*Palliative and Supportive Care*

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# Spiritual care interventions for palliative care patients: A scoping review

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**Review Article**

**Cite this article:** Jaman-Mewes P, Caetano da Silva de Oliveira M, Regina Mazotti M, Salvetti MdG (2024) Spiritual care interventions for palliative care patients: A scoping review. *Palliative and Supportive Care* **22**(5), 1449–1468. https://doi.org/10.1017/S1478951524000592

Received: 27 November 2023
Revised: 20 February 2024
Accepted: 17 March 2024

**Keywords:**
Interventions; spiritual care; spirituality; palliative care; scoping review

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## Abstract

**Objectives.** To identify and map spiritual care interventions to address spiritual needs and alleviate suffering of patients in the context of palliative care.

**Methods.** A scoping review using the PRISMA ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews) checklist was conducted according to the JBI (Joanna Briggs Institute) guidelines. The search was conducted from October 2022 to January 2023 using 9 electronic databases and gray literature. Studies on spiritual care interventions in palliative care were included. Disagreements between the 2 reviewers were resolved by discussion or a third reviewer.

**Results.** A total of 47 studies were included in this review. All selected articles were published between 2003 and 2022. In total, 8 types of spiritual care interventions were identified to assess spiritual needs and/or alleviate suffering: conversations between the patient and a team member, religious practice interventions, therapeutic presence, guided music therapy, multidisciplinary interventions, guided meditation, art therapy, and combined interventions with multiple components such as music, art, integrative therapy, and reflection.

**Significance of results.** Our study identified few spiritual care interventions in palliative care worldwide. Although this review noted a gradual increase in studies, there is a need to improve the reporting quality of spiritual care interventions, so they can be replicated in other contexts. The different interventions identified in this review can be a contribution to palliative care teams as they provide a basis for what is currently being done internationally to alleviate suffering in palliative care and what can be improved. No patient or public contribution was required to design or undertake this methodological research.

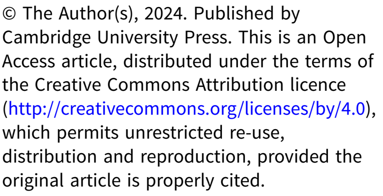
## Introduction

Spiritual care is essential to address the problems that arise when a person is diagnosed with a life-threatening disease. Life is forever changed, and existential questions arise about the meaning and significance of life, as well as the need for hope and fulfilment (Puchalski et al. 2018). Palliative care should respond to suffering of any kind and should not only seek to prevent and alleviate physical and psychological suffering, but also the social and spiritual suffering of patients and their families (WHO 2022).

Individuals and their families experience suffering defined as "the specific state of distress that occurs when the individual's imminent demise is perceived; it continues until the threat of disintegration has passed or until the person's integrity can otherwise be restored" (Benito et al. 2014; Cassell 1999). Loss of meaning and purpose in life, despair, and hopelessness, not being remembered, feelings of guilt and shame, and feeling angry with God are some examples described in the literature in relation to the spiritual suffering experienced by patients. They also include inability to forgive, feelings of abandonment, loneliness, profound sense of lack of control over physical and mental function, loss of faith, need for reconciliation with self or others, and the feeling and processes associated with loss of people, health, and relationships (Puchalski et al. 2018).

A sick and vulnerable person who senses the approach of death requires holistic care from a multidisciplinary team that more accurately understands the discomfort, spiritual needs, and spiritual suffering experienced at this stage of life. Studies indicate that patients expect nurses and other health-care professionals to provide spiritual care, especially in end-of-life situations (Ronaldson et al. 2017). However, it remains difficult for professionals to incorporate spiritual care into patient care (Ghorbani et al. 2021) and to demonstrate the health benefits for individuals.

Spiritual care is defined as "care that recognises and responds to the needs of the human spirit when faced with trauma, illness, or grief. It includes the need for meaning and self-worth,



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the need for self-expression, the need for faith support, or simply the need for a sensitive listener" (Hamilton et al. 2017). Other authors point out that spiritual care is a subjective and dynamic concept that has 7 defining attributes, such as healing presence, therapeutic use of the self, intuitive sense, exploration of spiritual perspective, patient-centered care, meaning-centered therapeutic intervention, and the creation of a spiritually enriching environment (Ramezani et al. 2014).

It is unclear what interventions are used in the palliative care setting to alleviate suffering and address spiritual needs. Some of the interventions that are generally mentioned are: spiritual support, facilitating spiritual growth, giving hope, decreasing anxiety, emotional support, presence, and care in dying (NANDA 2023; Tordable 2015). On the other hand, there are specialists who have not received sufficient training to provide spiritual care and do not know how to approach it (Ghorbani et al. 2021). This paper provides a scoping review to identify studies on spiritual care interventions in palliative care and highlight the gap in this area for future research.

The results of a study related to spiritual care in palliative care showed that spiritual care helps 88% to feel hopeful, 83% to feel comforted, 79.1% to find meaning and 73.4% to understand meaning, and 95.2% value the spiritual care needed in illness (Bermejo et al. 2013).

A qualitative study on palliative care nurses in Australia aimed to identify spiritual care interventions used in palliative care services. This study classified the interventions into 3 categories: humanistic, pragmatic, and religious interventions (Ronaldson et al. 2017). However, the authors did not describe the population to whom the intervention is delivered, nor did they describe each intervention.

There are systematic reviews related to spiritual care in pediatric and adolescent patients (Robert et al. 2019) and end-of-life patients through telemedicine (Viana and Abejas 2022). In addition, a systematic review was found that includes spiritual/existential support to end-of-life patients only by the nursing professional and excludes the multidisciplinary team (Mascio et al. 2022). There is another review that seeks to identify conceptual models of spiritual care interventions with the main outcome being to improve the spiritual well-being of patients in the advanced stage (Liu et al. 2019), not to mention the alleviation of suffering.

On the other hand, we found a scoping review conducted in 2017 with the aim of mapping an "intervention to facilitate forgiveness" implemented and evaluated in palliative care settings (Silva et al. 2020). While the latter review described may match some of the inclusion criteria for this study, this information is only a small part of addressing the spiritual needs of people in palliative care, so this result would only be a part of what we expect to find.

This review is different from the objectives set out in previous reviews. The difference is in the population and the concept which aims to identify spiritual care interventions that are in line with alleviating suffering and addressing the spiritual needs of adult patients in palliative care units by the multidisciplinary team. Thus, although there are reviews related to spiritual care in palliative care, no systematic review was found (published or ongoing) that comprehensively covers what this review aims to find.

The scoping review aims to examine and clarify broad areas to identify gaps in evidence, clarify key concepts, and inform the types of evidence that address and inform practice in a topic area (Peters et al. 2020). The aims were to identify and map spiritual care interventions to address spiritual needs and alleviate suffering of patients in the context of palliative care by the multidisciplinary team.

## Method

### *Study design*

This scoping review was conducted according to the guidelines of the JBI (Joanna Briggs Institute) methodology (Khalil et al. 2021; Peters et al. 2020) and the PRISMA ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews) checklist, in accordance with a protocol registered on Open Science framework (OSF) (Registration DOI 10.17605/OSF.IO/A327W) (Jaman-Mewes et al. 2022).

### *Review question*

The main review question was: What spiritual care interventions are provided to adults and older persons in palliative care units to address spiritual needs and/or alleviate suffering? More specific review questions were:

(i) What are the characteristics of the spiritual care interventions: individual and/or group, name, resources, objectives, frequency, duration, theoretical reference of the spiritual care intervention?
(ii) Which members of the palliative care team developed the intervention?
(iii) What were the dependent variables and the instruments used to measure outcomes?
(iv) Which outcomes were found after the intervention was implemented?

### *Search strategy*

The search was conducted from October 2022 to January 2023. The search strategy aimed to find published and unpublished studies. A 3-step search strategy was used in this review. The first step is a limited search on a small number of keywords in CINAHL and PsycINFO. Following this search, an analysis of the words in the titles and abstracts and the indexed terms was undertaken. The second step of the search strategy involved the use of the planned databases using all identified keywords and index terms extracted. The third step of the search strategy included articles from the reference lists of published studies and gray literature. A librarian contributed to develop the search strategy. Studies published in any language and in any year were considered for inclusion in this review. The full search strategies are provided in Appendix I and II.

The search terms of this review included: "Palliative Care," "End of Life Care," "Spiritual Care," "Spiritual Intervention," "Spiritual Needs," "Suffering," "Adult," and "Older Adult."

### *Information sources*

The databases consulted were: CINAHL, PsycINFO (APA), MEDLINE/PUBMED, EMBASE (Elsevier), Scopus (Elsevier), ProQuest, Cochrane Library (John Wiley), LILACS, and CUIDEN. The search for unpublished studies included: RCAAP; DART-Europe; Tesis Capes; Cybertesis; TESEO and ProQuest. We also manually searched studies using other sources. The search on gray literature included WHO, health departments of different countries, such as the UK, Australia, Canada, Spain, United States, and Google Scholar. Other important sources of information such as peer-reviewed studies were considered. The authors of 1 primary study were contacted for full text access, however no response was obtained.

https://doi.org/10.1017/S1478951524000592 Published online by Cambridge University Press

**Table 1.** Inclusion and exclusion criteria

| | Inclusion criteria | Exclusion criteria |
|---|---|---|
| Population | Adult patients aged 18 years or older who are terminally ill and assisted by palliative care teams, including health professionals (doctors, nurses, physiotherapists, psychologists, social workers, occupational therapists, chaplains, and/or volunteers). | Children or adolescents under 18 years of age |
| Concept | Spiritual care interventions that address the spiritual needs and/or alleviate the suffering of adults and older people in palliative care. **Spiritual care** is defined as "care that recognises and responds to the needs of the human spirit when faced with trauma, illness, or grief. It includes the need for meaning and self-worth, the need for self-expression, the need for faith support, or simply the need for a sensitive listener" (Hamilton et al. 2017). | – |
| Context | Studies in the context of palliative care at all care levels (primary, secondary, and tertiary); including nursing homes, outpatient, and inpatient. | – |
| Study design | Quantitative study, mixed-methods study, qualitative study. In addition, systematic reviews, text, and opinion papers were considered for inclusion in the proposed scoping review. | – |

### Study selection

Studies were included or excluded guided by the inclusion and exclusion criteria based on the Population, Concept, and Context framework in Table 1. All identified citations were copied and uploaded into ENDNOTE and duplicates were removed using the software and double validation by 2 reviewers. Retrieved articles were imported into the RAYYAN review manager for reviewing and screening. Two independent reviewers screened the titles and abstracts to identify potentially relevant articles. The 2 independent reviewers continued to assess the full texts of those relevant articles for including or excluding them in/from the review. Disagreements between the 2 reviewers were resolved through discussion or with a third reviewer, when required. The author further searched the reference list of included articles to identify any additional relevant articles.

### Data extraction

The data extracted was in accordance with JBI and aligned with the objectives and question of this study. Two tables were developed by the research team for data summarizing. General information included author, year of publication, country of study, type of study (quantitative, qualitative, mixed, case study, report, review), population, and study setting (Table 2).

Other data extracted relevant to the research questions for the purposes of this publication are shown in Table 2, including name of the intervention, information of the spiritual care intervention characteristics (description, frequency, duration, and conceptual framework or theoretical model), and who from the palliative care team carried out the intervention. The assessment tools for measuring suffering or spiritual needs were also mapped and the main results obtained were described in the findings. Three reviewers extracted data from included studies independently, and disagreements were resolved through discussion and consulting the third author. Any disagreements that arose between the reviewers were resolved through discussion or with a third reviewer.

### Data presentation

The data were extracted from the included documents using a Microsoft Excel worksheet based on a preliminary document. This instrument was developed in accordance with the preliminary search and review questions. Two authors independently selected the data, and a third author was involved in case of disagreement.

## Results

The electronic database search identified 1,254 studies, of which 401 were duplicates. The title and abstract screening excluded 777 studies. After full-text assessment, 31 studies were further excluded and 25 additional studies were identified through manual search via other sources: websites, organizations, and experts recommended. Finally, a total of 47 studies were included in this review. Figure 1 shows the PRISMA flow diagram (Page et al. 2021) which describes the flow of decisions of this process and the exclusion reasons of studies.

### Characteristics of the included studies

All articles selected in this scoping review were published between 2003 and 2022. Of 47 studies included in this review, 14 used a quantitative design, 8 mixed-methods, 5 qualitative, 9 case studies, and 11 reviews and reports. Regarding their origin, most studies were conducted in the United States ($n = 14$), followed by Spain ($n = 8$) and Australia ($n = 4$), and other countries such as Japan ($n = 3$), Malaysia, Brazil, the Netherlands, and the United Kingdom, with 2 articles each. One study found from each of: Germany, Italy, Switzerland, Belgium, Portugal, China, Pakistan, New Zealand, and Chile, and a report from Latin America. Most of the studies were written in English ($n = 39$), followed by Spanish ($n = 7$), and 1 article in Basque. All patients in the populations had an advanced incurable disease. The study settings varied and included communities, hospices, hospitals, palliative care units, and nursing homes. Table 2 presents a summary of the main characteristics of included studies and the main findings of the scoping review.

### Spiritual care interventions for patients in palliative care

A variety of spiritual care interventions were identified. All interventions were individual, mostly based on a theoretical model and with a holistic approach. In total, 8 types of spiritual care interventions were identified to assess spiritual needs and/or alleviate suffering. They included: conversations between the patient and a team member ($n = 33$), religious practice interventions ($n = 10$), therapeutic presence ($n = 8$), music therapy ($n = 6$), multidisciplinary interventions ($n = 4$), guided meditation ($n = 3$), art therapy ($n = 2$), and combined interventions ($n = 7$) with multiple components such as music, art, integrative therapy, among others.

**Guided conversations** are interventions that are carried out by the palliative care team member and use a questionnaire of semi-structured or structured questions based on a specific theoretical model to facilitate dialogue and reflection with the patient. These interventions include legacy intervention (Allen et al. 2014), life

**Table 2.** Summary of included studies and findings of spiritual care interventions

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Allen et al. 2014) | USA | RCT | **TP:** PC patients suffering from an advanced disease or combination of chronic illnesses and caregivers.<br>**A:** >55 YO<br>**SS:** 45 | Home visits and supportive telephone calls for PC patient and caregivers | Legacy intervention | **Description:** Conversation with preestablished questions. Construction of a personal legacy: usually a scrapbook with photographs; 3 supportive telephone calls.<br>**F:** 3 home visits (1 per week)<br>**D:** NA<br>**TM:** Theoretical model modified from the Revised Stress and Coping Model (Folkman, 1997). | Retired senior volunteers. |
| (Ando et al. 2010) | Japan | RCT | **TP:** Cancer patients from the PC units<br>**A:** >20 YO<br>**SS:** 68 | PC units of 2 general hospitals | Short-term life review | **Description:** Conversation through guided questions and album making.<br>**F:** 3 sessions, with an interval of 1 week between the first and the second session.<br>**D:** Each session were between 30 and 60 min.<br>**TM:** Dignity therapy – Chochinov | Physicians, nurses, clinical |
| (Gomez-Castillo et al. 2015) | USA | OS | **TP:** Outpatients of pain and PC service with serious life-altering illness.<br>**A:** -<br>**SS:** 79 | Chaplains visit with PC clinicians for all new outpatients within their first 3 visits and/or intervening hospital admissions | Spiritual Assessment Quality Improvement | **Description:** Conversation based on semi-structured questions<br>**F:** 3 visits<br>**D:** NA<br>**TM:** Christina Puchalski | Physicians, nurses, fellows, chaplains |
| (Ichihara et al. 2019) | Japan | Non RCT | **TP:** Incurable advanced cancer<br>**A:** Age mean: 65.8 YO<br>**SS:** 46 | Hematology and oncology ward and 2 PC units | Spiritual pain assessment sheet (SpiPas) | **Description:** Conversation through a structured evaluation tool incorporating specific dimensions: relatedness, autonomy, and temporality.<br>**F:** NA<br>**D:** 30 min<br>**TM:** The conceptual framework of Murata | Nurses |

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https://doi.org/10.1017/S1478951524000592 Published online by Cambridge University Press

**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Kestenbaum et al. 2017) | USA | Pre- to post-intervention | **TP:** Patients with advanced cancer<br>**A:** Age mean: 59.4 YO<br>**SS:** 31 | Outpatient PC services at a cancer center | Spiritual AIM | **Description:** There is an unstructured conversation focusing on 3 spiritual needs.<br>**F:** 3 sessions<br>**D:** 45–60 min<br>**TM:** Assessment and Intervention Model (AIM) | Chaplains |
| (Lim et al. 2021) | Malaysia | RCT | **TP:** Patients under PC<br>**A:** >18 YO<br>**SS:** 60 | Inpatient PC unit | 5-min mindfulness of love | **Description:** Mindfulness can transform suffering by changing what the mind is processing.<br>**F:** NA<br>**D:** 5 min<br>**TM:** Mindfulness (Kabat-Zinn 1994); loving-kindness meditation (Salzberg 1995) | Physicians |
| (Rosenfeld et al. 2017) | USA | Pilot study | **TP:** Diagnosed with terminal cancer.<br>**A:** Age mean: 66.9 YO<br>**SS:** 12 | Inpatient PC hospital | Meaning-centered psychotherapy | **Description:** Guided conversation in relation to meaning in life, significant moments in life and sources of meaning.<br>**F:** 3 sessions.<br>**D:** 45 min.<br>**TM:** Viktor Frankl's Logotherapy | Psychologist |
| (Rudilla et al. 2015) | Spain | QES | **TP:** Patients with a palliative oncological and advanced non-oncological diagnosis<br>**A:** Age mean: 70.61 YO<br>**SS:** 131 | PC unit and home care unit | Counselling | **Description:** Guided conversation with semi-structured questions.<br>**F:** 2–3 sessions per week.<br>**D:** 30–50 min each session.<br>**TM:** Guide objectives in a counselling session (Arranz et al. 2003); Spiritual Model SECPAL | Psychologist |
| (Soto-Rubio et al. 2020) | Spain | RCT | **TP:** Advanced and terminal disease<br>**A:** Age mean: 65.18 YO<br>**SS:** 60 | Patients were at home or in the corresponding ward | Kibo therapeutic interview in PC | **Description:** Guided conversation with semi-structured questions. The patient is asked questions regarding the 3 dimensions of spirituality.<br>**F:** During the week<br>**D:** 1–3 h<br>**TM:** Spiritual Model SECPAL and based on the GES questionnaire. | Psychologist, physician, nurse, other |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Steinhauser et al. 2008) | USA | Pilot RCT | **TP:** Participants' primary diagnoses included cancer (48), heart disease (5), lung disease (10), and other (19)<br>**A:** 28–96 YO<br>**SS:** 82 | Two local hospices, a PC service, home-based care program, and the extended care and rehabilitation center | "Outlook: Life review, forgiveness and legacy" | **Description:** Guided conversation with semi-structured questions. Session 1: life story; session 2: forgiveness; session 3: legacy.<br>**F:** 3 times, spaced a week apart<br>**D:** 45 min–1 h each<br>**TM:** The authors developed a conceptual model | Nonphysician clinician |
| (Sun et al. 2016) | USA | QES | **TP:** Advanced or terminally ill<br>**A:** Age mean: 66.17 YO<br>**SS**: 475 patients and 354 family caregivers | National Cancer Institute designated comprehensive cancer center | The interdisciplinary PC intervention | **Description:** Educational sessions. Session focused exclusively on spiritual well-being with the following topics: hope, inner strength, uncertainty, purpose and meaning in life, positive changes, redefining self and priorities and spirituality/religiosity.<br>**F:** 4 sessions<br>**D:** 25–32 min.<br>**TM:** National Consensus Project's Clinical Practice Guidelines for PC | Nurses |
| (Dean Vuksanovic et al. 2017a) | Australia | RCT | **TP:** Advanced disease with a life expectancy of less than 12 months<br>**A:** Age mean: 57.7 YO<br>**SS:** 56 | Outpatients or at home and inpatient ward. | "Dignity therapy/life review" | **Description:** Guided conversation through a standard framework of questions.<br>**F:** 4 contacts over 10 days during active interventions<br>**D:** 60 min.<br>**TM:** Erik Erikson's concepts; dignity therapy – Chochinov | Psychologist |
| (Warth et al. 2021) | Germany | Multicenter RCT | **TP:** Advanced cancer<br>**A:** 66.1 YO (SD = 12)<br>**SS:** 104 | Two PC wards | "Song of life" music therapy intervention | **Description**: A novel music therapy intervention working with a biographically meaningful song and conversations guided by predefined questions in the last session<br>**F:** 3 consecutive days.<br>**D:** 20–30 min<br>**TM:** Dignity therapy – Chochinov | Music therapist |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Yik et al. 2021) | Malaysia | RCT | **TP:** Advanced cancer and other chronic illnesses<br>**A:** Age mean: 56.74 YO<br>**SS:** 40 | PC unit | 5-min mindfulness of peace | **Description:** A patient is invited to relax and concentrate through a guidance script read by the researcher. The control group received 5 min of active listening, in which they were asked about their life experience.<br>**F:** NA **D:** 5 min<br>**TM:** Mindfulness – Scott Bishop, 2004 | Physician |
| (Chochinov et al. 2005) | Australia | MM | **TP:** Terminally ill patients with cancer<br>**A:** Age mean: 63.9 YO<br>**SS:** 100 | Inpatient and outpatient | Dignity therapy | **Description:** Designed to address psychosocial and existential distress. Semi-structured guided conversation inviting patients to discuss issues that matter most.<br>**F:** 3–4 contacts over approximately 7–10 days.<br>**D:** 30–60 min<br>**TM:** Dignity model of PC | Psychiatrist, nurse, psychologist |
| (De Araújo et al. 2006) | Brazil | MM | **TP:** PC patients with terminal cancer<br>**A:** Ranged age 27–76 YO<br>**SS:** 11 | Units of PC in public hospitals | Relaxation, mental images, and spirituality for spiritual pain (RIME) | **Description:** The intervention consists of 3 steps. The first is the identification of the symbolic pain of death through a semi-structured interview. Then transforming the spiritual pain data into images and then using mental relaxation techniques.<br>**F:** Between 1 and 11 sessions<br>**D:** NA<br>**TM:** NA | Nurses, physicians, psychologist, Alternative therapist |
| (Ganzini et al. 2015) | USA | MM | **TP:** Terminally ill patients<br>**A:** A $>$ 21 YO<br>**SS:** 55 | Hospitalization | Harp Music Vigil | **Description:** Music-thanatology is a palliative modality that uses harp and voice to provide bedsides vigils. The music is usually not familiar to the patient.<br>**F:** NA **D:** 45 min.<br>**TM:** The founder was Therese Schroeder-Sheker. | Music thanatologist |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Keall et al. 2013) | Australia | MM | **TP:** PC patients with advanced cancer<br>**A:** A 50–89 YO<br>**SS:** 10 | Inpatient PC unit, or outpatient community settings | Outlook intervention | **Description:** Conversation through predetermined questions. Content of the 3 sessions: life story, forgiveness, and legacy.<br>**F:** 3 sessions, 1 week apart<br>**D:** 30 min<br>**TM:** Erikson E, 1982 | Nurses |
| (Kwan et al. 2019) | China | MM | **TP:** People suffering from life-limiting diseases.<br>**A:** Mean A 64.4 (SD: 11.98); 28–89 YO<br>**SS:** 109 | Hospitalization, day hospice, or outreach home care | Short-term life review | **Description:** A conversation with 8 guiding questions from the life review to explore life stories.<br>**F:** 2 sessions. 1 week apart.<br>**D**: NA<br>**TM:** Ando et al. 2010. | Nurses |
| (Peng et al. 2019) | USA | MM | **TP:** PC patients<br>**A:** Age mean: 66.8 YO<br>**SS:** 46 | Patients receiving a hospice or PC consult. | Music intervention | **Description:** A live musician interacts with the patient and gives patients the possibility to choose their preferred music according to their wishes and needs in a dynamic and intuitive way.<br>**F:** NA<br>**D:** NA<br>**TM:** NA | Musician |
| (Poletti et al. 2019) | Italy | MM | **TP:** People with metastatic cancer<br>**A:** Age mean: 54 YO<br>**SS:** 20 | Early PC inpatient facility within the oncology unit | Mindfulness-based stress reduction | **Description:** Each session they followed techniques of meditation such as sitting meditation, body scan, light yoga, simple walking meditation, and aikido exercises.<br>**F:** 8 weekly meetings<br>**D:** 2.5 h a week, a 4.5 h session between the 6th and 7th week, and 0.5 h home practice daily.<br>**TM:** Cognitive-constructivist framework | Psychologist, physician trained in meditation, nurse. |
| (Renz et al. 2005) | Switzerland | MM | **TP:** Terminally ill cancer patients.<br>**A:** Age mean: 59 YO<br>**SS**: 135 | Palliative cancer care in the oncology center. | "Music therapy/psychotherapy/spiritual intervention" | **Description**: A mixture of psychotherapy and music therapy, verbal, and nonverbal communication, including or excluding religious or spiritual elements such as prayer, words from the bible, blessings, and rituals.<br>**F:** NA **D:** NA<br>**TM:** Active imagination: Jung and Chodorow | Psychologist |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Abad and López 2020) | Spain | QS | **TP:** Nurses caring for terminally ill patients.<br>**A:** Age mean: 37 YO<br>**SS:** 24 | Multiple public, private, or subsidized health centers | Spiritual care interventions | **Description:** Addresses different areas of the spiritual dimension. Among them: Importance of the presence. Therapeutic accompaniment. Practicing compassionate action. Spiritual support. Facilitating spiritual growth. Improving coping. Facilitating grief. Therapeutic communication. Life review therapy.<br>**F:** NA<br>**D:** NA<br>**TM:** NANDA-NIC NOC; Kübler-Ross; Christina Puchalski | Nurses |
| (Tamura et al. 2006) | Japan | QS | **TP:** Terminal cancer patients<br>**A:** Age mean: 64.9 YO<br>**SS:** 10 | PC unit in a general hospital | Spiritual pain assessment sheet | **Description:** Assessment of spiritual suffering through a worksheet. The purpose is to identify and characterize spiritual suffering in relation to temporality, relationship with others and concerns.<br>**F:** NA<br>**D:** 30–40 min<br>**TM:** Framework of spiritual pain, Murata, 2004 | Nurses |
| (Vermandere et al. 2013) | Netherlands | QS | **TP:** Professional caregivers and palliative patients<br>**A:** Patient: 60–80 YO; professional, caregivers: 30–60 YO<br>**SS:** Patient: 4; caregivers: 11 | Palliative home care | Spiritual conversation | **Description:** Spiritual conversation, guided by the Ars Moriendi Model. The interview was based on preestablished questions about life and death from the model.<br>**F:** 1–2 session(s)<br>**D:** NA<br>**TM:** Ars Moriendi Model | Physician, nurses |
| (Vuksanovic et al. 2017b) | Australia | QS | **TP:** Advanced cancer<br>**A:** 41–78 YO<br>**SS**: 56 | Inpatient PC, outpatient, or home | Dignity therapy, waitlist dignity therapy, and life review | **Description:** Psychotherapeutic interventions and examines the content of legacy documents. These interventions aimed at reinforcing a sense of purpose, meaning and sense of dignity in terminally ill patients.<br>**F:** NA<br>**D:** NA<br>**TM:** Erik Erikson's concepts; dignity therapy – Chochinov | Psychologist |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Walker and Waterworth 2017) | New Zealand | QS | **TP:** PC nurses<br>**A:** Age mean: 53 YO<br>**SS:** 9 | Inpatient and community PC services | Spiritual care experiences | **Description:** Assessment of spiritual needs; recognition of spiritual distress; provision of spiritual care.<br>**F:** NA<br>**D:** NA<br>**TM:** NA | Nurses |
| (Amonoo et al. 2020) | USA | CS | **TP:** A patient metastatic cancer recurrence<br>**A:** 70 YO<br>**SS**: 1 | Hospitalization PC | Helping patients with existential suffering | **Description:** The article names 12 activities which reinforce a sense of community, transcendence, and meaning.<br>**F:** NA<br>**D:** NA<br>**TM:** Different theoretical models according to the intervention. Example: Victor Frankl and Irving Yalom | Physician |
| (Baumrucker 2003) | USA | CS | **TP:** A patient with metastatic liver cancer<br>**A:** 60<br>**SS:** 1 | Inpatient | Spirituality in hospice and PC | **Description:** Through conversation, the doctor listens to the patient's concerns and resolves the spiritual problem.<br>**F:** NA<br>**D:** NA<br>**TM:** NA | Physician, chaplain |
| (Benito et al. 2016) | Spain | CS | **TP:** Patient with medulloblastoma<br>**A:** 24 YO<br>**SS:** 1 | PC unit in hospital care in private clinic | Spiritual accompaniment as a therapeutic intervention | **Description:** It used semi-structured conversation to initiate the spiritual accompaniment.<br>**F:** NA<br>**D:** NA<br>**TM:** Spiritual Model SECPAL, person-centered. | Interdisciplinary team |
| (Collette and Pascual 2010) | Spain | CS | **TP:** Advanced cancer patients.<br>**A:** 54 and 69 YO<br>**SS:** 2 | PC unit | Art therapy | **Description:** The creation of works of art (drawing, painting, clay, creative writing) offers the patient the possibility to discover and interpret symbolic and aesthetic clues to his or her inner world.<br>**F:** 5–7 sessions spread over 15 days<br>**D:** 1 h<br>**TM:** Malchiodi, 1999; Wood, 2004 | Art therapist |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (da Silva et al. 2015) | Brazil | CS | **TP:** Advanced pancreas cancer<br>**A:** 43 YO<br>**SS:** 1 | Pain ambulatory of the service of pain therapy and PC | Integration of the spiritual dimension to health disease | **Description:** Home assessment by the multi-professional team, including the chaplain.<br>**F:** Fortnightly by the team and weekly by the chaplain.<br>**D**: 40–60 min.<br>**TM:** Saporetti, 2008; Campbel, 2011 | Physician, nurse, psychologist, social worker, chaplain |
| (Kearney et al. 2017) | USA | CS | **TP:** Advanced heart failure<br>**A:** Age mean: 60 YO<br>**SS:** 128 | Inpatient | Spiritual care interventions | **Description:** Conversations about patients' hopes and fears for the future. Interventions include theological reflection; compassionate presence; life review; mind/body practice; prayer/meditation; search for meaning; relationship with God.<br>**F:** NA **D:** NA<br>**TM:** The national consensus project for quality PC clinical practice guidelines | Chaplain |
| (Makhani 2015) | Pakistan | CS | **TP**: Patient with chronic kidney disease<br>**A:** 85 YO<br>**SS:** 1 | Inpatient | PC intervention: addressing physical and spiritual needs | **Description:** The patient was facilitated to perform religious practices and helped to meet his spiritual needs.<br>**F:** NA<br>**D:** NA<br>**TM:** Christina Puchalski | Nurse |
| (Tang et al. 2020) | USA | CS | **TP**: Patients with advanced cancer<br>**A:** 69 and 71 YO<br>**SS:** 2 | Inpatient | Psychosocial interventions | **Description:** An interdisciplinary approach including expressive supportive counselling, spiritual care, and integrative medicine were used, followed by pharmacological treatment if refractory.<br>**F:** NA<br>**D:** NA<br>**TM:** Christina Puchalski | Interdisciplinary team |
| (Tordable 2015) | Spain | CS | **TP:** Patient with metastatic colon cancer<br>**A:** 65 YO<br>**SS:** 1 | Home care | Spiritual support | **Description:** Some activities were: spiritual support; giving hope; facilitating forgiveness; dying care.<br>**F:** NA<br>**D:** 60 days of home monitoring<br>**TM:** NANDA Model: 00066 Spiritual Suffering | Nurse |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Balboni et al. 2017) | USA | Report | **TP:** Patients and family in PC; chaplains and interdisciplinary team members<br>A: NA | Hospital settings | Spiritual care interventions | **Description:** Different spiritual needs assessment within PC is presented: chaplain care, psychotherapeutic interventions, life review interventions, multidisciplinary team interventions, mind-body interventions.<br>**F:** NA<br>**D:** NA<br>**TM:** Multiple models depending on the type of intervention: Chochinov's dignity therapy, Puchalski and Romer's FICA Model, etc. | Physician, nurse, chaplain |
| (Espinel and Colautti 2020) | Latino Americana Association | Report | **TP:** Patient and families in PC.<br>**A:** Children, adolescents, adults, and older adults | PC in all setting | Spiritual care | **Description:** Spiritual history, spiritual screening, formal spiritual assessment, general and specialized spiritual care interventions are explained.<br>**F:** NA<br>**D:** NA<br>**TM:** Mako et al. 2006; Balboni et al. 2017; Steinhauser et al. 2004; Best et al. 2020; National Consensus Project for Quality PC 2018; Fitchett et al. 2017 | Interdisciplinary team |
| (Guerrero-Torrelles et al. 2017) | Spain | SLR | **TP:** Studies that include patients with any kind of advanced disease.<br>Included articles: 12 | Ambulatory or hospitalized patients | Meaning in life interventions | **Description:** The details of the meaning in life interventions are described. Conversations exploring concepts and sources of meaning, discussing life priorities and changes in goals that give personal meaning among others.<br>**F:** Between 2 and 8<br>**D:** Between 30 and 90 min<br>**TM:** Frankl's logotherapy; Park and Folkman and Morita Model. | Professionals' therapist |
| (MINSAL, 2022) | Chile | Report | **TP:** Patients in PC<br>**A:** Adults | PC in all setting | Total, pain approach; "Being There"; spiritual needs approach. | **Description:** Three spiritual care interventions are described in general terms. The GES questionnaire, ENESE instrument, and FICA tool are recommended.<br>**F:** NA<br>**D:** NA<br>**TM:** Christina Puchalski; SECPAL | Interdisciplinary team |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Milligan 2011) | Scotland – UK | Review | **TP:** Studies that include PC patients near the end-of-life<br>**A:** NA | PC in all setting | Spiritual care intervention | **Description:** This report identifies some of the practical ways in which nurses can identify, support, and assist people to meet their spiritual care needs. Some spiritual assessment tools: FICA, HOPE, Spiritual Need Questionnaire, FACIT.<br>**F:** NA<br>**D:** NA<br>**TM:** Marie Curie Cancer Centre (2003); Christina Puchalski et al. (2006) | Nurses |
| (Pawuk and Schumacher 2010) | USA | Review | **TP:** Studies that include PC patients in hospice. | Patients and families in hospice and PC | Music therapy | **Description:** Numerous music therapy techniques can be used such as music listening, music focused relaxation, live music entertainment, the Bonny Method of Guided Imagery and Music, song writing, song dedications, musical legacy, musical autobiography, among others. The recording becomes a significant touchstone for the bereavement journey of the family members.<br>**F:** NA<br>**D:** NA<br>**TM:** Bonny method of guided imagery and music | Music therapists |
| (Silva et al. 2020) | Portugal | Scoping review | **TP:** Studies that focus on PC patients.<br>**A:** >18 YO<br>**Included articles:** 23 | Hospices and PC units | Forgiveness facilitation intervention | **Description:** Some characteristics describes are active listening, life review, reminiscence, verbalization of family conflict, exploration of feelings: love, guilt, will reconcile, exploration of concerns reinforcing coping forces, facilitating dialogue.<br>**F:** NA **D:** 30 min–3 h<br>**TM:** The Nursing Interventions Classification (NIC). | Social workers, nurses, doctors, psychologists |
| (Serrano-Pejenaute and Ortiz-Jauregui 2018) | Spain | SLR | **TP:** Studies that focus on PC patients.<br>A: **NA**<br>SS: **NA** | PC in all setting | Spiritual care at the end of life | **Description:** The GES questionnaire stands out as a tool for the assessment of spiritual needs, which also has a therapeutic utility.<br>**F:** NA **D:** NA<br>**TM:** Spiritual Model SECPAL; Christina Puchalski | Interdisciplinary team |

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**Table 2.** (*Continued.*)

| Author, year | Country | Study design | Population | Study setting | Name of the intervention | Characteristics of spiritual care intervention | Intervention delivery personnel |
|---|---|---|---|---|---|---|---|
| (Slootweg 2013) | Netherland | Clinical guide | **TP:** Patients in PC<br>**A:** Adult<br>**SS:** NA | PC in all setting | Spiritual care nation-wide guideline | **Description:** The phases of the process of spiritual accompaniment are described: assistance, counselling, crisis intervention. Assessment instruments such as FICA/SPIRIT are required to enable a conversation with the person.<br>**F:** NA **D:** NA<br>**TM:** Christina Puchalski; The "Ars Moriendi" model | Physician, nurse, psychologist, social worker, psychiatrist |
| (Universities of Hull and Aberdeen 2010) | UK | SLR | **TP:** Studies that include adults at the end of life.<br>**A**: Adults<br>**SS:** NA | PC in all setting | Spiritual care intervention | **Description:** It describes psychosocial interventions for spiritual suffering: a supportive-expressive approach; providing comfortable environments; meaning centered approach; being education and coping skills training; and a religious approach.<br>**F:** NA **D:** NA<br>TM: The review yielded 12 spiritual care models. | Interdisciplinary team |
| (Wierstra et al. 2023) | Netherland | Proposal intervention | **TP:** Palliative patients<br>**A:** Adult<br>**SS:** NA | Home care | "In dialogue with your life story" | **Description:** Chaplain-led intervention to assess spiritual needs and contribute to spiritual well-being. Three important characteristics of intervention are (1) life review; (2) materiality, ritual, and embodiment; and (3) imagination.<br>**F:** 6 weekly meetings **D:** NA<br>**TM:** Park (2013) developed the "Meaning Making Model"; Christina Puchalski | Chaplain |

TP = target population; A = age; SS = sample size; YO = years old; NA = not appear; PC = palliative care; RCT = randomized controlled trial; CS = case study; F = frequency; D = duration; TM = theoretical model; SECPAL = Spirituality Group of the Spanish Society of PC; QS = qualitative study; MM = mix methods; SLR = systematic literature review; OS = observational study; QES = quasi-experimental study.

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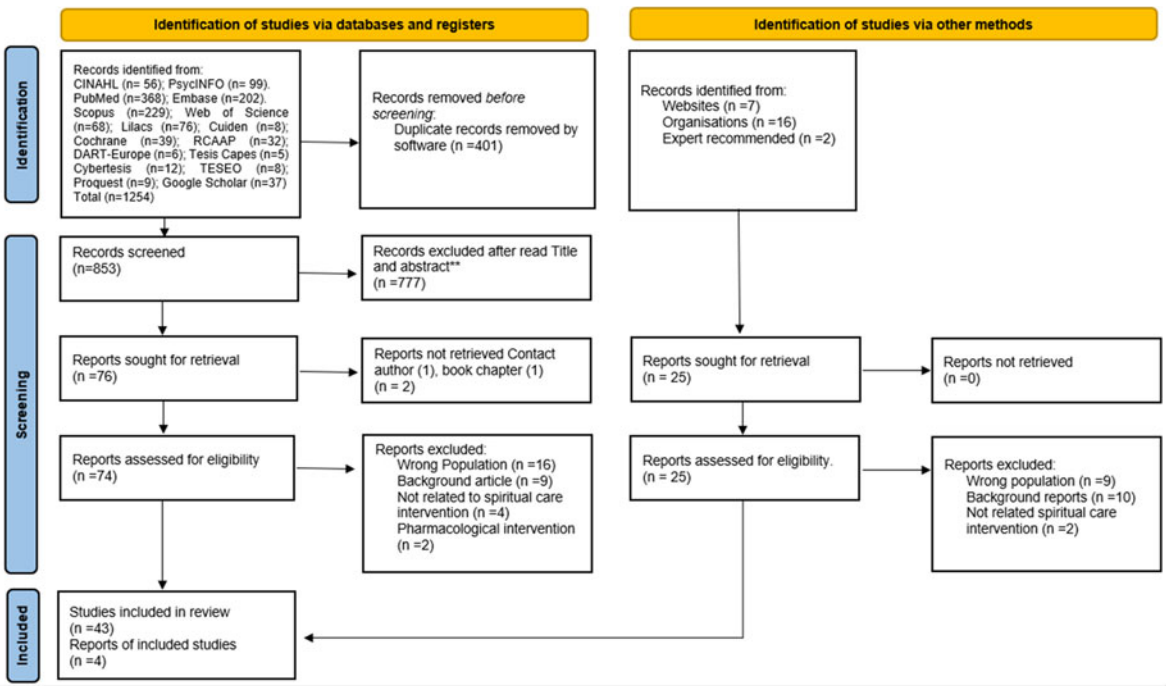


**Figure 1.** PRISMA flow diagram.

review (Abad and López 2020; Ando et al. 2010; Balboni et al. 2017; Kearney et al. 2017; Kwan et al. 2019; Silva et al. 2020; Steinhauser et al. 2008; Vuksanovic et al. 2017a, 2017b; Wierstra et al. 2023), meaning-centered therapy (Guerrero-Torrelles et al. 2017; Kearney et al. 2017; Rosenfeld et al. 2017; Universities of Hull and Aberdeen 2010), counselling (Amonoo et al. 2020; Rudilla et al. 2015; Slootweg 2013; Tang et al. 2020), Kibo therapy (Soto-Rubio et al. 2020), dignity therapy (Chochinov et al. 2005; Vuksanovic et al. 2017a, 2017b), outlook intervention (Keall et al. 2013), spiritual conversation (Milligan 2011; Vermandere et al. 2013), and forgiveness facilitation intervention (Silva et al. 2020). In addition, there are conversations through spiritual needs and spiritual suffering assessment tools that have both a therapeutic approach and use semi-structured assessment questionnaires (Balboni et al. 2017; Benito et al. 2016; Espinel and Colautti 2020; Gomez-Castillo et al. 2015; Ichihara et al. 2019; Kestenbaum et al. 2017; Milligan 2011; MINSAL 2022; Serrano-Pejenaute and Ortiz-Jauregui 2018; Slootweg 2013; Tamura et al. 2006; Walker and Waterworth 2017). On the other hand, there are **unstructured conversations** that are characterized by free listening to the patient's needs, acknowledging the patient's problem and alleviating the patient's spiritual suffering (Baumrucker 2003; Tordable 2015).

Interventions of **religious practices** (Balboni et al. 2017; Baumrucker 2003; da Silva et al. 2015; Gomez-Castillo et al. 2015; Ichihara et al. 2019; Kearney et al. 2017; Makhani 2015; Renz et al. 2005; Tang et al. 2020; Universities of Hull and Aberdeen 2010) include the intervention of a chaplain or facilitation of practices by a member of staff.

There is **therapeutic presence**, as another type of intervention described in some studies from different countries: Spain, New Zealand, United Kingdom, Chile, USA, and Latin America (Abad and López 2020; Benito et al. 2016; Espinel and Colautti 2020; Kearney et al. 2017; Milligan 2011; MINSAL 2022; Universities of Hull and Aberdeen 2010; Walker and Waterworth 2017). "Presence" is understood as giving time and being physically with the patient. It is also called "compassionate presence" (Benito et al. 2016; Kearney et al. 2017) and "being there" (MINSAL 2022). It highlights the importance of the therapist's presence as a form of spiritual care to facilitate the transcendence of suffering. In Latin America, compassionate presence is spoken of as a fundamental therapeutic tool.

**Interventions through music** are guided by the music therapist, who explores feelings in the person and significant aspects of life. It also uses predefined pre- and post-intervention questions (Ganzini et al. 2015; Pawuk and Schumacher 2010; Peng et al. 2019; Warth et al. 2021). There are **interventions by the interdisciplinary team** (Balboni et al. 2017; da Silva et al. 2015; Sun et al. 2016; Tang et al. 2020), such as **Mindfulness interventions** which are guided interventions that allow the patient to transform suffering by changing what the mind is processing (Lim et al. 2021; Poletti et al. 2019; Yik et al. 2021). **Art interventions** are another way to address emotional and spiritual needs (Collette and Pascual 2010; Renz et al. 2005). Finally, **Combination interventions** combine any of the methods described above (Amonoo et al. 2020; De Araújo et al. 2006; Kearney et al. 2017; Renz et al. 2005; Tang et al. 2020; Universities of Hull and Aberdeen 2010; Wierstra et al. 2023).

### *Characteristics of the spiritual care interventions*

All interventions were characterized as individual. The objectives of the interventions depended on the type of study conducted. For example, quantitative studies sought to examine the effectiveness or efficacy of an intervention or to assess the feasibility and acceptability of an intervention. The other types of studies remain at a more descriptive level of existing interventions.

Quantitative and mixed studies provide more information regarding the frequency and duration of interventions, unlike the

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other types of studies that do not present structured interventions. Specifically, the number of sessions (frequency of intervention) ranged between 1 and 11 sessions, separated by different intervals of time. The duration of the interventions ranged from 5 min to 3 h.

Regarding theoretical reference, multiple models exist depending on the type of intervention. A total of 39 out of 47 studies reported theoretical models. The main ones described were Christina model Puchalski's in the United States stands out with the most references ($n = 11$) (Abad and López 2020; Balboni et al. 2017; Gomez-Castillo et al. 2015; Makhani 2015; Milligan 2011; MINSAL 2022; Serrano-Pejenaute and Ortiz-Jauregui 2018; Slootweg 2013; Tang et al. 2020; Universities of Hull and Aberdeen 2010; Wierstra et al. 2023). In Spain, the spiritual model of SECPAL stands out ($n = 5$) (Benito et al. 2016; Milligan 2011; Rudilla et al. 2015; Serrano-Pejenaute and Ortiz-Jauregui 2018; Soto-Rubio et al. 2020). In the Netherlands, there is the "Ars Moriendi model" (Slootweg 2013; Vermandere et al. 2013). For the interventions related to the meaning of life, Viktor Frank's logotherapeutic model ($n = 3$)(Amonoo et al. 2020; Guerrero-Torrelles et al. 2017; Rosenfeld et al. 2017) and Park (Guerrero-Torrelles et al. 2017; Wierstra et al. 2023) and Folkman (Allen et al. 2014; Guerrero-Torrelles et al. 2017) developed the "the meaning Making Model." In Japan, there is the spiritual pain framework of Hisayuki Murata (Ichihara et al. 2019; Tamura et al. 2006) and Shoma Morita model (Guerrero-Torrelles et al. 2017).

Nursing Intervention Classification was another frame of reference for some studies (Abad and López 2020; Silva et al. 2020; Tordable 2015). Other interventions are based on Erik Erikson's concepts of generativity and ego integrity (Keall et al. 2013; Vuksanovic et al. 2017a, 2017b) and there are several other interventions with different currents in psychology such as Jung, Chodorow, Vaughn, Wilber (among others), and psychiatry such as Kubler-Ross. In meditation therapies, the models of Kabat-Zinn, Slazberg, Bishop, and the Cognitive constructivist framework were prominent (Lim et al. 2021; Poletti et al. 2019; Yik et al. 2021). The founder of the field in music therapy was Therese Schroeder-Sheker (Ganzini et al. 2015), and Bonny Method (Pawuk and Schumacher 2010), and Malchiodi and Wood in art therapy (Collette and Pascual 2010). Table 2 displays the characteristics of the spiritual care interventions.

## Health team members

Regarding the question "Which members of the health-care team provide spiritual care?" the results demonstrate that in most of the studies ($n = 19$), spiritual care can be provided by any member of the interdisciplinary team, but the most involved are nurses, physicians, and psychologists. Some interventions were delivered by specific professionals: 10 interventions were delivered by nurses (Abad and López 2020; Ichihara et al. 2019; Keall et al. 2013; Kwan et al. 2019; Makhani 2015; Milligan 2011; Sun et al. 2016; Tamura et al. 2006; Tordable 2015; Walker and Waterworth 2017), 5 were provided by psychologists (Renz et al. 2005; Rosenfeld et al. 2017; Rudilla et al. 2015; Vuksanovic et al. 2017a, 2017b), 4 were given by music therapists (Ganzini et al. 2015; Pawuk and Schumacher 2010; Peng et al. 2019; Warth et al. 2021), 3 were delivered by physicians (Baumrucker 2003; Lim et al. 2021; Yik et al. 2021), 4 were offered by chaplains (Baumrucker 2003; Kearney et al. 2017; Kestenbaum et al. 2017; Wierstra et al. 2023), 1 was given by an art therapist (Collette and Pascual 2010), 1 was offered by volunteers (Allen et al. 2014), and another intervention of spiritual care was delivered by a nonphysician clinician (Steinhauser et al. 2008).

## Assessment tools to assess suffering and/or spiritual needs in palliative care

Assessment instruments used as resources included: sociodemographic, clinical, psychological, and spiritual tools, and quality of life questionnaires. The instruments were used in quantitative studies, mixed-methods studies, and reports. The instruments were not required in qualitative studies and cases of patients, because numeric systems are not used in these types of studies.

Concerning clinical tools, the Edmonton Symptom Assessment Scale was the most used instrument (Chochinov et al. 2005; Kestenbaum et al. 2017; Peng et al. 2019; Soto-Rubio et al. 2020). The questionnaire is used to rate symptoms experienced by cancer patients, encompassing pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well-being, and shortness of breath. Psychological tools were widely used in the selected studies and the prevalent scales found in the studies refers to anxiety and depression. Most of the studies applied spiritual tools to evaluate patients' spiritual well-being, such as the Functional Assessment of Chronic Illness Therapy-Spiritual (FACIT-Sp) Scale (Ando et al. 2010; Ichihara et al. 2019; Kestenbaum et al. 2017; Lim et al. 2021; Milligan 2011; Sun et al. 2016; Universities of Hull and Aberdeen 2010; Warth et al. 2021; Yik et al. 2021), and the FICA Spiritual Assessment Tool (F: Faith or Beliefs; I: Importance or influence; C: Community; A: Address) (Balboni et al. 2017; Espinel and Colautti 2020; Gomez-Castillo et al. 2015; Milligan 2011; Serrano-Pejenaute and Ortiz-Jauregui 2018; Slootweg 2013; Universities of Hull and Aberdeen 2010; Wierstra et al. 2023). Although FACIT-Sp and FICA were more common in the included studies, other scales were also relevant, including the GES (Grupo Espiritualidad SECPAL: Spirituality Group SECPAL) Questionnaire (Espinel and Colautti 2020; MINSAL 2022; Rudilla et al. 2015; Serrano-Pejenaute and Ortiz-Jauregui 2018; Soto-Rubio et al. 2020) and SPIRIT (Spiritual History) (Balboni et al. 2017; Serrano-Pejenaute and Ortiz-Jauregui 2018; Slootweg 2013; Universities of Hull and Aberdeen 2010). Another way of assessing spiritual suffering was through the Pictogram suffering (Lim et al. 2021; Yik et al. 2021), and through the Spiritual Suffering Assessment Worksheet (Tamura et al. 2006).

## Measurement of outcomes after intervention

The outcomes of spiritual interventions can approach different areas of the human being. In the spiritual dimension, the quantitative studies in this review shows interventions which increased patients' spiritual well-being (Kestenbaum et al. 2017; Lim et al. 2021; Rudilla et al. 2015; Sun et al. 2016; Tamura et al. 2006; Warth et al. 2021; Yik et al. 2021), alleviate suffering (Allen et al. 2014; Warth et al. 2021; Yik et al. 2021), and increased ego integrity (Vuksanovic et al. 2017a; Warth et al. 2021). Other interesting outcomes were reinforced spirituality (Soto-Rubio et al. 2020), increased spiritual assessment and treatment (Gomez-Castillo et al. 2015), end of life preparation (Ando et al. 2010; Steinhauser et al. 2008), and acceptance (Yik et al. 2021).

The main outcomes in studies with mixed-methods were related to improvement in physical and psychological symptoms that indicate suffering, such as improvements in breathing, reduced anxiety and depression, and reduced pain (Ganzini et al. 2015; Kwan et al. 2019; Peng et al. 2019; Renz et al. 2005). Furthermore, in the spiritual dimension, interventions presented improvement of spiritual well-being, provided improved sense of meaning, purpose, and continued sense of worth, and increased sense of wholeness,

https://doi.org/10.1017/S1478951524000592 Published online by Cambridge University Press

personal integrity, inner peace, and changed attitude toward life and death (Chochinov et al. 2005; Kwan et al. 2019; Renz et al. 2005).

Qualitative studies introduced the perspective of the patient and the professionals about spiritual care. They also presented the importance of establishing a relationship between the patient and health-care professional to improve care effectiveness (Abad and López 2020; Tamura et al. 2006; Vermandere et al. 2013; Vuksanovic et al. 2017b; Walker and Waterworth 2017). The case studies presented relevant findings related to the treatment of spiritual pain and the recognition of spiritual needs (Amonoo et al. 2020; Baumrucker 2003; Benito et al. 2016; Collette and Pascual 2010; da Silva et al. 2015; Kearney et al. 2017; Tang et al. 2020; Tordable 2015).

Finally, the reports and literature review made the context of this type of care clear. The findings support that even though a substantial literature base for spiritual care can be found, many tools have been developed to detect, assess, and address spiritual needs, but there is a need to educate and raise awareness among professionals (Serrano-Pejenaute and Ortiz-Jauregui 2018). These studies describe interventions which led to improved spiritual care, and reduced symptoms of psychological and spiritual distress (Balboni et al. 2017; Guerrero-Torrelles et al. 2017; Silva et al. 2020; Wierstra et al. 2023), increased quality of life (Guerrero-Torrelles et al. 2017), and well-being, peace, and hope (Silva et al. 2020).

## Discussion

This scoping review analyzed 47 studies describing different interventions to assess the spiritual needs and/or alleviate suffering of adult and older adult patients in palliative care. This review provides systematic information for palliative care teams in different contexts and shows the need for further research on interventions to alleviate suffering and to report in detail the characteristics of these interventions for recommendations for clinical practice and/or to build on what has already been done to develop new interventions. A group of experts developed a Template for Intervention Description and Replication (TIDieR) checklist and guide (Hoffmann et al. 2014) to improve the completeness of reporting, and ultimately the replicability of interventions.

The approach to spiritual suffering is a broad problem that needs to be addressed and defined when designing the intervention. The loss of meaning in life, the rupture of the person's relationship with their inner world, the lack of inner peace, the loss of relationships with significant people, and the loss of faith or beliefs are different manifestations of suffering, and it has been shown that one of the most frequent intervention forms is through dialogue in a conversation with predetermined questions based on a model or theoretical referential that supports it. Countries such as the United States and Spain are benchmarks for what is currently published. Many countries are not mentioned and the information they report is brief and general. There is a need to know how to operationalize spiritual care. This review sheds light on this.

Sidani and Braden (2021) propose a methodology that can contribute to the operationalization of complex health interventions. The initial stage involves gaining a thorough understanding of the problem, and this review highlights a significant gap in this aspect. It is crucial to comprehend suffering to effectively address it. Suffering, being a broad and intricate concept, possesses various attributes that require definition and analysis before the design of an intervention. This approach is essential for evaluating the future effectiveness and impact of spiritual care on individuals' health. It becomes paramount to distinguish between different types of suffering, which are denoted in various terms and may lead to confusion for the reader. These include spiritual suffering, spiritual distress, existential suffering, spiritual pain, and total pain. Clarity is needed regarding whether distinctions exist between these terms or if they represent the same concept expressed in different ways. This clarification is essential for establishing a common language in future systematic reviews concerning spiritual care.

The phenomenon of spiritual suffering is profound and more specific, necessitating the development of instruments to assess this health issue and ascertain whether the provided intervention effectively addresses the problem.

The encounter between patient and therapist allows the patient to reestablish a sense of connection, achieving greater awareness on a personal level and in the relationship with others (Guerrero-Torrelles et al. 2017), facilitating relief in difficult moments. These conversations not only influence the spiritual level of the person, but also have implications in a holistic way at the biopsychosocial level, so there are multiple assessment instruments reported in the studies. The interventions measured psychological aspects such as anxiety and depression, quality of life, clinical symptoms, and spiritual well-being. Spiritual well-being considers the aspects of meaning of life, peace, and faith, which when diminished can be interpreted as not having spiritual well-being, but it is not specified as suffering per se. However, the concrete measurement of suffering as an individual concept was seen in few studies through the suffering pictogram (Lim et al. 2021; Yik et al. 2021).

The interdisciplinary approach in palliative care allows patients' individuality and multidimensionality to be preserved, because different professionals with specific competences together aim at healing or relieving (da Silva et al. 2015). In our study, many of the spiritual interventions could be offered by any member of the team, although nurses stood out the most probably because this professional category is at the patient's side most of the time. Music therapists, art therapists, chaplains, and volunteers are also part of the team, demonstrating the importance of the art and faith in improving spiritual well-being.

A spiritual care intervention that is little known to some health-care professional is the "therapeutic presence," also referred as "Healing presence" in some studies (Ramezani et al. 2014). In Spain it is called "Presencia terapéutica" and is defined as a way of being with the patient that enhances the therapeutic relationship. This approach allows practitioners to remain stable, open, attentive, and available to whatever arises in the encounter, facilitating the welcoming of the experiences of both the patient and the practitioner (Benito and Mindeguía 2021). Puchalski et al. (2018) calls it "compassionate presence," emphasizing listening to the patient's spiritual pain with compassion and without judgement. This practice helps patients gain a deeper understanding of their suffering and find peace over time in the presence of individuals who can listen in this empathic way. The practice of compassionate presence can be characterized as "being fully present with another as a witness to the patient's suffering."

The patient's spiritual domain is a subjective topic, but there are some tools that can be useful to assess a patient's spiritual needs and suffering. Clinical, psychological, spiritual tools, and quality of life questionnaires were found in our study. Regarding spiritual tools, FICA and FACIT-Sp were the most relevant in the included studies. The FICA Spiritual History Tool is an acronym that includes Faith, Belief, Meaning; Importance and Influence; Community; Address in Care (Puchalski et al. 2018). FACIT-Sp was created to measure spiritual well-being in cancer patients, is not limited to

https://doi.org/10.1017/S1478951524000592 Published online by Cambridge University Press

religious tradition and includes 2 subscales: meaning/peace and faith (Peterman et al. 2002). The use of spiritual tools can be a great strategy to build a trust bond with the patient and a pathway to plan spiritual care.

There is a lack of studies with interventions which more precisely describe the intervention's characteristics, including the duration, and the optimal frequency to achieve the desired outcomes. The duration of the intervention effect is also not described. On the other hand, it is striking that there are no interventions to alleviate suffering with the use of technology support, which could be an opportunity and innovation to design interventions with a technological approach, especially in the current times. It is important to consider the training of the professional implementing the intervention. Another opportunity for further research is in relation to the operationalization of the problem of spiritual suffering. The concept is so broad that this could explain the various interventions and their multiple measurement instruments. However, there are also specific interventions that address the problem of loss of meaning in life (Amonoo et al. 2020; Guerrero-Torrelles et al. 2017; Rosenfeld et al. 2017), lack of forgiveness and lack of relationship with oneself or a loved one (Silva et al. 2020), seeking to achieve relief from suffering.

The spiritual dimension and its components have been increasingly studied and described in recent years. However, more studies are needed to demonstrate the efficacy and impact of structured spiritual interventions in health care, which are necessary to help the patient and family to alleviate suffering and promote peace at the end of life.

### *Strengths and limitations*

One of the strengths of this review is that it brings together spiritual care interventions from different parts of the world and has allowed us to integrate information from a range of different studies. There are limitations of this scoping review. We acknowledge that this review is limited to patients in palliative care only. All studies with interventions in patients with advanced cancer disease in the oncology service were not included. A serious limitation was that the exclusion criteria of the studies did not explicitly exclude pharmacological interventions, however, 2 studies that sought to alleviate suffering with drugs and other hallucinogens appeared and were excluded because drugs are not part of the study. We have included multiple databases, gray literature, and governmental websites to provide a comprehensive scope of the phenomenon studied. However, we did not assess the quality of the included studies or the quality of the gray literature, as this is not the focus of this type of review.

## Conclusion

This scoping review provides a general analysis and mapping of current spiritual care interventions in palliative care for adult and older adult patients to alleviate suffering and/or assess spiritual needs. A gradual increase of studies has been observed in this review, moving from a descriptive approach, to demonstrating with evidence the effects of interventions at the biopsychosocial and spiritual level. The different interventions presented in this review can be a contribution to palliative care teams as they show how interventions are delivered, the contexts, the professionals involved, and the effects they have and could have.

**Supplementary material.** The supplementary material for this article can be found at https://doi.org/10.1017/S1478951524000592.

**Acknowledgments.** We would like to thank Juliana Takahashi and Fabiana Gulin Longhi, librarians at the University of Sao Paulo Brazil, for their willingness and assistance in the search strategy.

**Author contributions.** All authors designed the study, analyzed the data, drafted the manuscript, critically revised the manuscript, and approved the final version.

**Funding.** This study was financed in part by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – Brasil (CAPES) – Finance Code 001.

**Competing interests.** The author(s) declare none.

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https://doi.org/10.1017/S1478951524000592 Published online by Cambridge University Press