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REVIEW ARTICLE

A systematic review of spiritual distress and needs among patients with cancer

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Abstract
Chronic illnesses such as cancer often lead to spiritual distress and unmet spiritual needs. These conditions cause patients to lose their sense of meaning in life and daily purpose. Furthermore, spiritual issues may have a significant impact on physical and psychosocial domains. However, reviews focusing on both aspects of spiritual distress and need are limited in the databases. Therefore, this project aims to synthesize quantitative evidence on the prevalence of spiritual distress and needs, and to identify its characteristics among patients with cancer. Of the various types of reviews, a systematic review was selected because it is well-suited to answer the review's objectives. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guideline was used during the process. The review involved four online databases, including PubMed, Scopus, Science Direct, and Taylor & Francis. Literature searches were conducted from August 2022 to June 2025. Two reviewers independently screened potentially eligible articles, and those meeting the eligibility criteria underwent quality appraisal using the Joanna Briggs Institute (JBI) Critical Appraisal Tools. Of 3745 potentially eligible studies, 17 were included in the review. Patients reported unmet spiritual needs that varied across geographic locations, including desires for prayer, inner peace, connection with significant others, and kindness. Spiritual needs were associated with psychological factors such as anxiety and depression. A high prevalence of spiritual distress was found among patients with cancer. Patients' spiritual distress and needs were influenced by demographic, clinical, and psychological variables. Therefore, establishing adequate assessment and appropriate spiritual care is fundamental for nurses working in the cancer area.

Keywords: Cancer, inner peace, prayer, religiosity, spiritual anguish, spiritual distress, spiritual need, spiritual pain

Introduction

Spirituality is a personal experience that can occur both within and outside the context of religious traditions (Sena et al., 2021). For patients with cancer, spirituality often becomes a vital resource for coping that providing a framework for finding meaning and hope amidst suffering (Nagy et al., 2024). Many patients find strength and comfort in prayer, meditation, or simply connecting with a sense of inner peace (Meneses-La-Riva et al., 2025). At its core, spirituality involves showing love, forgiveness, worship, and a deeper understanding of life's purpose, even in the face of suffering (Rabitti et al., 2020). Although spirituality is a fundamental part of holistic cancer care, more assistance is required to comprehend and put spirituality-focused interventions into practice (Miller et al., 2025). A study involving larger samples of patients with advanced cancer reported a prevalence of spiritual pain in more than 40% of the patients (Pérez-Cruz et al., 2019). According to research, 52.2% of patients with cancer believe that religion and spirituality are "very important," whereas 55.9% of patients identify as both spiritual and religious, 27.9% as spiritual but not religious, and 16.2% as neither spiritual nor religious (Kelly et al., 2021). However, spirituality can also be a source of distress, especially when patients feel abandoned by their faith or dealing with profound questions about their beliefs in the face of serious illness. A study highlighted that 195 patients with cancer stated that their spiritual or religious needs had not been met during the care (Delgado-Guay et al., 2021). Through exploration and reflection, nurses help patients identify and address spiritual needs and offer emotional and spiritual support for their hope and resilience. This process empowers patients to find meaning, experience peace, and cope more effectively with the challenges of illness.

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Being diagnosed with cancer is a painful experience that affects all dimensions of human life, including physical, psychological, and spiritual aspects (Caldeira et al., 2017; Miller et al., 2024). Furthermore, patients seem more susceptible to spiritual distress throughout the cancer trajectory, from diagnosis, during treatment, and cancer progression, to the end-of-life (Iskandar et al., 2021). Spiritual distress is recognized as a state associated with the human dimension that encompassing existential and religious issues (Martins et al., 2024). In fact, spiritual distress has been conceptualized in various ways, including spiritual pain and spiritual struggles (Ordons et al., 2018). Moreover, research has shown that spiritual distress is linked to psychosocial needs, communication issues, death anxiety, hopelessness, and despair (Heidari et al., 2019). Consequently, patients and families experiencing spiritual distress often report a lack of meaning and purpose in life, as well as uncertainty about the future (Ordons et al., 2018). It is worth highlighting that spiritual distress is prevalent among patients with life-limiting illnesses and is associated with poor quality of life (Breitbart et al., 2018). Given the impact of spiritual distress on overall well-being, it is essential to emphasize and address spirituality in the context of comprehensive care among patients with cancer.

Despite increasing acknowledgment of its significance in healthcare, spirituality is a complex and multidimensional concept that influenced by patients and contextual factors. Demographic attributes were associated with variations in spiritual beliefs and needs such as age, gender, cultural background, and religious affiliation (Shi et al., 2023). Furthermore, illness-related factors (disease severity, symptom burden, prognosis, and functional status) have been identified as significant contributors to the manifestation of spiritual distress and the articulation of spiritual needs, among patients with chronic or life-limiting conditions (Klimasiński et al., 2022). In recent years, a growing body of evidence has emerged on spiritual distress and spiritual needs in patients with life-limiting illnesses, such as cancer (Austin et al., 2025; Prieto-Crespo et al., 2024). Numerous studies have explored the relationship between demographic variables, illness-related variables, and spiritual distress and needs (Fradelos et al., 2021; Zhou et al., 2024). However, there is currently no comprehensive synthesis on the prevalence of spiritual distress and spiritual needs among patients with cancer. Therefore, a systematic review of spiritual distress and needs is important to identify specific needs, plan appropriate interventions, and provide spiritual care for stress reduction. This review aimed to synthesize the prevalence of spiritual distress and needs, as well as factors associated with spiritual distress and spiritual needs in patients with cancer. Moreover, the review addresses a dimension of care that is often overlooked in clinical settings: the spiritual well-being of patients facing life-threatening illness. With reviewing existing research, healthcare professionals can better understand the prevalence, manifestations, and consequences of spiritual distress in cancer patients. This knowledge is essential for developing holistic nursing care plan that focused on physical symptom management and incorporate spiritual support as a core component of palliative and psychosocial care. Without a comprehensive synthesis of current findings, oncology nurses may rely on assumptions or generic approaches that fail to meet patients' unique spiritual needs. The findings of this review are expected to inform the integration of spiritual care into oncology that potentially reducing spiritual distress and achieving the spiritual need. Lastly, this review serves as a foundational step toward truly patient-centered cancer care that addresses the physical, emotional, and spiritual needs of patients with cancer.

Method

After considering the study objective, the authors chose a systematic review design as the most appropriate approach for this topic of interest. The updated Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement 2020 was utilized for reporting to ensure transparency, completeness, and accuracy in accordance with the guidelines (Page et al., 2021). To focus this review, the authors developed the following research question: what is the prevalence of spiritual distress and spiritual needs among patients with cancer? A literature search was conducted across several electronic databases, including PubMed, Scopus, Science Direct, and Taylor & Francis. The main reason for using these databases is their comprehensive coverage of biomedical, nursing, psychological, and psychosocial publications. The use of multiple databases was essential to maintain thematic focus, minimize duplication, and preserve methodological integrity.

The article search included publications from August 2022 to June 2025 by using search strategy: “spiritual needs AND spiritual distress OR spiritual pain OR spiritual struggle AND cancer AND patient”. The inclusion criteria included original research studies with cross-sectional and cohort designs, studies reporting spiritual needs and/or spiritual distress, adult individuals with cancer as the population (regardless of cancer type), and articles published in English. Additionally, the authors included studies that examined various aspects of spiritual distress, including spiritual pain, spiritual struggle, existential suffering, spiritual anguish, and spiritual need. To make sure a comprehensive search, the authors also scanned the reference lists of relevant existing literature reviews and included articles. Exclusion criteria were studies that were not original research (reviews, editorials, case reports, commentaries), qualitative studies,

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studies not reporting outcomes on spiritual distress or spiritual needs, and studies involved populations other than adults with cancer. The authors utilized EndNote software (version 20) to manage references during the selection process. Each database citation was examined, and any duplicates were eliminated. Authors screened whole texts, abstracts, and titles. The authors then evaluated each study by taking into account the criteria for inclusion and exclusion. All of the authors' disagreements were settled through intensive discussion which led to a consensus. Articles that met the requirements for inclusion were shown. The full texts of all the included studies were carefully read by the authors. Through inclusive discussion, interpretations and conclusions were agreed upon. The findings from the several investigations were then combined by the study team. They were able to make inferences and practical implications as a result of this approach. The analysis got more thorough and evidence-based as a result of the teamwork.

Methodological quality was assessed using the Joanna Briggs Institute (JBI) checklist for cross-sectional and cohort studies. The risk of bias evaluation considered factors such as sampling (inclusion criteria), study subject and setting, confounding factors, outcome measurements, and statistical analysis. Each criterion was rated as yes, no, unclear, or not applicable. Studies with a score of 75% or higher yes answers were included. The results of the included studies were summarized in tables for transparency and clarity **(Table 1 & 2)**. A data extraction form was developed to capture key study characteristics, including study design and country/region, as well as participant characteristics such as age, gender, and religious affiliation. The form also extracted data on outcome measurements, spiritual distress (frequency and type), and spiritual needs (most needed aspects of spirituality). The characteristics of the included studies are summarized in the table **(Table 3)**.

Table 1. Risk of bias and quality assessment for cross-sectional studies.

Parameters	1	2	3	4	5	6	7	8	9	10	11	12	13
Were the criteria for inclusion in the sample clearly defined?	+	+	+	+	+	+	+	+	+	+	+	+	+
Were the study subjects and the setting described in detail?	+	+	+	+	+	+	+	+	+	+	+	+	+
Was the exposure measured in a valid and reliable way?	+	+	+	+	+	+	+	+	+	+	+	+	+
Were objective, standard criteria used for measurement of the condition?	+	+	+	+	+	+	+	+	+	+	+	+	+
Were confounding factors identified?	-	+	-	-	-	-	-	-	-	-	-	-	-
Were strategies to deal with confounding factors stated?	+	-	-	-	-	-	-	-	-	-	-	-	-
Were the outcomes measured in a valid and reliable way?	+	+	+	+	+	+	+	+	+	+	+	+	+
Was appropriate statistical analysis used?	+	+	+	+	+	+	+	+	+	+	+	+	+
Was the statistical significance assessed?	+	+	+	+	+	+	+	+	+	+	+	+	+

1=Wisesrith et al. (2021), **2**=Martins et al. (2021), **3**=Huang et al. (2021), **4**=Caldeira et al. (2016), **5**=Höcker et al. (2014), **6**=Taylor (2006), **7**=Hampton et al. (2007), **8**=Sastra et al. (2021), **9**=Damen et al. (2021), **10**= Silva et al. (2019), **11**=Gielen et al. (2017), **12**=Mako et al. (2006), **13**=Stripp et al. (2025)

The authors employed a quantitative synthesis approach to summarize, synthesize, and integrate the extracted data (Schick-Makaroff et al., 2016). The I^2 statistic was used to assess heterogeneity, and a random-effects model was applied due to high heterogeneity (I^2=99.56%). In this review, the I^2 of 99.56% showed that the prevalence and associated factors of spiritual distress and needs varied across studies that possibly due to differences in populations, cultural aspects, measurement tools, and study designs. This heterogeneity was likely due to differences in populations, cultural aspects, measurement tools, and study designs. Consequently, a random-effects model was applied rather than a fixed-effects model. For our included cross-sectional and cohort studies, the implication is that the pooled prevalence and association should be interpreted as an average effect across settings and populations rather than a single common effect, which is appropriate given the observed variability. Key findings are presented in the following areas such as description of included studies, prevalence of spiritual distress, types of spiritual distress, and spiritual needs. The review protocol was registered in the International Prospective Register of Systematic Reviews (PROSPERO: CRD42022352390). Registering the protocol provides transparency and reduces the likelihood of reporting bias.

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Results

The figure shows the PRISMA flowchart for updated systematic reviews. The diagram illustrates the study selection process and the decision pathways leading to the final inclusion of studies. The initial literature search was conducted then an updated search was performed in July 2025 prior to final analysis to ensure inclusion of the most recent evidence. The initial search included 16 studies. The updated search removed 6 duplicates, and screened 478 studies for eligibility of titles and abstracts, of which 476 were excluded for not meeting the inclusion criteria. A total of 2 full-text articles were retrieved and reviewed, and 1 article were excluded as data cannot be extracted. 17 studies were finally included in the review **(Figure 1)**.

Table 2. Risk of bias and quality assessment for cohort studies.

Parameters	14	15	16	17
Were the two groups similar and recruited from the same population?	+	+	+	+
Were the exposures measured similarly to assign patients to both exposed and unexposed groups?	+	+	+	+
Was the exposure measured in a valid and reliable way?	+	+	+	+
Were confounding factors identified?	-	-	+	+
Were strategies to deal with confounding factors stated?	-	+	+	+
Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)?	+	+	+	+
Were the outcomes measured in a valid and reliable way?	+	+	+	+
Was the follow up time reported and sufficient to be long enough for outcomes to occur?	-	+	+	-
Was follow up complete, and if not, were the reasons to loss to follow up described and explored?	+	+	+	-
Were strategies to address incomplete follow up utilized?	-	-	+	-
Was appropriate statistical analysis used?	+	+	+	+

14=Delgado-Guay et al. (2021), **15**=Ullrich et al. (2016), **16**=Gudenkauf et al. (2019), **17**=Hui et al. (2011).

A total of 17 studies were included in the review, with their characteristics summarized in the table **(Table 3)**. The majority of studies (n=13) used a cross-sectional design, while four employed a cohort design. Geographically, most studies were conducted in the United States (n=8), followed by Portugal (n=2) and Germany (n=2), with single studies from India, Indonesia, Brazil, Thailand, and Denmark. The studies primarily focused on either spiritual distress (n=9) or spiritual needs (n=7), although one study reported findings on both. The studies employed a range of data collection instruments to measure spiritual distress, which had demonstrated varying levels of internal and external validity. These instruments included the Edmonton Symptom Assessment Scale (n=2), the Martin Spiritual Distress scale (n=1), Spiritual Well-Being scale (n=1), Problem and Need Palliative Care Questionnaire (n=1), FACIT (n=1), Symptom Distress Scale (n=1), and Brief Religious and Spiritual Struggle Scale (n=1). To assess spiritual needs, the included studies utilized several tools, such as the Spiritual Needs Questionnaire (n=3), Spiritual Needs Scale (n=1), Spiritual Needs Inventory (n=1), Martin's Spiritual Distress scale (n=1), and the Spiritual Interest Related to Illness Tool (SpIRIT) (n=1). Additionally, two studies used study-specific instruments: one developed a new 36-item spirituality questionnaire in Hindi (Gielen et al., 2017), and another used question assessing spiritual pain, religiosity, and faith activity (Mako et al., 2006). A total of 11,329 patients were included across the studies. The mean age of participants ranged from 41.08 (Sastra et al., 2021) to 72.67 (Huang et al., 2021). Most studies included patients with various types of cancer, with only one study focusing exclusively on lung cancer patients (Gudenkauf et al., 2019). Among the included studies, one study recruited both patients and family members (Huang et al., 2021), while the majority (n=13) focused on patients receiving care in acute oncology settings. The remaining studies involved patients in palliative care settings (Delgado-Guay et al., 2016; Gielen et al., 2017; Ullrich et al., 2021).

More than half of the included studies (n=10) provided an operational definition of spirituality or spiritual distress. The prevalence of spiritual pain among patients with cancer varied widely, ranging from 6% to 96% **(Figure 2)**. The pooled prevalence of spiritual distress was 51% (95% CI, 31%-70%) **(Figure 3)**. Notably, studies conducted in the USA generally reported higher percentages of spiritual distress, although one study found a much lower prevalence of 8% (Gudenkauf et al., 2019). Similarly, a study in India reported a lower prevalence of 18%, which may be attributed to the significant role of religion in shaping spirituality in the Indian context (Gielen et al., 2017). The characteristics of spiritual distress were also explored in the included studies. For example, a study in Germany found that patients struggled with issues such as feeling useless (18.4%), being unavailable to others (24%), concerns about the meaning of death (22.1%), and accepting

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their disease (24.7%) (Ullrich et al., 2016). Another US-based study identified spiritual struggles, including feeling angry at God (21%), feeling guilty (25%), and experiencing doubts about religion or spirituality (22%) (Taylor, 2006). Seven out of seventeen studies focused on the spiritual needs of patients with cancer, utilizing the Spiritual Need Questionnaire to measure patients' self-reported spiritual needs (Höcker et al., 2014; Sastra et al., 2021). The most identified spiritual need was being with others, including friends and family (Hampton et al., 2007; Höcker et al., 2014; Huang et al., 2021; Martins et al., 2021; Taylor, 2006). Notably, analysis revealed that praying and attending religious services were the most frequent unmet needs in both religiously predominant countries like Portugal and Indonesia (Martins et al., 2021; Sastra et al., 2021) and non-religiously predominant countries (Hampton et al., 2007). Additionally, one study in Thailand found that preparing for death was considered an important spiritual need by patients with cancer (Wisesrith et al., 2021). Other significant spiritual needs included inner peace and actively giving (Höcker et al., 2014; Taylor, 2006).

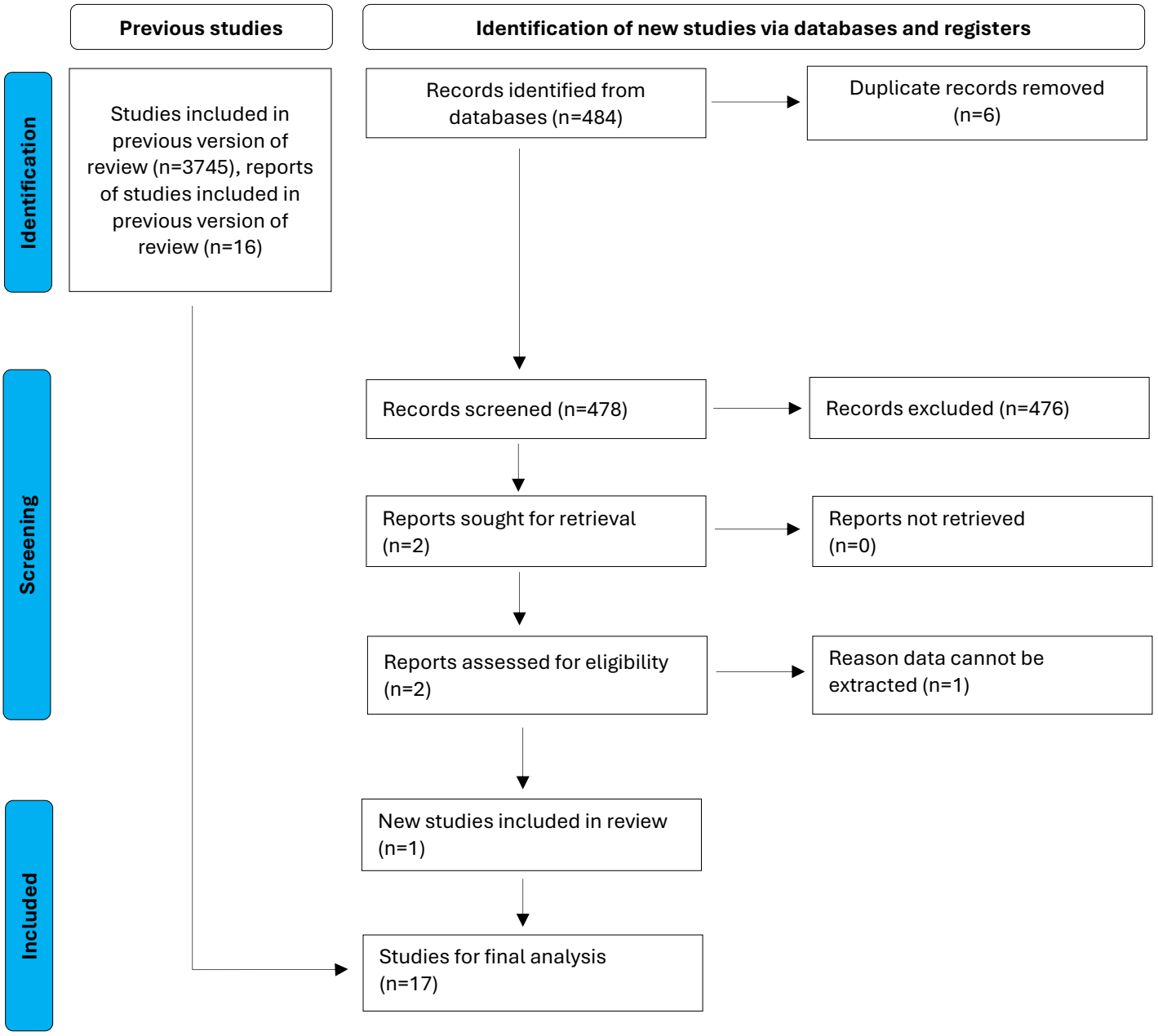

Figure 1. PRISMA flow diagram.

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The findings of studies on the association between spiritual distress and demographic and illness-related variables were varied. A significant inverse correlation between spiritual distress and age was reported in four studies (Gielen et al., 2017; Hui et al., 2011; Martins et al., 2021; Silva et al., 2019), whereas one study found no variation in spiritual distress by age (Mako et al., 2006). Spiritual distress was associated with several variables, including a significant link to having no religious affiliation (Martins et al., 2021; Taylor, 2006), although another study found no such association (Mako et al., 2006). In patients with cancer, better spiritual coping was correlated with lower spiritual distress (Silva et al., 2019). Additionally, spiritual distress was positively associated with emotional distress, as reported in two studies (Delgado-Guay et al., 2016; Gudenkauf et al., 2019). Furthermore, four studies found that spiritual distress was linked to greater symptom burden (Damen et al., 2021; Delgado-Guay et al., 2016; Gielen et al., 2017; Hui et al., 2011). Spiritual needs have been found to be associated with gender and age (Sastra et al., 2021). Additionally, living with family has been linked to spiritual needs (Taylor, 2006; Wisesrith et al., 2021). Research by Sastra et al. (2021) and Taylor (2006) also suggests an association between spiritual needs and the duration since cancer diagnosis. Notably, Stripp et al. (2025) found an 8% increase in spiritual needs within the first six months after diagnosis. Furthermore, studies have consistently shown that higher anxiety levels are associated with greater spiritual needs among patients with cancer (Gudenkauf et al., 2019; Höcker et al., 2014; Huang et al., 2021; Ullrich et al., 2021).

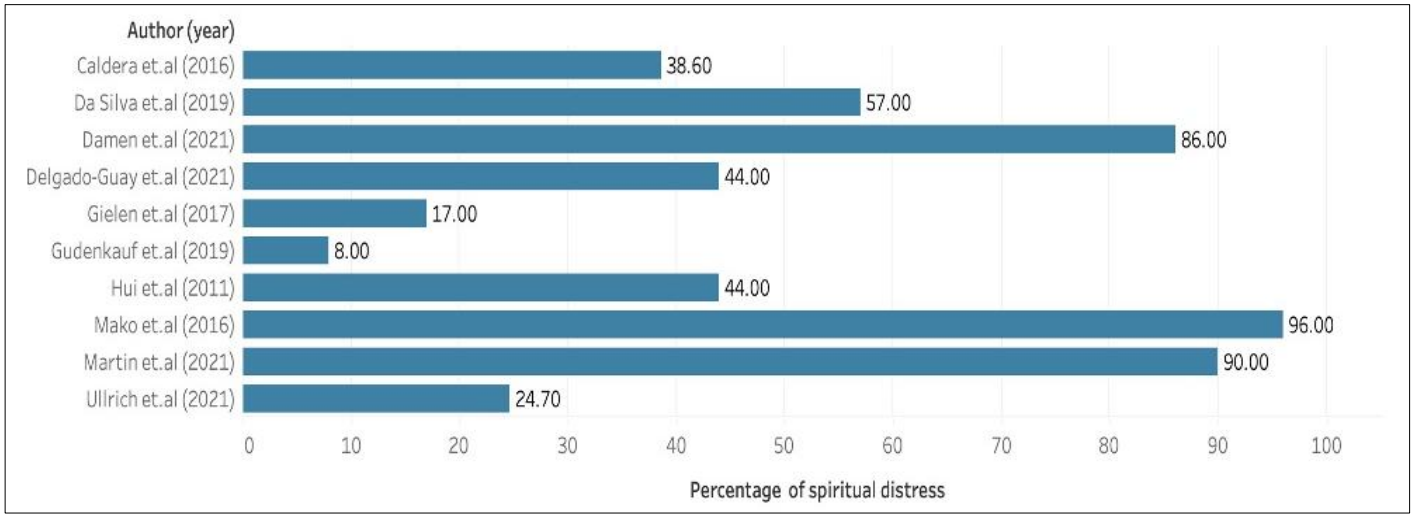

Figure 2. Percentage of spiritual distress from seventeen included studies.

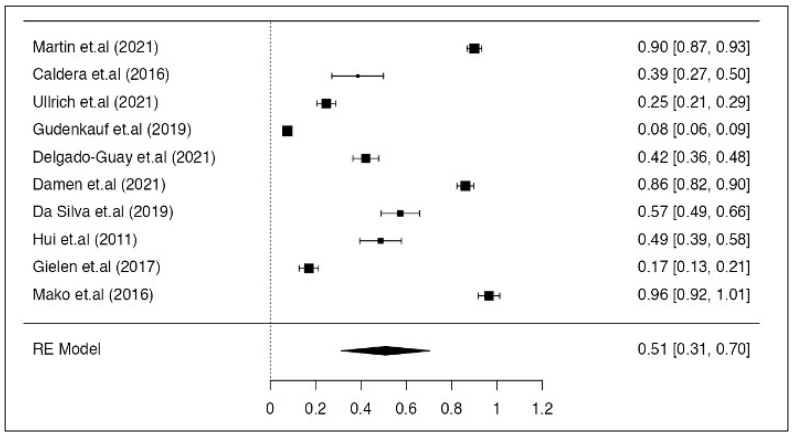

Figure 3. Pooled prevalence of spiritual distress.

Discussion

The review identified a relatively high prevalence of spiritual distress among patients with cancer. This indicates that spiritual distress is a common experience that should be considered alongside physical and psychosocial aspects (Nolan et al., 2020). In addition, patients' spiritual distress and need appear as a dynamic concept influenced by combinations of demographic, clinical and psychological characteristics (Klimasiński et al., 2022). Oncology nurses are essential in recognizing and responding to spiritual distress by assessing needs, offering supportive presence, and referring patients to specialized spiritual care if needed. Amongst of the included studies, the range of point prevalence in eight studies reported a higher prevalence of spiritual distress compared to a previous scoping review (Ordons et al., 2018). The majority of studies were conducted in the United States, with additional studies conducted in India, Portugal, Indonesia, Thailand, and Germany. The variation across countries provided insight into the potential impact of cultural differences on the prevalence of spiritual distress among the group of patients.

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Table 3. Study findings.

Author, year	Study's purposes	Design	Country, setting	Sample size	Instruments	Results	
						Spiritual distress	Spiritual needs
Wisesrith et al. (2021)	Investigate spiritual needs of patients with advanced cancer.	Cross-sectional	Thailand, hospital	332 participants	Researchers developed spiritual need scale	N/A	The dimensions of spiritual needs are preparing death, having meaning, having opportunity to pursue most important thing in life, having opportunity to practice activities related belief.
Martins et al. (2021)	Assess spiritual distress in patients with cancer who were initiating chemotherapy.	Cross-sectional	Portugal, hospital	322 participants	Spiritual Distress Scale	81.7% patients experience spiritual distress (9.6% high level; 31% moderate level and 40.9% low level).	The most unmet spiritual needs are going to religious services and being with friends.
Huang et al. (2021)	Investigate the effects of spiritual needs on the quality of life in patients with advanced cancer and their family caregivers.	Cross-sectional	United States of America, clinic	660 participants	Spiritual Needs Inventory	N/A	The most spiritual need domains are being with family, seeing smiles of others, thinking happy thought.
Caldeira et al. (2016)	Validate nursing diagnosis spiritual distress.	Cross-sectional	Portugal, hospital	70 participants	Spiritual Well-Being Scale	38.6% patients experiencing very spiritual distress.	N/A
Höcker et al. (2014)	Investigate the significance and nature of spiritual needs among patients, to clarify the role of demographic	Cross-sectional	Germany, hospital	285 participants	Spiritual Need Questionnaire	N/A	The spiritual need elements are having inner peace and giving, plunging to someone in a loving attitude, solace someone, finding peace in patient's life,

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Table 3. Continue.

Author, year	Study's purposes	Design	Country, setting	Sample size	Instruments	Results	
						Spiritual distress	Spiritual needs
	and clinical factors in spiritual needs, and to identify their associations with dimensions of psychological distress.						talking with others about fear and worries, dwelling at a place of quietness and peace, giving away something from self.
Taylor (2006)	Measure the prevalence of spiritual needs and identify factors associated with spiritual needs among patients with cancer and family caregivers.	Cross-sectional	United States of America, in patient and out-patient	156 participants	Spiritual interest related to illness tool (SpIRIT)	N/A	Spiritual need score is associated with frequency of attendance at religious services.
Hampton et al. (2007)	Assess spiritual needs of patients with advanced cancer who were newly admitted to hospice home care.	Cross-sectional	United States of America, non-profit hospital	90 participants	Spiritual Need Inventory	N/A	The most common identified spiritual needs are attending religious services, praying, being with family and friends, think happy thought, see smiles of others. Being with family was the need among patients (80%), and 50% cited prayer as frequently or always a need. Study suggests the importance of a focus on the spiritual more than the religious in providing care.

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Table 3. Continue.

Author, year	Study's purposes	Design	Country, setting	Sample size	Instruments	Results	
						Spiritual distress	Spiritual needs
Sastra et al. (2021)	Examine the spiritual needs and influencing factors of Indonesian Muslims with cancer during hospitalization (IMCH).	Cross-sectional	Indonesia, one public hospital	122 participants	Spiritual Need Questionnaire	N/A	The highest spiritual needs are religious needs, pray five times a day, someone prays for patient, turn to a higher presence, find inner peace.
Ullrich et al. (2021)	Explore and identify problems and needs related to psychosocial and spiritual of patients at initiation and during specialized palliative care.	Cohort	Germany, in and out-patient	425 participants	Problems and needs in palliative care	N/A	Spiritual issues experienced by patients are difficulties to be engaged usefully, difficulties to be of avail others, difficulties concerning the meaning of death, difficulties to accept the disease, higher spiritual distress.
Gudenkauf et al. (2019)	Assess relationship between spirituality and emotional distress in newly diagnosed lung cancer survivors.	Cohort	United States of America, Mayo Clinic	864 participants	FACIT	Spirituality was associated with lower prevalence of emotional distress. Aspect of spirituality may serve as a protective factor for emotional distress among lung cancer survivors in the research settings.	N/A

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Table 3. Continue.

Author, year	Study's purposes	Design	Country, setting	Sample size	Instruments	Results	
						Spiritual distress	Spiritual needs
Delgado-Guay et al. (2021)	Assess spiritual distress/spiritual pain among patients with cancer with limited supportive care.	Cohort	United States of America, Specialist Palliative care	292 participants	Modified Edmonton Symptom Assessment Scale (ESAS) by adding spiritual pain.	44% patients had spiritual pain, Spiritual pain is correlated with depression.	N/A
Damen et al. (2021)	Examine the prevalence, predictors and correlates of religious/spiritual struggles.	Cross-sectional	United States of America, six outpatient palliative care service	331 participants	Brief religious and spiritual struggle scale	66% reported some religious/spiritual struggle, religion/spiritual struggle was associated with greater symptom burden.	N/A
Silva et al. (2019)	Investigate the relation between the presence of spiritual distress and use of religious spiritual coping in patients with cancer.	Cross-sectional	Brazil, Community	129 participants	Spiritual Distress Scale	Spiritual distress showed positive correlation with negative religious/spiritual coping among patients. The use of positive religious coping was significant in patients who have religious practices. Spiritual distress is a phenomenon that is present in the lives of people with cancer.	N/A

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Table 3. Continue.

Author, year	Study's purposes	Design	Country, setting	Sample size	Instruments	Results	
						Spiritual distress	Spiritual needs
Hui et al. (2011)	Determine the frequency and factors associated with spiritual distress in patients with advanced cancer.	Cohort	United States of America, Hospital	113 participants	Spiritual Distress Scale	44% patient had spiritual distress. The factors are younger, to have pain and depression.	N/A
Gielen et al. (2017)	Measure the spiritual distress among Indian palliative care patient.	Cross-sectional	India, Hospital	300 participants	Researcher's developed instrument	Patients who experience spiritual distress were younger, pain and depression. More than half of the patients would benefit from spiritual counselling. More research on spirituality palliative care is urgently required.	N/A
Mako et al. (2006)	Explore the spiritual distress in patients with advanced cancer.	Cross-sectional	United States of America, hospital	57 participants	Researcher's developed instrument	The intensity of spiritual pain did not vary by age, gender, disease course or religious affiliation.	N/A
Stripp et al. (2025)	Examine spiritual needs, level of spiritual needs and frequency specific needs type of spiritual needs.	National cross-sectional	Denmark, community	6781 participants	Spiritual Needs Questionnaire	N/A	Spiritual needs are finding meaning in suffering, talking about fears, clarifying open aspects of life and to talking about life after death.

The disparity in spiritual distress could reflect differences, methodological variations, and sample characteristics like cancer stage, treatment status, and psychological comorbidities. These factors likely contribute to the very high heterogeneity observed (I^2 = 99.56%), suggesting that prevalence estimates are context-dependent rather than universal. Most studies included in the review provided an operational definition of spirituality or spiritual distress, which aligned with the concept of spirituality described in the literature (Balboni et al., 2022; Puchalski, 2012). This is essential for advancing nursing knowledge, as it standardizes understanding, facilitates cross-study comparisons, and promotes the incorporation of spiritual assessment and interventions into comprehensive cancer care (Nejat et al., 2023). Studies included in the current review utilized different instruments with different criteria and interpretation for classifying levels of spiritual distress. The SpNQ stands out as the most valuable instrument available. Developed to assess a broad range of spiritual needs in cancer patients, it has been validated in various contexts, is relatively brief, and is easy for nurses to administer in busy clinical environments. For oncology nurses, using the SpNQ helps identify unmet spiritual needs to guide interventions. Furthermore, amongst included studies, two studies provided specific element of spiritual distress such as divine, demonic (Damen et al., 2021; Ullrich et al., 2016), while other studies reported the percentage of total score (Ordons et al., 2018). The type, quality, and level of spiritual distress can vary significantly among patients that resulting in distinct differences in their experiences. Despite variations in instruments and interpretation methods, addressing nursing interventions to meet patients' specific needs is important (Nashwan et al., 2023; Zhao et al., 2021). Future studies conducted across different countries, using standardized instruments and scoring criteria, will provide valuable insights into the characteristics of spiritual distress in patients from diverse geographical locations.

The review also presented that unmet spiritual needs vary based on geographic location. For example, two studies conducted Muslim majority country (Sastra et al., 2021) and Catholic predominant country in non-religion predominant country (Martins et al., 2021) reported the most unmet spiritual need is prayer and go to religious services. This finding in line with previous research in Indonesia and Portugal that identified a centrality of religion in everyday life (Rego et al., 2020, Rochmawati et al., 2018). The variation in unmet spiritual needs across countries clearly reflects the influence of cultural and religious contexts. In these contexts, practices like prayer and attending services hold different levels of importance in daily life (Pour & Hojjati, 2015). For nurses, this finding underscores the necessity for nurses to conduct spiritual assessment and ensure that care is based on patient's background and values or belief (Lazenby, 2018; Zumstein-Shaha et al., 2020). One study conducted in Thailand found that preparing for death was a highly cited concern among patients (Wisesrith et al., 2021). This finding contrasts with a previous study, which highlighted that discussing death in Thailand can be sensitive and often requires an approach that combines religious perspectives with the use of euphemisms (Wilainuch, 2013). The use of euphemisms and indirect communication in Thailand demonstrate healthcare professionals' awareness of Buddhist concepts of impermanence and karma to convey meaning in a way that is respectful, acceptable, and less threatening. This review also highlighted two included studies stated the need of inner peace and actively giving (Sastra et al., 2021; Höcker et al., 2014).

The findings are congruent with recent study from Lithuania that patients with cancer state the exceptional importance of inner peace and generativity (Riklikienė et al., 2020). This is contrast to studies on patients with cancer in India, where spirituality is strongly affected by economic and religious attributes (Gielen et al., 2017). Differences in spiritual needs among patients with cancer may influence how these needs are addressed. Therefore, spiritual care should focus on supporting religious practices, promoting inner peace, giving and generativity. Nurses are central to meeting the complex and diverse needs of patients by assessing individual spiritual concerns and facilitating access to religious practices. Nurses also provide a supportive presence to promote inner peace and encourage opportunities for giving and generativity as key components of spiritual care. This review found a correlation between spiritual distress and some patient demographic characteristics. For instance, younger patients and those with no religious affiliation were more vulnerable to experience spiritual distress (Hui et al., 2021). The findings, however, are contrary to previous evidence showing no association between age, religious affiliation and spiritual well-being (Rabow & Knish, 2015). The inconsistency may be due to sample differences, such as the inclusion of outpatients with cancer receiving concurrent oncologic and palliative care. Nurses should therefore use these insights as guidance for their practice. However, nurses must continue to conduct individualized spiritual assessments to ensure that each patient's unique needs are recognized and addressed. Amongst the included studies in this systematic review, spiritual distress was associated with emotional distress. Such finding support previous scoping review that summarizing association of demographic characteristics to spiritual distress among inpatient setting (Ordons et al., 2018). Further, this review also identified associations between spiritual distress and symptoms and quality of life, previously reported amongst outpatients with cancer receiving palliative care (Pérez-Cruz et al., 2019, Rabow & Knish, 2015). The finding highlights the need for integration of spiritual

assessment and support into routine symptom management. This strategy may reduce suffering among the group of patients. Only one study included in this review identified female as predictor of spiritual needs. The finding is consistent with previous study that cited female as predictors of spiritual need in patients with cancer (Delgado-Guay et al., 2019). The difference may be attributed to women's tendencies to be more expressive about existential concerns, their greater engagement in religious or spiritual practices, and their likelihood of seeking social and spiritual support during illness. Such gender-related distinctions may account for why female cancer patients are identified as having higher spiritual needs.

Our review found that the spiritual need is associated with living with family, that is consistent with previous findings that both the patient and family receive psychological and spiritual support when they are at home (Vigna et al., 2020). Family caregivers provide emotional and practical support that helps patients cope with illness. Being surrounded by family also strengthens spiritual well-being through shared beliefs, mutual support, and opportunities to maintain meaningful connections. Spiritual need has been associated with anxiety in four included studies (Huang et al., 2021; Höcker et al., 2014; Hampton et al., 2007; Ullrich et al., 2021). The finding concurs with previous studies that found anxiety is prevalent with patients who reported spiritual needs (Delgado-Guay et al., 2019) and spiritual care can improve patient's anxiety (Moeini et al., 2014). These findings emphasize the importance of healthcare professionals considering sociodemographic and clinical variables that impact patients' spiritual distress, informing appropriate interventions. However, this review has several limitations during the process. For instance, data heterogeneity across included studies precluded meta-analysis. Additionally, the use of diverse data collection tools to measure spiritual distress and needs complicated data extraction and synthesis. Furthermore, the review's inclusion of only English-language evidence may have overlooked valuable insights from non-English speaking countries.

Conclusion

This systematic review reveals that patients' spiritual distress is associated with younger age, religious affiliation, and various burdens. Moreover, spiritual needs exhibit geographical variability that influenced by factors such as gender, length of cancer diagnosis, and anxiety. To effectively address spiritual distress, care provision should incorporate spiritual assessments that consider demographic, psychological, and illness-related factors. Additionally, spiritual care should encompass religious rituals as well as aspects of inner peace and generativity. Future studies should focus on developing and utilizing valid and reliable instruments to measure spiritual needs and distress among cancer patients in both hospital and community settings.

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AI statements

The development of this manuscript did not involve the use of AI text generator. The views and opinions presented in this review are based on the authors' analysis.

Author's declaration

All authors made significant contributions to the conceptualization, design, analysis, interpretation of data, drafting, and critical revision of the manuscript, and approved the final version for publication.

Availability of data and materials

All data and materials are available from the authors on a case-by-case basis and for research purposes.

Competing interests

The authors declare that they have no conflicts of interest.

Ethical clearance

Ethical approval was not required for this project because it analyzed published data and did not involve direct interaction with human participants. However, the review protocol has been registered in the International Prospective Register of Systematic Reviews (PROSPERO: CRD42022352390).

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Publishers and journal's note
The systematic review highlights the need to assess spiritual distress and needs among patients with cancer. The method was appropriate for examining the extent to which clinical issues have been investigated in the literature. Oncology nurses should take this into close account in daily practice.

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Authors' insight

Key points

- Patients with cancer frequently experience spiritual distress which is a state of suffering related to a loss of meaning, purpose, or connection with themselves, others, or a higher power.
- A patient's spiritual needs aren't always religious and can change over the course of their illness such as seeking peace and hope and maintaining relationships with loved ones.
- Healthcare professionals, including nurses, need to understand the concept of spiritual care to optimally meet patients' needs.

Emerging nursing avenues

- How can healthcare institutions integrate spiritual care into standard cancer treatment protocols as a routine part of a patient's care plan from the moment of diagnosis?
- What specific training and educational tools would be most effective in equipping oncology nurses and other healthcare professionals to address the spiritual needs of their patients without imposing their own beliefs?
- Given the dynamic nature of a cancer patient's spiritual needs, what kind of assessment tools or frameworks are needed to track and respond to these evolving needs throughout their illness and beyond?

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