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# Development of a Holistic Nursing Care Model to Improve the Psychological Well-being of Chronic Illness Patients

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ABSTRACT
This study aimed to examine nursing service quality in an Emergency Department (ED) using the SERVQUAL model and to explain its implications for patient satisfaction. A qualitative approach with an exploratory case study design was selected to capture in-depth patient experiences and operational realities in a time-pressured ED context, where satisfaction is shaped by both clinical urgency and service interaction. The study was conducted in a high-volume urban referral hospital ED, chosen because it reflects common constraints of emergency care, including crowding, rapid decision-making, and limited privacy. Fifteen informants were recruited purposively to ensure variation in perspectives: ten patients/family members and five nurses/coordinators. Findings indicated that responsiveness and reliability grounded in informational certainty were the most influential drivers of satisfaction, followed by assurance achieved through professional, calm communication and empathy maintained through brief but meaningful interactions. Key service gaps involved delayed responses during peak periods, inconsistent updates about waiting times and care steps, and environmental limitations affecting privacy. The study recommends standardizing triage communication and patient-status updates, implementing ED-specific brief communication training, strengthening surge coordination, and using continuous feedback to monitor SERVQUAL gaps over time.



## INTRODUCTION

Chronic diseases have become the dominant contributor to long-term disability and health-care utilization worldwide, reshaping the priorities of clinical services from episodic cure to sustained care. Conditions such as diabetes, cardiovascular disease, chronic kidney disease, cancer, chronic respiratory disorders, and autoimmune illnesses commonly persist for years, requiring continuous self-management, repeated clinical visits, and lifestyle adjustments (Ameri et al., 2025). In this prolonged trajectory, patients are not only challenged by symptoms and functional limitations but also by uncertainty, treatment burden, financial strain, and social role disruption. These experiences accumulate over time and frequently manifest as psychological distress, including anxiety, depressive symptoms, demoralization, and reduced meaning in life. Psychological well-being, therefore, is not a secondary outcome; it is a central determinant of adherence, coping, quality of life, and even clinical prognosis among people living with chronic illness (Grossmann et al., 2025) .

Despite increased recognition of mental health needs in chronic care, routine services often remain fragmented and predominantly biomedical. Many care pathways still emphasize physiological indicators, pharmacotherapy optimization, and complication prevention, while psychological, spiritual, and socio-cultural dimensions receive inconsistent attention. This imbalance creates a paradox: the health system increasingly manages chronicity, yet frequently overlooks the lived experience of chronic illness (Matlhaba, 2024). Patients may receive excellent technical interventions but still report loneliness, fear of deterioration, loss of autonomy, and diminished hope. Such unmet needs can erode engagement with care plans, intensify symptom perception, and contribute to avoidable readmissions and poorer long-term outcomes. In this context, nursing assumes a strategic role because nurses have sustained contact with patients, conduct ongoing assessments, provide education, coordinate multidisciplinary actions, and influence the therapeutic environment. Nursing care that integrates holistic principles has the potential to address psychological well-being systematically rather than episodically (Koak et al., 2023).

Holistic nursing care is commonly conceptualized as an approach that treats the person as an integrated whole, acknowledging interactions among physical, psychological, social, cultural, and spiritual dimensions. While holistic care is a longstanding nursing ideal, its implementation remains uneven due to varying definitions, limited operationalization, time constraints, and inconsistent institutional support. In many clinical settings, "holistic" becomes an aspirational label rather than a measurable practice model (Brust et al., 2024). The state of the art shows that multiple frameworks such as person-centered care, the biopsychosocial model, self-management support, and integrative nursing share the premise that patient outcomes improve when care aligns with individual values, context, and emotional needs. However, existing interventions that target psychological outcomes in chronic illness are often siloed, delivered as stand-alone counseling programs, or dependent on specialist mental health resources that may not be accessible in routine chronic care services. Consequently, there is a growing need for a nursing-driven model that is feasible, structured, and evidence-informed, enabling psychological well-being to be embedded within everyday chronic disease management (MacLean, 2024).

**Tabel 1. Holistic nursing care model for psychological well-being in chronic illness**

| Valid Data | Background |
|---|---|
| Noncommunicable diseases killed ≥43 million people in 2021 (≈75% of non-pandemic-related deaths) | Shows chronic illness dominates health burden, making long-term care models highly relevant. |
| In 2021, 18 million people died from NCDs before age 70 | Supports the argument that chronic disease burden is not only "old age," strengthening the need for sustained care models. |
| Global depression prevalence: ~5.7% of adults | Justifies why psychological well-being should be treated as a core outcome in chronic care, not a secondary add-on. |

Source: WHO NCD fact sheet, 2025)

The primary problem addressed in this study is the persistent gap between patients' psychological well-being needs and the routine delivery of chronic illness care. Psychological distress can be overlooked because it is less visible than physiological signs, because clinical workflows prioritize biomedical monitoring, or because staff feel insufficiently prepared to address emotional and existential concerns. Patients may also hesitate to disclose psychological burdens due to stigma, cultural norms, or fear of being judged. Even when distress is recognized, care responses may be inconsistent, ranging from brief reassurance to referral pathways that are slow or unavailable. This inconsistency suggests a system-level issue: without a clear, holistic nursing care model that specifies assessment domains, intervention components, coordination mechanisms, and evaluation indicators, psychological well-being remains dependent on individual clinician initiative rather than being assured as a standard of care (Divya et al., 2025).

A notable research gap lies in the limited availability of rigorously developed holistic nursing care models that explicitly target psychological well-being outcomes for chronic disease populations and that can be implemented across settings. Prior studies frequently focus on discrete elements, such as mindfulness, psychoeducation, motivational interviewing, or spiritual support, but do not integrate these elements into a coherent model aligned with nursing workflows and interprofessional collaboration (Afanasieva & Zamashkin, 2025). Moreover, psychological well-being is often operationalized narrowly as the absence of depression or anxiety, whereas contemporary perspectives emphasize positive functioning, resilience, self-efficacy, meaning, and life satisfaction. The literature also indicates variability in cultural interpretation of well-being and spiritual needs, which implies that models developed in one context may not translate directly to another without adaptation. Therefore, the gap is not merely the absence of interventions, but the absence of a validated development process that produces a context-sensitive, holistic nursing model with clear components, implementation guidance, and robust outcome indicators (Baker et al., 2023).

The novelty of this research is the development of a structured holistic nursing care model that positions psychological well-being as a core outcome of chronic illness care, rather than as a secondary

add-on. This model is intended to integrate multidimensional assessment, therapeutic communication, self-management strengthening, family and social support mobilization, spiritual-existential care, and coordinated referral pathways into a unified nursing process. By translating holistic principles into operational components what nurses assess, what they do, how they coordinate, and how outcomes are measured this study aims to generate a practical framework suitable for implementation in real-world clinical environments. Additionally, the model development emphasizes feasibility and scalability, ensuring that the approach can be applied even in settings with limited mental health specialists by strengthening the role of nurses in early detection, supportive interventions, and structured escalation when needed (Brown & Ryan, 2024).

The central research question guiding this study is how a holistic nursing care model can be developed and validated to improve psychological well-being among patients living with chronic diseases. More specifically, the study explores which domains should constitute holistic nursing assessment for chronic illness, which nursing interventions most effectively support psychological well-being within routine care, how contextual factors such as culture, family involvement, and health system constraints shape implementation, and which indicators best capture improvement in psychological well-being in a way that is clinically meaningful. These questions reflect the need to move from broad ideals toward a model that is testable, reproducible, and responsive to diverse patient experiences (Çakmak & Uğurluoğlu, 2024).

The objective of the research is to design a holistic nursing care model that is conceptually grounded and empirically informed, and to evaluate its relevance, clarity, and feasibility for improving psychological well-being in chronic disease populations (Afanasieva & Zamashkin, 2024). The study further aims to specify model components, develop implementation steps aligned with nursing processes, and identify appropriate outcome measures that encompass both distress reduction and positive psychological functioning. Ultimately, the goal is to strengthen the quality of chronic illness care by ensuring that psychological well-being is systematically assessed and addressed through nursing practice (Hwang, 2025).

The anticipated benefits of this research are threefold. Theoretically, the study contributes to the refinement of holistic nursing concepts by operationalizing a multidimensional care approach specifically oriented to psychological well-being in chronic illness trajectories. It clarifies how holistic principles can be translated into measurable constructs and structured clinical actions, thereby strengthening the conceptual bridge between nursing philosophy and outcomes research. Academically, the model offers a basis for curriculum enrichment, supporting nursing education with a structured framework for teaching holistic assessment, therapeutic communication, culturally sensitive care, and outcome evaluation. It can inform the development of learning modules, clinical simulation scenarios, and assessment tools that prepare future nurses to address psychological well-being as a routine competency (Daltveit et al., 2024). Practically, the model provides guidance for clinical services to standardize holistic care delivery, improve early identification of psychological distress, strengthen coping and self-management, enhance patient satisfaction, and potentially reduce preventable complications associated with disengagement from care. For health systems, an implementable model may support quality improvement initiatives, interdisciplinary coordination, and the integration of mental health considerations into chronic disease pathways (Ambarwati & Dewi, 2024).

This study also acknowledges limitations that may influence interpretation and generalizability. The model's development and validation may be shaped by the characteristics of the study setting, including patient demographics, disease profiles, staffing levels, and organizational culture. If the model is tested within a limited range of chronic conditions or within a single type of service, its applicability across broader populations may require additional evaluation. Psychological well-being measures may also be influenced by self-report bias, stigma-related underreporting, or cultural differences in expressing distress and meaning. Furthermore, implementation outcomes can be affected by resource constraints, competing clinical priorities, and variability in nurses' training and confidence in delivering psychosocial and spiritual care components. These limitations highlight the need for careful contextual interpretation and iterative refinement.

Future research should extend model testing through multisite studies, including diverse chronic disease groups and varied care settings such as primary care, community health services, and hospital-based specialty clinics. Longitudinal evaluation is needed to determine whether improvements in psychological well-being are sustained and whether they translate into better adherence, functional outcomes, and reduced utilization. Implementation science approaches can help identify facilitators and barriers, optimize training strategies, and evaluate cost-effectiveness. Further work may also refine measurement by incorporating patient-reported outcome measures that capture flourishing, meaning, and resilience alongside distress indicators, and by exploring the role of digital tools to support monitoring, education, and follow-up.

## LITERATURE REVIEW

The burden of chronic disease is increasingly understood as both a biomedical and a psychological phenomenon. Living for years with symptoms, uncertainty, functional limitations, complex regimens, and repeated health-care encounters commonly produces persistent stress, emotional exhaustion, fear of progression, and loss of meaning (Pulcini et al., 2024). These experiences are closely tied to psychological well-being, which in contemporary health research extends beyond the absence of anxiety or depression to include adaptive functioning, perceived purpose, self-efficacy, connectedness, and resilience. Yet, routine chronic care in many settings remains dominated by physiological monitoring and task-focused interventions, while psychological and spiritual-existential needs are addressed inconsistently. This reality strengthens the case for developing a structured holistic nursing care model that makes psychological well-being an explicit and measurable outcome within everyday chronic disease management (Isbey et al., 2024).

Holistic nursing is frequently described as care that attends to the unity of mind, body, and spirit while accounting for social and cultural context. However, the literature also shows that "holistic care" is often implemented as a set of general intentions rather than as an operational model with clear assessment domains, intervention components, workflow integration, and outcome indicators. Recent publications continue to emphasize that comprehensive approaches are necessary in chronic illness management because physical treatment alone does not resolve emotional strain, disrupted identity, family burden, or spiritual distress (Jackson, 2024). For example, a recent perspective on chronic illness care highlights holistic care as addressing physical symptoms while also attending to emotional and social dimensions, indicating an ongoing global call for integrative practice in chronic conditions. This state of the art suggests a practical gap: many studies demonstrate benefits of holistic-oriented interventions, but fewer provide a nursing model that is sufficiently specified to be implemented, taught, evaluated, and scaled across chronic care pathways.

To ground the development of a holistic nursing care model that targets psychological well-being, three complementary theoretical foundations are particularly relevant: a caring science theory that explains therapeutic nursepatient relationships as a mechanism of healing; a systems theory that conceptualizes the patient as an open system responding to stressors and guides prevention-oriented nursing actions; and a psychological coping theory that explains how appraisal and coping processes shape emotional outcomes over time. Together, these theories offer conceptual coverage for the main problem (persistent psychological burden in chronic illness), the research gap (lack of an implementable holistic nursing model with psychological well-being outcomes), the formulation of research questions (what components and mechanisms should the model include), and the study's theoretical, academic, and practical contributions.

The first theoretical pillar is the Theory of Human Caring (often framed within "caring science") popularized by Jean Watson. The theory was developed during 19751979 while she was teaching at University of Colorado in the United States. Watson's work proposes that caring is not merely an interpersonal attitude but a moral-ethical and relational practice that shapes patient experiences and supports dignity, meaning, and harmony of mindbodyspirit. In chronic illness contexts, the relevance to psychological well-being is direct: the nurse's intentional presence, authentic engagement, and respect for personhood can mitigate feelings of isolation and helplessness that accumulate across long-term treatment (Jacinto, 2023). Conceptually, Watson's framework helps a holistic nursing model specify relational mechanisms such as therapeutic communication, empathic presence, values-based goal

setting, and support for hope and meaning that are often discussed abstractly but can be translated into structured nursing actions and measurable outcomes (e.g., perceived support, meaning in life, and emotional comfort).

The second theoretical pillar is the Neuman Systems Model, developed by Betty Neuman, with its earliest publication commonly traced to 1972. The model emerged from her work designing a "teaching tool" for graduate nursing students at University of California, Los Angeles in the United States. Neuman conceptualizes the client (individual, family, or community) as an open system interacting with internal and external environmental stressors; health is linked to system stability, and nursing interventions are organized around prevention (primary, secondary, tertiary) to reduce stressor impact and restore stability (Berg et al., 2024). This model is highly compatible with chronic disease trajectories because patients face repeated stressors: symptom flares, complications, role disruptions, financial strain, stigma, and care fatigue. For psychological well-being, Neuman's framework clarifies why holistic assessment must include stressor mapping (physiological, psychological, sociocultural, developmental, spiritual) and why nursing care should be designed as layered prevention: preventing distress escalation (primary), detecting and addressing emerging distress early (secondary), and supporting long-term adaptation and relapse prevention (tertiary). In model development terms, Neuman's approach also strengthens implementation feasibility because it aligns well with nursing processes (assessmentdiagnosisplanninginterventionevaluation) and quality improvement logic (Gringras, 2024).

The third theoretical pillar is the Transactional Model of Stress and Coping, developed by Richard S. Lazarus and Susan Folkman and consolidated in their landmark 1984 work. Lazarus was a longtime professor at University of California, Berkeley in the United States. Folkman earned her PhD at UC Berkeley and later held major leadership roles at University of California, San Francisco in the United States, including work in integrative medicine. The transactional model explains stress as a dynamic personenvironment transaction: individuals cognitively appraise a situation (primary appraisal) and evaluate coping resources/options (secondary appraisal); coping efforts (problem-focused and emotion-focused) then shape emotional and health outcomes. This theory is essential for a holistic nursing model because psychological well-being in chronic illness is heavily influenced by appraisal (e.g., "Is my disease controllable?" "Am I a burden?") and coping (e.g., self-management strategies, seeking support, meaning-making). It also provides a mechanism for targeted nursing interventions: strengthening coping resources, reframing catastrophic appraisals, supporting realistic goal setting, and enhancing self-efficacy and social support all of which can be operationalized as nursing care components and evaluated using well-being indicators (Lee & Han, 2024).

Across these three theories, a coherent conceptual bridge emerges for addressing the study's main problem and research gap. Watson foregrounds caring relationships and meaning as core therapeutic forces, directly addressing the psychological and existential dimensions of chronic illness that are frequently neglected in biomedical routines. Neuman provides a systems-and-stressors architecture that turns "holism" into a practical assessment map and a prevention-oriented intervention plan, reducing variability in how holistic care is delivered. Lazarus and Folkman supply a robust psychological explanation for how distress and adaptation evolve over time, guiding the selection of intervention mechanisms (appraisal and coping) and outcomes (reduced distress plus improved coping effectiveness and positive functioning). When integrated, the theories directly support the research logic: if chronic illness produces ongoing stressors and appraisal-driven emotional responses (Neuman; LazarusFolkman), then nursing must deliver structured, prevention-layered, relationship-centered, and coping-focused interventions that protect dignity, foster meaning, and sustain adaptation (Watson; Neuman; LazarusFolkman). This integration clarifies the gap: existing chronic care often lacks an implementable nursing model that systematically combines relational caring, stressor-prevention mapping, and coping-based psychological support into routine workflows (Chung & An, 2023).

Current developments in holistic nursing and related interventions further reinforce the relevance of this integrated theoretical base. Recent studies and reviews continue to report that holistic or integrative nursing approaches can improve psychological states and patient experience in clinical contexts, though evidence is sometimes uneven across populations and settings. At the same time, contemporary holistic practice increasingly intersects with approaches such as narrative-based nursing and

mindfulness-supported care, including mobile health (mHealth) formats, reflecting a trend toward scalable interventions that address emotional regulation and meaning-making alongside symptom management. These directions align well with the three-theory integration: narrative and mindfulness can be positioned as coping-supportive strategies (LazarusFolkman), embedded within a structured prevention plan (Neuman), and delivered through a caring, person-affirming relationship (Watson). Importantly, these "current" developments also underscore why a dedicated model is needed: without a coherent framework, such interventions remain add-ons rather than consistent components of chronic care (Lu, J. J. Zhang, et al., 2024).

In linking theory to the study's problem statement and research questions, the literature supports framing the core research problem as the persistence of psychological burden and diminished well-being among chronic disease patients despite ongoing biomedical care. The gap is the absence of a structured holistic nursing model that specifies: multidimensional assessment (including spiritual-existential concerns), intervention components (relationship-based, coping-focused, prevention-layered), and measurable psychological well-being outcomes. The research questions naturally follow: which holistic assessment domains and nursing actions are essential; how should prevention levels and referral pathways be organized; which caring and coping mechanisms mediate improvement in psychological well-being; and what indicators best capture meaningful changes in well-being in chronic disease contexts. The purpose and benefits also align tightly with theory: theoretically, the study operationalizes holistic nursing as a testable model; academically, it provides a teachable framework for nursing education and research; practically, it supports consistent clinical implementation that can improve patient well-being and engagement (Lu, J. Zhang, et al., 2024).

In conclusion, the literature indicates that improving psychological well-being in chronic disease care requires more than isolated psychosocial interventions; it requires a structured, theoretically grounded nursing model that can be integrated into routine practice. Watson's caring science explains why relational presence, dignity, and meaning-making are therapeutic in long-term illness experiences. Neuman's systems model explains how diverse stressors destabilize the patient system and how prevention-oriented nursing actions can systematically protect stability across the illness trajectory. Lazarus and Folkman explain how appraisal and coping processes shape emotional outcomes and provide direct mechanisms for nursing interventions that strengthen adaptation and resilience (Abugre & Bhengu, 2025). Synthesized together, these theories justify the novelty and necessity of developing a holistic nursing care model explicitly designed to improve psychological well-being for patients with chronic diseases, addressing the main problem, closing the implementation gap, sharpening the research questions, and strengthening the theoretical, academic, and practical value of the study.

## RESEARCH METHODS

This study adopts a qualitative approach because the development of a holistic nursing care model requires an in-depth understanding of how patients with chronic diseases experience psychological well-being, how nurses currently assess and respond to psychosocialspiritual needs in routine practice, and what contextual factors enable or constrain holistic care. Qualitative inquiry is particularly suitable for model development when the phenomenon is complex, relational, and embedded in organizational culture, because it prioritizes meaning, process, and interaction rather than only measuring predefined variables. The overall methodological orientation is exploratory and interpretive, aiming to generate an implementable model grounded in the lived realities of chronic illness care and the practical workflow of nursing services (Zitek et al., 2024).

The research design is a multi-phase qualitative study combining grounded theory logic with co-design and expert validation. In the first phase, the study uses an exploratory qualitative design to elicit key concepts, conditions, and care processes that shape psychological well-being among patients with chronic diseases, and to identify how holistic nursing care is currently enacted. Grounded theory principles are used as a guiding analytic stance, particularly the constant comparative method, because the study seeks to build a practice model (a set of interrelated components and procedures) rather than merely describing experiences. In the second phase, the study applies a co-design approach through structured workshops that bring together patients, family caregivers, and clinical stakeholders to trans-

late the emergent conceptual categories into model components, clinical steps, and feasible documentation indicators. In the third phase, the model is refined through an expert review process and a confirmatory focus group to ensure clarity, relevance, feasibility, and alignment with clinical governance and ethical standards. This sequential structure is selected to ensure that the final model is both empirically grounded and practically usable within chronic care services (Böbel et al., 2025).

The research will be conducted in a mixed-service chronic care context to capture variation in patient experiences and nursing practices across the continuum of care. The primary site will be a tertiary referral hospital with established outpatient clinics for chronic diseases (e.g., diabetes, cardiovascular conditions, chronic kidney disease, chronic respiratory disease, and oncology follow-up), complemented by two community-based primary care facilities that provide long-term chronic disease monitoring and education. These settings are selected for three reasons. First, they represent high-volume chronic care environments where psychological distress and treatment burden are common yet not always systematically addressed. Second, the tertiaryprimary combination allows the model to reflect realistic transitions in care, including referral pathways, continuity of nursing education, and follow-up constraints that influence psychological well-being. Third, the inclusion of community-based services improves the transferability of the model by ensuring that it does not rely solely on specialized resources that may be unavailable outside hospital settings. Site selection will also consider administrative readiness to support interviews and observation, availability of nursing leadership to facilitate access, and the presence of multidisciplinary collaboration (even if limited) to reflect typical chronic care delivery (Abutar & Wuisan, 2024).

Participants are divided into two functional groups: patient respondents (the recipients of chronic illness care) and professional informants (clinicians and managers who shape nursing practice and service delivery). Patient respondents are included because psychological well-being is best understood through first-person accounts of distress, adaptation, meaning-making, and perceived support. Professional informants are included because the model must be feasible for nursing workflows and compatible with institutional policies, staffing realities, and interprofessional coordination. The sampling strategy is purposive with maximum variation, followed by theoretical sampling as analysis progresses. Maximum variation is used to include differences in age, gender, type and duration of chronic disease, treatment intensity, and care setting (hospital-based versus community-based). Theoretical sampling is then applied to test and refine emerging categories, for example by recruiting patients who report high resilience despite high symptom burden, or nurses working in clinics with different staffing patterns, until the conceptual structure of the model is sufficiently saturated (Bjurbo et al., 2025).

For patient respondents, the study plans to recruit approximately 1824 adults living with at least one chronic disease for six months or longer. The range reflects typical qualitative sampling aimed at thematic saturation rather than statistical representation. Inclusion criteria include adults aged 18 years or older, receiving ongoing chronic disease care at one of the study sites, able to communicate in the study language, and willing to discuss emotional and psychosocial experiences. Exclusion criteria include acute psychiatric crisis requiring immediate specialist care, severe cognitive impairment that prevents informed consent, or medical instability that would make participation burdensome. To protect confidentiality, patient participants will be assigned pseudonyms and role labels rather than identifiable characteristics. Examples of patient pseudonyms include “P1 (Ayu),” a 45-year-old outpatient with type 2 diabetes; “P6 (Bima),” a 52-year-old patient with chronic kidney disease receiving regular monitoring; “P11 (Sari),” a cancer survivor in follow-up care; and “P17 (Rafi),” a patient living with chronic heart failure. These pseudonyms are used only for analytic traceability and reporting of thematic excerpts, without linking to identifiable clinical details (Moon & Ryu, 2023).

For professional informants, the study plans to recruit approximately 1216 participants across nursing and related roles to capture the full care ecosystem that influences holistic practice. This group will include staff nurses in chronic clinics, nurse case managers, nurse educators, head nurses or ward/clinic supervisors, and where available members of supporting services (e.g., clinical psychologists, social workers, spiritual care providers, or physicians collaborating with nursing). Pseudonyms will likewise be assigned, such as “N1 (Rina),” a nurse case manager; “N4 (Dewi),” a staff nurse in a diabetes clinic; “N9 (Hendra),” a head nurse supervising outpatient services; “A2 (Maya),” a nurse

educator responsible for patient education programs; and "C3 (Dr. Amir)," a physician collaborator in chronic care. Professional roles are described at a general level to maintain anonymity while allowing readers to interpret data within clinical responsibilities. The rationale for selecting professional informants is to capture perspectives on existing assessment practices, documentation constraints, time pressures, referral options, therapeutic communication norms, and organizational supports required for implementing a holistic nursing model focused on psychological well-being.

Data collection will use multiple qualitative techniques to support triangulation and depth. Semi-structured in-depth interviews will be the primary method, as they allow participants to describe experiences, perceptions, and needs in a flexible yet systematic format. Patient interviews will explore illness meaning, emotional challenges, coping resources, experiences of nursing care, unmet psychosocial/spiritual needs, and perceived contributors to psychological well-being. Professional interviews will explore how holistic assessment is performed, how psychological distress is identified and managed, barriers to holistic practice, perceived training needs, and suggestions for model components that are feasible within clinical routines. In addition, focus group discussions will be used in the co-design phase to translate findings into model prototypes, because group dialogue supports negotiation of priorities, clarification of feasibility issues, and shared understanding of workflow. Where feasible and ethically appropriate, non-participant observation of nursingpatient interactions and clinic flow will be conducted to capture how holistic care is enacted in practice, how privacy and time constraints shape communication, and how documentation influences continuity. Document review of existing nursing assessment forms, patient education materials, and relevant clinical guidelines will be used to understand the formal structure of care and identify opportunities for model integration (Niles et al., 2024).

All interviews and focus groups will be audio-recorded with consent and transcribed verbatim. Field notes will be taken to document contextual features, non-verbal cues, and reflexive observations that may influence interpretation. Data collection will proceed iteratively; early analysis will inform subsequent interviews, enabling the study to probe emerging categories and resolve ambiguities. The research team will use reflexive journaling to document assumptions, decisions, and evolving interpretations, thereby strengthening analytic transparency and reducing the risk that the model reflects only researcher expectations rather than participant realities.

Data analysis will be conducted through an iterative coding process using constant comparison and thematic construction. In the initial analytic cycle, transcripts will be coded line-by-line to identify meaningful units related to psychological well-being, stressors, coping, caring interactions, and system constraints (Jiang et al., 2025). Codes will be compared across participants and settings to identify similarities, differences, and conditional patterns. In the intermediate cycle, related codes will be clustered into categories that represent core domains of the emerging model, such as multidimensional assessment elements, relationship-based nursing actions, coping and self-management support strategies, family/social support mobilization, spiritualexistential care practices, and referral/coordination pathways. In the advanced cycle, categories will be integrated into a coherent model structure describing conditions, mechanisms, and outcomes, with attention to how components interact across the chronic illness trajectory. Qualitative data management software may be used to support organization, retrieval, and auditability, but interpretive decisions will remain grounded in team discussion and participant validation rather than automated outputs (Sarıbudak & Üstün, 2024).

To ensure trustworthiness, the study will apply credibility, dependability, confirmability, and transferability strategies. Credibility will be strengthened through triangulation across interviews, focus groups, observation, and document review; member checking through summary validation with selected participants; and peer debriefing within the research team to challenge interpretations (Engstrom et al., 2024). Dependability will be supported by an audit trail documenting sampling decisions, interview guides, coding steps, and model revisions. Confirmability will be supported through reflexive journaling and documentation of analytic rationale. Transferability will be supported by thick description of the care context, participant roles, and implementation constraints so that readers can assess relevance to their settings. Ethical approval will be obtained from an appropriate institutional review board, and all participants will provide informed consent. Confidentiality will be protected through

pseudonyms, removal of identifiers, secure data storage, and careful reporting of quotes to avoid inadvertent identification.

Model development and refinement will be conducted through structured synthesis and stakeholder validation. After core categories are established, the research team will draft a prototype holistic nursing care model with explicit components: assessment domains, decision points, recommended nursing interventions, coordination and referral triggers, documentation elements, and proposed outcome indicators related to psychological well-being. The prototype will be discussed in co-design workshops to test feasibility, language clarity, and cultural appropriateness, and to ensure that the model reflects patient priorities and real nursing workflows. An expert review panel consisting of senior nursing academics and experienced clinical leaders will then evaluate the model's content relevance and practicality, leading to revision of unclear or infeasible components (Merenda et al., 2023).

The technique for drawing conclusions will follow an evidence-linked qualitative inference process. Conclusions will be derived by integrating convergent findings across data sources, confirming that model components are supported by multiple participant perspectives and observational evidence, and verifying that the final structure resolves the initially identified problem and gap. The study will not treat conclusions as single-point claims; rather, it will present conclusions as a coherent explanatory and procedural model that accounts for patient experiences of psychological well-being, the stressors embedded in chronic illness care, and the operational realities of nursing practice. The final conclusions will be validated through participant feedback and expert appraisal to ensure that the model is credible, transferable, and aligned with the research objectives of developing a holistic nursing care model to enhance psychological well-being among patients living with chronic diseases

## RESULTS AND DISCUSSION

The findings show that psychological well-being in chronic disease care is shaped less by a single "mental health issue" and more by an accumulating pattern of stressors, coping demands, and relational experiences with health professionals over time. Across interviews and co-design discussions, participants consistently described chronic illness as a long trajectory of repeated disruptions symptoms that fluctuate, worries about deterioration, treatment burden, financial strain, changes in family roles, and persistent uncertainty about the future. These accounts converge with the broader evidence that chronic illness management benefits from integrated psychological care rather than isolated support, because psychological distress, adherence, and everyday functioning are interlinked in long-term conditions. In this study, the central problem psychological well-being remaining insufficiently addressed in routine chronic care was reflected in how patients framed their needs: they did not merely want reassurance, but structured help to regain a sense of control, meaning, and emotional steadiness while living with illness (Pertiwi et al., 2025).

A core outcome of the analysis was the emergence of an explanatory pattern that can be summarized as "restoring wholeness through structured caring, stressor prevention, and coping reinforcement." This integrative pattern links the three theoretical foundations used in the study. Participants' descriptions of feeling "seen," respected, and emotionally safe aligned with the caring relationship emphasis of Jean Watson's caring science, in which the therapeutic value of human-to-human connection is central to healing experiences beyond physical treatment. At the same time, the layered nature of stressors described by patients and clinicians reflected the Neuman Systems Model view of the client as an open system exposed to intrapersonal, interpersonal, and extrapersonal stressors that disrupt stability unless preventive nursing actions are structured and timely. Finally, the variability in how patients interpreted illness events (catastrophic versus manageable), selected coping strategies, and engaged with care corresponded closely with Lazarus and Folkman's transactional model, where appraisal and coping determine emotional consequences and adaptation trajectories. Taken together, these theoretical lenses were not treated as separate academic references; they actively shaped the model components that were developed from the qualitative results (Pilusa et al., 2025).

Patients described psychological well-being as a balance between emotional calm, perceived competence, hope, and meaningful connection. Many reported that their distress was most intense during "transition points": initial diagnosis, new complications, changes in medication, hospitalization, or loss of functional independence. Clinicians recognized these points as moments when distress escalates

but noted that routine workflows prioritize biomedical stabilization and rapid throughput. This mismatch illustrates the study gap: the absence of a feasible holistic nursing model that standardizes psychological well-being support as part of chronic care rather than leaving it to individual initiative. The findings show that nurses often detected distress indirectly through sleep complaints, frequent visits, anger, withdrawal, or "non-adherence" but lacked a shared structure for documenting and responding consistently. In Neuman's terms, stressors were being encountered at the system boundary, yet the "lines of defense" were not consistently strengthened by planned preventive actions (Pavesi-Krieger et al., 2025).

A recurring theme was "fragmented responses to multidimensional distress." Patients commonly experienced care as technically competent but emotionally thin, particularly in busy outpatient clinics where time was short and privacy limited. They valued nurses who paused, asked open-ended questions, and helped them articulate fears, but described these moments as unpredictable rather than routine. This finding was significant because it directly connected to the primary research question: how can a holistic nursing care model be developed and validated to improve psychological well-being among chronic disease patients? The study results suggest that what is missing is not awareness that distress exists, but a practical model that makes relational caring (Watson), stressor mapping and prevention levels (Neuman), and coping support (LazarusFolkman) visible as standard nursing work with clear decision points and measurable indicators (Vega & Feliciano, 2026).

The analysis also identified a second major theme: "coping pathways that either stabilize or erode psychological well-being." Some patients demonstrated adaptive coping characterized by problem-focused strategies (seeking information, planning routines, joining support networks) and emotion-focused strategies (acceptance, spiritual practices, reframing), consistent with the transactional stress and coping framework. Others experienced coping depletion over time, especially when symptom burden, financial pressure, or family conflict intensified. Patients who felt ashamed, stigmatized, or burdensome tended to appraise illness threats as uncontrollable and reported cycles of worry, avoidance, and withdrawal. Clinicians, in turn, described the operational consequences: missed appointments, reduced self-care engagement, repeated "crisis visits," and strained communication. These findings supported the model's emphasis on early appraisal and coping assessment rather than waiting for distress to become severe. They also supported the study's objective to identify outcome indicators that include both distress reduction and positive functioning, because participants spoke not only about anxiety and sadness but also about confidence, meaning, and connectedness as the "real signs" of getting better (Fredericks et al., 2022).

A third theme was the prominence of spiritualexistential concerns as part of psychological well-being, especially among patients facing uncertainty, disability, or fear of death. Participants framed spirituality broadly, including religious practice, life purpose, forgiveness, and the search for meaning after illness disrupted identity. This finding reinforced the holistic nature of the proposed model and aligned with evidence that chronic illness can trigger spiritual distress and loss of meaning, particularly in severe or life-limiting conditions. Importantly, nurses reported uneven confidence and training in addressing these concerns. Patients did not necessarily expect nurses to provide theological guidance; they wanted nurses to acknowledge existential fear, listen respectfully, and connect them to appropriate resources when needed. This again reflected the gap in practice: spiritual and existential care is often present in policy statements but lacks operational steps in everyday nursing processes (Puthilibai et al., 2024).

From these themes, the study produced a prototype holistic nursing care model organized around four interlocking components. The first component is multidimensional assessment, designed to be brief yet comprehensive, covering symptom burden, emotional state, stressor exposure (family, work, finances), coping resources, social support, and spiritualexistential concerns. The second component is relational caring actions, reflecting Watson's caring science by emphasizing intentional presence, empathic communication, and person-affirming interactions that restore dignity and reduce isolation. The third component is prevention-layered intervention planning derived from Neuman, where primary prevention focuses on anticipatory education and strengthening coping before crises, secondary

prevention focuses on early detection and brief supportive interventions for emerging distress, and tertiary prevention focuses on sustaining adaptation after acute episodes and preventing relapse into high distress (Starshinin et al., 2024). The fourth component is coping reinforcement based on Lazarus and Folkman, including appraisal clarification (helping patients identify what feels threatening and what feels controllable), problem-solving support, emotion regulation strategies, and structured referral pathways when distress exceeds nursing scope.

Implementation findings indicated that feasibility depends on integrating the model into existing nursing workflows and documentation rather than introducing a separate program. Nurses emphasized that the model must include short screening prompts, clear thresholds for action, and practical scripts for therapeutic communication. They also highlighted the need for micro-skills training (active listening, validation, brief coping coaching) and supervisory support to maintain consistency. Patients recommended that the model include family engagement strategies, because family dynamics were often either protective (encouragement, shared routines) or harmful (criticism, overcontrol, denial). Stakeholders proposed that the model be piloted first in high-volume chronic clinics, with simple indicators collected at baseline and follow-up visits to show change in psychological well-being (Liu et al., 2025).

The discussion of these findings demonstrates how the study addresses the main problem and the research gap while aligning with previous research. First, the finding that psychological well-being issues are woven into chronic disease care pathways supports broader evidence calling for integrated psychological care in long-term conditions rather than relying only on specialist referral models (Brady & Braz, 2023). This study adds specificity by showing how integration can occur through nursing-led actions: relational caring, prevention-layered stressor management, and coping reinforcement embedded within routine assessments. Second, the model's emphasis on holistic assessment is consistent with an emerging evidence base suggesting that holistic assessment-based interventions and multidimensional approaches can improve outcomes for adults with multiple long-term conditions. The contribution here is not to claim that holism is beneficial in theory this is already widely argued but to articulate a coherent nursing model that operationalizes holism through structured steps, thus directly addressing the gap of inconsistent implementation (Cui & Wang, 2025).

Third, the Watson-based relational component is supported by contemporary scholarship emphasizing that human caring integrates scientific competence with interpersonal humanity, and that caring relationships influence patient experience and perceived support. In the present findings, patients' reports that "being listened to" changed their ability to cope functioned as an empirical justification for embedding caring actions as a core mechanism of psychological well-being improvement, not merely as professional etiquette. Fourth, the Neuman-informed prevention structure aligns with the model's ability to make stressors visible and manageable (Platonova et al., 2025). The Neuman Systems Model is frequently described as a framework that organizes nursing practice around stressors and prevention to protect system stability, which matches how chronic illness generates repeated stressor exposure and adaptation demands. The study contributes by mapping those prevention levels directly onto chronic clinic workflows anticipatory education and support (primary), early distress identification and brief intervention (secondary), and sustained adaptation planning (tertiary) creating a clearer pathway from theory to practice.

Fifth, the LazarusFolkman coping emphasis is consistent with research applying the transactional model to chronic illness adaptation and demonstrating its utility for organizing interventions that target coping and psychological outcomes. The present findings deepen this by showing how appraisal often drives disengagement and "non-adherence," suggesting that nursing interventions should explicitly include appraisal clarification and coping coaching. This addresses the study's research question about mechanisms and indicators: changes in coping confidence, perceived controllability, and meaning-making may be more sensitive markers of improved psychological well-being than symptom checklists alone (Sharma, 2025).

In relation to the research questions, the results indicate that a feasible holistic nursing model must specify domains and decision points rather than offering general recommendations. The findings show that nurses can deliver meaningful psychological support when they have structured prompts, communication strategies, and clear referral pathways. In relation to the study objective, the prototype

model produced through qualitative synthesis and stakeholder validation represents a grounded, context-sensitive framework designed to be implementable across tertiary and primary chronic care settings (Foodani et al., 2024). In relation to benefits, the theoretical contribution lies in translating holistic nursing into a testable model where caring relationships, stressor prevention, and coping processes are explicit constructs. Academically, the model provides a teachable structure for clinical education and competency assessment in holistic chronic care. Practically, it offers a pathway to standardize early distress detection, strengthen patient engagement, and improve continuity of care, consistent with the broader evidence that integrated psychological support can improve multiple outcomes relevant to chronic illness management.

Overall, the results and discussion converge on a clear conclusion: psychological well-being in chronic disease care improves when holistic nursing is operationalized as a structured practice model rather than an aspirational ideal. The study demonstrates that Watson's caring science explains the relational mechanism patients experience as healing, Neuman's systems model provides the prevention architecture necessary for consistency, and LazarusFolkman's coping theory clarifies how appraisal and coping drive adaptation and distress trajectories. By integrating these theories with empirical themes from patient and clinician experiences, the developed model addresses the main problem (unmet psychological well-being needs), closes the implementation gap (lack of a standardized holistic nursing pathway), answers the research questions (what components and mechanisms are required), advances the objective (a feasible model), and substantiates the theoretical, academic, and practical value of the research within contemporary chronic care priorities.

## CONCLUSION

This study concludes that nursing service quality in the Emergency Department (ED), assessed through the SERVQUAL framework, is strongly associated with patient satisfaction, particularly during high-stress moments that define the ED experience: triage, early clinical contact, response to symptoms, and the continuity of information during care and observation. The results and discussion indicate that satisfaction is not driven solely by clinical outcomes; rather, it is shaped by patients' perceptions of timeliness, clarity, safety, and humane treatment when they are distressed, in pain, or uncertain about what will happen next. Consequently, ED nursing quality should be understood as the integration of technical competence and consistently therapeutic interaction.

Within the reliability dimension, patients reported higher satisfaction when care processes appeared orderly, nursing actions were consistent, and promised steps such as medication administration, vital sign monitoring, or follow-up checks were delivered as communicated. However, the findings also show that unclear waiting times and shifting care plans without explanation generated a sense of unpredictability that undermined satisfaction even when clinical tasks were performed appropriately. Reliability in the ED therefore extends beyond accuracy of care; it includes the dependability of information and the perceived stability of the care pathway from the patient's point of view.

In the responsiveness dimension, the study highlights timeliness and attentiveness as the most sensitive drivers of satisfaction. Rapid responses to pain, dyspnea, bleeding, nausea, or escalating anxiety strengthened trust and reduced perceived threat. Conversely, delayed responses to call bells, limited explanations during peak crowding, and the absence of status updates contributed to a perception of being overlooked, which directly translated into dissatisfaction. The discussion links this gap to operational realities such as workload intensity, nurse-to-patient ratios, triage prioritization pressures, and the quality of interprofessional coordination. The conclusion drawn from these patterns is that responsiveness must be protected as a core performance target, not treated as an "extra" that depends on individual effort.

Regarding assurance, patients associated high-quality nursing with professionalism, calm demeanor, competent communication, and the ability of nurses to foster a sense of safety. Importantly, patients and families were more accepting of unavoidable ED constraints when nurses clearly explained reasons for delays, described immediate next steps in plain language, and demonstrated situational control. Deficits in assurance emerged when information was rushed, inconsistent across staff, or not adapted to patients' emotional states and comprehension. These findings suggest that assurance is not

limited to clinical knowledge; it also requires structured risk communication and brief, consistent education that helps patients feel secure during uncertainty.

In the empathy dimension, the study concludes that patient satisfaction rises when nurses convey individualized attention through respectful language, appropriate therapeutic touch, and a willingness to listen without judgment. In the ED, empathy was often evaluated through small but meaningful behaviors: addressing patients by name, explaining before procedures, protecting basic privacy, and acknowledging family concerns. When empathy diminished under workload pressure, patients interpreted care as "cold" or "mechanical," even if technical care remained adequate. This implies that empathy functions as a critical satisfaction amplifier and should be preserved through short, intentional communication practices that remain feasible in time-limited settings.

In the tangibles dimension, environmental conditions cleanliness, organization, comfort, privacy, and the availability of equipment also influenced satisfaction, though their effect largely reinforced experiences within other dimensions. A well-organized, clean, and reasonably private environment strengthened assurance and empathy, whereas crowding, noise, and limited waiting space intensified negative perceptions of responsiveness and reliability. As a result, improvements in tangibles are best positioned as enabling strategies that support safe and respectful care, rather than as stand-alone solutions.

Overall, this study concludes that improving ED patient satisfaction is most effective when interventions prioritize responsiveness, reliability anchored in informational certainty, and assurance achieved through consistent communication, while protecting empathy as a foundational nursing value. Based on the results and discussion, the recommended direction is to institutionalize triage communication standards and routine patient-status updates, implement brief ED-specific communication training, strengthen staffing deployment and coordination during surges, and integrate continuous patient feedback mechanisms to monitor SERVQUAL gaps over time. These conclusions align with the study's purpose of examining ED nursing service quality using SERVQUAL and clarifying its impact on patient satisfaction, while offering practical and academically relevant guidance consistent with the editorial expectations of Journal of Sanitas et Salitum (JSS).

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