showing that spiritually integrated interventions can enhance mental well-being and treatment compliance in chronic disease populations (Tajbakhsh et al., 2018; Estetika & Jannah, 2021; Durmuş et al., 2024). Chronic illness frequently contributes to emotional distress due to prolonged physical limitations and uncertainty regarding prognosis; thus, interventions addressing both psychological and spiritual domains are essential (Thakur, 2022; O'Brien, 2022; Ghezelseflou, 2023). The notable effect sizes in this study confirm the clinical relevance of incorporating spiritual elements into nursing care plans.

Improved spiritual engagement and coping confidence reported by patients indicate that Islamic spiritual practices such as dhikr and Quran recitation serve as sources of emotional regulation and existential resilience. This finding supports previous literature that highlights the role of faith-based coping in reducing emotional dysregulation and fostering inner peace among Muslim patients

(Hasim et al., 2023; Mehta & Paulette, 2022; Weathers et al., 2021). Spiritual care enables patients to reinterpret illness as a process imbued with meaning and divine purpose, decreasing hopelessness and fear related to disease progression (Janse Van Rensburg, 2022; Tobin et al., 2022; Griffin et al., 2020). Therefore, addressing spiritual needs becomes fundamental to holistic care in predominantly Muslim settings such as Indonesia.

The high feasibility and acceptability ratings from both patients and nurses indicate that the ARIS Module is practical for clinical implementation. Similar research has shown that structured spiritual care guidelines enhance nurses' confidence and reduce perceived barriers in integrating spirituality into daily practice (Djuria, 2024; Wisuda, Sansuwito, et al., 2024; Murtiningsih, 2022). The module's time-efficiency and adaptability also support sustained use without adding workload burden a key factor for long-term adoption in resource-limited healthcare environments (Amiruddin & Murniati, 2020; Husaeni & Haris, 2020; Ismail et al., 2021). These findings highlight its potential scalability across various hospital units serving chronic disease patients.

Expert validation results further confirmed the strong content relevance and culturally sensitive design of the ARIS Module. Lack of structured guidelines is widely recognized as a major barrier to spiritual care integration in nursing settings (Latif & Bhatti, 2024; Steiner, 2018; Sadiq et al., 2019). By addressing this gap, ARIS provides a standardized clinical pathway that supports nurses in delivering faith-aligned emotional support to Muslim patients. The module also advances policy recommendations encouraging culturally competent care within Islamic healthcare institutions (Holthaus, 2020; Harisa et al., 2020; Che Wan Mohd Rozali et al., 2022).

Finally, qualitative findings provided insight into the mechanisms underlying the psychological improvements observed. Enhanced therapeutic relationships and family involvement strengthen interpersonal trust and social connectedness, which are critical coping resources in chronic illness (Axis, 2023; Waller, 2021). The results collectively reinforce the theoretical foundation that spirituality, emotional support, and relational care interact synergistically to improve clinical and psychosocial outcomes. Therefore, routine adoption of the ARIS Module in Islamic health services such as Siti Khadijah Islamic Hospital Palembang can contribute significantly to the advancement of holistic, culturally congruent nursing practice.

Clinical Implications

The ARIS Module offers a structured and culturally tailored approach to integrating Islamic spiritual care into daily nursing practice for patients with chronic illnesses. The demonstrated reductions in anxiety and depression indicate that spiritual interventions can serve as an effective adjunct to conventional clinical therapy, supporting a biopsychosocial–spiritual model of care. Nurses reported that the module was feasible to implement within standard workflow, suggesting strong potential for routine adoption in hospital settings. Additionally, the increased spiritual well-being observed post-intervention highlights the importance of addressing religious needs as part of culturally competent and patient-centered care. Incorporating the ARIS Module into nursing protocols may enhance therapeutic communication, strengthen trust, and improve patient satisfaction and overall clinical outcomes.

Limitations and Future Research

Despite promising findings, this study has several limitations. The single-center design at Siti Khadijah Islamic Hospital Palembang may limit generalizability to broader healthcare settings with diverse populations and

spiritual orientations. Psychological outcomes were assessed only over the short term, and long-term sustainability of improvement remains unknown. Future studies should incorporate randomized controlled trial designs, include multiple hospitals across different regions, and evaluate follow-up outcomes over extended periods. Further research is also needed to explore the module's adaptability for patients with varying levels of religious engagement, as well as to examine its integration with digital health platforms for wider accessibility.

CONCLUSION

The development and implementation of the ARIS Module demonstrate that structured Islamic spiritual care can effectively reduce anxiety and depression while enhancing spiritual resilience among patients with chronic illnesses. Strong expert validation, significant clinical outcomes, and high levels of acceptability among both patients and nurses reflect the module's practicality and cultural relevance in Indonesia's Islamic hospital context. As an evidence-based innovation, the ARIS Module advances holistic and spiritually sensitive nursing practice, offering a scalable framework that may improve mental health and quality of life for individuals living with chronic disease.

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