

PREVALENCE OF SPIRITUAL DISTRESS AND ITS ASSOCIATION WITH SYMPTOM BURDEN AMONG PATIENTS RECEIVING PALLIATIVE RADIOTHERAPY AT TERTIARY CARE HOSPITAL OF WESTERN INDIA: A CROSS-SECTIONAL ANALYTICAL STUDY

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ABSTRACT

Background: A diagnosis of advanced, metastatic or recurrent cancer is a profoundly distressing life event that often results in significant spiritual distress. These patients frequently experience multiple existential concerns which can adversely affect their overall well-being. Recognition of patients' spiritual needs has therefore become an integral component of palliative care. Evidence examining the relationship between spiritual distress and multidimensional symptom burden among patients receiving palliative radiotherapy remains limited. Therefore, present study was undertaken to determine the prevalence of spiritual distress and its association with symptom burden among patients receiving palliative radiotherapy. **Materials and Methods:** Analytical cross-sectional study. Participants were recruited according to inclusion & exclusion criteria. Demographic and clinical information was collected. Spiritual distress was assessed using Spiritual Distress Scale for Palliative Care Patients in India (SpiDiSci) tool. Symptom burden was assessed using Edmonton Symptom Assessment System-Revised (ESAS-r). Depressive symptoms were evaluated using Patient Health Questionnaire-9 (PHQ-9). **Results:** Total of 171 patients included in the study. 41(24.0%) patients had severe spiritual distress. The mean spiritual distress score was 47.8 ± 25.1 . The mean PHQ-9 score was 11.7 ± 7.0 , while the mean total ESAS-r score was 31.1 ± 14 . Spiritual distress demonstrated a weak but statistically significant positive correlation with overall symptom burden ($\rho = 0.251$, $p < 0.001$), depressive symptoms ($\rho = 0.304$, $p < 0.001$), and anxiety ($\rho = 0.265$, $p < 0.001$). No statistically significant correlation was observed between spiritual distress and pain score ($\rho = 0.124$, $p = 0.107$) or ECOG performance status ($\rho = 0.085$, $p = 0.272$). **Conclusion:** Present study concludes that Spiritual Distress is highly prevalent in patients undergoing palliative radiotherapy. Positive correlation exists between spiritual distress and physical and psychological symptoms burden. So there should be routine spiritual distress screenings and culturally adaptive management strategy for the patients receiving palliative radiotherapy.



INTRODUCTION

A diagnosis of cancer, particularly in the context of advanced disease, progression, or recurrence, is a profoundly distressing life event that often results in significant spiritual suffering. Patients with advanced cancer frequently experience multiple existential concerns, including fear of pain, physical deterioration, dependency, helplessness, loneliness, and death. These experiences can challenge their sense of meaning, purpose, and hope, thereby adversely affecting their overall well-being.^[1] Previous studies have demonstrated that spiritual suffering is closely associated with unmet psychosocial needs, ineffective communication, fear of death, hopelessness, and despair.^[2]

Spirituality is generally understood as an individual's search for meaning, purpose, and connectedness with self, others, nature, or a transcendent reality. In contrast, religion is typically expressed through an organized system of beliefs, rituals, and practices shared within a faith community. Although spirituality and religion are distinct concepts, they are closely interconnected and frequently influence each other in the context of health and illness.^[3] Spirituality is a deeply personal and dynamic experience that may exist both within and outside formal religious traditions. Rather than being defined by specific religious beliefs, spirituality reflects how individuals understand their lives and live according to their personal values, purpose, and sources of meaning.^[4]

Spiritual distress has been defined as "a state of suffering related to impaired meaning in life and disrupted connections with oneself, others, the world, or a higher power."^[5]

It is a multidimensional phenomenon that affects existential well-being and has important consequences for physical, psychological, social, and spiritual health. As cancer progresses, spiritual concerns often become more pronounced, particularly during the palliative phase of care, when patients face increasing uncertainty and awareness of mortality. Loss of meaning and purpose during this period may diminish the desire to continue living and impair coping with illness. Poor spiritual well-being has been associated with depression, anxiety, hopelessness, impaired coping, lower quality of life, and greater difficulty in managing physical symptoms.^[6]

Furthermore, evidence suggests that spiritual well-being serves as a protective factor against psychological distress in patients with advanced cancer and other life-limiting illnesses.^[7]

Recognition of patients' spiritual needs has therefore become an integral component of comprehensive palliative care. Early identification of spiritual distress facilitates individualized supportive interventions that may improve coping, symptom management, and overall quality of life. Nevertheless, routine assessment of spiritual distress

remains uncommon in clinical practice because of several barriers, including limited consultation time, inadequate training in spiritual care, uncertainty regarding appropriate interventions, and concerns about addressing sensitive personal beliefs.^[8]

Recent research has increasingly focused on the psychosocial and spiritual dimensions of palliative care and their influence on patients' quality of life. While numerous studies have examined the relationship between psychological distress—including depression, anxiety, and hopelessness—and symptom burden, comparatively fewer investigations have specifically evaluated spiritual distress among patients receiving palliative anticancer treatment, particularly in low- and middle-income countries.^[9]

Evidence examining the relationship between spiritual distress and multidimensional symptom burden among patients receiving palliative radiotherapy remains limited, especially in the Indian setting.

Addressing this knowledge gap is important for developing holistic, patient-centred palliative care strategies that integrate spiritual care into routine oncology practice. Therefore, the present study was undertaken to determine the prevalence of spiritual distress and examine its association with symptom burden among patients receiving palliative radiotherapy at a tertiary care hospital in Western India.

MATERIALS AND METHODS

Study Design and Setting: This hospital-based analytical cross-sectional study was conducted at the satellite centre of the State Cancer Institute, a tertiary care cancer hospital in Western India. The study was conducted between January 2026-May-2026. Written informed consent was obtained from all participants before enrolment.

Study Participants: Eligible participants were recruited consecutively from the outpatient radiotherapy departments during the study period.

Inclusion Criteria

Participants were eligible if they:

- were aged 18 years or older;
- had histologically or clinically confirmed advanced or metastatic cancer;
- were receiving palliative radiotherapy;
- had an Eastern Cooperative Oncology Group (ECOG) performance status of 0–3;
- were able to communicate effectively and provide written informed consent; and
- were able to understand and respond to the Hindi version of the study questionnaires.

Exclusion Criteria

Participants were excluded if they:

- had cognitive impairment or delirium that precluded reliable responses;
- had severe psychiatric illness interfering with study participation;

- had an ECOG performance status of 4; or
- were receiving structured spiritual counselling at the time of assessment, as this could influence the assessment of spiritual distress.

Data Collection: After enrolment, demographic and clinical information was collected using a structured case record form. The variables recorded included age, sex, marital status, educational status, primary cancer site, stage of disease and ECOG performance status.

Performance status was assessed using the Eastern Cooperative Oncology Group (ECOG) Performance Status Scale.^[10]

Study Instruments

Spiritual Distress: Spiritual distress was assessed using the Spiritual Distress Scale for Palliative Care Patients in India (SpiDiSci), a validated instrument developed for Indian palliative care patients. The scale consists of 16 dichotomous (Agree/Disagree) items evaluating spiritual suffering experienced during the preceding two weeks. Responses were scored as 1 ("Agree") and 0 ("Disagree"). The total spiritual distress score was calculated as the mean item score multiplied by 100, with higher scores indicating greater spiritual distress.^[11]

Symptom Burden: Symptom burden was assessed using the Edmonton Symptom Assessment System–Revised (ESAS-r). The ESAS-r evaluates ten common symptoms experienced by patients with advanced cancer, including pain, tiredness, drowsiness, nausea, appetite, shortness of breath, depression, anxiety, overall well-being, and an additional patient-selected symptom. Each symptom is rated on an 11-point numerical rating scale ranging from 0 (absence of symptom) to 10 (worst possible severity). Higher scores indicate greater symptom burden.^[12]

Depressive Symptoms: Depressive symptoms were evaluated using the Patient Health Questionnaire-9 (PHQ-9). The PHQ-9 comprises nine items corresponding to the diagnostic criteria for major depressive disorder. Each item is scored from 0 ("Not at all") to 3 ("Nearly every day"), yielding a total score ranging from 0 to 27. Depression severity was categorized as minimal (0–4), mild (5–9), moderate

(10–14), moderately severe (15–19), and severe (20–27).^[13]

Outcome Measures

The primary outcome was the prevalence of spiritual distress among patients receiving palliative radiotherapy. The secondary outcome was the association between spiritual distress and symptom burden, including individual symptom scores, depressive symptoms, and performance status.

Statistical Analysis

Data were entered into Microsoft Excel and analysed using Jamovi (version 2.7.31). Continuous variables were assessed for normality using the Shapiro–Wilk test and summarized as mean $\pm$ standard deviation (SD) or median (interquartile range [IQR]), as appropriate, while categorical variables were presented as frequencies and percentages. Associations between spiritual distress and symptom burden (ESAS-r), depressive symptoms (PHQ-9), pain score, anxiety score, and ECOG performance status were assessed using Spearman's rank correlation coefficient. Spiritual distress scores were compared between sex using the Mann–Whitney U test. Multiple linear regression analysis was performed to identify factors independently associated with total symptom burden (ESAS-r score), including age, sex, treatment modality, ECOG performance status, spiritual distress score, and PHQ-9 score. Model assumptions, including multicollinearity and normality of residuals, were evaluated before analysis. A two-sided p value <0.05 was considered statistically significant.

RESULTS

A total of 171 patients with advanced cancer receiving palliative radiotherapy were included in the study. The mean age of the participants was 50.5 ± 13.0 years. Most participants were male (61.4%), and head and neck cancer was the most common primary malignancy (55.6%), followed by breast cancer (13.5%) and lung cancer (6.4%). The majority had an ECOG performance status of 2 (64.9%), followed by ECOG 1 (27.5%) and ECOG 3 (7.6%). Detailed baseline demographic and clinical characteristics are presented in. [Table 1]

Table 1: Baseline demographic and clinical characteristics of the study participants (N = 171)

Characteristic	Value
Age (years), mean $\pm$ SD	50.5 $\pm$ 13.0
Sex, n (%)	
Male	105 (61.4)
Female	66 (38.6)
Primary cancer site, n (%)	
Head and neck	95 (55.6)
Breast	23 (13.5)
Lung	11 (6.4)
Cervix	9 (5.3)
Endometrium	5 (2.9)
Esophagus	5 (2.9)
Others*	23 (13.4)
ECOG [#] performance status, n (%)	
1	47 (27.5)
2	111 (64.9)
3	13 (7.6)

Others included pancreatic (n = 4), rectal (n = 4), malignancy of unknown origin (n = 3), prostate (n = 2), urinary bladder (n = 2), renal cell carcinoma (n = 2), ovarian (n = 1), chondrosarcoma (n = 1), ependymoma (n = 1), malignant peripheral nerve sheath tumour (n = 1), multiple myeloma (n = 1), and

skin carcinoma (n = 1); #ECOG, Eastern Cooperative Oncology Group; Among the 171 study participants, 41 (24.0%) had severe spiritual distress, defined as a SpiDiSci score >60, while the remaining 130 (76.0%) had SpiDiSci scores ≤60. [Table 2]

Table 2: Prevalence of severe spiritual distress among study participants (N = 171)

SpiDiSci category	n	%
Severe spiritual distress (SpiDiSci score >60)*	41	24.0
SpiDiSci score ≤60	130	76.0
Total	171	100.0

Abbreviation: SpiDiSci, Spiritual Distress Scale for Palliative Care Patients in India.

***Note:** Severe spiritual distress was defined as a SpiDiSci score >60 according to the original SpiDiSci validation study. The mean spiritual distress score was 47.8 ± 25.1 , with a median score of 46.2 (IQR: 31.3–57.1). The mean PHQ-9 score

was 11.7 ± 7.0 , indicating an overall moderate level of depressive symptoms, while the mean total ESAS-r score was 31.1 ± 14.6 , reflecting a moderate symptom burden among the study participants. The distributions of spiritual distress, depressive symptoms, and symptom burden are presented in. [Table 3]

Table 3: Distribution of spiritual distress, depressive symptoms, and symptom burden among study participants (N = 171)

Variable	Mean ± SD	Median (IQR)	Minimum–Maximum
Spiritual Distress Score (SpiDiSci)	47.8 ± 25.1	46.2 (31.3–57.1)	0–100
PHQ-9 Score	11.7 ± 7.0	10.0 (7.0–16.0)	0–27
Total ESAS-r Score	31.1 ± 14.6	32.0 (19.0–43.0)	7–63

Abbreviations: SpiDiSci, Spiritual Distress Scale for Palliative Care Patients in India; PHQ-9, Patient Health Questionnaire-9; ESAS-r, Edmonton Symptom Assessment System-Revised; SD, standard deviation; IQR, interquartile range. Spiritual distress demonstrated a weak but statistically significant positive correlation with overall symptom burden ($p = 0.251$, $p < 0.001$), depressive symptoms ($p = 0.304$, $p < 0.001$), and anxiety ($p = 0.265$, $p < 0.001$). No statistically significant correlation was observed between spiritual distress and pain score ($p = 0.124$, $p = 0.107$) or ECOG performance status ($p = 0.085$, $p = 0.272$).

Abbreviations: ESAS-r, Edmonton Symptom Assessment System-Revised; PHQ-9, Patient Health Questionnaire-9; ECOG, Eastern Cooperative Oncology Group.

Note: Spearman's rank correlation coefficient was used because the spiritual distress scores were not normally distributed.

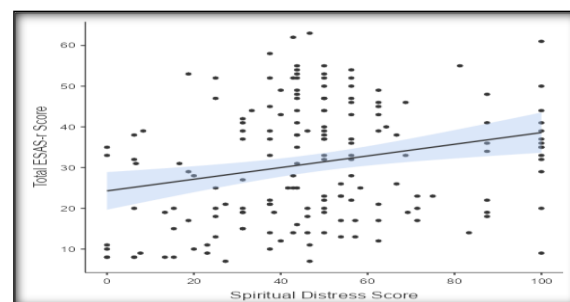


Figure 1: Scatter plot showing the relationship between Spiritual Distress Score and Total ESAS-r Score

Multiple linear regression analysis demonstrated that **spiritual distress was independently associated with higher symptom burden** after adjusting for age, sex, treatment modality, ECOG performance status, and depressive symptoms ($\beta = 0.113$, $p = 0.017$). None of the remaining variables were independently associated with total symptom burden. The overall model explained **9.5%** of the variability in ESAS-r scores ($R^2 = 0.095$, $p = 0.011$).

Table 4: Correlation between spiritual distress and clinical variables (N = 171)

Variable	Spearman's rho (ρ)	p-value
Total ESAS-r score	0.251	<0.001
PHQ-9 score	0.304	<0.001
Pain score	0.124	0.107
Anxiety score	0.265	<0.001
ECOG performance status	0.085	0.272

Table 5: Multiple linear regression analysis of factors associated with total symptom burden (ESAS-r score) (N = 171)

Predictor	Regression coefficient (β)	Standard Error	p-value
Age	-0.041	0.088	0.646
Male sex	-2.580	2.300	0.264
Palliative radiotherapy	1.080	2.267	0.634
ECOG performance status	-3.777	1.998	0.060

Spiritual distress score	0.113	0.047	0.017
PHQ-9 score	0.222	0.172	0.196

Model statistics: R = 0.308; R² = 0.095; Adjusted R² = 0.062; F = 2.85; p = 0.011.

DISCUSSION

It has been shown that religion and better health are significantly correlated in both healthy individual and numerous patients. As distinct from religion, the importance of spirituality in promoting health and managing illness has received attention in recent years.^[4]

Many cancer patients view spirituality as a vital aspect of their identity which becomes increasingly relevant as the disease advances.^[14] Patients' spirituality may help them feel better, by giving their challenging experiences structure and purpose and acting as a protective barrier against existential pain, hopelessness, sadness, and the desire to die. However, as disease advances, patients are faced with complicated psychological, physical and existential issues, spiritual distress may arise. It can also result from ongoing battles with fear, anger, bodily discomfort, loss of independence, shifting roles and relationships, and a lack of purpose.^[15]

In the present study, 41 patients (24%) presented with a severe spiritual distress. Similarly, Mako et al also found that 61% patients had spiritual pain while interview with 96 % had experienced some spiritual pain in their lives.^[16] Hui et al also found similar result with spiritual distress in 50 (44 %) patients. Variation in these frequencies may be due to the way spiritual distress was defined and measured.

Physical pain and spiritual distress are two different phenomena, this study found no correlation between pain and spiritual distress. This finding is comparable with result of Daniel et al.^[17] Similarly mako et al also found no significant correlation between physical pain and spiritual pain and concluded that One may be more capable to differentiate between physical and spiritual distress once physical pain has subsided. As physical pain relieved, Clinicians may have access to the underlying spiritual and existential issues that remains dormant under the urgency of physiological suffering.^[16]

Many research indicates that higher levels of spiritual well-being are consistently associated with better physical and mental health. A strong belief system and Spiritual wellbeing is positively impacted by a strong faith and belief system as well as by the capacity to discover meaning and purpose.^[18] Our study confirms a significant association between total symptom score (ESAS-r) and spiritual distress, aligning with findings of previous study demonstrated similar association between physical and spiritual dimension. They concluded that an interdisciplinary team approach is necessary to address the complex needs of such palliative care patients.^[19] These finding highlight vital important of interdisciplinary care. Because a high ESAS-r score serves as an indicator of potential spiritual distress,

routine symptom screening should act as a trigger for broader holistic assessments.

Spirituality has an important impact on the outcomes of patients on palliative treatment with favorable response on physical and emotional stress, reducing risk of depression. On the other hand, when the personal relationship with spirituality is negative, the effects are opposite. Present study showed that anxiety and depressive symptoms were associated with spiritual distress. Similarly, Judith hills in their study of 31 palliative care patients found that fatigue, anxiety and depression positively correlated with spiritual distress.^[20] Guilherme Gryscek et al found depressive symptoms significantly associated with negative spiritual coping and concluded that by understanding this relationship, caregivers and health-care professionals could better manage these essential aspects of the total pain.^[21] Depression is characterized by negative cognitive triads (negative views of self, world and future) which can directly affect spiritual coping mechanism and increases spiritual distress. While anxiety keeps the patient in a constant threat and uncertainty leading to experience of spiritual distress.

CONCLUSION

Present study concludes that Spiritual Distress is a highly prevalent in patients undergoing palliative radiotherapy. A positive correlation exists between spiritual distress and physical and psychological symptoms burden. Only managing physical or psychological symptoms is insufficient for holistic care of patients. So there should be routine spiritual distress screenings and culturally adaptive management strategy for the patients receiving palliative radiotherapy.

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