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Psychological and Social Interventions in Supporting Patients with Chronic Diseases

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ABSTRACT: Chronic diseases — including diabetes, cardiovascular disease, cancer, chronic respiratory disease, and chronic kidney disease — are now the leading causes of death and disability worldwide and in the Kingdom of Saudi Arabia. Their management extends far beyond medication and procedures. Living with a chronic condition reshapes a person's emotional life, family relationships, employment, finances, and sense of identity. Depression, anxiety, disease-specific distress, social isolation, financial strain, and caregiver burden are common, and they are not merely consequences of illness: they actively worsen adherence, self-management, clinical outcomes, and health-care costs.

This paper reviews the evidence on psychological and social interventions in the care of patients with chronic diseases, with a particular focus on the complementary roles of the clinical psychologist and the medical social worker. Anchored in Engel's biopsychosocial model, Wagner's Chronic Care Model, Lazarus and Folkman's transactional model of stress and coping, the social determinants of health framework, and self-efficacy theory, it examines the psychological and social burden of chronic illness; evidence-based psychological interventions such as cognitive behavioural therapy, acceptance and commitment therapy, motivational interviewing, mindfulness-based approaches, and collaborative care; and social work interventions including psychosocial assessment, case management, resource linkage, family intervention, discharge planning, and advocacy.

The paper analyses the Saudi context, including the high burden of non-communicable disease, the Model of Care under the Health Sector Transformation Program, the role of family and faith in coping, and persistent mental-health stigma. It identifies key barriers to integrated psychosocial care and proposes the UPLIFT Framework — Understanding psychosocial needs, Psychological intervention, Linking social resources, Involving family and caregivers, Facilitating self-management, and Tracking outcomes — as a practical model for embedding psychologists and social workers in chronic care pathways. It concludes that psychosocial care is not an optional supplement to chronic disease management but one of its essential components.

1. INTRODUCTION

The epidemiological profile of the world has changed decisively. Non-communicable diseases (NCDs) account for the large majority of global deaths, with cardiovascular disease, cancer, chronic respiratory disease, and diabetes leading the toll (World Health Organization [WHO], 2023). Advances in medicine mean that many people now live for decades with conditions that

were once rapidly fatal. This is a profound achievement, but it transforms the nature of health care: the central task is no longer to cure a short illness, but to support a person to live well, over many years, with a condition that will not go away.

Chronic disease is not experienced only in the body. A diagnosis of diabetes, heart failure, cancer, or kidney failure brings uncertainty, loss, fear, and repeated demands — daily medication, dietary restriction, monitoring, appointments, and sometimes painful procedures. Roles at work and at home may change; income may fall; relationships may be strained; and the person's sense of the future may be shaken. These psychological and social experiences are not peripheral. They influence whether patients take their medication, attend appointments, change their behaviour, and ultimately how their disease progresses.

Chronic disease is lived in the mind, the family, and the community as much as in the organ that is diseased. Care that ignores this treats only part of the patient.

The evidence for this is substantial. In the World Health Surveys, depression combined with a chronic physical disease produced worse health status than any chronic disease alone or any combination of chronic diseases without depression (Moussavi et al., 2007). Patients who are depressed are about three times more likely to be non-adherent to medical treatment recommendations than those who are not (DiMatteo et al., 2000). Strong social relationships are associated with a markedly greater likelihood of survival, an effect comparable to well-established clinical risk factors (Holt-Lunstad et al., 2010). Co-morbid mental health problems among people with long-term conditions have also been shown to raise the cost of their care substantially (Naylor et al., 2012).

Two professions are specifically trained to address these dimensions. The **clinical (health) psychologist** assesses and treats the emotional, cognitive, and behavioural aspects of illness — depression, anxiety, adjustment difficulties, illness beliefs, and health behaviours. The **medical social worker** assesses and addresses the social context of illness — family functioning, financial and employment problems, housing, access to services, social isolation, and the transition between hospital and community. Although their training and methods differ, their goals converge on the same patient, and their combined contribution is greater than either alone.

1.1 Aim and Objectives

The aim of this paper is to review the role of psychological and social interventions in supporting patients with chronic diseases, and to propose an integrated model of practice for psychologists and social workers suited to the Saudi health-care context. Its objectives are to:

- ◆ explain the theoretical foundations of psychosocial care in chronic illness;
- ◆ describe the psychological and social burden associated with chronic disease;
- ◆ review evidence-based psychological interventions delivered by psychologists;
- ◆ review core social work interventions delivered by medical social workers;
- ◆ examine interdisciplinary and family-centred models of integrated psychosocial care;
- ◆ analyse the Saudi context and identify barriers to integrated psychosocial care;
- ◆ propose an integrated framework and practical recommendations.

1.2 Methodological Approach

This paper uses a narrative, integrative review design. It synthesises foundational theory, systematic reviews and trials of psychosocial interventions in chronic illness, international policy guidance from the WHO, and Saudi policy and epidemiological sources. The purpose is conceptual and practical synthesis to inform service design and professional practice, rather than a quantitative meta-analysis, and findings are interpreted with appropriate caution regarding heterogeneity across diseases, settings, and populations.

2. THEORETICAL FOUNDATIONS

2.1 The Biopsychosocial Model

Engel (1977) challenged the dominant biomedical model by arguing that disease cannot be adequately understood or treated without considering psychological and social factors alongside biological ones. In the biopsychosocial model, illness emerges from the interaction of biological processes, psychological states, and social conditions, each influencing the others. For chronic disease, this model is especially apt: blood glucose in diabetes is shaped not only by insulin secretion but by stress hormones, eating behaviour, motivation, family routines, and the affordability of healthy food. The biopsychosocial model provides the overarching justification for including psychologists and social workers in chronic care.

2.2 The Chronic Care Model

Wagner's (1998) Chronic Care Model identifies the elements of a health system that produce "informed, activated patients" interacting with "prepared, proactive practice teams". Its components — self-management support, delivery system design, decision support, clinical information systems, health-system organisation, and links to community resources — map directly onto psychosocial practice. Self-management support draws on psychological expertise in motivation and behaviour change; community resource linkage is a core social work function; and delivery system design calls for multidisciplinary teams in which these roles are formally defined.

2.3 Stress, Appraisal, and Coping

Lazarus and Folkman's (1984) transactional model holds that stress arises when a person appraises a situation as threatening and judges that their resources are insufficient to cope with it. Coping may be problem-focused — acting to change the situation — or emotion-focused — managing the distress it causes. A chronic diagnosis is a prolonged stressor, and the way it is appraised strongly shapes adjustment. Psychological interventions frequently target appraisals and coping strategies, while social interventions often expand the resources available to the person, so that the balance between demands and resources becomes more favourable.

2.4 Illness Perceptions and the Common-Sense Model

Leventhal's common-sense model of self-regulation proposes that patients form their own representations of their illness — its identity, cause, timeline, consequences, and controllability — and that these representations guide their coping and treatment behaviour (Leventhal et al., 1980). A patient who believes that hypertension is "only present when I feel stressed" may take medication intermittently. Identifying and gently reshaping such beliefs is an important psychological intervention.

2.5 Self-Efficacy Theory

Bandura's (1977) concept of self-efficacy — a person's belief in their capability to carry out a specific behaviour — is one of the strongest predictors of successful self-management. Chronic disease self-management programs explicitly aim to build self-efficacy through mastery experiences, modelling, persuasion, and the reinterpretation of physical symptoms (Lorig & Holman, 2003).

2.6 Social Support and the Social Determinants of Health

Cohen and Wills (1985) showed that social support protects health partly by buffering the effects of stress. Beyond close relationships, the WHO Commission on Social Determinants of Health (2008) demonstrated that the conditions in which people are born, live, work, and age — income, education, employment, housing, and access to services — are fundamental drivers of health inequity. Social work practice is, in large part, the application of this framework at the level of the individual patient and family.

Table 1. Theoretical Models and Their Implications for Psychosocial Practice

Model	Core Idea	Implication for Psychologists	Implication for Social Workers
Biopsychosocial (Engel, 1977)	Illness arises from interacting biological, psychological, and social factors	Treat emotional and behavioural contributors to disease	Address social conditions that shape disease
Chronic Care Model (Wagner, 1998)	Activated patients and prepared teams improve outcomes	Lead self-management and behaviour-change support	Link patients to community resources
Stress & coping (Lazarus & Folkman, 1984)	Stress depends on appraisal of demands vs. resources	Modify appraisals; build coping skills	Increase practical and social resources
Common-sense model (Leventhal et al., 1980)	Illness beliefs guide behaviour	Explore and correct unhelpful illness beliefs	Address cultural and family beliefs about illness
Self-efficacy (Bandura, 1977)	Confidence predicts behaviour	Build mastery and confidence	Remove practical obstacles to action
Social determinants (WHO, 2008)	Living conditions drive health inequity	Recognise contextual limits on behaviour change	Advocate and connect to welfare and services

3. THE PSYCHOLOGICAL BURDEN OF CHRONIC DISEASE

3.1 Depression and Anxiety

Depression and anxiety are substantially more common among people with chronic physical illness than in the general population, and they frequently go unrecognised because their symptoms — fatigue, poor sleep, low appetite, poor concentration — overlap with those of the physical disease. The relationship is bidirectional: chronic illness increases the risk of depression through pain, disability, and loss, while depression worsens the course of physical disease through biological pathways (inflammation, neuroendocrine dysregulation) and behavioural pathways (reduced activity, poor diet, smoking, and non-adherence). The combination is associated with poorer health status, higher mortality, and greater health-care use (Moussavi et al., 2007; Naylor et al., 2012).

3.2 Disease-Specific Distress and Adjustment

Not all emotional difficulty in chronic illness amounts to a psychiatric disorder. Many patients experience disease-specific distress — the worry, frustration, and burnout that come from the relentless demands of managing a condition. In diabetes, "diabetes distress" is common, is distinct from clinical depression, and is closely linked to poorer glycaemic control (Fisher et al., 2012). In oncology, routine screening for distress is now recommended as a standard of care (Holland & Alici, 2010). Adjustment disorders, grief over lost health and roles, fear of recurrence, and changes in body image are frequent and deserve attention in their own right.

3.3 Cognitive and Behavioural Consequences

Psychological states shape health behaviours. Low mood reduces motivation; anxiety can lead to avoidance of check-ups or, conversely, to excessive health-care seeking; and unhelpful illness beliefs can undermine adherence. Some chronic diseases also

carry direct cognitive effects — for example, cognitive impairment associated with stroke, heart failure, or kidney disease — which complicate self-management and require adapted psychological approaches.

3.4 Psychological Assessment

Systematic screening is the gateway to psychological care. Brief, validated instruments allow busy clinical teams to identify patients who need further assessment. Commonly used tools include the Patient Health Questionnaire-9 for depression (Kroenke et al., 2001), the Generalized Anxiety Disorder-7 scale (Spitzer et al., 2006), and the Hospital Anxiety and Depression Scale, which was specifically designed to minimise confounding by physical symptoms (Zigmond & Snaith, 1983). Arabic versions of these instruments are available and widely used in Saudi clinical settings. Screening is only valuable, however, if a clear pathway exists from a positive result to assessment and intervention.

4. THE SOCIAL DIMENSIONS OF CHRONIC DISEASE

Chronic disease is embedded in a social context that can either support or undermine the patient. The social burden falls not only on the individual but on the family and wider community.

4.1 Financial and Employment Strain

Chronic illness frequently reduces the capacity to work, whether through symptoms, fatigue, treatment schedules such as haemodialysis three times a week, or disability. Loss of employment or reduced income may coincide with increased costs for transport, special diets, equipment, and medications not fully covered. Financial strain is itself a powerful stressor and can force difficult trade-offs, such as rationing medication.

4.2 Social Isolation and Stigma

Reduced mobility, fatigue, and the time demands of treatment can shrink the patient's social world. Some conditions carry stigma — for example, HIV, mental illness, or visible disfigurement — leading to concealment and withdrawal. Social isolation is associated with poorer health and higher mortality (Holt-Lunstad et al., 2010), making it a legitimate clinical target.

4.3 Family Disruption and Caregiver Burden

In many societies, and particularly in Saudi Arabia, the family is the primary source of care. Family members take on practical, emotional, and financial responsibilities, often without preparation or support. Caregiver burden — the physical, psychological, social, and financial strain of caregiving — is associated with depression, anxiety, poor physical health, and reduced quality of life among caregivers, and it can ultimately compromise the care the patient receives (Adelman et al., 2014). Family roles may also be disrupted, as when a primary earner or a mother of young children becomes seriously ill.

4.4 Access, Navigation, and Transitions of Care

Chronic disease care is fragmented across primary care, specialist clinics, hospitals, rehabilitation, home care, and social welfare services. Patients with limited health literacy, language barriers, or limited transport may struggle to navigate this system. Transitions — particularly hospital discharge — are periods of high risk for readmission when practical and social needs have not been addressed.

Table 2. The Psychosocial Burden of Chronic Disease

Domain	Common Problems	Consequences if Unaddressed
Emotional	Depression, anxiety, disease distress, grief, fear of recurrence	Poorer adherence, worse outcomes, reduced quality of life
Cognitive	Unhelpful illness beliefs, low self-efficacy, cognitive impairment	Inconsistent self-management, avoidance of care

Domain	Common Problems	Consequences if Unaddressed
Behavioural	Inactivity, poor diet, smoking, missed appointments	Disease progression and complications
Financial	Lost income, treatment-related costs, debt	Medication rationing, chronic stress
Social	Isolation, stigma, role loss	Loneliness, depression, higher mortality risk
Family	Caregiver burden, conflict, disrupted roles	Caregiver illness, breakdown of home care
System	Poor navigation, fragmented services, unsafe discharge	Readmission, unmet needs, inequity

5. PSYCHOLOGICAL INTERVENTIONS: THE ROLE OF THE PSYCHOLOGIST

Health and clinical psychologists bring a structured, evidence-based approach to the emotional and behavioural aspects of chronic illness. Their work spans assessment, brief and structured therapy, behaviour-change support, crisis intervention, and consultation and training for medical colleagues.

5.1 Cognitive Behavioural Therapy (CBT)

CBT is the most widely studied psychological intervention in chronic illness. It helps patients identify and modify unhelpful thoughts (for example, "there is no point managing my diabetes because complications are inevitable") and behaviours (such as avoidance or inactivity), while building practical coping skills, problem-solving, activity scheduling, and relaxation. CBT has been adapted for depression and anxiety in diabetes, heart disease, cancer, chronic pain, and chronic obstructive pulmonary disease, and it can be delivered individually, in groups, or remotely.

5.2 Acceptance and Commitment Therapy (ACT)

ACT is particularly suited to conditions that cannot be cured. Rather than attempting to eliminate difficult thoughts and feelings, it helps patients accept them, clarify their personal values, and commit to meaningful action despite illness (Hayes et al., 2012). ACT has shown promise in chronic pain, diabetes self-management, and cancer, where the goal is to live well with ongoing symptoms and uncertainty.

5.3 Motivational Interviewing (MI)

Motivational interviewing is a collaborative, person-centred conversational style designed to strengthen a person's own motivation for change (Miller & Rollnick, 2013). It is especially useful when patients are ambivalent about lifestyle change or medication. MI respects autonomy, avoids confrontation, and draws out the patient's own reasons for change. Psychologists both practise MI and train physicians, nurses, and dietitians to use it.

5.4 Mindfulness-Based Interventions

Mindfulness-based stress reduction, developed by Kabat-Zinn (1990) for patients with chronic pain and illness, teaches non-judgemental awareness of present-moment experience. Mindfulness-based programs can reduce stress, anxiety, and depressive symptoms and improve quality of life in a range of chronic conditions.

5.5 Psychoeducation and Self-Management Support

Psychoeducation helps patients and families understand the condition, its treatment, and the links between emotions, behaviour, and disease. Structured self-management programs combine information with skills training in goal-setting, action planning,

problem-solving, and symptom management, and they build self-efficacy (Lorig & Holman, 2003). Good patient education is consistently associated with better outcomes (Adams, 2010).

5.6 Collaborative Care

Collaborative care is an organisational model in which a care manager, a primary or specialist physician, and a mental health specialist work together to deliver structured, measurement-based psychological and pharmacological treatment. A Cochrane review found that collaborative care improves depression and anxiety outcomes compared with usual care (Archer et al., 2012). The TEAMcare trial demonstrated that a nurse-led collaborative care intervention simultaneously improved depression, glycaemic control, blood pressure, and cholesterol in patients with diabetes or coronary heart disease (Katon et al., 2010). This model shows that addressing mental health and physical disease together produces benefits in both.

5.7 Crisis and End-of-Life Psychological Care

Psychologists also support patients at moments of crisis — receiving a serious diagnosis, disease progression, amputation, starting dialysis — and at the end of life, helping patients and families with anticipatory grief, communication, and meaning-making.

Table 3. Evidence-Based Psychological Interventions in Chronic Disease

Intervention	Main Targets	Typical Applications	Key Evidence / Source
Cognitive Behavioural Therapy	Depression, anxiety, unhelpful beliefs, coping	Diabetes, cardiac disease, cancer, chronic pain, COPD	Wide trial base across conditions
Acceptance & Commitment Therapy	Psychological flexibility, values-based action	Chronic pain, diabetes, cancer	Hayes et al. (2012)
Motivational Interviewing	Ambivalence, motivation, adherence	Lifestyle change, medication adherence	Miller & Rollnick (2013)
Mindfulness-based programs	Stress, rumination, distress	Chronic pain, cancer, cardiac rehabilitation	Kabat-Zinn (1990)
Self-management education	Self-efficacy, skills, problem-solving	Arthritis, diabetes, heart failure, asthma	Lorig & Holman (2003)
Collaborative care	Depression with physical comorbidity	Diabetes, coronary heart disease	Archer et al. (2012); Katon et al. (2010)

6. SOCIAL INTERVENTIONS: THE ROLE OF THE MEDICAL SOCIAL WORKER

Medical social workers address the social circumstances that shape a patient's ability to live with and manage chronic disease. Their practice combines direct work with patients and families, coordination across services, and advocacy.

6.1 Psychosocial Assessment

A comprehensive psychosocial assessment explores the patient's family structure and relationships, living situation, financial and employment status, social support, cultural and religious beliefs, previous coping, access to transport and services, and any risks such as neglect, abuse, or unsafe living conditions. This assessment identifies needs and strengths and provides the basis for a care plan shared with the medical team.

6.2 Case Management and Care Coordination

Social workers coordinate the many services a chronically ill patient may require — specialist clinics, home health care, rehabilitation, equipment, and social welfare. Case management reduces fragmentation, prevents patients from "falling between the cracks", and supports continuity of care. Systematic reviews in older adults suggest that social work services can be cost-effective, particularly through reduced hospital use (Rizzo & Rowe, 2016).

6.3 Linking Patients to Resources

A central function is connecting patients to practical and financial support: social insurance and welfare benefits, charitable organisations, patient associations, transport support, medical equipment, home modifications, and vocational rehabilitation. Addressing these practical barriers often unlocks a patient's capacity to follow treatment plans.

6.4 Family Counselling and Support

Social workers help families understand the illness, adjust roles, resolve conflicts, and share caregiving responsibilities more equitably. They identify and support overwhelmed caregivers, provide information about respite and support services, and facilitate family meetings with the medical team.

6.5 Discharge Planning and Transitions

Safe discharge requires that the patient's home environment, caregiving arrangements, medication access, follow-up appointments, and transport have been addressed. Social workers lead discharge planning for complex patients, reducing the risk of avoidable readmission and ensuring that the transition from hospital to home or to long-term care is safe and dignified.

6.6 Advocacy and Protection

Social workers advocate for patients' rights and needs within the health system and in relation to employers, schools, and welfare agencies. They also play a key role in identifying and responding to situations of neglect, abuse, or exploitation, particularly among vulnerable groups such as elderly patients, people with disabilities, and children with chronic conditions.

6.7 Group Work and Community Integration

Support groups for patients and caregivers — for example, for dialysis patients, cancer survivors, or parents of children with diabetes — reduce isolation, normalise experiences, and allow peer learning. Social workers often establish and facilitate such groups and build links with community organisations to support reintegration into social and working life.

Table 4. Core Social Work Interventions in Chronic Disease Care

Intervention	Purpose	Expected Outcome
Psychosocial assessment	Identify social needs, risks, and strengths	Individualised, holistic care plan
Case management	Coordinate services across settings	Continuity of care; reduced fragmentation
Resource linkage	Connect to financial, practical, and community support	Reduced practical barriers to treatment
Family counselling	Support family adjustment and caregiving	Reduced caregiver burden; stronger support
Discharge planning	Ensure safe transition from hospital	Fewer avoidable readmissions

Intervention	Purpose	Expected Outcome
Advocacy & protection	Uphold rights; respond to neglect or abuse	Safer, more equitable care
Group work	Peer support and community integration	Reduced isolation; improved coping

7. INTEGRATED PSYCHOSOCIAL CARE: PSYCHOLOGISTS AND SOCIAL WORKERS TOGETHER

The psychological and social dimensions of chronic illness are intertwined. Financial stress fuels depression; depression undermines the energy needed to apply for support; family conflict worsens anxiety; and anxiety may strain family relationships. Interventions that address only one side are therefore often incomplete. Integrated psychosocial care brings the two professions together around a shared assessment and a coordinated plan.

7.1 Complementary Roles

In a well-functioning team, the psychologist focuses primarily on the patient's inner world — emotions, beliefs, coping, and behaviour — while the social worker focuses on the patient's outer world — family, resources, services, and environment. The boundary is permeable: both professions use counselling skills, both work with families, and both contribute to adherence and self-management. Clear role definition prevents duplication, while regular communication ensures that each professional's work reinforces the other's.

The psychologist helps the patient change how they face the illness; the social worker helps change the circumstances in which they face it. Together they strengthen both the person and the context.

7.2 Interprofessional Collaboration

Effective integration requires the competencies set out by the Interprofessional Education Collaborative (2016): values and ethics for interprofessional practice, understanding of roles and responsibilities, interprofessional communication, and teamwork. Practical mechanisms include joint psychosocial screening, shared documentation in the electronic health record, regular multidisciplinary meetings with physicians, nurses, dietitians, and pharmacists, and joint family conferences.

7.3 Disease-Specific Applications

Although the principles are common, the psychosocial priorities differ by condition. Table 5 summarises integrated psychosocial priorities for major chronic diseases.

Table 5. Integrated Psychosocial Priorities by Chronic Disease

Condition	Key Psychological Priorities	Key Social Priorities
Diabetes	Diabetes distress, depression, motivation for self-management, fear of hypoglycaemia	Family support for diet and routines, cost of supplies, school or workplace adjustment
Cardiovascular disease	Post-event anxiety and depression, fear of activity, lifestyle change	Return to work, cardiac rehabilitation access, family role adjustment
Cancer	Distress, fear of recurrence, body image, end-of-life concerns	Financial toxicity, travel for treatment, caregiver support, palliative transitions

Condition	Key Psychological Priorities	Key Social Priorities
Chronic kidney disease / dialysis	Depression, loss of autonomy, treatment fatigue	Dialysis transport, employment loss, transplant navigation
COPD and chronic respiratory disease	Panic and breathlessness-related anxiety, depression	Home oxygen, isolation, housing and environmental exposures
Stroke and neurological disease	Post-stroke depression, cognitive change, adjustment	Home adaptation, long-term care planning, caregiver training

7.4 Family-Centred Care

Because family members are central to chronic care, integrated programs should treat the family as a unit of care. Family-centred interventions include psychoeducation for relatives, caregiver skills training, family therapy where conflict is significant, respite planning, and caregiver mental health screening. Supporting caregivers protects their wellbeing and sustains the home-based care on which patients depend (Adelman et al., 2014).

7.5 Psychosocial Care Across the Life Course

Children and adolescents. Chronic conditions such as type 1 diabetes, asthma, epilepsy, sickle cell disease, and congenital heart disease affect not only the child but the entire family system. Children may experience anxiety, low self-esteem, school absence, and difficulties with peers, while adolescents face the added challenge of gradually taking responsibility for their own care at a developmental stage marked by a desire for independence and conformity with peers. Psychologists use developmentally appropriate interventions — play-based techniques, family-based behavioural therapy, and adolescent-focused motivational work — while social workers liaise with schools to arrange reasonable adjustments, support parents, and coordinate the transition from paediatric to adult services, a period widely recognised as high risk for disengagement from care.

Adults of working age. For working-age adults, chronic illness often threatens employment, financial security, and family roles. Psychological work frequently focuses on identity, role change, and adjustment, while social workers support negotiation with employers, access to sick leave and disability benefits, and vocational rehabilitation. Return-to-work planning is an important integrated goal, because meaningful work is itself protective of mental health.

Older adults. Older patients commonly live with several chronic conditions at once, alongside sensory loss, cognitive decline, bereavement, and reduced mobility. Depression in later life is frequently mistaken for normal ageing, and loneliness is common. Psychologists assess mood and cognition and adapt interventions to the patient's abilities, while social workers address home safety, caregiving arrangements, elder protection, long-term care planning, and advance care discussions. Integrated care for older adults is especially important because their psychosocial and medical needs are tightly interwoven.

7.6 Illustrative Case: Integrated Care in Practice

The following composite case, constructed for illustration, demonstrates how integrated psychosocial care operates. A 52-year-old man with type 2 diabetes and recently diagnosed chronic kidney disease attends a diabetes clinic. His glycaemic control has deteriorated, he has missed several appointments, and routine screening shows moderate depressive symptoms and high diabetes distress. He recently lost his job, and his wife has become the main source of household income.

The **psychologist** conducts a fuller assessment and identifies hopelessness ("my kidneys are failing anyway, so nothing I do matters"), poor sleep, and social withdrawal. Over eight sessions combining CBT and motivational interviewing, the patient learns to challenge catastrophic beliefs, sets small achievable self-care goals, and re-engages with activities he values. The **social worker** assesses the family's situation, helps the patient apply for social support and unemployment assistance, arranges transport support for upcoming nephrology appointments, and meets the patient and his wife together to discuss shared

responsibilities and reduce strain. A joint family conference with the physician and diabetes educator agrees a realistic management plan.

After three months, his depressive symptoms have fallen into the mild range, he has attended all appointments, his glycaemic control has improved, and his wife reports feeling less overwhelmed. Neither profession alone would likely have achieved this result: the psychological work restored motivation and hope, while the social work removed practical barriers and strengthened family support. The case illustrates the central argument of this paper — that psychological and social interventions are mutually reinforcing.

8. THE SAUDI ARABIAN CONTEXT

8.1 The Burden of Chronic Disease

Saudi Arabia, like other Gulf states, has experienced a rapid epidemiological transition. Diabetes, obesity, hypertension, cardiovascular disease, and chronic kidney disease are highly prevalent, and the country has among the highest diabetes prevalence rates in the region. Rapid urbanisation, dietary change, and physical inactivity have contributed to this burden. As life expectancy rises, the number of people living with multiple chronic conditions is expected to grow further, increasing demand for long-term, coordinated care.

8.2 Mental Health and Psychosocial Needs

The Saudi National Mental Health Survey provided the first nationally representative data on common mental disorders in the Kingdom and showed that such disorders are common and frequently begin early in life, with many people never receiving treatment (Altawijri et al., 2020). Among patients with chronic disease, psychological needs are compounded by the demands of illness, yet psychological care is not consistently integrated into chronic disease clinics.

8.3 Policy Framework: Vision 2030

The Health Sector Transformation Program under Vision 2030 seeks to restructure the health system around prevention, population health, and value-based, patient-centred care (Health Sector Transformation Program, 2021). The new Model of Care organises services around "systems of care", including chronic conditions, and emphasises care coordination, self-management, and community-based services. The Quality of Life Program and national mental health initiatives, including the work of the National Center for Mental Health Promotion, further support the integration of psychological wellbeing into health policy. These directions create a clear policy mandate for embedding psychologists and social workers within chronic care pathways.

8.4 Professional and Institutional Structures

The Saudi Commission for Health Specialties (SCFHS) classifies, registers, and licenses psychologists and social workers practising in health care, establishing professional standards and pathways for continuing development. The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) includes standards on patient and family rights, patient education, and discharge planning that rely on psychosocial input. Social welfare support for patients and families is linked to programs administered by the Ministry of Human Resources and Social Development, which social workers help patients to access.

8.5 Cultural Strengths and Challenges

Saudi society has important psychosocial strengths. Strong extended-family networks provide practical and emotional support, and religious faith is a central source of meaning, patience (*sabr*), and acceptance for many patients facing illness. Positive religious coping is associated with better adjustment in many studies (Koenig, 2012), and culturally sensitive interventions can integrate these resources respectfully. At the same time, stigma surrounding mental health can deter patients from accepting psychological referral, family involvement may sometimes limit patient autonomy or privacy, and gender norms may shape preferences for the gender of the therapist. Psychologists and social workers must navigate these factors with cultural competence, framing psychological support in acceptable terms — for example, as "coping support" or "living well with illness" — and engaging families as partners.

Table 6. Saudi Contextual Factors in Psychosocial Chronic Care

Factor	Opportunity	Challenge	Practice Implication
Vision 2030 Model of Care	Systems of care for chronic conditions	Translating policy into staffing and pathways	Define psychosocial roles in each chronic care pathway
Strong family networks	Rich caregiving and emotional support	Caregiver burden; limits on patient autonomy	Family-centred care with caregiver support
Religious faith	Meaning, acceptance, positive coping	Occasional fatalism affecting self-care	Integrate faith-sensitive coping into interventions
Mental health stigma	Growing public awareness campaigns	Reluctance to accept psychological referral	Normalise psychological care within routine clinics
Digital health platforms	Telehealth and national apps	Digital literacy among older patients	Hybrid in-person and remote psychosocial services

9. BARRIERS TO INTEGRATED PSYCHOSOCIAL CARE

Despite strong evidence and supportive policy, psychosocial care in chronic disease remains inconsistent internationally and in Saudi Arabia. The main barriers include:

- ◆ **Workforce shortages:** insufficient numbers of health psychologists and medical social workers relative to the size of chronic disease populations, and uneven distribution across regions.
- ◆ **Biomedical dominance:** care pathways, clinic templates, and performance indicators that prioritise biological measures and overlook psychosocial outcomes.
- ◆ **Lack of routine screening:** absence of systematic depression, distress, and social-needs screening in chronic disease clinics.
- ◆ **Unclear referral pathways:** uncertainty among physicians about when and how to refer, and long waiting times once referrals are made.
- ◆ **Role ambiguity:** overlapping or poorly defined roles between psychologists, social workers, nurses, and psychiatrists.
- ◆ **Stigma and patient reluctance:** fear that referral implies "madness" or weakness.
- ◆ **Fragmented information systems:** psychosocial notes not visible to the wider team, or not captured in structured form.
- ◆ **Limited evaluation:** psychosocial services rarely measured with outcome indicators, making their value less visible to decision-makers.

10. ETHICAL AND PROFESSIONAL CONSIDERATIONS

Psychosocial care in chronic disease raises distinctive ethical questions that psychologists and social workers must navigate with care, guided by their professional codes of ethics and the regulations of the Saudi Commission for Health Specialties.

10.1 Confidentiality and Information Sharing

Integrated care depends on information sharing within the team, yet psychological and social information is often highly sensitive — involving mental health, family conflict, finances, or abuse. Professionals must share what the team needs to provide

safe, coordinated care while protecting details that are not clinically necessary. Patients should be informed at the outset about how their information will be used within the team, and the limits of confidentiality — for example, where there is a risk of serious harm to the patient or others — must be explained clearly.

10.2 Autonomy and Family Involvement

In family-centred cultures, relatives may wish to make decisions on the patient's behalf or to withhold information about diagnosis or prognosis. Practitioners must balance respect for family roles with the patient's right to information and self-determination. In practice, this often means exploring the patient's own preferences about information and involvement, and facilitating family discussions that respect both the patient's autonomy and the family's caring intentions.

10.3 Cultural Competence and Respect for Faith

Effective psychosocial care respects the cultural and religious values of patients. Practitioners should understand how illness is interpreted within the patient's belief system, avoid imposing external value frameworks, and incorporate faith-based coping where the patient finds it meaningful. Cultural competence also includes sensitivity to the needs of non-Saudi patients and residents, including language support and awareness of their particular social circumstances.

10.4 Professional Boundaries and Self-Care

Working with long-term, sometimes deteriorating patients can be emotionally demanding. Psychologists and social workers are exposed to repeated grief, suffering, and difficult social situations, and they are at risk of compassion fatigue and burnout. Regular clinical supervision, peer support, reasonable caseloads, and organisational attention to staff wellbeing are essential not only for the professionals themselves but for the quality and safety of the care they provide.

10.5 Competence and Scope of Practice

Each profession must practise within its competence and scope, and refer appropriately — for example, to psychiatry for patients requiring medication or presenting significant risk, or to legal and protective services in cases of abuse. Continuing professional development, aligned with SCFHS requirements, ensures that practitioners keep pace with evolving evidence on psychosocial interventions in chronic disease.

11. THE UPLIFT FRAMEWORK

To address these barriers, this paper proposes the **UPLIFT Framework** for integrated psychological and social care of patients with chronic diseases. The framework positions psychologists and social workers as core members of the chronic care team and organises their contribution into six linked components that follow the patient's journey.

Table 7. The UPLIFT Framework for Integrated Psychosocial Chronic Care

Component	Description	Lead Role(s)	Indicators
U — Understanding psychosocial needs	Routine screening for depression, anxiety, distress, and social needs; comprehensive assessment where indicated	Psychologist & social worker (joint)	Screening coverage; time to assessment
P — Psychological intervention	Stepped care: psychoeducation, brief CBT/ACT/MI, structured therapy, collaborative care	Psychologist	Change in PHQ-9 / GAD-7 / distress scores
L — Linking social resources	Case management, welfare and financial support, transport, equipment, community services	Social worker	Needs resolved; service uptake

Component	Description	Lead Role(s)	Indicators
I — Involving family and caregivers	Family psychoeducation, caregiver support and screening, family meetings	Social worker & psychologist	Caregiver burden scores; family engagement
F — Facilitating self-management	Goal-setting, self-efficacy building, adherence support, peer and group programs	Psychologist with nursing team	Self-efficacy; adherence; clinical markers
T — Tracking outcomes	Measurement-based care, shared records, team review, quality improvement	Whole team	Quality of life; readmissions; patient experience

11.1 Stepped-Care Logic

UPLIFT applies a stepped-care approach so that limited specialist resources are matched to need. All patients receive psychosocial screening and basic psychoeducation from the clinic team. Patients with mild to moderate needs receive brief psychological or social interventions, often in groups or remotely. Patients with complex or severe needs — for example, major depression, suicidal thoughts, severe family breakdown, or acute financial crisis — receive intensive, individual intervention, with referral to psychiatry or protective services where required. Outcomes are monitored and care is "stepped up" or "stepped down" accordingly.

11.2 Operating Mechanisms

- ◆ **Shared psychosocial screening tool** embedded in the electronic health record for all chronic disease clinics.
- ◆ **Weekly multidisciplinary psychosocial meeting** to review complex patients and agree joint plans.
- ◆ **Defined referral criteria and response times** for both psychology and social work.
- ◆ **Joint family conferences** for patients with high caregiving needs or at major transition points.
- ◆ **Outcome dashboard** reporting psychosocial and clinical indicators to department leadership.

11.3 Implementation Phasing

Implementation can proceed in three phases. In the **foundation phase**, organisations define roles, train staff in screening and motivational interviewing, and introduce psychosocial screening in one or two pilot clinics such as diabetes and dialysis. In the **expansion phase**, they extend screening and stepped-care pathways to other chronic disease services, establish group programs, and integrate psychosocial data into records. In the **sustainability phase**, they embed outcome measurement in quality governance, develop tele-psychosocial services for remote regions, and evaluate cost-effectiveness to support further investment.

12. DIGITAL INNOVATION AND FUTURE DIRECTIONS

Digital technologies are expanding access to psychosocial care. Synchronous telepsychology — therapy delivered by video or telephone — has shown efficacy comparable to in-person treatment for anxiety, depression, and adjustment problems (Varker et al., 2019). For patients with mobility limitations, fatigue, or long travel distances, this can remove a major barrier. National digital health platforms and applications in Saudi Arabia, together with virtual care services, provide infrastructure on which remote psychological consultations, digital self-management programs, and social work follow-up can be built.

Digital tools also allow electronic patient-reported outcome measures to be collected between visits, alerting the team when distress rises. Mobile applications can deliver CBT-based self-help, mindfulness exercises, and adherence reminders. These

innovations must be designed with attention to privacy, cultural appropriateness, Arabic-language content, and the digital literacy of older patients, and they should complement rather than replace human relationships with the care team.

Future research priorities include culturally adapted psychological interventions evaluated in Saudi populations; studies of caregiver burden in Saudi families; cost-effectiveness analyses of integrated psychosocial care; and implementation studies examining how best to embed psychologists and social workers within the Model of Care.

13. RECOMMENDATIONS

13.1 For Policymakers

- ◆ Include psychologists and social workers as mandatory members of chronic disease systems of care under the Model of Care.
- ◆ Adopt national standards for psychosocial screening in chronic disease services.
- ◆ Expand training and employment pathways for health psychologists and medical social workers.
- ◆ Include psychosocial and quality-of-life indicators in health-system performance measures.

13.2 For Healthcare Organisations and Managers

- ◆ Establish stepped-care psychosocial pathways with clear referral criteria and response times.
- ◆ Integrate psychosocial assessment and notes into shared electronic health records.
- ◆ Create caregiver support programs and family conference processes.
- ◆ Fund tele-psychosocial services to reach patients in remote areas.

13.3 For Psychologists and Social Workers

- ◆ Use validated, culturally adapted assessment tools and measurement-based care.
- ◆ Coordinate closely with each other and with medical teams through joint planning.
- ◆ Integrate faith-sensitive and family-centred approaches respectfully.
- ◆ Train physicians and nurses in basic psychosocial skills such as motivational interviewing.

13.4 For Educators and Researchers

- ◆ Incorporate the biopsychosocial model and interprofessional practice into health curricula.
- ◆ Conduct local trials and implementation studies of integrated psychosocial interventions.
- ◆ Develop and validate Arabic-language psychosocial screening and outcome measures.

14. CONCLUSION

Chronic diseases demand a model of care that extends beyond biology. The emotional, cognitive, behavioural, family, financial, and social consequences of chronic illness are common and consequential: they shape adherence, self-management, clinical outcomes, quality of life, and costs. The evidence reviewed in this paper demonstrates that psychological interventions — including CBT, ACT, motivational interviewing, mindfulness, self-management support, and collaborative care — and social interventions — including psychosocial assessment, case management, resource linkage, family support, discharge planning, and advocacy — can meaningfully improve the lives of patients and their families.

The psychologist and the social worker play distinct but complementary roles. Their greatest contribution comes when they work together within an interdisciplinary team, sharing assessment, coordinating plans, and engaging families as partners. The proposed UPLIFT Framework offers a practical structure for achieving this integration through routine screening, stepped psychological care, social resource linkage, family involvement, self-management support, and outcome tracking.

In Saudi Arabia, the Vision 2030 health transformation, the new Model of Care, and growing attention to mental health and quality of life provide a strong foundation. Drawing on the Kingdom's cultural strengths — close families and deep faith — while addressing stigma, workforce gaps, and fragmented services, health institutions can make integrated psychosocial care a standard part of chronic disease management. Doing so will not only improve clinical outcomes but will honour the reality that patients are whole persons, living their illness within families and communities.

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