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Gender Disparity in Spirituality and Meaning in End of Life (EOL) Treatment in Cancer Patients.

Pranjal Duggal

Amity University, Noida

ABSTRACT

Confronting life-limiting condition such as cancer tends to prompt people to seriously consider questions of purpose, faith, and legacy. Spirituality and the pursuit of meaning in life are not only theoretical constructs but lived realities that influence the ways in which patients adapt to suffering and negotiate the end of life. Increasingly, evidence points to gender as a key factor in these experiences: women tend to be more vocal about spiritual needs, while men might be concerned with dignity, autonomy, and legacy. Yet end-of-life care systems tend to ignore these distinctions, providing cookie-cutter approaches that are not necessarily meaningful to all patients. This secondary research examines prior literature on gender differences in spirituality and meaning-making for cancer patients at the end of life in order to illuminate how differences impact care experiences and quality of life. Through synthesis of findings, the review emphasizes the necessity for gender-sensitive, person-focused interventions within palliative care.

Keywords: *Gender disparity in end of life, Spirituality in end of life, Meaning of life in palliative care, Palliative care*

1. Introduction

Cancer continues to be among the most common causes of death globally, with millions of people annually reaching late stages of the disease when cure becomes impossible. Care at this stage shifts to end-of-life (EOL) care, which aims not only to control physical symptoms but also to deal with psychological, social, and spiritual aspects of distress. Attending to these existential issues is linked with better quality of life, less despair, and more serene acceptance of death.

However, spirituality and meaning are not monolithic constructs; they are lived and articulated variably across individuals, influenced by culture, social roles, and gender. For psycho-oncology and palliative care, gender differences have been a persistent theme, affecting not just the reporting of spiritual needs in men and women but how they receive care and tell providers what they want for EOL treatment. It is essential to understand these differences in order to develop interventions that are equally effective as well as fair.

1.1 Defining Spirituality and Meaning in Life

Spirituality in health studies is typically conceptualized as an individual's pursuit of relating to self, others, nature, or transcendence. It can include formal religious observance, but it also includes secular concepts of peace, hope, forgiveness, and values. "Meaning in life" is a concept describing a person's feeling that life is coherent, purposeful, and meaningful, especially when facing suffering or death. The two constructs overlap but are not the same: spirituality tends to be the context in which meaning is pursued, while meaning is the result of that pursuit.

Studies indicate that increased spiritual well-being is associated with decreased depression, anxiety, and hopelessness, and that loss of meaning is linked to desire for a hastened death and lower quality of life.

1.2 Gender and End-of-Life Care Patterns

Studies have repeatedly reported gender differences in the end-of-life experience. Men are more likely to be given aggressive medical treatments at the end of life, including intensive care, and less likely to have early advance care planning. Women, on the other hand, are more likely to have emotional or relational issues raised during EOL discussions. These distinctions are not merely biological but based on socialization and gendered expectations: men are encouraged to prize autonomy, stoicism, and control, while women are expected to prize relationships, caregiving, and emotional expression.

These patterns have a direct effect on the way spiritual and existential needs are expressed. Women tend to have higher religiosity/spirituality scores and are more likely to report unmet spiritual needs, while men might underreport their distress or find meaning in legacy, success, or the protection of relatives.

1.3 Existing Evidence on Spirituality, Meaning, and Gender

Several cross-sectional surveys suggest that female cancer patients tend to hold more robust spiritual beliefs and practices and tend to employ spirituality as a coping resource more than men. They also indicate a higher need for emotional and spiritual support in palliative care. Conversely, men sometimes perform lower on religiosity scales but accentuate existential issues concerning autonomy, dignity, and control.

1.4 Importance of Studying Gender Disparities

Investigation of gender differences in spirituality and meaning at the end of life is not a dry academic exercise; it has direct clinical relevance. To begin, unresolved spiritual distress can exacerbate psychological symptoms, decrease compliance with care, and place a burden on family relationships. Second, knowledge of gendered difference can assist clinicians in communicating better — that is, by taking into account that women might define emotional or relational needs more explicitly, while men might appreciate formalized chances to work through dignity and autonomy. Third, the elimination of disparities is a matter of equity: women and men alike should receive care that speaks to their values and their cultural background, not constrained to fit standardized models.

1.5 Research Rationale

End-of-life cancer patients endure not only physical distress but also severe emotional and existential distress. Spirituality and meaning in life are paramount in coping and in sustaining dignity at the end of life. Such needs are, however, not homogenous but are constructed from gender roles, social expectations, and personal belief systems. Women tend to describe spiritual and relational issues, whereas men tend to focus on control and independence. In spite of these trends, end-of-life care today seldom considers gender-based differences in existential well-being. Investigating this difference through secondary research is necessary because it:

1. Focuses attention on an under-researched but crucial aspect of palliative care.
2. Helps clinicians understand how men and women may experience and express spirituality differently.
3. Encourages the formulation of values-based, individualized interventions that respect patients' values and promote quality of life.
4. Encourages fairness in care by creating a situation where spiritual needs are not universalized but substantively met.

2. Review of literature

The experience of cancer, especially toward the end of life, tends to bring forth deep existential and spiritual concerns. Researchers have increasingly underscored that interventions for spirituality and seeking meaning are as imperative as for physical pain and emotional distress in palliative care (Puchalski et al., 2013). Spirituality, different from religion, involves one's perception of connection, meaning, and transcendence. For most patients, this becomes an important source of strength, particularly when treatment options are all used up in the medical arena. Balboni et al. (2013), in their seminal study on advanced cancer patients, concluded that spiritual well-being was negatively correlated with depressive symptoms, hopelessness, and desire for hastened death. As an example, Pearce et al. (2012) reported that spiritual support by healthcare professionals helped to ensure higher quality of life and greater satisfaction with care, highlighting the clinical relevance of incorporating spiritual aspects into oncology and palliative medicine.

The pursuit of meaning has been considered key to human endurance in adversity. Frankl's (1963) existential model had argued that despite terminal illness, patients can uphold dignity and hope with meaning-making. Following this tradition, Breitbart et al. (2014) developed Meaning-Centered Psychotherapy (MCP) for cancer patients, showing it to be effective in decreasing hopelessness, despair, and even suicidal thoughts. Kissane (2012) prioritized the fact that existential interventions are used to assist patients in maintaining purpose and identity coherence, whereas Chochinov (2006) introduced Dignity Therapy to support patients in upholding self-worth, legacy, and a sense of meaning near the end of life. All these studies in aggregate point out that meaning-making is not only a coping mechanism but also an aim in therapy that improves quality of life.

Gender disparities, nonetheless, shape how patients respond to spirituality and meaning when dying. Chibnall et al. (2012) noted that female patients with terminal cancer were more likely to express spiritual issues and existential distress than men, frequently desiring relational proximity and emotional nurturance. Mystakidou et al. (2018) discovered that women described more existential suffering yet also responded more actively to religious and sense-making activities than did men. Kim, Sherman, and Taylor (2018) also showed that women relied on interpersonal and religion-based resources to address difficulties, while men were more likely to internalize stress, use denial, or highlight problem-solving. Later on, Fombuena et al. (2016) brought to the forefront that female patients with cancer always reported higher unmet spiritual needs, indicating gender-sensitive care to be critical in the field of palliative care.

Cultural context also influences the manner in which gender affects spiritual and existential coping. In collectivist cultures, for instance, India, spirituality tends to be rooted in religion, community practices, and family roles. Gupta and Singh (2015) found that Indian women with advanced cancer used religious rituals, praying, and visits to temples as sources of resilience, drawing from family and community networks. Men, on the other hand, preferred not to openly discuss spirituality but instead spoke of financial or practical obligations. Kumar and Kumari (2017) noted that women also depended greatly on prayer and communal spirituality as sources of strength, whereas men would rather be stoic or deny the existence of concerns. Rajesh et al.

(2019) supported these results, indicating that women in Indian palliative care found meaning through family intimacy and adherence to rituals, while men were distressed when their illness challenged their provider role.

Wider South Asian research reinforces these findings. Mathur et al. (2015) discovered that women were more inclined than men to freely discuss existential concerns with medical staff, as men were deterred by cultural norms of masculinity. Chaturvedi (2012) asserted that gender roles in India are central in the formation of existential expression, with women more likely to use collective coping and men employing individual stoicism. These results resonate with a central theme: gender is not simply a biological variable but overlaps profoundly with cultural expectations, social roles, and identity.

Clinically, the implications are important. Interventions like Meaning-Centered Therapy and Dignity Therapy have been shown to be effective in Western contexts (Breitbart et al., 2014; Chochinov, 2016), but their gendered use in Indian cultural contexts needs greater research. Few studies have systematically assessed whether men and women react differently to such interventions, or if spiritual care models should be adapted to address gender-specific needs. As an example, whereas Western research stresses autonomy and self-definition in signification, Indian patients will tend to stress relational identity, family tradition, and religious ritual (Kumar & Kumari, 2017). Without gender-sensitive research across these settings, palliative care threatens to follow a "one-size-fits-all" strategy that neglects crucial subtleties.

Although much progress has been achieved, there are significant gaps in literature. Much research on spirituality among cancer patients draws from Western populations, whose generalizability to Indian or South Asian contexts is limited because spirituality is strongly entangled with religion and tradition. Research documenting meaning-making too often employs gender as a demographic control variable and not as a key focus of investigation. Furthermore, little is known about how gender differences in spirituality and meaning contribute together to quality-of-life outcomes for patients in palliative care. There is also inconsistent measurement of spirituality and meaning

Therefore, although the evidence base unequivocally indicates that spirituality and meaning are core aspects of end-of-life care, more research is required into how these experiences are gendered, especially in Indian settings. Appreciation of these distinctions is critical for constructing interventions that are culturally respectful, meet existential requirements, and foster dignity at the last stage of life.

3. Research methodology

The current research employs a secondary research approach, which entails synthesis and critical appraisal of past literature on the interface of gender, spirituality, and meaning-making in end-of-life care among cancer patients. Instead of gathering new information, the research uses published scholarly materials, such as peer-reviewed articles, books, and reports.

A qualitative narrative review method was adopted since it supports the synthesis of results from varied cultural, clinical, and psychological standpoints. The review explores how gender variation constructs spiritual experience and meaning-making processes, and how these constructs map out to end-of-life care outcomes. The focus is on discovering patterns, contrasts, and emerging themes within research studies instead of quantifying statistical results.

3.2 Data Sources

The research accesses a variety of credible scholarly databases, including:

- Google Scholar
- PubMed
- PsycINFO
- Scopus
- ResearchGate

Culturally specific sources and Indian-based research were also used to bridge the contextual gap in international literature.

3.2 Inclusion and Exclusion Criteria

For relevance and rigor, the following criteria were used:

3.2.1 Inclusion Criteria:

- Peer-reviewed journal articles, systematic reviews, and dissertations published between 2013 and 2025.
- Smooth Care studies focus on cancer patients nearing the end of life.
- Literature centered around spirituality, meaning-making, existential distress, or dignity therapy.
- Research studies specifically examine or debate gender differences in coping, spirituality, or meaning.

- Research in Western and Indian/South Asian settings.

3.2.2 Exclusion Criteria:

- Cancer- or end-of-life care-unrelated articles.
- Research that examined only medical treatment outcomes without mentioning spirituality or existential concerns.
- Non-peer-reviewed materials (opinion essays, popular media, blogs).
- Research published prior to 2013, except for highly influential papers (e.g., Frankl's existential theory).

3.3 Data Collection Procedure

Relevant literature was determined through the application of keywords like:

- "Spirituality among cancer patients,"
- "Meaning-making in end-of-life,"
- "Gendered differences in palliative care,"
- "Existential distress in terminal cancer,"
- "Indian cancer patients spirituality and meaning."

3.4 Data Analysis

The chosen papers were thematically analyzed. Such recurring themes as spiritual well-being, existential distress, dignity, coping mechanisms, cultural differences, and gendered meanings were found. Patterns of similarity across Western and Indian contexts were compared in order to show cultural impact. Areas of research gap, particularly the lack of deeper exploration of gender-specific issues in Indian palliative care, were systematically recorded.

3.5 Ethical Considerations

Given that this is a secondary study, there was no direct contact of human participants. Ethical issues of informed consent and confidentiality did not come into play. Nonetheless, academic integrity was ensured through the use of only credible, duly referenced sources and not plagiarizing the sources used.

3.6 Limitations

Methodology has the following limitations:

- Use of available literature limits the research to published work.
- Methodological variations between studies limit comparisons.
- A lack of Indian research on gender differences in spirituality and meaning can lead to cultural imbalance.

4. Result

Synthesizing the current studies, there are key findings into the part played by spirituality and meaning in life for end-of-life care of cancer patients, with distinct patterns of gender inequity. Throughout the literature examined, five interconnected themes appear: gender-typed coping styles, the function of spirituality in meaning-making, cultural context for shaping spiritual experience, the impact of spirituality on existential distress, and implications for palliative care.

The repeated result in studies is that men and women approach spirituality differently when faced with terminal illness. Women tend to be found exhibiting their spirituality in the form of prayer, religious rituals, and relational relationships (Tanyi et al., 2006; Mystakidou et al., 2008). They will more openly speak of their fears and hopes, finding strength in God, family, and communal relationships. Indian research substantiates this view, with evidence that women tend to engage in communal rituals or use family-oriented practices as a source of comfort (Kaur & Sharma, 2017). Men typically have their coping strategies centered around autonomy, dignity, and legacy, and are less likely to articulate their spiritual issues (Chibnall et al., 2002). This implies that for women, spirituality operates as an expressive and relational resource, but for men it is typically internalized, related to identity, accomplishment, and duty.

Spirituality also plays a pivotal role in meaning-making at the end-of-life period. (Krikorian et al. 2014) highlighted that looking for meaning assists patients in grappling with mortality, although pathways vary by gender. Women are likely to find meaning through relationship roles and caregiving,

whereas men can find meaning through persevering strength, control, or leaving a legacy behind. In the Indian context, this distinction is more evident, with cultural expectations supporting traditional gender roles in the manner in which patients construct and find meaning (Narayanasamy, 2002). Women, for example, might seek sustenance of hope through rituals or devotional acts, whereas men tend to realize meaning in upholding family responsibilities or resilience.

The cultural background is another vital force influencing spirituality and its gendered aspects. Evidence indicates that whereas Western patients' involvement in spirituality might be a personal, individual process, Indian patients' lives are significantly rooted in collective and religious tradition (Kumar & Kumari, 2018). Spirituality is not just a personal resource but also a family- and community-shared practice and might enhance gender differentials. Women's duties of upholding home spirituality through prayers and rituals are consistent with their coping at the end of life, whereas men's roles as providers tend to support their emphasis on dignity and legacy. This shows how cultural gender scripts influence the expression and experience of spirituality at the end of life.

Another recurrent finding is the buffering effect of spirituality against existential distress. (Steinhauser et al. 2006) established that spirituality significantly reduces despair and hopelessness among terminally ill patients. Gender differences continue to be present, as women tend to be more forthcoming in expressing their distress and spiritual struggles compared to men, who tend to underreport or suppress these experiences. (Pandey et al. 2015) reported the same patterns of Indian patients, whereby women often described their phobias and relied on religion, but men did not, perhaps because of cultural beliefs regarding masculinity and strength. This silence can leave men's spiritual and existential concerns unaddressed, even if they feel them as intensely.

Together, these results underscore the practice implications of palliative care. Attention to meaning of life and spirituality in cancer care must be respectful of gendered experience. Women can be helped by supportive therapies like prayer groups, religious counseling, or family-centered spiritual care. Men are likely to respond to meaning-centered therapy, dignity therapy, or legacy work, as these are congruent with their coping schemas. Significantly, the evidence is that a "one-size-fits-all" policy threatens to overlook the specific needs of each gender. Rather, there is a need for a gender-sensitive, culturally responsive approach to provide comprehensive and dignified care in the end-of-life phase.

The literature reviewed here establishes that spirituality and meaning-seeking are common reactions to terminal cancer, but the paths diverge along gender lines and cultures. Women's spirituality tends to be expressive and relational, whereas men's is about identity, dignity, and silence. These distinctions need to be grasped in order to create effective palliative care models that honor both individuality and cultural situatedness.

5. Discussion and Analysis

The results of this secondary study emphasize that meaning-making and spirituality are a vital part of the end-of-life care experience among cancer patients. Of particular significance are the gender differences which appear across studies, suggesting that men and women not only perceive illness distinctively but also access spiritual and existential resources in different ways. The theoretical significance of these differences is extended into practical recommendations for palliative care practice.

One of the key insights in the literature is that women tend to depend on spirituality as an expressive and relational practice, whereas men tend to conceptualize spirituality as an autonomy-based, dignity-related, or legacy-based internal process. Prayer, rituals, and discussion regarding religion become essential coping mechanisms for women (Mystakidou et al., 2008; Kaur & Sharma, 2017). Their spirituality is often communicated to the outside world, opening up avenues for conversation, shared prayer, or support groups. Men often work through spirituality internally, not wanting to share fears or existential crises (Chibnall et al., 2002). This corresponds with wider societal expectations in which masculinity encompasses stoicism and strength, including in the context of terminal illness. As a result, the unarticulated spiritual needs of men might go unnoticed by professionals and caregivers, revealing an unseen imbalance in palliative care.

The analysis further reveals that spirituality serves as an end-of-life meaning-making framework. For women, meaning is frequently created through caregiving, nurturing, or community roles. Men, on the other hand, develop meaning through accomplishment, autonomy, or a need to leave a legacy (Krikorian et al., 2014). This difference has significant consequences. Whereas meaning is grounded in relational bonds, such as in women, family-oriented interventions that enhance relationships or include rituals of religion would work best. In contrast, meaning-centered therapy or dignity therapy might speak more to men, considering that these methods are centered on identity, independence, and legacy construction. Gender-sensitive care is thus not only desirable but also necessary in order to maximize the quality of dying experiences.

The cultural context cannot be avoided in understanding gender differences. Gender roles are deeply rooted in spirituality in Indian culture. Women tend to uphold family spirituality through daily devotions, rituals, and prayers that work in concert with their coping mechanisms when faced with terminal illness (Narayanasamy, 2002; Kumar & Kumari, 2018). Men's identities as protectors and providers, in turn, enhance their propensity to pair meaning with dignity, mastery, and toughness. These cultural constructions determine how cancer patients perceive spirituality and indicate that Western models of spiritual care would not necessarily cross over straightforwardly into Indian settings. Therefore, palliative care programs in India need to be culturally sensitive, acknowledging the communal and family-based understanding of spirituality, as opposed to using individualized forms solely.

One of the significant themes that arise from the analysis is how spirituality serves as a protective factor against existentially distressing states. Research overwhelmingly illustrates that spirituality decreases hopelessness and despair in cancer patients, though the effect is moderated by gender (Steinhauser et al., 2006; Pandey et al., 2015). Women tend to share their fears openly, thus enabling them to receive spiritual or emotional support. Men, on the other hand, can suffer in silence, thus losing out on potential intervention. This reflects silent distress that health practitioners might not recognize unless they

consciously provide safe spaces for men to share in conversation spirituality and meaning. If such is not given attention, men's distress can occur in less overt form, e.g., withdrawal, irritability, or repression, which can further complicate end-of-life adaptation.

The analysis further reflects the shortcomings in existing palliative care practices. Most interventions take spirituality for granted as a process that applies universally, ignoring the power of gender and culture. The studies examined as a whole indicate that doing so may over constrain the patient experience. Rather than that, there needs to be gender-responsive interventions to sensitive spirituality expressions. For instance, women patients can be helped with integrative models of care that incorporate rituals, prayers, and family-focused sessions, whereas men patients require organized dignity therapy opportunities, legacy work, or meaning-making exercises that fit their coping structures. Overall, palliative care has to be individualized, gender-sensitive, and culturally informed.

Lastly, the conversation poses an overarching ethical question: What is it to offer "holistic" care at the end of life? If meaning and spirituality are essential pieces of human dignity, then omission of their gendered aspects threatens to erode the very foundations of palliative care. This realization reinforces the argument for future practice and research, challenging healthcare professionals to revisit prevailing models of care with a critical eye on gender.

Overall, this discussion highlights that spirituality and meaning-making are not additives but central to how cancer patients live with the end of life. Gender has a profound effect on these processes, shaping men's and women's responses to coping, meaning-making, and seeking support. Cultural practices further condition such differences, especially in Indian contexts, where collective rituals and family-based practices predominate. Grasping and acting on these subtleties can result in more sensitive, effective, and fair treatment of patients confronting the intense challenges of terminal disease.

In spite of a wealth of literature on spirituality in oncology, the majority of research is not particularly men vs. women. The majority of the studies are about spirituality in general without examining gender differences. Moreover, there is a lack of evidence from Indian and South Asian populations even though they have very strong religious-cultural systems. There are few studies that combine intersectional variables like age, socioeconomic status, and cancer type with gender influencing spirituality.

6. Implications

- The findings highlight that men and women cope with terminal illness differently: women often rely on relational spirituality (prayer, rituals, community), whereas men focus on autonomy, dignity, and legacy.
- Palliative care teams must incorporate gender-sensitive spiritual assessments, tailoring interventions to these needs.
- Spiritual well-being should be formally recognized as a core component of end-of-life care, alongside physical and psychological needs.
- Clinicians, nurses, and psychologists require training in gender-sensitive, culturally attuned spiritual care. This will enhance holistic care delivery and reduce existential distress in terminally ill patients.
- Families of cancer patients can be educated to recognize these gender differences, helping them provide more effective emotional and spiritual support. This could reduce caregiver burden and improve quality of life for both patients and families.

7. Limitations

- Since this is not primary research, findings rely on existing literature, which may be subject to publication bias or lack of representation of diverse cultural perspectives.
- Many studies on spirituality and end-of-life care do not explicitly analyze gender differences, making conclusions somewhat inferential.
- Most research reviewed comes from Western contexts, while Indian and other collectivist societies are underrepresented, despite their strong role of religion and family in meaning-making.
- Different cancers bring unique existential challenges (e.g., breast vs. prostate cancer), but few studies accounted for this in gender comparisons.
- Spirituality is deeply personal and subjective; gender-based generalizations, while useful, may not apply to all individuals.

8. Future Directions

- Conduct more research in Indian and South Asian contexts where spirituality and gender roles are strongly shaped by culture and tradition.
- Explore how age, socioeconomic status, education, and type of cancer interact with gender in shaping spiritual and existential needs.
- Track patients over time to study how spirituality and meaning-making evolve with disease progression and impending death.
- Develop structured programs such as legacy-building workshops for men and communal spiritual circles for women to address gender-based needs.
- Assess how spiritual well-being as a measurable outcome in palliative care improves overall quality of care.

9. Conclusion

This secondary research underscores that spirituality and meaning-making are central to the end-of-life experience for cancer patients, but these experiences are shaped significantly by gender. Women often derive strength from faith, relational bonds, and communal rituals, while men tend 9.to focus on autonomy, control, and legacy. Such differences are not merely individual preferences but are deeply rooted in cultural expectations and gender roles.

By synthesizing existing literature, it becomes clear that neglecting spiritual and existential dimensions of care can exacerbate suffering, while sensitive interventions can foster peace, dignity, and acceptance at the end of life. However, gaps remain in the literature—particularly regarding gendered experiences in non-Western contexts such as India.

The implications of this study are far-reaching: clinicians, families, and policymakers must recognize spirituality as a core component of holistic care. Future research must bridge cultural and gender gaps, ensuring that end-of-life care is inclusive, compassionate, and tailored to the unique needs of both men and women.

Spirituality and meaning-making are not peripheral concerns but vital resources for psychological resilience, offering patients a sense of dignity and peace as they approach life's end.

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