Review Article

Beyond Heart "Failure": Why Spirituality Matters

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Abstract

Heart failure exemplifies a paradox of contemporary cardiology: as the possibilities for prolonging life and characterizing the disease with precision expand, aspects of the human experience that often shape how patients live with the condition remain insufficiently explored. In this review, spirituality is presented as a relevant dimension of person-centered care, highlighting its distinction from religiosity, its relationship with the experience of illness, and its potential role in promoting a more comprehensive approach to heart failure.

Introduction

In recent decades, heart failure (HF) has shifted from being a rapidly fatal condition to becoming a complex chronic disease. The incorporation of pharmacological therapies, devices, and multidisciplinary strategies has transformed the clinical trajectory of millions of patients, allowing for longer survival and better symptom control. However, this therapeutic success has brought a less-discussed challenge: more and more patients now live for years with a condition marked by physical limitations, recurrent hospitalizations, and prognostic uncertainty.[1]

For many patients, HF is not experienced as a reduction in ejection fraction or an increase in NT-proBNP. It is experienced when climbing a flight of stairs begins to require planning; when a trip is no longer possible; when activities that once defined who the person was cease to be part of daily life; when the imagined future no longer feels as accessible as before.

Although modern cardiology has learned how to prolong life, one question remains – one that no guideline can fully answer: how can we help patients live well in the face of a disease that often redefines the limits of the future?

This question leads us to a neglected aspect of care: spirituality.

Spirituality is not synonymous with religion

One of the greatest obstacles to incorporating spirituality into cardiovascular practice is the persistent confusion between spirituality and religiosity. The international definition proposed by Puchalski et al.[2] describes spirituality as an intrinsic aspect of humanity through which individuals seek meaning, purpose, and transcendence, as well as connection with themselves, with others, with nature, or with what they consider sacred. It is a universal dimension of human experience, present in both religious and non-religious individuals.

Religiosity, in turn, refers to the beliefs, practices, rituals, and organized communities that may serve as an expression of spirituality.[3,4] Although the two concepts often overlap, they are not equivalent. Many patients find meaning through religion; others find it in relationships, personal values, philosophy, art, contemplation, or service to others.

This distinction has important implications for research and clinical practice. Koenig has warned that many studies use overly broad definitions of spirituality, incorporating concepts such as happiness, inner peace, purpose, or psychological well-being.[5] When this occurs, it becomes difficult to determine whether we are measuring spirituality or simply assessing mental health under another name. In other words, it becomes difficult to distinguish spirituality from the very outcomes one intends to study.

However, the apparent divergence between Koenig et al. and Puchalski et al.[2,4,5] may reflect less a conceptual disagreement than different objectives. For research, definitions must be clear and methodologically rigorous. For clinical practice, the goal is not to measure spirituality, but to understand how the patient finds meaning in the face of illness.

In this context, several tools — including FICA, SPIRIT, HOPE, and SPIR — have been developed to support the clinical approach to spirituality.[6-9] Among them, FICA is the most frequently used; its purpose is not to quantify spirituality, but to facilitate the exploration of aspects of care that are often neglected. The instrument addresses four domains: "Faith and Beliefs", "Importance and Influence", "Community" (belonging to a spiritual or religious community), and "Address in Care" (how these issues should be considered in the therapeutic plan). The Central Figure illustrates the integration of these domains with the existential dimensions of HF and their incorporation into person-centered care.

At its core, more than producing scores, instruments such as FICA aim to create space for a simple and fundamental question: what sustains this patient in the face of illness?

Living with heart failure

Among cardiovascular diseases, few impose an existential burden as profound as that of HF.[1] Its trajectory rarely follows a linear course. Periods of stability alternate with episodes of decompensation, hospitalizations, and partial recovery. Many patients live for years with a constant awareness of their fragility, not knowing when the next hospitalization will occur or how their clinical course will unfold.

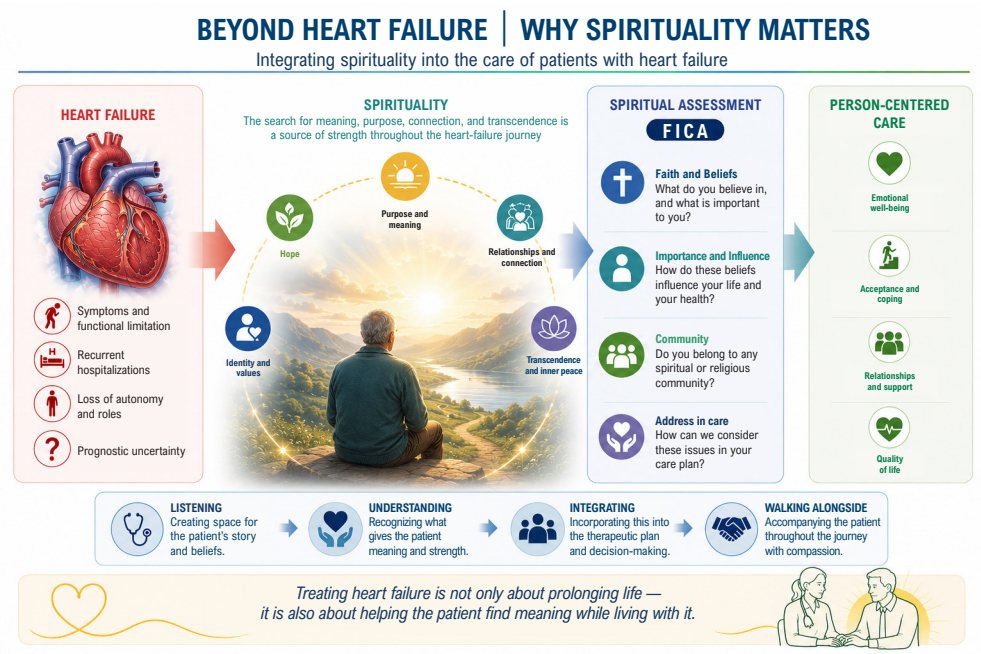
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Central Illustration: Beyond Heart "Failure": Why Spirituality Matters



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Beyond heart failure. Spirituality connects the experience of heart failure to person-centered care. Through meaning, purpose, hope, connection, and transcendence, spiritual assessment allows clinicians to recognize patients' values and needs, supporting adaptation, well-being, and quality of life throughout the entire course of the disease. Central illustration developed with the assistance of generative artificial intelligence (ChatGPT, OpenAI) and subsequently reviewed and refined by the authors.

Studies show that fear of death, loss of autonomy, social isolation, the feeling of being a burden to family members, and existential suffering are recurrent experiences in this population.[1,10,11] Data presented by Tobin et al. demonstrated that deficits in spiritual well-being are among the most frequently compromised aspects of quality of life in patients with HF.[1]

However, limiting spirituality to suffering would be an incomplete view. Although often discussed in the context of palliative care, spirituality does not belong exclusively to the end of life. Questions related to what gives life meaning – such as hope, purpose, and identity – arise long before the end of life and accompany the entire course of the disease.[3]

Coping, acceptance, and reconstruction

Pargament described religious–spiritual coping as the use of spiritual or religious resources to face situations that challenge usual adaptation mechanisms.[12] In patients with HF, this process often goes beyond emotional comfort. Spiritual beliefs, values, and practices can offer resources to interpret losses, deal with uncertainties, and reorganize one's personal narrative in the midst of illness.

In this context, spirituality should not be viewed merely as a factor potentially associated with clinical outcomes. For a significant proportion of patients, it represents a resource that allows them to face the disease without being defined by it. This perspective helps explain why, in a study of patients with HF, religious coping and acceptance were associated with greater meaning in life over time, which in turn was linked to better quality of life.[13]

It is important to emphasize, however, that not every expression of spirituality plays a protective role. Pargament et al. described negative religious-spiritual coping, understood as a response to a specific stressor characterized by attributing illness to divine punishment or demonic forces, questioning God's power, or experiencing feelings of abandonment, dissatisfaction with God, or conflicts with the religious community.[14] A related but distinct concept is that of religious–spiritual struggles, which correspond to persistent conflicts with the sacred across divine, demonic, interpersonal, moral, doubt, and ultimate-meaning domains, and which may exist independently of a specific stressor.[15]

Both negative religious coping and religious-spiritual struggles are relatively common among patients with serious illnesses and are associated with greater psychological distress, poorer emotional adjustment, and worse clinical outcomes.[3,16] Part of this association may be explained by stable personality traits, such as neuroticism; even so, spiritual struggles appear to contribute to suffering independently of this

effect.[16] Moreover, positive and negative coping may coexist and alternate throughout the course of the disease, meaning that periods of spiritual conflict do not necessarily represent psychopathology and may reflect a process of meaning reconstruction. However, because these struggles tend to persist over time, serial reassessment and early identification of unmet spiritual needs are recommended.[3,16]

Because the meaning of beliefs is defined by the patient, the clinical focus should fall on the suffering they express, recognizing that exploring this theme may also reactivate experiences of religious rejection.[3] Thus, when applying instruments such as FICA, in addition to asking "what sustains this patient?", it is also necessary to investigate "what, in the spiritual domain, may be amplifying this patient's suffering?" Both questions fit within the stepped process outlined by the National Consensus Project guidelines, in which both suffering and spiritual strengths and resources must be identified, allowing for more individualized and person-centered interventions.[17]

From evidence to practice

In recent decades, recognition of spirituality in health care has grown consistently. Balboni, VanderWeele et al. concluded that spirituality is an important component for most patients with serious illnesses and that their spiritual needs often remain unrecognized by health-care systems.[3]

This movement has extended beyond the field of palliative care. In 2025, the joint statement from the Heart Failure Society of America and the American Society for Preventive Cardiology acknowledged the relevance of spirituality and religiosity across the continuum of HF and suggested the use of tools such as FICA to help understand patients' needs.[18] In the same year, the American Heart Association emphasized that spirituality represents an important domain of quality of life in patients with advanced cardiovascular disease and should be considered part of comprehensive care.[19]

It must be recognized, however, that the literature on spirituality and HF remains limited by small samples, heterogeneous definitions of spirituality and religiosity, and short follow-up periods.[20] In observational studies, associations with quality of life, depressive symptoms, and mortality do not establish causality: they may reflect residual confounding by disease severity, social support, and health behaviors, as well as reverse causation (patients with better functional status are more likely to report spiritual peace). Randomized trials, in turn, have generally evaluated multicomponent interventions and focus on outcomes such as spiritual well-being, mental health, and quality of life,[21,22] with insufficient evidence to isolate the effect of the spiritual component on major clinical outcomes.[23]

In Brazil, researchers such as Lucchetti et al.[24] and Moreira-Almeida et al.[25] helped consolidate a more scientifically rigorous approach to spirituality in health. Paradoxically, in a country with high levels of religiosity, this progress has not yet been consistently reflected in medical training. The multicenter SBRAME study,[26] conducted by Lucchetti et al. in 12 Brazilian medical schools, revealed a significant gap between recognition and preparedness: although 71.2% of students acknowledge the impact of spirituality on patients' health and 58% would like to address the topic in clinical practice, nearly half (48.7%) feel unprepared to do so, and 81% had never received formal training on the subject.[26] This gap persists after graduation, becoming evident in clinical practice.[27] Despite curricular and extracurricular initiatives in Brazilian medical schools, more consistent training in this area is still needed. Thus, if spirituality matters to patients with HF in any setting, in the Brazilian context it can hardly be treated as an accessory topic — it is a dimension that most patients already bring to the consultation, even though many cardiologists have not yet received adequate training to integrate it into care.

Although medical education has not yet fully incorporated this dimension, the Brazilian Guideline for Cardiovascular Prevention was pioneering in recognizing religiosity and spirituality among the relevant factors for a comprehensive approach to cardiovascular health.[28] However, integrating spirituality into care cannot be limited to applying instruments or adding new fields to medical records. Recognizing the spiritual aspect of illness does not mean offering answers to all of the patient's questions. It means being willing to listen to them – an act of compassion that acknowledges the shared humanity between patient and healthcare professional.

Beyond the heart that "fails"

In recent years, VanderWeele has contributed to broadening this discussion by proposing the concept of human flourishing.[29] From this perspective, health cannot be reduced to the absence of disease or mere survival. A full life involves multiple interrelated domains, including physical and mental health, relationships, purpose, meaning, and overall well-being.

Through this lens, the relevance of spirituality does not depend solely on its association with hospitalizations or mortality. It matters because it influences aspects of human experience that many patients consider central to their well-being and personal fulfillment.

Interestingly, Koenig[5] and VanderWeele[29] converge on a fundamental point. Both challenge the contemporary tendency to reduce human experience to what can be easily measured. For Koenig, spirituality requires conceptual rigor.[5] For VanderWeele, health requires a broader understanding of what it means to live well.[29]

HF is one of the most closely monitored conditions in modern medicine. We quantify biomarkers, echocardiographic parameters, and risk trajectories with increasing precision. Yet we remain relatively have generally evaluated when a patient has lost hope, ceased to find meaning in their own existence, or is facing profound existential suffering.

Perhaps this is one of the greatest asymmetries of modern medicine: what is easiest to measure does not always correspond to what is most important to the patient. In an era marked by unprecedented technological and therapeutic advances, cardiology continues to be challenged to see not only the heart that "fails," but the person who lives knowing that this heart "fails."

For many patients, the greatest battle is not only against disease progression. It is against the limitations, uncertainties, and transformations the disease imposes on their life. Spirituality does not eliminate this vulnerability, but it can offer pathways to understand it, confront it, and sometimes transform it. Perhaps

the future of truly person-centered care depends not only on the ability to prolong life, but also on the ability to recognize what makes that life worth living. Because, as Puchalski suggests, the absence of cure for the disease does not imply the absence of healing for the person. Even in the face of an incurable illness, it is possible to experience a form of healing that emerges from acceptance, reconciliation with one's condition, and the ability to find peace. At its core, this is spiritual healing.[30]

For patients who live daily with heart failure, this reflection invites us to a question that may be as important as any therapeutic advance: when we have already done everything possible to treat the disease, are we equally prepared to care for the person who continues to live with it?

Conclusion

The incorporation of spirituality into the care of heart failure does not represent the introduction of a new therapeutic intervention, but rather an expansion of the very understanding of what it means to care. In a condition in which prolonging life does not always mean restoring the life previously lived, recognizing and integrating the spiritual dimension can help answer a fundamental question of care: not only how patients live longer, but how they live.

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Conception and design of the research; Acquisition of data; Analysis and interpretation of the data; Writing of the manuscript and Critical revision of the manuscript for intellectual content: Faria VS, Siqueira ARO, Siqueira SRO; Statistical analysis: Faria VS.

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During the preparation of this work, the author(s) used ChatGPT for creation of the Central Illustration. After using this tool/service, the author(s) reviewed and edited the content as needed and take full responsibility for the content of the published article.

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