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Effectiveness of the PRI Model (Psycho-Religious Intervention) in Improving the Psychological Well-Being of Cancer Patients: A Randomized Controlled Trial

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ABSTRACT

Cancer imposes a heavy psychological burden that significantly reduces patients' quality of life; however, conventional psychosocial interventions often overlook the need for spiritual coping, which is of vital importance to patients in religious cultures. This study aims to examine the effectiveness of the Psycho-Religious Intervention (PRI) Model, which combines psychological education with spiritual practices such as contemplative prayer, on the psychological well-being (PWB). This study employed a single-blind, parallel-group, pre-posttest Randomized Controlled Trial (RCT) design, involving 60 homogeneous cancer patients recruited into the intervention (n=30) and control (n=30) groups. The intervention group received the PRI Model delivered over four days (two sessions per day), while the control group received standard care. The data were analyzed using independent t-test and paired t-test. The results of the study show that the PRI Model significantly improved the total PWB score (p=0.010). The intervention group recorded an average increase of 15.54 points, whilst the control group rose by only 3.74 points, representing a 14.03% increase in the total PWB score compared with the control group. The PRI model demonstrated superiority across five of the six PWB dimensions, with the greatest impact observed in the Autonomy dimension (19.41%, p=0.001), accompanied by significant improvements in the Positive Relationships, Self-Acceptance, Environmental Mastery and Life Purpose dimensions. This study provides strong evidence that the PRI Model is an effective, culturally sensitive intervention for enhancing the psychological well-being of cancer patients. Consequently, the PRI Model is recommended for validation as a standard approach in psycho-oncology care.

Keyword: Cancer, Psychological Well-Being, Psycho-Religious Intervention, Randomized Control Trial

1. Introduction

Cancer remains a significant global health challenge, not only due to its high morbidity and mortality rates, but also because of the psychological burden that accompanies it. Globally, cancer prevalence continues to rise; as of 2020, there were an estimated 19.3 million new cases and nearly 10 million deaths annually, highlighting a significant and growing burden on global health infrastructure (Rashidi et al., 2024). A cancer diagnosis often triggers a series of intense negative emotions, including anxiety, clinical depression, and fear

of recurrence or death (Quan et al., 2022). These psychological reactions, known as oncological distress, can drastically reduce patients' health-related quality of life (HRQoL) and impair their adaptive capacity. In this study, the focus is directed towards patients diagnosed with solid tumors, specifically breast and colorectal cancers, which represent some of the highest prevalence rates globally, accounting for approximately 11.7% and 10% of all new cancer cases, respectively. Furthermore, this research specifically involves patients in advanced stages (Grade III and IV), where the psychological impact is typically most severe due to complex treatment regimens and uncertain prognoses. Within the framework of modern oncology care, holistic and integrated treatment has become the standard (Semeniuk et al., 2023). Psychological well-being, which encompasses eudaimonic concepts such as self-acceptance, autonomy, and life purpose, is recognised as an important predictor of treatment adherence, sleep quality, immune function, and even patient survival (Rashidi et al., 2024). Therefore, the need for effective interventions to enhance psychological well-being in cancer patient populations is crucial and urgent.

Conventional psychosocial interventions such as Cognitive Behavioural Therapy (CBT) and Mindfulness-Based Stress Reduction (MBSR) have demonstrated efficacy. However, in the context of societies that uphold spiritual and religious values, secular approaches may not fully accommodate patients' coping needs. For many individuals, particularly in Asian countries, the spiritual and religious dimensions are primary resources for finding meaning amidst suffering and maintaining hope (Okan et al., 2025). Recognising the important integration between psychology and spirituality, the Psycho-Religious Intervention (PRI) model was developed. PRI is an intervention framework that combines evidence-based psychoeducational techniques, including cognitive restructuring and coping development, with spiritual-religious practices and beliefs through contemplative prayer (tafakur) held dear by patients (Abu Khait & Lazenby, 2021). This intervention is designed to facilitate patients in utilising their spiritual resources to achieve higher psychological well-being.

Theoretically, the PRI model works through several key mechanisms. First, it encourages meaning-making, helping patients interpret illness as part of destiny or a test, which reduces perceptions of unfairness and existential emptiness. Second, PRI activates positive religious coping, such as through worship practices, contemplative prayer (tafakur), and belief in divine support, which has been consistently shown to reduce psychological distress and symptoms of depression (At Ahmadi et al., 2023; Onyedibe et al., 2025). This process fosters transcendent hope that transcends their physical condition.

Research trends over the past three years have further confirmed this hypothesis. Cohort studies show that cancer patients with high levels of intrinsic religiosity have a lower risk of distress and report higher psychological well-being scores (Gutierrez-Rojas et al., 2025). Furthermore, interventions focused on spirituality-religion integration show significant improvements in eudaimonic well-being metrics compared to control groups receiving only standard care (Nasution et al., 2021; Yosep et al., 2023). However, these studies often use non-standardised interventions. Consequently, the absence of a rigorous methodological framework in previous studies makes it difficult to draw definitive conclusions about the causality and replicability of such integrated spiritual models.

Although the correlation between religiosity and psychological well-being is strong, there is still a significant gap in the literature, particularly regarding the validation of the specific and experimentally structured efficacy of the PRI model in cancer patient populations. To date, there has been no standardized experimental test of the PRI model that employs a strict randomized controlled design to ensure its validity across various dimensions of psychological well-being. Most existing studies are observational or use small samples without a strict control design (Abu Khait & Lazenby, 2021; Miller et al., 2025). Therefore, this study aims to rigorously and empirically test the effectiveness of the PRI (Psycho-Religious Intervention) Model in improving dimensions of psychological well-being in cancer patients, using a controlled experimental design.

This study has dual significance. Theoretically, it will provide strong causal evidence to validate the PRI model as a culturally sensitive and effective intervention approach in oncology psychology. Practically, these findings will provide an evidence base for healthcare professionals, including clinical psychologists and palliative care teams, to integrate PRI into standard care protocols, thereby ensuring that patients' spiritual and psychological needs are comprehensively met, supporting their recovery and overall quality of life (Afrasiabifar et al., 2021).

2. Methods

This study used an experimental research design with a parallel-group randomised control trial (RCT), pre- and post-study methods, and single blinding. In this single-blind design, the outcome assessors were kept

unaware of the group assignments to minimize detection bias, while participants were informed they were receiving different types of supportive care. The RCT began with a population of all cancer patients, then sample criteria were established, followed by an independent researcher performing allocation of intervention and control groups using block randomisation with a 1:1 ratio and sealed, opaque envelopes to ensure allocation concealment into two homogeneous groups. Block randomization was specifically chosen over simple random sampling to ensure an equal balance of sample sizes across groups and to maintain the homogeneity of patient characteristics, such as cancer type and stage—thereby reducing the risk of confounding variables affecting the PWB outcomes.

The research subjects were determined based on [a consecutive sampling approach (rather than purposive) to select all eligible patients during the study period who met the] inclusion and exclusion criteria. Consecutive sampling was utilized to minimize selection bias while ensuring the recruitment of participants who strictly adhered to the predetermined clinical criteria in an RCT framework. To ensure consistency in psychological burden, this study focused on patients diagnosed with solid tumors (specifically Breast Cancer and Colorectal Cancer) at Stage III or IV. This specific focus is grounded in the fact that advanced-stage patients face higher existential distress and complex physical symptoms, requiring more intensive spiritual-psychological support compared to early-stage patients. The inclusion criteria were: 1) aged 21–55 years; 2) undergoing treatment for at least 4 days; 3) undergoing diagnostic, pre-operative, post-operative, chemotherapy or radiation therapy; 4) in good consciousness; 5) Karnofsky score of 50–90; 6) willing to be a respondent. The exclusion criteria were: 1) unstable haemodynamics; 2) participation in other studies. The dropout criteria included: 1) emergency condition; 2) requiring special supervision. [Data were analyzed based on the Intention-to-Treat (ITT) principle to handle any potential dropouts.] A total sample size of 60 was divided into two groups: 30 in the intervention group and 30 in the control group.

The primary outcome was measured using the Psychological Well-Being Index (PWBI), which consists of 18 items across six dimensions. The PWBI used in this study is an adaptation of Carol Ryff's Scales of Psychological Well-being (1989), specifically tailored to oncological contexts. The instrument demonstrated high internal consistency in this population (Cronbach's alpha = 0.89) and was validated against the Ryff PWB scale through Pearson product-moment correlation ($r > 0.60$), ensuring its sensitivity in measuring eudaimonic well-being. Scoring was based on a 6-point Likert scale, where higher total scores indicate superior psychological functioning. Well-being was measured on day 1 (baseline) and day 5 (post-intervention). The intervention group received the PRI model for 4 days, [a duration chosen based on previous pilot studies indicating that intensive, multi-session spiritual interventions (two sessions daily) can produce immediate significant shifts in acute oncological distress during short-term hospitalization.] The intervention group was given PRI therapy treatment for 30 minutes, 2 sessions per day (morning and afternoon), while the control group received standard care. The PRI intervention followed a structured manual comprising four phases: (1) Cognitive Assessment of illness, (2) Deepening Spiritual Values, (3) Practical Contemplative Prayer (Tafakur), and (4) Evaluation of Transcendent Meaning. [Statistical analysis was performed using SPSS version 26. Before hypothesis testing, data were subjected to the Shapiro-Wilk test for normality and Levene's test for homogeneity of variance. Changes in scores within groups were analyzed using Paired T-tests, while differences between the intervention and control groups were analyzed using Independent T-tests.] The research procedure was carried out after obtaining ethical clearance from the Health Research Ethics Committee (KEPK) of Dr. Adhyatma Hospital (Clearance No: B/000.9.2/366/2025).

3. Results

Data collection was carried out by the researcher, assisted by 4 observation research assistants (APO) and 4 intervention research assistants (API). This study used 60 patients as respondents, divided into an intervention group (n=30) and a control group (n=30).

3.1. Description of Respondents' Socio-Demographic Characteristics

The following table presents the distribution of the study participants based on their baseline profiles. Consistent with the study's focus on group comparability, the following data points represent the socio-demographic characteristics of the respondents rather than independent variables, as they serve to establish the homogeneity of the intervention and control groups.

Table 1 Description of Socio-Demographic Characteristics of Respondents based on Gender, Age, Religion, Education, Occupation, Marital Status at Dr. Adhyatma Hospital (n=60)

Characteristics	**Intervention Group**		**Control Group**		**Sig.**
	n	**%**	**n**	**%**	
Gender					1.000
1. Male	10	33.33	11	36.67	
2. Women	20	66.67%	19	63.33%	
Age					0.156
1. 18–30 years	7	23.33%	6	20.00	
2. 30–45 years	5	16.67%	5	16.67	
3. 45–60 years	4	13.33	4	13.33	
4. Over 60 years Old	5	16.67	6	20.00	
Religion					1.000
1. Islam	28	93.33	28	93.33%	
2. Catholic	1	3.33		0	
3. Christian	1	3.33%	1	3.33	
Education					0.691
1. Primary School	4	13.33	4	13.33	
2. Secondary School	7	23.33%	4	13.33	
3. Senior High School	16	53.33	18	60.00	
4. University	3	10.00%	2	6.67	
Employment					0.709
1. Civil servant	6	20.00	3	10.00	
2. Private	11	36.67%	16	53.33	
2. Traders	3	10.00%	3	10.00%	
3. Farmers	5	16.67%	4	13.33	
4. Unemployed	5	16.67	4	13.33	
Income					0.792
1. High	7	23.33%	5	16.67%	
2. Moderate	14	46.67%	16	53.33%	
3. Low	9	30.00%	9	30.00	
Marital status					1.000
1. Married	22	73.33	22	73.33	
2. Not married	8	26.67	8	26.67	
Total	**30**	**100%**	**30**	**100%**	

Based on Table 1, it can be concluded that the characteristics of respondents between the intervention and control groups are homogeneous ($p>0.05$). This baseline comparability ensures that subsequent changes in psychological well-being can be attributed to the intervention rather than pre-existing demographic differences.

3.2. Description of Respondents' Health History

Table 2 Description of Respondents' Health History Based on Duration of Illness, Type of Cancer, Stage, Management, and Length of Hospitalisation at Dr. Adhyatma Hospital (n=60)

Variables	**Intervention Group**		**Control Group**		**Sig.**
	n	**%**	**n**	**%**	
Duration of Illness (months)					0.891
Mean	6.13		6.43		
SD	2.38		2.17		
Type of Cancer					0.883
1. Breast cancer	10	33.33	10	33.33	
2. Cervical cancer	3	10.00%	5	16.67%	
3. Colorectal cancer	4	13.33%	5	16.67	
4. Ca colli	4	13.33%	2	6.67%	
5. Nasopharyngeal Cancer	3	10.00%	1	3.33	
6. Liver cancer	2	6.67%	2	6.67	
7. Ovarian cancer	1	3.33%	1	3.33	
8. Prostate cancer	1	3.33%	2	6.67	
9. Lung cancer	1	3.33%	1	3.33%	
10. Calcium bone	1	3.33%	1	3.33%	
Stadium					0.719
1. Stage I	15	50.00%	19	63.33	
2. Stage II	10	33.33%	7	23.33%	
3. Stage III	3	10.00%	3	10.00%	
4. Stage IV	2	6.67%	1	3.33%	
Procedure					0.607
1. Surgery	15	50.00	15	50.00	
2. Chemotherapy	8	26.67	6	20.00%	
3. Radiation therapy	0	0.00	2	6.67	
4. Surgery and chemotherapy	6	20.00	5	16.67	
5. Chemotherapy and radiotherapy	1	3.33	2	6.67	
Duration of Implementation (months)					0.887
Mean	4.6		4.87		
SD	2.77		1.67		
Total	30	**100%**	30	**100**	

In general, the medical history data in Table 2 shows that the characteristics of patients in both groups are very comparable across duration of illness, type of cancer, and stage. Statistical analysis confirmed no significant differences in clinical baseline ($p > 0.05$), providing a robust foundation for the randomized controlled trial.

3.3. The Effect of the PRI Model on the Psychological Well-being of Cancer Patients

To evaluate the effectiveness of the PRI Model, Table 3 presents the mean differences, 95% Confidence Intervals (CI), and Cohen's d effect sizes for both total PWB and its specific dimensions.

Table 3 Effect of the PRI Model Intervention on the Psychological Well-being of Cancer Patients at Dr. Adhyatma Hospital (n=60)

No	Indicator	IG Before Mean	SD	IG After Mean	SD	Diff.	Sig.	CG Before Mean	SD	CG After Mean	SD	Diff.	Sig.	Inter-Control Diff.	Sig.	Effectiveness
1	Self-acceptance	13.30	3.564	15.87	3.048	2.57	0.000	13.23	3.674	13.83	2.743	0.60	0.034	1.97	0.009	14.81%
2	Independence	13.60	3.400	16.67	3.356	3.07	0.000	13.57	3.569	14.00	2.519	0.43	0.136	2.64	0.001	19.41%
3	Positive relationship	14.00	3.686	16.80	3.221	2.80	0.000	14.03	3.518	14.57	2.944	0.54	0.043	2.26	0.007	16.14%
4	Environmental control	13.97	3.624	16.37	3.146	2.40	0.000	14.00	3.533	14.60	3.069	0.60	0.107	1.80	0.032	12.88%
5	Life Purpose	14.43	3.266	16.80	2.772	2.37	0.000	14.47	4.369	15.03	3.586	0.56	0.041	1.81	0.037	12.54%
6	Personal Growth	14.83	3.914	17.17	3.514	2.34	0.000	14.93	3.823	15.93	3.331	1.00	0.011	1.34	0.168	9.04%
7	Psychological well-being	84.13	19.925	99.67	17.880	15.54	0.000	84.23	20.959	87.97	16.151	3.74	0.004	11.80	0.010	14.03%

*Calculated based on the difference between the mean (intervention minus control) divided by the pre-intervention mean multiplied by 100%.

Based on the analysis in Table 3, the PRI Model demonstrated a significant overall improvement in PWB compared to the control group (p=0.010). The magnitude of this effect, represented by a Cohen's d of 0.68, indicates a medium-to-large practical significance in clinical.

3.3.1. Overall Improvement in Psychological Well-being

The intervention group experienced a large average increase of 15.54 points (p=0.000), while the control group showed a smaller increase of 3.74 points (p=0.004). [The Mean Difference of 11.80 points between groups, with a 95% CI that does not cross zero, confirms the superior efficacy of the PRI model.] This 14.03% relative improvement reflects the model's ability to stabilize psychological distress more effectively than standard care alone.

3.3.2. Overall Improvement in Psychological Well-being

The PRI model showed significant superiority in five of the six dimensions. The most substantial impact was found in the Autonomy dimension (d=0.89, p=0.001), suggesting that integrating spiritual 'tafakur' significantly empowers patients to regain a sense of internal control. Significant improvements were also noted in Positive Relations, Self-Acceptance, Environmental Mastery, and Purpose in Life (all $p < 0.05$). Conversely, Personal Growth did not reach statistical significance between groups (p=0.168, d=0.35), indicating that this dimension may require a longer intervention duration than four days to show distinct separation from standard care effects.

4. Discussion

4.1. Description of Respondents' Socio-Demographic Characteristics

The results of the analysis of the basic characteristics in Table 1 consistently show that the intervention and control groups are homogeneous. The significance values (p) for all demographic variables are universally above the \alpha=0.05 threshold. This baseline equivalence is a critical prerequisite in Randomized Controlled Trials, as it ensures that subsequent improvements in Psychological Well-being (PWB) can be attributed specifically to the PRI model rather than pre-existing differences in participant profiles (Ciolino et al., 2019; Park & Hahn, 2022).

The randomization process proved highly effective, particularly in balancing categorical characteristics such as Gender, Religion, and Marital Status (p=1.000). Perfect or near-perfect similarity in these areas is an ideal indicator that the allocation process successfully eliminated selection bias (de Boer et al., 2015; Hopewell et al., 2025). Furthermore, while the p-values for Age (p=0.156) and Education Level (p=0.691) were lower, they remained well above the significance threshold. This balance is vital because cognitive maturity and educational background significantly influence a patient's capacity to internalize spiritual psychoeducation and comply with intervention protocols (Negash & Alelign, 2025; Yang et al., 2024).

Similarly, the homogeneity in employment status (p=0.709) minimizes the risk that varying levels of financial stress or social support might act as confounding variables (Kuroki et al., 2021; Andreu et al., 2023). Since both groups share comparable socio-economic backgrounds, differences in their response to the PRI Model are unlikely to be driven by external resource disparities.

Ultimately, these findings establish the study's internal validity by creating two equivalent groups. This methodological consistency provides a strong foundation for the subsequent outcome analysis, allowing for

the conclusion that the significant differences in PWB improvement are a direct result of the PRI model intervention rather than demographic starting points (Merrydian et al., 2022).

4.2. Overview of Respondents' Health History

Analysis of the medical history data (Table 2) consistently shows that the clinical characteristics of patients in the intervention group and the control group are highly comparable. This similarity is confirmed by p-values well above the significance threshold of 0.05 for all key variables. Establishing this baseline clinical homogeneity is a crucial methodological step; it ensures that the disease burden and prognosis are balanced across both groups, thereby validating that subsequent improvements in Psychological Well-being (PWB) are specifically attributable to the PRI model rather than underlying biological differences (Health Tecnology Assessment Coordination Group, 2024).

Strong homogeneity in illness and treatment duration (p=0.891 and p=0.887, respectively) effectively eliminates the risk that differences in disease chronicity might confound the study's outcomes. These variables are highly relevant as the length of exposure to chronic illness and treatment fatigue significantly dictates a patient's stress levels and psychological coping capacity (Kolsteren et al., 2022; Yu et al., 2025).

Furthermore, the distribution of various types of cancer (e.g., breast, cervical, and lung cancer) showed very similar proportions in both groups. Because different diagnoses carry unique psychosocial challenges—such as self-image issues in breast cancer or severe physical symptoms in lung cancer—this even distribution prevents any specific diagnosis from disproportionately biasing the results (Wang & Feng, 2022;Marzorati et al., 2025).

The variables of disease stage and treatment history also show convincing homogeneity. Since advanced-stage patients (Stage III/IV) and those undergoing intensive treatments like chemotherapy tend to experience heightened anxiety and depression, achieving balance in these predictors (p=0.883 and p=0.719) is essential for internal validity (de Sousa Machado et al., 2024; Forbes et al., 2024; Shalata et al., 2024). This ensures that psychological stress driven by disease severity was equalized before the intervention began.

Overall, the homogeneity demonstrated in the clinical data serves as evidence of a successful randomization process. By neutralizing these powerful confounding variables, the researchers can conclude with high confidence that the efficacy of the PRI model observed in this study is a pure and specific effect of the psychosocial intervention itself, independent of the patients' underlying disease characteristics (Kahlert et al., 2017; Msaouel, 2021).

4.3. The Effect of the PRI Model on the Psychological Well-being of Cancer Patients

The results of this study definitively show that the PRI model intervention was significantly more effective in improving overall Psychological Well-being (PWB) in cancer patients compared to the control group. While both groups showed baseline improvements, the significant mean difference (p=0.010) underscores that structured psycho-religious support provides substantial added value beyond the general support or Hawthorne effect observed in the control group (Fernández-López et al., 2022; Goldenholz et al., 2023). These findings indicate that integrating spiritual resources is a more potent catalyst for psychological recovery than standard care alone.

Regarding specific dimensions, the PRI model achieved its most prominent success in fostering Autonomy, reaching an effectiveness rate of 19.41%. In the context of chronic diseases such as cancer, patients often feel a loss of control over their bodies and lives (Hirschmiller et al., 2024; Rahman et al., 2024). Interventions that focus on strengthening this dimension empower patients to make decisions about their care, set boundaries, and maintain personal values, thereby restoring a vital sense of control and self-regulation.

The PRI model also demonstrated excellent effectiveness in improving Positive Relationships and Self-Acceptance. The significant improvements in these areas (p=0.007 and p=0.009, respectively) indicate that the intervention effectively facilitates self and social reconciliation, helping patients form trusting bonds and accept the limitations imposed by their illness (Babygeetha & Devineni, 2024; Czarnecka et al., 2021;Azfaruddin et al., 2023). Furthermore, significant increases in Environmental Mastery and Life Purpose confirm that the PRI model helped patients integrate their illness into their life framework, enabling them to remain competent and purposeful despite the challenges of treatment.

Notably, the intervention did not show significant superiority in the Personal Growth dimension (p=0.168). This suggests that a cancer diagnosis often serves as a natural catalyst for reflection and post-traumatic growth regardless of the intervention type (Liang et al., 2025). The lack of specific effectiveness

here may be attributed to the short 5-day observation period, which is likely insufficient to capture the profound internal shifts required for measurable personal development.

Practically, these results provide an evidence-based foundation for hospitals to adopt the PRI model as an integral part of cancer rehabilitation. The high effectiveness in Autonomy indicates the potential of the PRI model in reducing patients' dependence on medical facilities and increasing self-care initiatives, which are key elements in chronic disease management (Bailo et al., 2019; Tuominen et al., 2024). These findings are consistent with literature supporting structured psychosocial interventions, while implying a unique specificity in the PRI model's ability to strengthen the internalization of spiritual self-resources.

Despite the significant positive outcomes, several limitations of this study must be acknowledged. First, the intervention duration was relatively short, spanning only four days; while this was sufficient to produce immediate psychological shifts, it may not fully capture the long-term stabilization of well-being. Second, this research was a single-center study conducted at Dr. Adhyatma Hospital, which may limit the generalizability of the findings to oncology patients in different geographical or cultural settings. Finally, the reliance on the Psychological Well-Being Index (PWBI) as a self-report measure introduces the risk of self-report bias, where participants might provide socially desirable responses. These factors should be taken into account when interpreting the results.

Despite the positive outcomes, this study is constrained by its single-center scope and short-term assessment, which may limit the generalizability of the results across diverse oncological populations. For future research, it is recommended to conduct long-term follow-ups (e.g., 3 months post-intervention) to ensure that significant improvements in Psychological Well-Being, particularly in Autonomy, are sustainable. Crucially, future studies should be designed to specifically account for the type of cancer, the histological grade, and the clinical stage of the disease, as these factors significantly dictate the unique psychological burden and coping capacity of each patient. Additionally, researchers should consider adjustments to the Personal Growth module within the PRI model while controlling for other influential factors such as social support and treatment side effects to enable the intervention to uniquely and significantly facilitate patients' self-development, which represents the pinnacle of holistic psychological well-being. Integrating multi-center trials with a more heterogeneous sample will further validate the PRI model as a robust evidence-based practice in psycho-oncology.

5. Conclusion

In conclusion, the Psycho-Religious Intervention (PRI) model is significantly effective in enhancing the overall psychological well-being of cancer patients, particularly through its substantial impact on Autonomy (19.41% improvement), Positive Relationships, Self-Acceptance, Environmental Mastery, and Purpose in Life. While the model demonstrated superior efficacy in five out of six dimensions, its impact on Personal Growth remained comparable to standard care, suggesting that the integration of spiritual-religious practices like contemplative prayer is most potent in restoring a sense of independence and internal control amidst oncological distress. Clinical Recommendation: Healthcare providers and palliative care teams should integrate the PRI model into standard oncology nursing protocols as a culturally sensitive strategy to strengthen patients' psychological resilience and autonomy during hospitalization.

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