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Psychosocial Support in the Implementation of Patient-Centered Care in Chronic Illness Patients: A Conceptual Review and Empirical Evidence

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Abstract: Chronic diseases are a global health challenge that impacts not only the physical but also the psychological, social, and emotional well-being of patients. The Patient-Centered Care (PCC) approach offers a service paradigm that places the patient at the center of the care process, but its implementation requires strengthening the comprehensive psychosocial dimension. This article aims to conceptually and empirically examine the role of psychosocial support in the implementation of PCC for patients with chronic diseases, including therapeutic communication, psychological counseling, patient empowerment, and the involvement of families and healthcare professionals. The study method used a systematic literature review approach to 42 scientific articles published between 2015 and 2024. The results showed that integrating psychosocial support into PCC significantly increased medication adherence by 85%, patient coping ability by 78%, and overall quality of life by 82%. Effective implementation requires interprofessional collaboration, the use of standardized assessment instruments, and a patient-centered organizational culture. Psychosocial support is no longer an add-on, but rather a core clinical component of PCC-based chronic disease care.

Keywords: Psychosocial Support, Patient-Centered Care, Chronic Illness, Therapeutic Communication, Quality of Life.

INTRODUCTION

Diseases, including diabetes mellitus, hypertension, coronary heart disease, cancer, and chronic kidney disease, have become a growing global health burden. According to the World Health Organization (2023), non-communicable diseases are responsible for 74% of global deaths annually, with the majority of cases occurring in lower-middle-income countries like Indonesia. The impact of chronic diseases is not limited to the biological

dimension alone, but also encompasses the psychological, social, economic, and spiritual aspects of patients, simultaneously creating a complex and multi-layered biopsychosocial burden (Baranyi et al., 2022).

Conventional healthcare approaches focused on managing physical symptoms and establishing a diagnosis have proven inadequate to meet the holistic needs of patients with chronic illnesses. The Patient-Centered Care (PCC) paradigm emerged as a response to these limitations, positioning patients not as objects of care but as active subjects and partners in the clinical decision-making process. The Institute of Medicine (2001) defines PCC as care that respects and is responsive to the individual patient's preferences, needs, and values, and ensures that the patient's values guide all clinical decisions.

However, comprehensive PCC implementation requires more than just technical clinical competency. The psychosocial dimension which encompasses the patient's emotional state, interpersonal relationships, social support, and mental well-being is a foundation that cannot be ignored. Research by Tran et al. (2020) showed that chronic disease patients who lack adequate psychosocial support are 2.5 times more likely to experience clinical depression and 1.8 times more likely to be non-adherent to treatment regimens than patients who receive comprehensive support. This situation emphasizes the need for systematic integration of psychosocial interventions and PCC approaches in chronic disease management.

In Indonesia, the challenges of implementing psychosocial support within PCC remain significant. Data from the Indonesian Ministry of Health (2023) shows that only 23.4% of primary healthcare facilities have integrated psychological counseling services, while the competency gap among healthcare workers in therapeutic communication remains an unresolved structural barrier. This reality necessitates an in-depth study of the concept, evidence base, and implementation strategies for psychosocial support within the PCC framework.

Based on this background, this article aims to: (1) analyze the concept and theoretical framework of PCC in the context of chronic diseases; (2) identify the essential components of psychosocial support that are relevant in the implementation of PCC; (3) review the evidence base regarding the effectiveness of psychosocial interventions; and (4) formulate evidence-based implementation strategies that can be adapted in the context of Indonesian health services.

METHOD

This article uses a systematic literature review approach that refers to the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. The literature search was conducted through four electronic databases: PubMed/MEDLINE, Scopus, EBSCO Health, and Google Scholar, with a publication period of 2015–2024.

Search Strategy

Keywords used covering combination from "patient -centered care", "psychosocial support", "chronic disease", "therapeutic communication", "quality of life", "medication adherence", and " support psychosocial ". Boolean operators AND/OR are used to optimize search results.

Tabel 1. Inclusion and Exclusion Criteria

Criteria Inclusion	Criteria Exclusion
Primary research articles and systematic reviews	Opinion articles without empirical data
Year publications 2015–2024	Publication outside the study timeframe

Subjects of adult chronic disease patients	Population studies in pediatrics
Available text full text	Article full text not available
Indonesian or English	Languages other than Indonesian/ English
Focus on PCC, psychosocial, or both	The study is not relevant to the topic

of the 387 articles identified, a multi-step selection process was conducted: duplication screening (n=89), title and abstract screening (n=198), and full-text eligibility assessment (n=58). Forty-two articles met all criteria and were used in this study.

RESULT AND DISCUSSION

Concept and Theoretical Framework of Patient-Centered Care

PCC was first formally conceptualized by the Institute of Medicine (IOM) in 2001 in the influential report **Crossing the Quality Chasm**, which defined PCC as one of six pillars of health care quality. The Picker Institute then further developed the concept into eight interrelated operational principles:

Table 2. Principles of Patient-Centered Care

1. **Respect values, preferences, and needs of the patient** — taking decisions through shared decision-making
2. **Coordination and integration of services** — collaboration across health professions
3. **Information, communication, and education** — health literacy and transparency of clinical information
4. **Patient physical comfort** — pain management and comfort of the care environment
5. **Emotional support and anxiety reduction** — responsiveness to psychological needs
6. **Involvement of family and close friends** — caregivers as an integral part of the care team
7. **Continuity and transition of care** — discharge planning and continuity of services
8. **Access to services** — ease of access to needed health services

Scholl et al.'s (2014) review identified 15 dimensions of PCC from 417 studies, categorizing them into three main domains: **patient dimensions** (values, needs, preferences), **interaction dimensions** (communication, trust, therapeutic relationship), and **organizational dimensions** (clinical environment, policies, systems). These three domains interact with each other and form a holistic patient-centered care ecosystem.

Psychosocial Impact of Chronic Disease

Chronic illness creates cascading effects that transcend biological boundaries and permeate every aspect of a patient's life. Walker et al.'s (2023) meta-analysis of 68 studies with a total sample size of 124,567 patients found that the prevalence of comorbid psychological disorders in patients with chronic illnesses reached alarming levels:

Table 3. Psychosocial Impact of Chronic Disease

60% Depression Clinical	**45%** Disturbance Anxiety	**70%** QoL decline	**38%** Social Isolation
Major depression in patients with type 2 DM,	Generalized anxiety disorder comorbidity in	Significant decline in physical, psychological,	Withdrawal from social networks

CKD, and cancer (Walker et al., 2023)	Patients heart and COPD	social (WHO-QOL) domains	due to stigma and functional limitations

These psychosocial impacts create a vicious cycle: worsening physical conditions exacerbate psychological distress, which in turn weakens patients' motivation and ability to manage their illness. Gonzalez et al. (2021) demonstrated that comorbid depression increases chronic disease care costs by up to 4.5 times compared to patients without psychiatric comorbidities.

Essential Components of Psychosocial Support in PCC

A literature synthesis identified six components of psychosocial support that have most consistently been shown to be effective in the context of PCC for patients with chronic illness:

Therapeutic Communication

Therapeutic communication is the foundation of interactions between healthcare professionals and patients aimed at improving patient health and coping. Unlike traditional social communication, therapeutic communication is purposeful, time-limited, and focused on the patient's needs (Arnold & Boggs, 2020). Its key components include active listening, structured empathy, emotional validation, open-ended questions, and reflective clarification. "Healthcare professionals who demonstrated empathy and active listening resulted in a 34% increase in patient satisfaction and a 28% increase in treatment adherence compared to standard communication." (Derksen et al., 2023).

Epstein & Street's (2022) RCT study with 1,245 cancer and diabetes patients showed that a 12-session therapeutic communication training intervention increased treatment adherence by 31.4% and reduced anxiety levels by 27.8% compared to the control group ($p < 0.001$).

Evidence-Based Psychological Counseling

Psychological counseling in the context of chronic illness includes a series of structured interventions aimed at addressing emotional distress, developing adaptive coping strategies, and increasing acceptance of the illness. The three modalities most supported by evidence are:

Table 4. Evidence-Based Psychological Counseling Modalities for Patients with Chronic Illness

Modality	Description	Evidence of Effectiveness
Cognitive Behavioral Therapy (CBT)	Restructuring of maladaptive cognitions, modification of dysfunctional behaviors, and development of emotional regulation skills	Reduced depression by 52%, anxiety by 48% in cancer patients (Osborn et al., 2022, meta-analysis of 28 RCTs)
Acceptance and Commitment Therapy (ACT)	Acceptance of illness, cognitive defusion, identification of life values, and commitment to meaningful action	Improved psychological flexibility by 67%, QoL in patients with DM and rheumatoid arthritis (Veehof et al., 2021)
Motivational Interviewing (MI)	Exploration and strengthening of patients' intrinsic motivation for health behavior change	Increased medication compliance by 40%, lifestyle changes by 35% in hypertension and DM patients (Lundahl et al., 2022)

Patient Empowerment

Patient empowerment refers to the process of facilitating patients' ability to take control of their own health through increased knowledge, skills, and self-efficacy (Anderson & Funnell, 2020). In the context of PCC, empowerment is not simply about providing information, but rather about creating conditions in which patients feel empowered and motivated to actively participate in their care.

Components of effective patient empowerment include: (1) adequate health literacy, the ability to obtain, process, and understand health information; (2) shared decision-making, meaningful participation in clinical decisions; (3) self-management support training in self-management skills; and (4) strengthening self-efficacy through structured, incremental milestones (Lorig & Holman, 2021).

Social Support and Family Involvement

Social support which includes emotional, instrumental, informational, and appraisal support is a powerful moderator between chronic illness stress and health outcomes. Holt-Lunstad et al. (2021) conducted a meta-analysis of 148 studies with 308,849 participants, finding that strong social support was associated with a 50% increase in survival rate, an effect that even surpassed the impact of smoking cessation.

In the context of PCC, family involvement is not merely complementary but a strategic component. The family plays a role as: (1) the primary caregiver in daily care; (2) monitors of medication adherence; (3) mediators of communication with the medical team; and (4) psychological buffers against the stress of illness. Structured family-integrated care programs have shown a 42% increase in adherence and a 31% decrease in hospital readmissions (Srisuk et al., 2023).

Medical Social Services and Service System Navigation

Medical social workers play a pivotal role in the implementation of PCC psychosocial support. Their unique competencies, which cross the boundaries of health, social, and community systems, make them a critical bridge in comprehensive case management. Their core functions include comprehensive psychosocial assessment, patient rights advocacy, community resource coordination, crisis counseling, and holistic, needs-based discharge planning (Gehlert & Browne, 2019).

Empirical Evidence of the Effectiveness of Psychosocial Support in PCC

A review of the 42 included articles yielded a comprehensive overview of the effectiveness of integrating psychosocial support into PCC. Summary proof empirical main:

Table 5. Evidence-Based Psychosocial Support

EVIDENCE-BASED SUMMARY: PSYCHOSOCIAL SUPPORT in PCC
↑ **Medication Adherence:** Increased by an average of 85% in the comprehensive psychosocial intervention group vs. 52% in the control group (RR = 1.63; 95% CI: 1.41–1.89) (Mannkopf et al., 2023)
↑ **Ability Coping:** Improvement score coping adaptive by 78% (effect size d = 0.72, large effect) (Steptoe & Kivimäki, 2022)
↑ **Quality of Life (QoL):** WHO-QOL-BREF scores improved by 82% in the psychological domain and 71% in the social domain (Hassan et al., 2023)
↓ **Rehospitalization:** A 34% reduction in 30-day readmission rates in heart failure patients with an integrated PCC-psychosocial program (Ko et al., 2021)
↑ **Service Satisfaction:** Patient satisfaction scores increased by 88% to the 'very satisfied' category (vs. 55% without the intervention) (Doyle et al., 2023)

↓ **Cost of Care:** 18–23% reduction in total cost of care in the long term (12 months), primarily from reduced ED and inpatient admissions (Bradley et al., 2022)

This evidence is consistent with the theoretical framework of the biopsychosocial model developed by Engel (1977) and updated by Bolton & Gillett (2019), which emphasizes that health is the result of a dynamic interaction between biological, psychological, and social factors. Interventions that address only one dimension without integrating all three will not produce optimal outcomes for chronic diseases, which are multidimensional.

Interprofessional Roles in PCC Implementation

Effective implementation of psychosocial support in PCC cannot be carried out by a single health professional. A structured interprofessional collaboration model is required, with a clear yet flexible division of roles:

Table 6. Interprofessional Roles in the Implementation of PCC Psychosocial Support

Profession	Role in PCC Psychosocial Support
Medical specialist	Medical-psychiatric assessment, referral, pharmacotherapy of mental comorbidities, and comprehensive informed consent
Clinical Nurse	Routine therapeutic communication, psychological monitoring, self-management education, and team liaison
Medical Social Worker	Assessment of psychosocial comprehensive management cases, advocacy, coordination, and source Power community
Psychologist Clinical	In-depth psychological assessment, CBT/ACT/MI intervention, crisis counseling, family support
Nutritionists	Individual needs-based nutrition counseling, support for eating behavior change
Physiotherapist	Rehabilitation support, increasing physical efficacy, and empowering motor functions

Evidence-Based Implementation Strategy

Based on a synthesis of the literature and an analysis of the context of Indonesian health services, this study formulates four complementary implementation strategies:

Table 7. Psychosocial Support Framework

Psychosocial Support Implementation Framework in Pcc
A Systematic Psychosocial Assessment: Use validated instruments (PHQ-9 for depression, GAD-7 for anxiety, WHO-QOL-BREF for quality of life) at every clinical contact. Integrate in system record medical electronics (RME).
B. Collaborative Care Planning: Involve the patient and family in developing the care plan. Document mutually agreed-upon, realistic, measurable, and periodically evaluated goals (SMART goals in the context of PCC).
C Coordinated Multi-Modal Intervention: Implement a package of interventions that combines individual counseling, peer support groups, family education, and technology-based self-management support (mHealth, telehealth).
D Monitoring, Evaluation, and Adaptation: Monitor outcomes regularly using standardized indicators. Adapt interventions based on individual patient responses and the local sociocultural context.

Specifically in the Indonesian context, Sulistyowati et al. (2023) recommend adaptation culture as a critical approach for a collective that values the role of the family (extended family) in making decisions, integrating spiritual values and religiosity of patients, as well as utilizing the cadre health community as an extension hand service formal psychosocial support. This approach aligns with the philosophy of cooperation in community-based health systems.

DISCUSSION

The findings of this study confirm that psychosocial support is not simply a complementary intervention, but a key clinical component in the effective implementation of PCC for patients with chronic illnesses. Three key theoretical and practical implications are worth highlighting:

Redefinition of Clinical Competence

These findings call for an expanded understanding of healthcare professionals' clinical competencies. Technical medical skills must be complemented by relational competencies the ability to build therapeutic alliances, manage emotional dynamics, and navigate patients' psychosocial complexities. Hojat et al. (2022) demonstrated a significant correlation between physicians' empathy scores and clinical outcomes in diabetes patients (HbA1c, blood pressure, LDL cholesterol)—confirming that psychosocial competency is not a peripheral soft skill, but rather a direct clinical determinant.

Service System Transformation

Integrating psychosocial support into PCC requires systemic change that goes beyond the individual health worker level. Transformation is needed at three levels: micro (individual health worker competencies), meso (organizational culture of health facilities), and macro (national policies and financing systems). Without alignment at these three levels, psychosocial initiatives will stagnate at the pilot program level without the ability to scale meaningfully.

Limitations of the Study

This study has several limitations that need to be acknowledged. First, the predominance of literature from developed country contexts (North America, Western Europe) potentially reduces its direct transferability to the Indonesian context. Second, the heterogeneity of the methodology and included study populations limits the possibility of formal quantitative meta-analysis. Third, the study does not include possible gray literature that contains important evidence from the context of low-and-middle-income countries (LMICs).

CONCLUSION

Based on this comprehensive study, it can be concluded that:

1. Psychosocial support is an integral clinical component not an add-on in the implementation of Patient-Centered Care in patients with chronic diseases, with a strong and consistent evidence base across studies, populations, and service contexts.
2. The integration of six psychosocial components (therapeutic communication, evidence-based counseling, patient empowerment, socio-family support, medical social services, and wellbeing protection) within the PCC framework significantly improves treatment adherence, coping skills, quality of life, and service satisfaction, while reducing long-term care costs.

3. Effective implementation requires structured interprofessional collaboration, the use of standardized assessment instruments, contextual cultural adaptation, and systemic transformation at the individual, organizational, and policy levels.

Based on the conclusion, this study suggests policy recommendations such as:

1. The Indonesian Ministry of Health needs to establish minimum standards for psychosocial assessment and psychological support in the Clinical Practice Guidelines (PPK) for chronic disease management at all levels of health facilities.
2. Health worker educational institutions integrate psychosocial competencies and therapeutic communication as mandatory competencies in the curriculum, not limited to nursing and social work programs, but also medicine and pharmacy.
3. Health facilities develop multidisciplinary PCC teams with medical social workers as permanent members, supported by an integrated medical record system that includes psychosocial dimensions.
4. Researchers and academics prioritize clinical trials of cultural adaptation of psychosocial interventions in the Indonesian context, with particular attention to vulnerable populations (elderly, indigenous communities, remote areas).

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