

Measures of religiosity and spirituality used in Spanish-speaking health contexts and health research and their conception of religiosity/spirituality: a systematic review

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Abstract

Background

Research on religiosity and spirituality (R/S) in health is growing in Spain and other Spanish-speaking contexts. Reliable instruments are needed to assess these constructs, reflecting the variety of conceptualizations used.

Objectives

The objective of this systematic review was to identify and categorize Spanish-adapted measures used in health contexts and health-related research in Spain and Latin America, as well as to determine the conception of R/S used by these measures.

Method

A primary search was conducted using a strategy based on terms related to religiosity/spirituality, measurement, health, and Spanish-speaking contexts, complemented by a secondary search in additional sources.

Results

A total of 110 relevant studies was obtained, through which 56 Spanish-language measures were recognized, categorized as measures of broader constructs including a spiritual dimension ($n = 11$), functional measures ($n = 27$) and substantive measures ($n = 18$). These instruments assessed a large number of aspects (meaning in life, spiritual well-being, hope, spiritual needs, religious coping, etc.), which encompass different established conceptions of R/S. Overall, while some measures show robust psychometric evidence, the majority of instruments present incomplete or limited psychometric data, with several lacking full validation in Spanish.

Conclusion

The identified measures provide some useful options to assess R/S in Spanish-speaking health contexts and health research, although in most cases caution is warranted or their use is not recommended. Priority may be given to tools with stronger psychometric evidence, particularly the GES Questionnaire. Researchers and practitioners should balance conceptual focus and psychometric quality when selecting a measure.

1. INTRODUCTION

The last 40 years have seen an increase in the number of research studies on religion, spirituality and health, reflecting a growing interest in the topic among scholars who study psychosocial and behavioral factors affecting the health of human populations [1]. R/S has been shown to have a positive relationship with people's health, physically [2, 3], mentally [4–6] and socially [7], although the results of longitudinal studies are not uniform. For example, Coelho-Junior et al. [4] found that longitudinal studies suggest R/S is associated with lower levels of depression and fear of death, as well as better mental health, whereas Garssen et al. [5] concluded that only participation in public religious activities and the importance of religion were significantly related to mental health, with small effect sizes. However, sometimes existential, religious, or spiritual crises can arise at cognitive, emotional, behavioral, and social levels [8], and in these cases R/S may have a negative impact on health. For instance, religious/spiritual struggles—understood as negative thoughts, emotions, worries, or conflicts arising from R/S beliefs, practices, or experiences [9]—have been associated with worse health outcomes [10, 11].

Religion is usually defined as the organized system of beliefs, practices and rituals having to do with the divine or transcendent, conceived as a multidimensional construct encompassing both organizational and non-organizational types of activities, as well as personal commitments and experiences or beliefs about life and death [12–14]. Regarding spirituality, various authors understand it as the search for and relationship with the divine or transcendent [15]. Thus, spirituality has commonly been understood as the subjective side of religious experience, so that religiosity and spirituality can be understood as related and overlapping constructs, but not identical [16, 17].

In this sense, religion and spirituality differ in a series of basic oppositions, in which religion is seen as substantive, static, institutional, and objective, while spirituality is evaluated as functional, dynamic, personal, subjective, and experience based [18]. To a certain extent, these differentiations reflect a classic idea from Allport and Ross [19], which still holds heuristic value: while extrinsic religiosity originates in doctrine and ritual and is oriented towards using religion for personal purposes and the fulfillment of social norms, intrinsic religiosity is oriented towards the complete experience of religion as a framework of meaning for the individual's life. Thus, as Delgado [20] points out, intrinsic religiosity would be closely related to spirituality. In any case, due to its subjectivity and dynamism, spirituality can be interpreted and experienced through the practice of a given religion or outside of an organized religious system [21]. Therefore, there is an understanding of spirituality that is not necessarily religious and is frequently negatively biased against religion.

Schnell [22] conceptualizes spirituality in two directions, referring to a vertically transcendent spirituality and a horizontally transcendent spirituality: the former incorporates concepts of an eternal and supernatural God or higher powers, while the latter moves away from supernatural concepts to highlight the existence of an immanent absolute. This second aspect would encompass more personal aspects, such as the search for the meaning of life, transcendence, hope, peace, or a sense of connection with oneself, others, the environment, or a higher entity (the universe, the Ultimate Meaning, God, or a Higher Power) [20, 21, 23, 24]. With the aim of establishing a mostly agreed-upon definition in the literature that

allows for covering the scope of this study, this review follows a conceptualization of spirituality that encompasses the four basic characteristics proposed by Delgado [20]: spirituality requires faith or acceptance of a belief system, which implies a personal search for meaning and purpose, encompasses an awareness of connection or relationship, and is self-transcendent. Additionally, following Vachon [25], spirituality involves both self-transcendence and transcendence beyond the self. Self-transcendence provides a sense of coherence that helps give meaning to life. Transcendence with a Higher Being, in turn, entails a sense of connection with a higher power, a relationship characterized by deep faith and belief, which contributes to preserving hope and sustaining meaning in life.

The importance of clearly defining spirituality lies in its subsequent impact on the way it is measured in health research. It should not be lost out of sight that the variety of dimensions that make up religion and the heterogeneity of conceptions of spirituality, together with the imprecision of some of the definitions, have historically posed many problems for the measurement of spirituality [26]. Thus, authors such as Zwingmann et al. [27] have highlighted the need to clarify what is intended by religiosity, and what is understood by spirituality, in order to adapt the instruments to what is to be measured, so that respondents can understand, and identify with, these conceptions and thus avoid biases in the information obtained through them.

Parallel to the growth in the research literature on religion, spirituality and health, many instruments have been developed to assess R/S in this context [27–29]. Consequently, given the increasing need for reliable measures in different geographical contexts, a significant amount of research has focused on adapting and validating predominantly American measures for use in non-English-speaking countries [30].

There are numerous reviews of R/S measures in healthcare settings, most of which classify and operationalize them on the basis of the R/S dimensions assessed [26, 28, 31, 32], while many of them also focus on evaluating the psychometric properties of these instruments [33, 34]. Some of these reviews have also proposed additional criteria beyond the usual psychometric properties, such as item formulation guidelines to ensure clarity and consistency in meaning across respondents [32]. However, this type of analysis does not fall within the scope of the present review. Notably, only a few reviews add an analysis of the conceptions of spirituality that underlie the development of these measures [35]. Few of these reviews have focused on adaptations of instruments to other cultures and languages, considering that most of them have been developed in the United States [36]. For example, Selman et al. [36], identified nine cross-culturally validated measures in the specific field of palliative care. Other authors have focused on the review of validated measures in other specific languages, such as Portuguese [37, 38] or German [39].

In Spain, Galiana et al. [40] provided a review of the main measures of spirituality within the context of palliative care, noting that, despite the existence of numerous cross-culturally validated measures, the lack of Spanish adaptations and validations stands out. However, there are Spanish versions of some of the most recognized instruments [40].

Spain and Latin America have deep-rooted Catholic traditions, which have historically shaped the conception of R/S. However, Spain's religious landscape is undergoing significant change. As Herranz-de-Rafael and Fernández-Prados [41] have recently pointed out, while religiosity and belief in God remain prevalent, religious practice is declining, reflecting broader secularization trends in Western Europe. As a result, contemporary Spanish society presents a diverse and evolving spiritual landscape [41].

This evolving context shapes how R/S aspects are integrated into healthcare. Nevertheless, despite this process of secularization, many people in health contexts feel that an integral, holistic view is necessary, where the religious and spiritual aspects take their place in care, interventions or treatments [42]. Therefore, it remains essential to develop and adapt instruments in Spanish that allow the measurement of these constructs in different health-related settings. Moreover, the religious and spiritual diversity present in Spanish-speaking contexts may lead to conceptual discrepancies, making it necessary to ensure the measurement instruments are not only linguistically but also culturally valid.

Although research on R/S measurement has expanded in Spain and Latin America, most studies focus on Spanish palliative care, with little attention given to broader healthcare contexts. Furthermore, there is an absence of reviews on R/S instruments in these wider healthcare settings, highlighting the need to assess whether the conceptualizations and operationalizations of R/S in these instruments adequately reflect both the religious and spiritual diversity shaped by secularization processes and the wide variety of individual ways in which spirituality can be understood and experienced.

In addition to the heterogeneity of conceptualizations of both constructs, it is necessary to clarify what is meant by R/S when a given measure is used [43]. For this reason, reviews of measurement instruments should also assess the conceptions of R/S underlying these measures. Given the diversity of religious and spiritual beliefs, practices, and attitudes in Spain and Spanish-speaking countries, the review examines how these conceptualizations and their operationalizations reflect this diversity, providing researchers with information to select instruments appropriate for specific populations and contexts.

Therefore, the research question guiding the review is: Which are the main measures (and operationalizations) of religiosity/spirituality validated in Spanish for use in health contexts or health-related research and which understandings and conceptions of religiosity/spirituality do these measures employ?

2. METHOD

A systematic review was conducted, focused on mapping and analyzing the available instruments while also summarizing key findings from studies that used them to explore the relationship between R/S and health. To this end, we followed the recommendations of the PRISMA 2020 Guide [44], aiming to recognize potential biases and prevent their inclusion in the conclusions. Moreover, adhering to this guideline ensures transparency and accuracy in the process, which is adequately reflected in the systematic review report. The protocol was not registered.

Data sources

First, we carried out a preliminary search in various databases, including the Evidence-Based Medicine Reviews (EBMR) systematic review databases, in order to avoid duplication of reviews.

For this review, we consulted five databases, three of them international (Pubmed, PsycInfo and Web of Science) and two of them Spanish (Psicodoc and Dialnet). To find instruments that might not have been included in the main database search, we performed an additional hand search using the following sources: specialized journals (Journal of Spirituality in Mental Health, Journal of Religion and Health, Psychology of Religion and Spirituality, Archive for the Psychology of Religion, Supportive Care in Cancer, International Journal for the Psychology of Religion), reference lists of studies identified in the main search and relevant reviews, communication with experts and Google search engine. Spanish terms were also used in the latter source.

Search strategy

The search was conducted between March and May 2023. We performed a repetition check through an updated database search in March 2024, to verify the existence of new studies published from the end of the original search to the time of publication. D.A. developed the search strategy, and K.B. discussed and confirmed it prior to implementation. To be as specific as possible within the breadth of the search, we focused on the title and abstract fields, using a combination of controlled (MeSH) and free-text terms grouped into four categories: "religion/spirituality", "measurements", "health" and "context" (see Table 1), which were combined to cover all elements of the research question.

Table 1
Terms used in the search strategy.

Religion/Spirituality	Measures	Health	Context
Religio*	Measure	Health	Spain
Spiritual*	Scale	Illness	Spanish
Faith	Questionnaire	Disease	
Church	Assessment	Chronic	
Pray	Evaluation	Well-Being	
Meaning in life	Outcome	Quality of life	
Religious belief*	Tool		
Spiritual belief*	Instrument		
Existential	Inventory		
	Psychometric		
	Validation		
	Adaptation		

We used the same strategy in the Spanish databases but using the terms in Spanish. In the specific case of the Dialnet database, which does not allow such broad search strings, we simplified the search equation. In addition, since this database does not allow searching in specific fields, we performed a general search.

Eligibility criteria

D.A. and K.B. established the eligibility criteria. The inclusion criteria were as follows:

1. Original research studies that evaluated religious and/or spiritual aspects in health contexts or in health research in Spanish-speaking countries. Several things should be clarified with respect to this criterion. We considered studies with populations from Spain and Latin America that evaluated religiosity/spirituality in relation to health, including: (a) people affected by health problems or health care professionals (i.e., studies conducted in health-related contexts), and (b) populations without specific health conditions in which health-related variables such as well-being, quality of life, or mental health were assessed. Included studies must assess R/S through a specific measure designed to evaluate religiosity/spirituality, or through a measure of a broader construct including a spiritual dimension. In addition, validation studies of instruments to measure religious and/or spiritual aspects in Spanish were included, provided they were conducted with Spanish or Latin American populations in health-related contexts. In addition, according to the World Health Organization [45], health is conceptualized as a state of complete physical, mental, and social well-

being and not merely the absence of disease and infirmity. For this reason, we included studies that evaluated constructs such as well-being or quality of life.

2. Studies published in English and Spanish.
3. Studies using quantitative methodology.
4. Studies published in academic journals.

Exclusion criteria were as follows:

1. Studies conducted with Spanish-speaking populations outside Spain or Latin America (e.g., Latinos in the United States).

Data extraction

D.A. and K.B. decided the data to be extracted from the R/S measures used in the identified studies: measure, authors, year, type, number of R/S items, population of validation, populations of study, evaluated R/S construct, psychometric properties, R/S conception used in the measure and results obtained with the measure. D.A. extracted the data on a common table designed by D.A. and K.B., with K.B. confirming the extracted data. The following aspects guided our analysis:

First, the review focused on the measures used by the studies and not on the studies themselves, so the latter were not analyzed.

The measures were classified according to whether they are measures developed for a broader purpose, such as quality of life or well-being, and in which R/S represents one dimension, or whether they specifically measure R/S. These measures of broader constructs including a spiritual dimension were included as they reflect instruments that seek to assess a broader set of domains, but still incorporate R/S as a relevant aspect of the person's experience. In the case of instruments that specifically measure R/S, moreover, we employed the classic distinction proposed by Zinnbauer et al. [46], which differentiates between a functional approach (exploring the role or function that an individual's R/S beliefs or practices play in their life) and a substantive approach (exploring the content or substance of an individual's R/S beliefs, such as their beliefs, emotions, and practices related to a higher power or divine being). Following Hill and Edwards [47], this categorization provides an organizational framework from which to understand the available measures. This practice is common and recommended in systematic reviews of R/S measures in the field of health [36, 40, 47, 48]. Following these, we performed this categorization based on the analysis of the items, the purpose of the instrument and the recommendations of other authors.

Regarding the conception of R/S used by the measures in the included studies, when the authors explicitly stated their definition, we contrasted it with the content of the items and made adjustments when necessary. In cases where no explicit definition was provided, we inferred the underlying conceptualization of R/S by analyzing the items, considering the dimensions explored and the

commonalities across instruments, in order to provide a consistent and comparable basis for presenting the different measures.

When all data were extracted, the authors met to analyze the results and discuss them, including possible biases and discrepancies. The involvement of a third reviewer was not necessary to resolve disagreements.

3. RESULTS

Article selection process

A total of 2224 studies were obtained (1995 without counting duplicates). 201 of these were judged as relevant after analysis of the title and abstract. After in-depth analysis of the full text, 67 of these studies were relevant to the purpose of the study. The secondary search

yielded a total of 35 additional studies, resulting in a total of 102 studies relevant to the purpose of the review. Finally, 8 more eligible articles were obtained through the updated database search, giving a total of 110 studies. Thus, eliminating 16 repeated measures contained in all searches, a total of 56 R/S measures used in Spanish-speaking health research or health contexts were identified. The complete review process can be seen in Fig. 1.

Main research results

Relationship between R/S and health

The study results obtained with these measures in relation to health generally indicate that higher levels of R/S tend to be associated with better health outcomes. Specifically, associations were frequently observed between R/S and mental health variables, such as lower levels of depression, anxiety and stress, as well as greater psychological well-being, and physical health variables, such as greater functional well-being or a lower level of pain or other symptoms.

Of the reviewed studies, 32 were conducted in healthy populations (e.g., elderly adults, students, healthcare professionals). Another 22 assessed patients with physical diseases (e.g., cancer $n = 9$, palliative care $n = 11$), and 8 in populations with mental disorders.

The results obtained with each measurement are detailed in Additional file 1 (Supplementary Table 1).

Description of the measures according to their categorization and their R/S conception

The 56 measures that were used in Spanish-speaking health contexts or health research were categorized, noting 11 measures of broader constructs including a spiritual dimension (Table 2), 27 functional R/S measures (Table 3), and 18 substantive R/S measures (Table 4).

Two main patterns of conceptualization of R/S were observed: a concept of spirituality understood as something proper to or closely related to religion, and a concept of spirituality as separate from religion. Thus, different components of R/S were observed depending on the concept used and reflected in the constructs assessed by the instruments. Some of the instruments, composed of different subscales (for example, the BMMRS, the SpREUK or the DUREL), assessed more than one component of R/S (see Additional file 1, Supplementary Table 1 for details of the R/S conceptions used for each measure).

Measures of broader constructs including a spiritual dimension

In the case of the *measures of broader constructs including a spiritual dimension* (Table 2), it was observed that most of them assessed quality of life, considering R/S as one of its components. These measures share a common understanding of spirituality as a subjective experience encompassing aspects such as the search for purpose and meaning in life or transcendence. This group include the Multicultural Quality of Life Index [49, 50], Quality of Life in Life-Threatening Illness-Family Caregiver Version [51, 52], Quality of Life instrument of Ferrell et al. [53, 54], WHOQOL-100 [55, 56] and WHOQOL-HIV-BREF [57, 58].

Other instruments that aim to assess other broader constructs also share this conception of spirituality as a subjective experience with an emphasis on the search for meaning and transcendence. One of them is the Psychosocial and Spiritual Needs Evaluation Scale [59], which assesses psychosocial needs and, therefore, establishes spirituality as a dimension of these needs. Another one is the Post-Traumatic Growth Inventory-Short Form [60, 61], in which the spiritual represents an element to be considered in posttraumatic growth. Finally, in the Patient Dignity Inventory [62, 63] the spiritual is presented as an element relevant to dignity at the end of life.

In contrast, other tools in this category present a more focused view of spirituality as connection with others and/or with a higher entity. These include the Successful Aging Inventory [64, 65], in which spirituality is understood as an element of adequate aging, or the Self-Care Behavior Scale [66], for which spirituality is a component to be considered in self-care. Similarly, the Quality of Dying and Death Questionnaire [67, 68] added to this conception elements related to transcendence and peace, determining the spiritual as a dimension to be considered in the quality of dying.

Finally, the Kolcaba General Comfort Questionnaire-ICU [69, 70] evaluated comfort, understood as the experience of empowerment derived from the satisfaction of relief needs in various contexts, among which is the spiritual [70]. Thus, spirituality as a subjective experience of faith and beliefs would be a component of such comfort.

Table 2
Measures of broader constructs including a spiritual dimension

Purpose of the measure	Measure
Quality of life measures with a spiritual dimension	Multicultural Quality of Life Index (MQLI) [49, 50]
	Quality of Life in Life-Threatening Illness-Family Caregiver Version (QOLLTI-F) [51, 52]
	Quality of Life scale of Ferrell et al. [53, 54]
	WHOQOL-100 / WHOQOL-HIV-BREF [55–58]
Measures of health and care outcomes with spiritual aspects as a dimension	Kolcaba General Comfort Questionnaire-ICU (CQ-ICU) [69, 70]
	Patient Dignity Inventory (PDI) [62, 63]
	Quality of Dying and Death Questionnaire (QODD-ESP-12) [67, 68]
	Self-Care Behavior Scale [66]
	Successful Aging Inventory (SAI) [64, 65]
Measures for evaluating post-traumatic growth with a spiritual dimension	Post-Traumatic Growth Inventory-Short Form (PTGI-SF) [60, 61]
Measures for assessing needs with a spiritual dimension	Psychosocial and Spiritual Needs Evaluation Scale (ENP-E) [59]

Functional measures

As shown above, most of the measures correspond to a functional approach to R/S measurement (Table 3). First, it was observed that many tools employ this functional perspective when assessing spiritual well-being. That is, how does spirituality play a role in the well-being of individuals? Some of these measures, such as the FACIT-Sp [71] or the Spiritual Well-Being Scale [72, 73] conceived of spirituality as a subjective experience that may include religious elements, such as the search for or connection with God, but also others such as meaning in life or peace.

Other functional tools, such as the Multidimensional Inventory for Religious/Spiritual Well-Being [74, 75] follow a similar conception but adds the connection with oneself or with others as part of it. It is observed, therefore, that religiosity acquires some importance within the conceptions that guide these instruments. In contrast, within the measures that assess spiritual well-being, the Spirituality Index of Well-Being [76, 77] is more focused on meaning and purpose in life, without including explicit religious items.

Secondly, another salient function of spirituality appears to be a capacity or need to seek and find meaning in life. Several measures, such as the Demoralization Scale-II [78, 79], the Positive Psychotherapy Inventory [80], the Purpose in Life Test [81–84], the Meaning in Life Questionnaire [85],

and the Scales of Psychological Well-Being [86, 87], focus on the search for meaning in life, and may or may not involve religious elements. However, although another series of tools followed this concept, they added slight contributions. The Seeking of Noetic Goals-8 items [88, 89] extended the search for meaning to existential aspects, such as the ultimate meaning in life. Likewise, the Personal Meaning Profile-Brief [90, 91] and the PERMA Profiler [92, 93] additionally considered aspects such as self-transcendence or self-acceptance, as well as connection to self and others. Regarding the latter, the Meaning in Life Scale [94, 95] added to its conception the connection with the sacred. Unlike the rest, this measure explicitly recognized the functionality of spirituality as a source of meaning in life. In addition, this contribution about the sacred hints at the religious, which is considered by the Finding Meaning Through Caregiving Scale [96, 97], which conceives of spirituality as the search for the ultimate meaning in life, which is determined by God.

Thirdly, it is worth highlighting a perspective of spirituality as an element that fulfills the function of giving hope. Along these lines, the Herth Hope Scale [98–101] conceives of spirituality as a subjective experience that brings together faith, meaning and connection with oneself and others. Underlying the Scale for Measuring Hope in Terminal Status [102] is also a spirituality that implies a connection with oneself or others, but also with God or the transcendent, i.e., it includes religious elements.

Another set of functional scales conceives spirituality as an intrinsic aspect of human beings through which they seek meaning in life, transcendence, and connection with oneself, others, and a higher entity. One of these is The Spiritual Care Competence Questionnaire [103, 104], which recognizes spirituality as an aspect to be considered in healthcare and, therefore, plays a role in improving overall health. Another is the Numerical Scale to Assess Spiritual Symptoms [105], where the evaluation of spirituality focuses on spiritual symptoms, aiming to reflect problems arising from spirituality. Under this conception of spirituality, there is also the Edmonton Symptom Assessment System-Financial and Spiritual [106, 107], where spirituality is measured as spiritual pain, which in advanced cancer patients refers to a 'pain deep in your soul that is not physical' (p. 342) [107]. Finally, following this conception, there is also the Spiritual Connection Questionnaire [108, 109], which assesses the extent to which spirituality fulfills the function of providing happiness through connection with others, with oneself, or with a higher entity.

Finally, it should be noted that many of the measures, within their functional approach, assessed R/S as a coping method/strategy. Usually, it is religiosity that is evaluated in this sense, although sometimes the term spirituality is used interchangeably. Thus, these constructs are defined as the relationship with God, a conceptualization that underlies instruments such as the COPE [110–113], the Brief RCOPE [114–116], the Questionnaire Modified Coping Strategies Scale [117, 118], the Coping Strategies Questionnaire [119, 120], the Multifaceted Loneliness Inventory [121] and the Coping with Stress Questionnaire [122]. The only instrument within this perspective that conceived of spirituality in a way that was not necessarily interchangeable with religiosity, but mainly as the search for meaning and answers to the ultimate questions about life, was the Spiritual Coping Scale [123, 124].

Table 3
Functional measures

Purpose of the measure	Measure
Measures that assess spiritual well-being	FACIT-Sp12/FACIT-Sp-Ex/FACIT-Sp-Non-Illness [71]
	Multidimensional Inventory of Religious/Spiritual Well-Being (MI-RSWB) [74, 75]
	Spiritual Well-Being Scale (SWBS) [72, 73]
	Spirituality Index of Well-Being (SIWB) [76, 77]
Measures that assess meaning in life (one dimension or the entire scale)	Demoralization Scale-II (DS-II) [78, 79]
	Finding Meaning Through Caregiving Scale (FMTCS) [96, 97]
	Meaning in Life Questionnaire (MLQ) [85]
	Meaning in Life Scale (MiLS-Sp) [94, 95]
	PERMA Profiler [92, 93]
	Personal Meaning Profile-Brief (PMP-B) [90, 91]
	Positive Psychotherapy Inventory (PPTI) [80]
	Purpose in Life Test (PIL) / PIL-10 / PIL-SF [81–84]
	Scales of Psychological Well-Being (SPWB) [86, 87]
	Seeking of Noetic Goals-8 items (SONG-8) [88, 89]
Measures that assess spirituality as a source of hope	Herth Hope Scale (HHS) / Herth Hope Index (HHI) [98–101]
	Scale for Measuring Hope in Terminal Status [102]
Measures that assess R/S coping (one dimension or the entire scale)	Brief RCOPE / S-BRCS [114–116]
	COPE / COPE28 [110–113]
	Coping Strategies Questionnaire (CSQ) [119, 120]
	Coping with Stress Questionnaire (CAE) [122]
	Multifaceted Loneliness Inventory [121]
	Questionnaire Modified Coping Strategies Scale (EEC-M) [117, 118]
Measures that assess spirituality as a source of distress	Spiritual Coping Scale (SCS) [123, 124]
	Edmonton Symptom Assessment System-Financial and Spiritual (ESAS-FS) [106, 107]

Purpose of the measure	Measure
	Numerical Scale to Assess Spiritual Symptoms (ENESE) [105]
Measures that assess spirituality as a competency in caregiving	Spiritual Care Competence Questionnaire (SCCQ) [103, 104]
Measures that assess spirituality as a source of connection	Spiritual Connection Questionnaire (SCQ) [108, 109]

Substantive measures

Finally, a series of measures focused on *substantive aspects* of R/S came to light (Table 4). In this sense, it is necessary to make a distinction between those that measure substantive aspects of spirituality and those that measure substantive aspects of religiosity. However, the appearance of religious elements in some conceptualizations of spirituality has also been observed.

Focusing on the former, the Spiritual Index for Elderly [125], the GES Questionnaire [126], the Reed's Spiritual Perspective Scale [127, 128], the Expressions of Spirituality Inventory [129–131] and the Spirituality Questionnaire [132, 133] assess spirituality as a construct per se. In their conceptualizations of spirituality, all agree that spirituality is a subjective experience, which involves the search for meaning and the relationship or connection with some higher reality. The GES Questionnaire adds the connection with oneself, others or nature. For its part, the Expressions of Spirituality Inventory includes in its underlying conceptualization existential elements, mystical or transcendent experiences and aspects related to religious commitment.

On the other hand, the Beliefs and Values Scale [134, 135] and the System of Beliefs Inventory [136, 137] focused on spiritual beliefs as a substantive aspect, although the latter also included religious components. Both conceive of spirituality as the search for meaning and connection to the divine, and to oneself and others in the case of the Beliefs and Values Scale.

Another group of measures focused on substantive aspects of spirituality conceives it as a set of beliefs that facilitate the search for meaning and the relationship with the divine. One of these is the Spiritual Needs Questionnaire for Palliative Care [138], which assesses spiritual needs. Other measures that follow this conceptualization include the Religious/Spiritual Struggles Scale [8, 139], which focused on religious and spiritual struggles, the Daily Spiritual Experiences Scale [140, 141], which assessed spiritual experiences, and the SpREUK-SF10 [142, 143], which assessed attitudes toward spirituality, as substantive aspects of spirituality.

As an aside, an instrument appeared that assessed both spirituality and religiosity as substantive aspects: the Brief Multidimensional Measure of Religiousness/Spirituality [144, 145]. The underlying

conceptualization treated both constructs as the experience of relationship with a higher being, in which religiosity referred to the social experience, and spirituality to the personal or subjective experience.

Finally, several measures focused on substantive aspects of religiosity. All of them followed a common conceptualization of religiosity, as the relationship with God or the divine, framed within a religious belief system. However, each assessed different substantive aspects. The Brief Trust/Mistrust in God Scale [146, 147] focused on trust and mistrust in God. The DUREL [148, 149], was focused on the organizational, non-organizational and intrinsic elements of religiosity. Additionally, the Centrality of Religiosity Scale [150] focused on five different dimensions of religiosity, namely: intellectual religiosity, ideological religiosity, public practice, private practice and religious experience. In addition, religious orientation was assessed using two different instruments: the Age Universal I-E Scale, which assessed the intrinsic and extrinsic dimensions of religiosity [151, 152], and the Religious Orientation Scale which measured, in addition to the above, the search dimension [153, 154]. Finally, the Five-Item Francis Scale of Attitudes Toward Christianity [155, 156] focused on attitudes toward God, Jesus and religious practices.

Table 4
Substantive measures

Purpose of the measure	Measure
Spirituality as a construct per se	Expressions of Spirituality Inventory (ESI) / ESI-Revised (ESI-R) [129–131]
	GES Questionnaire [126]
	Reed's Spiritual Perspective Scale (SPS) [127, 128]
	Spirituality Index for Elderly People [125]
	Spirituality Questionnaire (SQ) [132, 133]
Spiritual beliefs	Beliefs and Values Scale (BVS) [134, 135]
	System of Beliefs Inventory (SBI-15R) [136, 137]
Spiritual needs	Spiritual Needs Questionnaire for Palliative Care (SNQPC) [138]
R/S struggles	Religious/Spiritual Struggles (RSS) Scale [8, 139]
Spiritual experiences	Daily Spiritual Experiences Scale (DSES) [140, 141]
Attitudes toward spirituality	SpREUK-SF10 [142, 143]
Attitudes toward Christianity	Five-Item Francis Scale of Attitude Toward Christianity (Francis-Five) [155, 156]
Both religiosity and spirituality as constructs per se	Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS) [144, 145]
Trust and mistrust in God	Brief Trust/Mistrust in God Scale (BTMGS) [146, 147]
Religiosity as a construct per se	Centrality of Religiosity Scale (CRS) [150]
	DUREL [148, 149]
Religious orientation	Age Universal I-E-12 Scale (I-E-12) [151, 152]
	Religious Orientation Scale (ROS) [153, 154]

Psychometric properties

As summarized in Table 5, most of the measures reported adequate internal consistency, which was the most consistently evaluated property across instruments. Structural validity and convergent validity were also frequently assessed, though in many cases only partially supported or with limited evidence. In contrast, fewer measures reported criterion validity or discriminant validity, and for several instruments data in these domains were lacking. Content validity, which reflects the process of item development and conceptual grounding, was inconsistently documented and often only partially addressed. Overall,

while many instruments demonstrate solid reliability and some aspects of validity, the evidence base is heterogeneous, and several tools lack comprehensive validation across all psychometric criteria.

Table 5
Evaluation of the psychometric qualities of the scales

Measure	Internal consistency	Structural validity	Criterion validity	Convergent validity	Discriminant validity	Content validity
BMMRS	+	+	?	?	+	?
Brief RCOPE / S-BRCS	+	+ -	+	+	?	?
BTMGS	+	+	+	?	+	?
BVS	+	?	+	?	?	?
CAE	+	?	?	?	?	?
COPE-28 / COPE	+	?	?	?	?	?
CQ-ICU	+	+ -	?	?	+	?
CRS	+	?	?	?	?	?
CSQ	+	?	?	?	?	?
DSES	+	+	+	?	?	?
DS-II	+	?	+	+	?	+ -
DUREL	+	+ -	+	?	?	?
EEC-M	+	+	-	?	?	?
ENESE	+	+ -	?	?	?	?
ENP-E	+ -	+ -	+	+	?	+
ESAS-FS	+	?	+	?	?	+
ESI / ESI-R	+	+	+	?	+	?
FACIT-Sp12	+	+ -	+	+	+	+ -
FMTCS	+	?	+ -	?	?	+ -
Francis-Five	+	+ -	?	?	?	?
GES	+	+	+	+	+	+ -
HHS / HHI	+	+	+	?	?	?
I-E-12	+	+	+	?	?	?
MiLS-Sp	+	?	?	?	?	?

Note: + = criterion is met; + - = criterion is sometimes or partially met; - = criterion is not met; ? = no data available.

Measure	Internal consistency	Structural validity	Criterion validity	Convergent validity	Discriminant validity	Content validity
MI-RSWB	+	+ -	?	+	+	?
MLQ	+	+	?	+	+	?
MQLI	+	+ -	?	+	+ -	?
Multifaceted Loneliness Inventory	+	?	?	+	+	?
PDI	+	+ -	?	?	+ -	+ -
PERMA-Profiler	+	+	+	+ -	+	?
PIL / PIL-10 / PIL-SF	+	+	?	+	+	?
PMP-B	+	+	?	+	+	?
PPTI	?	?	?	?	+	?
PTGI-SF	+	+	+	?	?	+ -
QODD-ESP-12	?	+	?	?	?	+ -
QOLLI-F	+	-	?	?	?	+
QoL scale of Ferrell	+	+ -	?	?	?	?
ROS	+	?	?	+	+	?
RSS Scale	+	?	+	?	+	?
SAI	+	+	+	+	?	?
SBI-15R	+	?	?	?	?	?
Scale for Measuring Hope in Terminal Status	+	+	?	?	?	+ -
SCCQ	+	+	+	?	?	?
SCQ	+	+ -	?	?	?	?
SCS	+	?	?	?	?	?
Note: + = criterion is met; + - = criterion is sometimes or partially met; - = criterion is not met; ? = no data available.						

Measure	Internal consistency	Structural validity	Criterion validity	Convergent validity	Discriminant validity	Content validity
Self-Care Behavior Scale	+	+	+ -	+ -	+ -	?
SIWB	+	+ -	?	+	?	?
SNQPC	?	?	?	?	?	+
SONG-8	+	+	?	+	?	?
Spirituality Index for Elderly People	+	+ -	?	+	+	?
SpREUK-SF10	+	?	?	?	?	?
SPS	+	+	?	+	?	?
SPWB	+	+	?	?	?	?
SQ	+	+	?	+ -	?	+
SWBS	+	+ -	?	+	+	?
WHOQOL-100 / WHOQOL-HIV-BREF	+	+	+ -	+ -	+ -	?
Note: + = criterion is met; + - = criterion is sometimes or partially met; - = criterion is not met; ? = no data available.						

4. DISCUSSION

In this systematic review, 56 instruments assessing religious/spiritual aspects in health-related research or health contexts in Spanish-speaking settings have been recognized. According to these studies, generally, empirical evidence has been reported that the different R/S variables assessed are significantly related to better physical and mental health.

The review reflects the growing interest in the study of R/S in relation to health in recent years [1] and the consequent increase in measurement instruments [28] also in Spanish and Latin American contexts. In this sense, it has been observed that R/S has been considered in many measures that do not have as their main objective the evaluation of R/S itself but their (cor)relations with parameters of health. Based on the categorization of the instruments, a total of 11 measures of broader constructs including a spiritual dimension adapted to Spanish were identified. Of these, in line with the findings of Selman et al. [36], several measures focused on assessing patients' psychosocial needs (e.g., ENP-E) or the outcomes of their care (e.g., PDI), while a large proportion focused on measuring quality of life (e.g., MQLI or WHOQOL-100). In reference to the latter, the findings of this review show the existence of a range of

instruments to assess quality of life from a holistic perspective, in which the importance of spiritual issues is recognized [157].

In this respect, the religious and spiritual constructs assessed by the identified quality of life measures (e.g., purpose and meaning in life, preparation for death or feeling at peace) are similar to those described by Albers et al. [158] in a review of quality of life instruments in palliative care.

In any case, most of the measures used in Spanish-speaking health contexts or health research focused on different substantive (n = 15) or functional (n = 25) aspects of R/S. Taken together with those present in the measures of broader constructs, all of these measures reflect the problem pointed out by authors such as Hall et al. [26] or Zwingmann et al. [27] about the heterogeneity of R/S conceptions and the need to understand them in order to know the scope of the measures. Before we return to the distinction of functional and substantive aspects, three short remarks on the conceptions of R/S in Spanish-speaking research measures are due:

First, following the idea of authors such as Paul Victor and Treschuk [21], there is sometimes an overlap between the two constructs of R/S, often due to the “intrinsic” relationship between the two, so that they can be used interchangeably. This is true in cases in which spirituality is understood as framed or rooted within a religion, implying the search for and relationship with the divine [15]. In some measures identified in the review, such as the BMMRS [144], spirituality is conceptualized in this way (e.g., “I feel the presence of God”).

Secondly, however, in these cases there is a preference for the term “religiosity”. Indeed, through this review, many measures have been recognized that, while following a similar definition, overtly assess religiosity rather than spirituality. Several examples of this can be found in measures such as the Brief RCOPE [114] (e.g., “I sought a stronger closeness to God”) or the Brief Trust/Mistrust in God Scale [146] (e.g., “God loves me immensely”). These two instruments refer to different elements that are present in the relationship with the divine and therefore form part of religiosity, such as religious coping or trust in God respectively, although there are other elements such as attachment to God, religious experience, religious beliefs or motivation [14]. These are also measured in some of the identified research tools used in Spanish-speaking research projects. In any case, our findings reflect that religiosity is not reduced to a connection to some God, but may also include a series of cognitive, emotional, social and moral elements (believing, bonding, belonging, behaving) [159], some of them categorizable as organizational (attending mass or other activities related to a religious group) and non-organizational elements (such as prayer or the study of sacred scriptures) [160].

Thirdly then, in many cases “spirituality” is not conceptualized as necessarily linked to a religious belief system or to a relationship with the divine. Throughout the review, a large number of measures adapted to Spanish have been recognized which use a concept of spirituality similar to that proposed by authors such as Vachon et al. [25] or Delgado [20]. These concepts of spirituality include a personal or subjective experience, the search for and presence of meaning or purpose in life, the connection and relationship with oneself, others, nature, the transcendent, the sacred or God/Higher Self, or aspects such as faith,

peace, attitudes towards death or hope. This may clarify the distinction of spirituality and religion, but also allows to evaluate the role of religiosity within the spiritual world of the individual. Although this breadth of elements seems to indicate a lack of agreement on what experts understand spirituality to mean, they all have a correlate in the wide variety of measures that assess such constructs. In other words, although conceptual ambiguity can be a problem, in health research in Spanish-speaking contexts there is a wide range of instruments available to assess different components of spirituality as proposed by experts.

Taking these points into account, it becomes necessary to distinguish some differences between the functional and substantive aspects of R/S. In this review we can observe that spirituality is evaluated from a functional approach to a greater extent than religiosity. This, to some extent, is in line with the findings of Vivat [48].

On the one hand, it was observed that spirituality is often evaluated from a functional approach insofar as it fulfills the function of giving well-being to individuals. This makes sense, given the relevance that spiritual well-being has acquired as part of people's holistic health and well-being [161]. This seems to be true, too, in the different Spanish-speaking contexts in which measures of spiritual well-being are applied. Focusing on these measures, the present review coincides to some extent with the one conducted by Lu et al. [162], who also identified instruments such as the Spiritual Well-Being Scale (SWBS) [73], the Spirituality Index of Well-Being (SIWB) [77], the FACIT-Sp12 [71] or the Multidimensional Inventory for Religious/Spiritual Well-Being (MI-RSWB) [75]. The Spanish versions of all these well-established instruments, along with others that have also been widely used in research, were also identified 10 years ago in the review by Galiana et al. [40] in the context of palliative care. Again, the importance of meaning in life as a component of spirituality is evident in all of them, as they all value this element. In addition, the SWBS assesses religious and existential aspects, the SIWB self-efficacy and the life scheme, the FACIT-Sp peace and faith, and the MI-RSWB elements such as forgiveness, immanent and transcendent hope, connectedness and religiosity. Therefore, important similarities can be seen in all of them between the dimensions assessed as part of spirituality and those identified by Vachon et al. [25] in their broad definition of the term.

Meaning in life is particularly relevant to functional measures of spirituality. In fact, meaning in life stands out as the most frequently repeated element in the conceptions used by the identified research tools. Albers et al. [158] have found meaning in life as the most frequently used construct in relation to spirituality already in 2010; this review now confirms this finding and has recognized meaning in life as the construct related to spirituality that is most frequently assessed by measures in Spanish-speaking contexts up to 2022. There are measures which focus solely on meaning in life, such as the MiLS-Sp [94] or the MLQ [85]. It is worth noting that measures assessing meaning in life have been categorized as functional measures: different spiritual dimensions serve the function of giving meaning to life. The clearest case is found in the MiLS-Sp which, based on the findings of authors such as Brandstätter et al. [163], considers dimensions such as purpose in life, transcendence or faith to obtain an assessment of meaning in life. On the other hand, however, other measures assess meaning in life through a subscale

within the instrument itself. For example, general multidimensional measures such as the QOLLI-F [51] understand meaning in life as an element that influences quality of life and therefore must be considered in the assessment of quality of life. This is similar for measures focused on the assessment of psychological states, such as the Scales of Psychological Well-Being [86] or the Positive Psychotherapy Inventory [80]. They show that meaning in life appears as a component of psychological well-being, although it is also a central element of spirituality. Therefore, as proposed by Koenig et al. [15], it is evident from the results obtained with these measures that meaning in life is associated with better psychological well-being. In any case, the findings of the review in this regard highlight the recognized need to clearly differentiate (which does not mean separate) between spirituality and mental health [8].

Within the functional perspective, the relevance of spirituality has also been observed in hope or symptoms of spiritual problems. However, despite the predominance of spirituality within this approach, religiosity has also been considered functionally in that it plays an important role in coping with stressful events. In this sense, six of the instruments (e.g., the Brief RCOPE or the Coping Strategies Questionnaire) followed the conceptualization of religiosity as the search for and connection with God. Only the Spiritual Coping Scale [123] understood spirituality more broadly and distanced it from religion. Thus, our findings seem to reflect a prevalence of religiosity over spirituality only when the functional approach is directed towards coping.

However, when we refer to a substantive perspective, the scales are (more) balanced as to religiosity and spirituality. When talking about substantive aspects of spirituality, we note that in many cases spirituality is assessed as a construct per se (e.g., Spiritual Index for Elderly or GES Questionnaire), although other substantive aspects such as R/S struggles, attitudes towards spirituality, beliefs, experiences and spiritual needs were identified. Spiritual needs deserve a special mention. Two measures focused on these needs were observed: the ENP-E [59] and Spiritual Needs Questionnaire for Palliative Care (SNQPC) [138]. However, neither of these tools nor our search yielded any information on the Spiritual Needs Questionnaire (SpNQ) by Büssing et al. [164]. As an aside, it is noteworthy that this author has developed numerous R/S measures, such as DUREL [160], BENEFIT [165], SCCQ [104], ASP [166] or SpREUK [161], among others, of which DUREL, SCCQ and SpREUK have been identified in this review. The SpNQ, unlike the other measures of spiritual needs mentioned, has the particularity that it is not limited to questions related to the end of life, but is also relevant to earlier and less severe phases of the disease, and is applicable to adolescents and healthy people in difficult life situations [168]. It has been translated into many languages, including Spanish, although the Spanish version available has not been published, which is why it did not appear in the search. In this regard, this measure should be seriously considered in future research on spiritual needs in different Spanish-speaking health care settings.

Furthermore, an important fact appears in reference to the substantive understandings. Most measures of spirituality that employed a substantive approach involved the religious as a part of their conception of spirituality (e.g., ESI or Spirituality Index for Elderly). This can be especially useful in a context such as Spain or other Spanish-speaking countries, where historically there is a deep-rooted Catholic tradition and where, therefore, spirituality has always been closely associated with religion (although, given the

progressive secularization of these societies, both concepts are increasingly separated). In this sense, in the field of palliative care in Spain, the aforementioned GES Questionnaire has been developed [126] that collects the different elements of spirituality, including the relationship with a higher entity which, given the current secular perspective, may or may not be a God.

The significance of religiosity in substantive considerations becomes more obvious in many measures that recognize the search for, and relationship with, God as the underlying definition of the religiosity construct. In this sense, measures were identified that involved substantive cognitive or emotional aspects of religiosity, such as trust/mistrust in God [146], religious orientation [153] or attitude to religion [155], while others focused on substantive behavioral aspects, such as public (organizational religiosity) and private (non-organizational religiosity) religious practice [148].

Thus, our results seem to be in line with the idea that spirituality is more present in functional approaches, while religiosity acquires more importance in substantive ones [169].

In sum, this is the first systematic review that has identified the measures of R/S used in Spanish and Latin American health contexts or health research, and which, in addition, tries to capture systematically the way in which religiosity and spirituality are understood in these measures. This has several implications for health practice and research.

First, this review aims to facilitate the understanding of the instruments available in Spanish. Understanding what each measure assesses can help researchers determine the purpose of their work and more precisely delineate the scope of their results. Many of these measures employ very broad conceptions of spirituality, which align with current views of this human experience. These conceptions can be used to understand the spiritual aspects linked to different physical and mental health issues at various stages of these conditions. In any case, we consider it important that researchers clarify the definition of spirituality guiding their studies and justify the use of the measures employed and their appropriateness to the study population to avoid bias in their conclusions. In this sense, in addition to identifying measures of spirituality that are both broad in their conceptualization and more general, the review provides clarity about existing measures of religiosity in Spanish-speaking contexts, with equally positive implications for researchers interested in aspects related to the experience of religious beliefs. In any case, it is also important for researchers to pay attention to the study population and its cultural context in order to select a measure that best captures the religious aspects of that population.

In addition to these conceptual considerations, our findings also allow drawing some applied recommendations based on the psychometric evidence available. Several instruments in Spanish show solid validity and reliability across multiple properties, such as the FACIT-Sp12, the Meaning in Life Questionnaire (MLQ), or the Brief Trust/Mistrust in God Scale (BTMGS). Among those developed within Spanish-speaking contexts, the GES Questionnaire stands out as a particularly robust tool. The broad vision of spirituality proposed by the Spirituality Group of the Spanish Society of Palliative Care, who developed the GES, can be an important basis for continuing to use and refine this measure, which is also one of the most widely employed in the clinical practice of palliative care in Spain. These

instruments can be recommended as priority options when selecting measures for future research or clinical use.

At the same time, caution should be exercised with instruments that either lack sufficient psychometric data or have only been translated without a complete validation process (e.g., SpREUK-SF10, PPTI, SCS, SCQ, SNQPC), as well as with those showing weaknesses in specific properties such as internal consistency or construct validity. In fact, as reflected in Table 5, many of these instruments lack most of the required evidence, and therefore we do not recommend their use until more robust validation studies are available. Therefore, researchers and practitioners are encouraged to balance conceptual fit with psychometric soundness when choosing the most appropriate tool.

This issue is particularly relevant for practitioners who use holistic approaches in patient care. Selecting measures with both robust evidence and cultural appropriateness -such as the GES Questionnaire in the Spanish palliative care context- can facilitate an accurate understanding of patients' religious and spiritual concerns. This, in turn, enables health professionals to improve treatments and interventions aimed at meeting patients' R/S needs. Given the correlations between spiritual well-being and physical, psychological, and social well-being, addressing patients' spiritual concerns may contribute to enhancing their quality of life and overall well-being. Nevertheless, it should be borne in mind that these associations do not imply causality. Future research in this field should aim to clarify potential causal mechanisms underlying these relationships. In addition, it is noteworthy that a well-established spiritual needs scale, the SpNQ, has not yet been used in published Spanish-speaking research, despite its availability, which highlights an area for development in future studies.

Limitations

This review has several limitations. In the first place, the search is centered on elements that may be more characteristic of spiritualities linked to religious traditions specific to the context in which the research is carried out, such as Catholicism. Thus, we included in our search terms related to measures that addressed concepts associated with God or more behavioral aspects such as praying or going to church, as well as more general aspects such as spiritual, existential or personal beliefs. This kind of historical-cultural bias might not be a problem in countries such as Spain, where there are other major world religions (such as Islam or Judaism) that have similar characteristics and can be properly studied by measures of this type, too [15]. However, in the different Spanish-speaking contexts there are different religious/spiritual currents that are less common and may present characteristic elements that have not been studied and (hence) included in the review.

Regarding the psychometric quality of the identified instruments, although some Spanish adaptations presented good evidence across several validity domains, this was not the case for the majority of measures. In many cases, evidence was partial, inconsistent, or absent, particularly for aspects such as criterion validity, discriminant validity, or content validity. Therefore, the findings of this review should be interpreted in light of the heterogeneity and, in some cases, the insufficiency of the available psychometric data.

In this review, we have provided an overview of the psychometric quality of the identified instruments and have highlighted those with stronger evidence supporting their validity and reliability. We recommend referring to the lists provided above when selecting measures for use in Spanish-speaking health contexts. However, researchers should still carefully examine the psychometric adequacy of each instrument in relation to their specific research objectives. Additionally, based on the instruments identified, further validation efforts are needed for those lacking psychometric data, or those that present problematic values in key psychometric properties. Following Selman et al. [36], it is necessary for future studies to focus on testing, adapting, and improving the reliability and validity of existing instruments in Spanish for their use in different contexts. Future reviews could also consider evaluating item formulation, as some authors emphasized the importance of ensuring clarity and consistency in how spiritual terms are presented to avoid misunderstandings and enhance cross-cultural validity [32, 170].

Additionally, a methodological limitation of this review is the inclusion criteria requiring studies to employ a quantitative methodology. While this decision was made to ensure that the instruments analyzed had undergone psychometric validation, it inherently excluded qualitative research, which is highly relevant for exploring the lived experiences and conceptualizations of R/S in healthcare. Given that R/S is deeply embedded in the humanities and qualitative research traditions, future reviews may benefit from incorporating qualitative studies to provide a richer understanding of how these instruments capture the complexity of R/S experiences in diverse Spanish-speaking healthcare settings.

Finally, the review focused on health in general, without focusing on specific areas, unlike other reviews that focused on palliative care [40]. This has certain advantages, such as broadening the scope of the search to include both mental and physical health articles. However, given the importance of spirituality at the end of life [171], the use of palliative care terms may allow for the identification of very specific palliative care measures. Thus, on future occasions, the combination of generic terms related to health with terms more specific to areas where spirituality is more important may help to better identify and select measures according to the field of work or research.

5. CONCLUSION

There are numerous instruments available for assessing religiosity and spirituality (R/S) in health contexts and health research, yet until now, no systematic reviews have specifically aimed at identifying these instruments adapted for use in Spanish-speaking contexts. This study addresses this gap by providing a comprehensive overview of the R/S instruments available in Spanish, which are essential for the assessment of R/S in diverse health settings.

This review adds valuable insights by cataloging these instruments, detailing their psychometric properties, and considering their applicability within the context of health and well-being. It offers a detailed mapping of the instruments available in Spanish-speaking contexts, enabling researchers and healthcare professionals to select the most appropriate tools for their specific populations and research

settings. Furthermore, it emphasizes the importance of considering the varying definitions of religiosity and spirituality that underlie these instruments, as well as the need to ensure their psychometric soundness.

The importance of this review lies in its practical implications for health practice and research. By understanding the available tools and their specific applications, healthcare providers can better address the religious and spiritual needs of patients, potentially improving their overall well-being. This study also encourages further testing of existing measures to improve their psychometric properties while considering the cultural, religious, and spiritual aspects of Spanish-speaking populations. Additionally, improving the psychometric properties of existing instruments remains an important area for future research, ensuring that they are robust and reliable in diverse healthcare settings. Ultimately, this review not only bridges a critical gap in the assessment of R/S in Spanish-speaking health research but also lays the groundwork for future advancements in culturally relevant and methodologically rigorous measurement tools. By doing so, it contributes to a more comprehensive understanding of the role of R/S in health, empowering both researchers and healthcare professionals to integrate these dimensions more effectively into patient care and well-being.

Declarations

Ethics approval and consent to participate.

Not applicable.

Consent for publication.

Not applicable.

Competing interests.

The authors declare that they have no competing interests.

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Author Contribution

D.A. selected the databases and search strategy, which was reviewed and confirmed by K.B. before implementation. D.A. and K.B. established the eligibility criteria for the studies, as well as the data to be extracted from each one. The data were extracted by D.A., which were compared and confirmed by K.B. D.A. and K.B. were responsible for implementing the PRISMA guidelines. D.A. and K.B. prepared the

original manuscript, which was critically revised several times by D.A., K.B., J.S. and F.M.M. until it reached its final form. All authors read and approved the final manuscript.

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Data Availability

The set of data collected and analysis during this review are available upon request to corresponding author.

References

1. Koenig HG, Hamilton JB, Doolittle BR. Training to conduct research on religion, spirituality and health: A commentary. *J Relig Health*. 2021;60:2178–89.
2. Firkins JL, Tomic I, Hansen L, Woodrell CD. Association of spirituality and quality of life in cancer survivors: a systematic review and meta-analysis. *Support Care Cancer*. 2025;33(3):246.
3. Jim HS, Pustejovsky JE, Park CL, et al. Religion, spirituality, and physical health in cancer patients: A meta-analysis. *Cancer*. 2015;121(21):3760–8.
4. Coelho-Júnior HJ, Calvani R, Panza F, et al. Religiosity/Spirituality and Mental Health in Older Adults: A Systematic Review and Meta-Analysis of Observational Studies. *Front Med*. 2022;9:877213.
5. Garssen B, Visser A, Pool G. Does spirituality or religion positively affect mental health? Meta-analysis of longitudinal studies. *Int J Psychol Relig*. 2021;31(1):4–20.
6. Hodapp B, Zwingmann C. Religiosity/Spirituality and Mental Health: A Meta-analysis of Studies from the German-Speaking Area. *J Relig Health*. 2019;58(6):1970–98.
7. Sherman AC, Merluzzi TV, Pustejovsky JE, et al. A meta-analytic review of religious or spiritual involvement and social health among cancer patients. *Cancer*. 2015;121(21):3779–88.
8. Baumann K. Spiritual Health ist nicht Mental Health. In: Büssing A, Giebel A, Roser T, editors. *Spiritual Care & Existential Care interprofessionell*. Heidelberg: Springer Nature; 2024.
9. Exline JJ, Pargament KI, Grubbs JB, Yali AM. The Religious and Spiritual Struggles Scale: Development and initial validation. *Psychol Relig Spirit*. 2014;6(3):208–22.
10. Currier JM, Foster JD, Witvliet CV, Abernethy AD, Root Luna LM, Schnitker SA, VanHarn K, Carter J. Spiritual struggles and mental health outcomes in a spiritually integrated inpatient program. *J Affect Disorders*. 2019;249:127–35.
11. Park CL, Sacco SJ, Kraus SW, Mazure CM, Hoff RA. Influences of religiousness/spirituality on mental and physical health in OEF/OIF/OND military veterans varies by sex and race/ethnicity. *J Psychiatr*

Res. 2021;138:15–23.

12. Smart N. Dimensions of the sacred. An anatomy of the world's beliefs. Fontana; 1997.
13. Glock CY, Stark R. Religion and society in tension. Chicago: Rand McNally & Company; 1971.
14. Koenig HG, Zaben FA, Khalifa DA, Shohaib SA. Measures of religiosity. In: Boyle GJ, Saklofske DH, Matthews G, editors. Measures of personality and social psychological constructs. Elsevier Academic; 2015. pp. 530–61.
15. Koenig HG, King DE, Carson VB. Handbook of religion and health. 2nd ed. New York: Oxford University Press; 2012.
16. Hill PC, Pargament KI. Advances in the Conceptualization and Measurement of Religion and Spirituality. Implications for Physical and Mental Health Research. *Am Psychol*. 2003;58(1):64–74.
17. Aldwin CM, Park CL, Jeong YJ, Nath R. Differing pathways between religiousness, spirituality, and health: A self-regulation perspective. *Psychol Relig Spiritual*. 2014;6(1):9–21.
18. Quinceno JM, Vinaccia S. The health in the mark of the psychology of the religion and the spirituality. *Diversitas-Persp Psi*. 2009;5(2):321–36.
19. Allport GW, Ross JM. Personal religious orientation and prejudice. *J Pers Soc Psychol*. 1967;5(4):432–43.
20. Delgado C. A discussion of the concept of spirituality. *Nurs Sci Q*. 2005;18(2):157–62.
21. Paul Victor CG, Treschuk JV. Critical literature review on the definition clarity of the concept of faith, religion, and spirituality. *J Holist Nurs*. 2020;38(1):107–13.
22. Schnell T. Spirituality with and without religion—Differential relationships with personality. *Arch Psychol Relig*. 2012;34(1):33–61.
23. Frankl V. Man's search for meaning: an introduction to logotherapy. New York: Washington Square; 1963. p. 21.
24. Chiu L, Emblen JD, Van Hofwegen L, Sawatzky R, Meyerhoff H. An integrative review of the concept of spirituality in the health sciences. *West J Nurs Res*. 2004;26(4):405–28.
25. Vachon M, Fillion L, Achille M. A conceptual analysis of spirituality at the end of life. *J Palliat Med*. 2009;12(1):53–9.
26. Hall DE, Meador KG, Koenig HG. Measuring religiousness in health research: review and critique. *J Relig Health*. 2008;47(2):134–63.
27. Zwingmann C, Klein C, Büssing A. Measuring religiosity/spirituality: Theoretical differentiations and categorization of instruments. *Religions*. 2011;2(3):245–57.
28. Austin P, Macdonald J, MacLeod R. Measuring spirituality and religiosity in clinical settings: A scoping review of available instruments. *Religions*. 2018;9(3):70.
29. Koenig HG. Religion and mental health: Research and clinical applications. Elsevier Academic; 2018.
30. Koenig HG, Al Zaben F. Psychometric Validation and Translation of Religious and Spiritual Measures. *J Relig Health*. 2021;60(5):3467–83.

31. Kilpatrick SD, Weaver AJ, McCullough ME, Puchalski C, Larson DB, Hays JC, Farran CJ, Flannelly KJ. A review of spiritual and religious measures in nursing research journals: 1995–1999. *J Relig Health*. 2005;44(1):55–66.
32. de Jager Meezenbroek E, Garssen B, van den Berg M, van Dierendonck D, Visser A, Schaufeli WB. Measuring spirituality as a universal human experience: a review of spirituality questionnaires. *J Relig Health*. 2012;51(2):336–54.
33. Monod S, Brennan M, Rochat E, Martin E, Rochat S, Büla CJ. Instruments measuring spirituality in clinical research: a systematic review. *J Gen Intern Med*. 2011;26(11):1345–57.
34. Nissen RD, Falkø E, Stripp TK, Hvidt NC. Spiritual Needs Assessment in Post-Secular Contexts: An Integrative Review of Questionnaires. *Int J Environ Res Public Health*. 2021;18(24):12898.
35. Sessanna L, Finnell DS, Underhill M, Chang YP, Peng HL. Measures assessing spirituality as more than religiosity: a methodological review of nursing and health-related literature. *J Adv Nurs*. 2011;67(8):1677–94.
36. Selman L, Harding R, Gysels M, Speck P, Higginson IJ. The measurement of spirituality in palliative care and the content of tools validated cross-culturally: a systematic review. *J Pain Symptom Manage*. 2011;41(4):728–53.
37. Lucchetti G, Lucchetti AL, Vallada H. Measuring spirituality and religiosity in clinical research: a systematic review of instruments available in the Portuguese language. *Sao Paulo Med J*. 2013;131(2):112–22.
38. Forti S, Serbena CA, Scaduto AA. Spirituality/religiousity measurement and health in Brazil: a systematic review. *Cien Saude Colet*. 2020;25(4):1463–74.
39. Zwingmann C. Assessment of spirituality/religiosity in the context of health related quality of life. *Psychother Psychosom Med Psychol*. 2005;55(5):241–6.
40. Galiana L, Oliver A, Gomis C, Barbero J, Benito E. Evaluation and spiritual intervention questionnaires in palliative care: a critical review. *Med Paliativa*. 2014;21(2):62–74.
41. Herranz-de-Rafael G, Fernández-Prados JS. Religious Beliefs and Socialization: An Empirical Study on the Transformation of Religiosity in Spain from 1998 to 2018. *Religions*. 2024;15(7):848.
42. Bermejo JC. Spirituality and health. *Horizonte*. 2021;19(60):1202–41.
43. Cutting M, Walsh M. Religiosity scales: What are we measuring in whom? *Arch Psychol Relig*. 2008;30:137–53.
44. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, Shamseer L, Tetzlaff JM, Akl EA, Brennan SE, Chou R, Glanville J, Grimshaw JM, Hróbjartsson A, Lalu MM, Li T, Loder EW, Mayo-Wilson E, McDonald S, McGuinness LA, Stewart LA, Thomas J, Tricco AC, Welch VA, Whiting P, Moher D. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71.
45. World Health Organization. Basic documents. Geneva: World Health Organization; 2020.

46. Zinnbauer BJ, Pargament KI, Cole B, Rye MS, Butter EM, Belavich TG, et al. Religion and spirituality: Unfuzzifying the fuzzy. *J Sci Study Relig.* 1997;36(4):549–64.
47. Hill PC, Edwards E. Measurement in the psychology of religiousness and spirituality: Existing measures and new frontiers. In: Pargament KI, Exline JJ, Jones JW, editors, *APA handbook of psychology, religion, and spirituality (Vol. 1): Context, theory, and research*. Washington: American Psychological Association; 2013. pp. 51–77.
48. Vivat B. Measures of spiritual issues for palliative care patients: a literature review. *Palliat Med.* 2008;22(7):859–68.
49. Álvarez I, Bados A, Però M. Factorial structure and validity of the Multicultural Quality of Life Index. *Qual Life Res.* 2010;19(2):225–9.
50. Mezzich JE, Ruipérez MA, Pérez C, Yoon G, Liu J, Mahmud S. The Spanish version of the quality of life index: presentation and validation. *J Nerv Ment Dis.* 2000;188(5):301–5.
51. Arias-Rojas M, Arredondo Holgín E, Carreño Moreno S, Posada López C, Tellez B. Validation of the Latin American-Spanish version of the scale 'Quality of Life in Life-Threatening Illness-Family Caregiver Version' (QOLLTI-F). *Health Soc Care Community.* 2022;30(3):e832–41.
52. Cohen R, Leis AM, Kuhl D, Charbonneau C, Ritvo P, Ashbury FD. QOLLTI-F: measuring family carer quality of life. *Palliat Med.* 2006;20(8):755–67.
53. Barrera Ortiz L, Carrillo González GM, Chaparro Díaz L, Sánchez Herrera B, Vargas Rosero E, Patricia Carreño S. Construct validity and reliability of quality of life instrument family version in Spanish. *Enferm Glob.* 2015;14(37):227–38.
54. Ferrell BR, Dow KH, Grant M. Measurement of the quality of life in cancer survivors. *Qual Life Res.* 1995;4(6):523–31.
55. Lucas-Carrasco R. The WHO quality of life (WHOQOL) questionnaire: Spanish development and validation studies. *Qual Life Res.* 2012;21(1):161–5.
56. WHOQOL Group. The World Health Organization Quality of Life Assessment (WHOQOL): development and general psychometric properties. *Soc Sci Med.* 1998;46(12):1569–85.
57. Fuster-Ruiz de Apodaca MJ, Laguía A, Safreed-Harmon K, Lazarus JV, Cenoz S, Del Amo J. Assessing quality of life in people with HIV in Spain: psychometric testing of the Spanish version of WHOQOL-HIV-BREF. *Health Qual Life Outcomes.* 2019;17(1):144.
58. O'Connell KA, Skevington SM. An international quality of life instrument to assess wellbeing in adults who are HIV-positive: a short form of the WHOQOL-HIV (31 items). *AIDS Behav.* 2012;16(2):452–60.
59. Mateo-Ortega D, Limonero JT, Maté-Méndez J, Beas E, González-Barboteo J, Barbero E, Ela S, Gómez-Batiste X. Development of a tool to identify and assess psychosocial and spiritual needs in end-of-life patients: The ENP-E scale. *Palliat Support Care.* 2019;17(4):441–7.
60. Cárdenas M, Barrientos J, Ricci E, Páez D. Spanish Adaptation and Validation of the Posttraumatic Growth Inventory-Short Form. *Violence Vict.* 2015;30(5):756–69.

61. Cann A, Calhoun LG, Tedeschi RG, Taku K, Vishnevsky T, Triplett KN, Danhauer SC. A short form of the Posttraumatic Growth Inventory. *Anxiety Stress Coping*. 2010;23(2):127–37.
62. Rullán M, Carvajal A, Núñez-Córdoba JM, Martínez M, Carrasco JM, García I, Arantzamendi M, Belar A, Centeno C. Spanish Version of the Patient Dignity Inventory: Translation and Validation in Patients With Advanced Cancer. *J Pain Symptom Manage*. 2015;50(6):874–81.
63. Chochinov HM, Hassard T, McClement S, Hack T, Kristjanson LJ, Harlos M, Sinclair S, Murray A. The patient dignity inventory: a novel way of measuring dignity-related distress in palliative care. *J Pain Symptom Manage*. 2008;36(6):559–71.
64. Gutiérrez M, Tomás JM, Calatayud P. Contributions of Psychosocial Factors and Physical Activity to Successful Aging. *Span J Psychol*. 2018;21:E26.
65. Troutman M, Nies MA, Small S, Bates A. The development and testing of an instrument to measure successful aging. *Res Gerontol Nurs*. 2011;4(3):221–32.
66. Torres Soto NY, Corral Verdugo V, Corral Frías NS, Rojas Armadillo ML. Design and validation of the Self-Care Behaviors Scale. *Behav Psychol*. 2021;29(3):721–41.
67. Pérez-Cruz PE, Padilla Pérez O, Bonati P, Thomsen Parisi O, Tupper Satt L, Gonzalez Otaiza M, Ceballos Yáñez D, Maldonado Morgado A. Validation of the Spanish Version of the Quality of Dying and Death Questionnaire (QODD-ESP) in a Home-Based Cancer Palliative Care Program and Development of the QODD-ESP-12. *J Pain Symptom Manage*. 2017;53(6):1042–49.
68. Curtis JR, Patrick DL, Engelberg RA, Norris K, Asp C, Byock I. A measure of the quality of dying and death. Initial validation using after-death interviews with family members. *J Pain Symptom Manage*. 2002;24(1):17–31.
69. Gonzalez-Baz MD, Del Pacheco E, Ferrer-Ferrándiz E, Araque-Criado I, Merchán-Arjona R, de la Rubia Gonzalez T, Moro Tejedor MN. Psychometric validation of the Kolcaba General Comfort Questionnaire in critically ill patients. *Aust Crit Care*. 2023;36(6):1025–34.
70. Kolcaba KY. Holistic comfort: operationalizing the construct as a nurse-sensitive outcome. *ANS Adv Nurs Sci*. 1992;15(1):1–10.
71. Peterman AH, Fitchett G, Brady MJ, Hernandez L, Cella D. Measuring spiritual well-being in people with cancer: the functional assessment of chronic illness therapy–Spiritual Well-being Scale (FACIT-Sp). *Ann Behav Med*. 2002;24(1):49–58.
72. Montero-López M, Sierra C. Spiritual Well-Being Scale: A validation study. *La Psicología Social en México*. 1996;6:28–33.
73. Paloutzian RF, Ellison CW. Loneliness, spiritual well-being and the quality of life. In: Peplau LA, Perlman D, editors. *Loneliness: A sourcebook of current theory, research and therapy*. New York: Wiley; 1982. pp. 224–36.
74. Berger D, Fink A, Perez Gomez MM, Lewis A, Unterrainer HF. The Validation of a Spanish Version of the Multidimensional Inventory of Religious/Spiritual Well-Being in Mexican College Students. *Span J Psychol*. 2016;19:E3.

75. Unterrainer H, Nelson O, Collicutt J, Fink A. The English version of the Multidimensional Inventory for Religious/Spiritual Well-Being (MI-RSWB-E): First results from British college students. *Religions*. 2012;3(3):588–99.
76. Vinaccia S, Riveros F, Quinceno JM. Construct validity and reliability of the Spanish version of Spirituality Index of Well-Being (SIWB) in Colombian population with chronic lung disease. *Rev Univ Ind Santander Salud*. 2016;48(3):321–30.
77. Daaleman TP, Frey BB. The Spirituality Index of Well-Being: a new instrument for health-related quality-of-life research. *Ann Fam Med*. 2004;2(5):499–503.
78. Belar A, Arantzamendi M, Rodríguez-Núñez A, Santesteban Y, Martinez M, López-Saca M, Consigli S, López-Fidalgo J, Centeno C. Multicenter Study of the Psychometric Properties of the New Demoralization Scale (DS-II) in Spanish-Speaking Advanced Cancer Patients. *J Pain Symptom Manage*. 2019;57(3):627–34.
79. Robinson S, Kissane DW, Brooker J, Hempton C, Michael N, Fischer J, Franco M, Sulistio M, Clarke DM, Ozmen M, Burney S. Refinement and revalidation of the demoralization scale: The DS-II-external validity. *Cancer*. 2016;122(14):2260–7.
80. Rashid T, Seligman M. Positive psychotherapy. In: Corsini R, Wedding D, editors. *Current psychotherapies*. 10th ed. Belmont: Cengage; 2013. pp. 461–99.
81. Noblejas MA. Logotherapy. Foundations, principles, and application. An experience of assess the internal achievement of meaning [dissertation]. Madrid, Spain: Complutense University of Madrid; 1994.
82. García-Alandete J, Rosa E, Sellés P. Factorial structure and internal consistency of a Spanish version of the Purpose-In-Life Test. *Univ Psychol*. 2013;12(2):517–30.
83. Rubio-Belmonte C, Mayordomo Rodríguez T, García-Alandete J. Psychometric properties of the Purpose In Life-Short Form in the Spanish population. *J Clin Psychol*. 2023;79(4):1099–112.
84. Crumbaugh JC, Maholick LT. Manual of instructions for the Purpose-in-Life-Test. Munster: Psychometric Affiliates; 1969.
85. Steger MF, Frazier P, Oishi S, Kaler M. The meaning in life questionnaire: Assessing the presence of and search for meaning in life. *J Couns Psychol*. 2006;53(1):80–93.
86. Díaz D, Rodríguez-Carvajal R, Blanco A, Moreno-Jiménez B, Gallardo I, Valle C, Van Dierendonck D. Spanish adaptation of the Psychological Well-Being Scales (PWBS). *Psicothema*. 2006;18(3):572–7.
87. Ryff CD. Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *J Pers Soc Psychol*. 1989;57(6):1069–81.
88. García-Alandete J, Rubio-Belmonte C, Soucase Lozano B. The Seeking of Noetic Goals revisited among Spanish young people. *J Humanist Psychol*. 2020;60(1):77–98.
89. Crumbaugh JC. The Seeking of Noetic Goals Test (SONG): a complementary scale to the Purpose in Life Test (PIL). *J Clin Psychol*. 1977;33(3):900–7.

90. Carreno DF, Eisenbeck N, Cangas AJ, García-Montes JM, Del Vas LG, María AT. Spanish adaptation of the Personal Meaning Profile-Brief: Meaning in life, psychological well-being, and distress. *Int J Clin Health Psychol*. 2020;20(2):151–62.
91. McDonald MJ, Wong PTR, Gingras DT. Meaning-in-life measures and development of a Brief Version of the Personal Meaning Profile. In: Wong PTP, editor. *The human quest for meaning: Theories, research, and applications*. New York: Routledge/Taylor & Francis Group; 2012. pp. 357–82.
92. Chaves C, Ballesteros-Valdés R, Madrudejos E, Charles-Leija H. Perma-profiler for the evaluation of well-being: Adaptation and validation in a sample of university students and employees in the mexican educational context. *Appl Res Qual Life*. 2023;18:1225–47.
93. Butler J, Kern ML. The PERMA-Profiler: A brief multidimensional measure of flourishing. *Int J Well-Being*. 2016;6(3):1–48.
94. Reig-Ferrer A, Arenas MD, Ferrer-Cascales R, Fernández-Pascual MD, Albaladejo-Blázquez N, Gil MT, de la Fuente V. Evaluation of spiritual well-being in haemodialysis patients. *Nefrologia*. 2012;32(6):731–42.
95. Jim HS, Purnell JQ, Richardson SA, Golden-Kreutz D, Andersen BL. Measuring meaning in life following cancer. *Qual Life Res*. 2006;15(8):1355–71.
96. Gual García P, Farran CJ, Fernández Capo M. Validation of the Spanish version of the Finding meaning through caregiving scale. *Informaciones Psiquiátricas*. 2006;(184):187–98.
97. Farran CJ, Miller BH, Kaufman JE, Donner E, Fogg L. Finding meaning through caregiving: development of an instrument for family caregivers of persons with Alzheimer's disease. *J Clin Psychol*. 1999;55(9):1107–25.
98. Arnau RC, Martinez P, De Guzmán IN, Herth K, Konishi CY. A Spanish-language version of the Herth Hope Scale: Development and psychometric evaluation in a Peruvian sample. *Educ Psychol Meas*. 2010;70(5):808–24.
99. Calderón C, Ferrando PJ, Lorenzo-Seva U, Ferreira E, Sorribes E, Hernández R, Planellas-Kirchner I, Mihic-Gongora L, Corral MJ, Jiménez-Fonseca P. Psychometric Properties and Measurement Invariance of the Herth Hope Index in Spanish Cancer Patients. *Psicothema*. 2024;36(1):72–9.
100. Herth K. Development and refinement of an instrument to measure hope. *Sch Inq Nurs Pract*. 1991;5(1):39–56.
101. Herth K. Abbreviated instrument to measure hope: development and psychometric evaluation. *J Adv Nurs*. 1992;17(10):1251–9.
102. Bermejo JC, Villacieros M. Components of hope in situation of terminality. Study for development of a measurement scale. *Gerokomos*. 2016;27(3):97–103.
103. Pastrana T, Frick E, Krikorian A, Ascencio L, Galeazzi F, Büssing A. Translation and Validation of the Spanish Version of the Spiritual Care Competence Questionnaire (SCCQ). *J Relig Health*. 2021;60(5):3621–39.
104. Frick E, Theiss M, Rodrigues Recchia D, Büssing A. Validation of a spiritual care competence scale in German language. *Spiritual Care*. 2019;8(2):193–207.

105. Reyes MM, de Lima L, Taboada P, Villarroel L, Vial JD, Blanco O, González R, Parra I, Toledo G, Bonati P, Nervi F. A scale to assess spiritual symptoms in palliative care. *Rev Med Chil.* 2017;145(6):747–54.
106. Maldonado J, Arrarás I, Iriarte M, Otano C, Carvajal A, Centeno C. Unlocking the Hidden Dimensions of Cancer Care: Cross-Cultural Adaptation and Feasibility Study of ESAS-FS, Assessing Spiritual Pain and Financial Distress in a Spanish-speaking Population with Advanced Cancer. *J Pain Symptom Manage.* 2024;67(4):290–5.
107. Delgado-Guay MO, Chisholm G, Williams J, Frisbee-Hume S, Ferguson AO, Bruera E. Frequency, intensity, and correlates of spiritual pain in advanced cancer patients assessed in a supportive/palliative care clinic. *Palliat Support Care.* 2016;14(4):341–8.
108. Rodríguez Martín BC, Molerio Pérez O, Martínez Viamontes D, Rivera Delgado LN, Méndez Morell T. Spiritual Connection Questionnaire. In: Rodríguez B, Molerio O, editors. *Validation of Psychological Instruments.* Santa Clara: Feijóo; 2012. pp. 56–60.
109. Wheeler P, Hyland ME. The development of a scale to measure the experience of spiritual connection and the correlation between this experience and values. *Spiritual Health Int.* 2008;9(4):193–217.
110. Crespo M, Cruzado JA. The assessment of coping: Spanish adaptation of the COPE questionnaire with a sample of university students. *Análisis y Modificación de Conducta.* 1997;23(92):797–830.
111. Morán C, Landero R, González MT. COPE-28: a psychometric analysis of the Spanish version of the Brief COPE. *Univ Psychol.* 2010;9(2):543–52.
112. Carver CS, Scheier MF, Weintraub JK. Assessing coping strategies: a theoretically based approach. *J Pers Soc Psychol.* 1989;56(2):267–83.
113. Carver CS. You want to measure coping but your protocol's too long: consider the brief COPE. *Int J Behav Med.* 1997;4(1):92–100.
114. Rivera-Ledesma A, Montero-López M. Measures of religious coping and spirituality in Mexican older adults. *Salud Mental.* 2007;30(1):39–47.
115. Martinez NC, Sousa VD. Cross-cultural validation and psychometric evaluation of the Spanish Brief Religious Coping Scale (S-BRCS). *J Transcult Nurs.* 2011;22(3):248–56.
116. Pargament KI, Smith BW, Koenig HG, Pérez L. Patterns of positive and negative religious coping with major life stressors. *J Sci Stud Relig.* 1998;37(4):710–24.
117. Londoño NH, Henao López GC, Puerta IC, Posada S, Arango D, Aguirre Acevedo DC. Psychometric properties and validation of the Modified Coping Strategies Scale (EEC-M) in a Colombian sample. *Univ Psychol.* 2006;5(2):327–49.
118. Chorot P, Sandín B. *Coping Strategies Scale Revised (EEC-R).* Madrid: UNED; 1993.
119. Rodríguez Franco L, Cano García FJ, Blanco Picabia A. Assessment of chronic pain coping strategies. *Actas Esp Psiquiatr.* 2004;32(2):82–91.

120. Rosenstiel AK, Keefe FJ. The use of coping strategies in chronic low back pain patients: relationship to patient characteristics and current adjustment. *Pain*. 1983;17(1):33–44.
121. Montero-López M. Loneliness: development and validation of a multifaceted inventory for its measurement [dissertation]., Mexico DF. Mexico: National Autonomous University of Mexico; 1999.
122. Sandín B, Chorot P. Coping Strategies Questionnaire (CAE): Development and preliminary validation. *RPPC*. 2003;8(1):39–54.
123. Quinceno JM. Beliefs and spiritual-religious coping, perception of illness and health-related quality of life and health-related quality of life in chronically ill Colombians. Unpublished.
124. Baldacchino DR, Buhagiar A. Psychometric evaluation of the Spiritual Coping Strategies scale in English, Maltese, back-translation and bilingual versions. *J Adv Nurs*. 2003;42(6):558–70.
125. Sánchez Estrada M, González Forteza C, Robles García R, Andrade Palos P. Development and psychometric evaluation of a Spirituality Index for elders in Mexico. *Psicología Iberoamericana*. 2012;20(2):41–8.
126. Benito E, Oliver A, Galiana L, Barreto P, Pascual A, Gomis C, Barbero J. Development and validation of a new tool for the assessment and spiritual care of palliative care patients. *J Pain Symptom Manage*. 2014;47(6):1008–18.
127. Canaval GE, González MC, Sánchez MO. Spirituality and resilience in battered women that denounce intimate partner violence. *Colombia Médica*. 2007;38(4):72–8.
128. Reed PG. Spirituality and well-being in terminally ill hospitalized adults. *Res Nurs Health*. 1987;10(5):335–44.
129. Muñoz-García A. Is religion independent of students' approaches to learning? *Studia Psychol*. 2013;55(3):215–20.
130. López E, Jodar R, MacDonald DA. Psychometric properties of a Spanish adaptation of the Expressions of Spirituality Inventory-Revised (ESI-R). *IJTP*. 2017;36(1):110–21.
131. MacDonald DA. Spirituality: description, measurement, and relation to the five factor model of personality. *J Pers*. 2000;68(1):153–97.
132. Díaz Heredia LP, Muñoz Sánchez AI, de Vargas D. Reliability and validity of spirituality questionnaire by Parsian and Dunning in the Spanish version. *Rev Lat Am Enfermagem*. 2012;20(3):559–66.
133. Parsian N, Dunning T. Developing and validating a questionnaire to measure spirituality: A psychometric process. *Glob J Health Sci*. 2009;1(1).
134. Carrasco Y. Religion and its influence on health behaviors [dissertation]. Huelva, Spain: Huelva University; 2016.
135. King M, Jones L, Barnes K, Low J, Walker C, Wilkinson S, Mason C, Sutherland J, Tookman A. Measuring spiritual belief: development and standardization of a Beliefs and Values Scale. *Psychol Med*. 2006;36(3):417–25.
136. Riveros F, Bernal L, Bohórquez D, Vinaccia S, Quinceno JM. Belief system inventory (SBI-15 R) in Colombia: factorial structure and reliability in university population and chronic patients. *Rev*

- Colomb Enferm. 2018;17:13–20.
137. Holland JC, Kash KM, Passik S, Gronert MK, Sison A, Lederberg M, Russak SM, Baider L, Fox B. A brief spiritual beliefs inventory for use in quality of life research in life-threatening illness. *Psychooncology*. 1998;7(6):460–9.
 138. Vilalta A, Valls J, Porta J, Viñas J. Evaluation of spiritual needs of patients with advanced cancer in a palliative care unit. *J Palliat Med*. 2014;17(5):592–600.
 139. Pagán-Torres OM, Cumba-Avilés E. Spanish Translation, Validation, and Factor Structure of the Religious/Spiritual Struggles Scale With Puerto Rican Adults. *J Psychol Theol*. 2022;51(2):1–17.
 140. Mayoral EG, Underwood LG, Laca FA, Mejía JC. Validation of the Spanish version of Underwood's Daily Spiritual Experience Scale in Mexico. *Int J Hisp Psychol*. 2013;6(2):191–202.
 141. Underwood LG, Teresi JA. The daily spiritual experience scale: development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health-related data. *Ann Behav Med*. 2002;24(1):22–33.
 142. Quinceno JM, Vinaccia S. Spirituality from the SpREUK scale in patients with rheumatic diseases. *Revista de Investigación Psicológica*. 2019;(22):55–66.
 143. Bussing A. The SpREUK-SF10 questionnaire as a rapid measure of spiritual search and religious trust in patients with chronic diseases. *Zhong Xi Yi Jie He Xue Bao*. 2010;8(9):832–41.
 144. Gallardo-Peralta LP, Cuadra-Peralta A, Veloso-Besio C. Validation of a Brief Index of Religiosity and Spirituality among elderly people. *Rev Psicol*. 2018;27(1):1–13.
 145. Fetzer Institute & National Institute on Aging Working Group. Multidimensional measurement of religiousness/spirituality for use in health research. Kalamazoo: Fetzer Institute; 1999.
 146. Almaraz D, Saiz J, Sánchez-Iglesias I, Rosmarin DH. Validation of Trust/Mistrust in God Scale for Spanish cancer patients. *Religions*. 2021;12(12):1077.
 147. Rosmarin DH, Pirutinsky S, Pargament KI. A brief measure of core religious beliefs for use in psychiatric settings. *Int J Psychiatry Med*. 2011;41(3):253–61.
 148. Taylor P. Psychometric properties of the Duke University Religion Index, English and Spanish versions, for Hispanic-American women [dissertation]. San Diego, United States: San Diego State University; 2013.
 149. Koenig H, Parkerson GR Jr, Meador KG. Religion index for psychiatric research. *Am J Psychiatry*. 1997;154(6):885–6.
 150. Huber S. Are religious beliefs relevant in daily life. In: Streib H, editor. *Religion inside and outside traditional institutions*. Leiden: Brill Academic; 2007. pp. 211–30.
 151. Simkin H, Etchezahar E. The extrinsic and intrinsic religious orientations: Validation of the Age Universal I-E Scale in the Argentinian context. *Psyke*. 2013;22(1):97–106.
 152. Gorsuch RL, Venable GD. Development of an Age Universal I-E scale. *J Sci Stud Relig*. 1983;22(2):181–7.

153. de la Ramírez MC. A Spanish adaptation of the Batson and Ventis's Religious Orientation Scale. *Revista de Psicología Gen y Aplicada*. 2006;59(1–2):309–18.
154. Batson CD, Ventis WL. *The religious experience: A social-psychological perspective*. New York: Oxford University Press; 1982.
155. Campo-Arias A, Oviedo HC, Cogollo Z. Internal consistency of a five-item form of the Francis Scale of Attitude Toward Christianity among adolescent students. *J Soc Psychol*. 2009;149(2):258–62.
156. Francis LJ. Reliability and validity of a short scale of attitude towards Christianity among adults. *Psychol Rep*. 1993;72(2):615–8.
157. Panzini RG, Mosqueiro BP, Zimpel RR, Bandeira DR, Rocha NS, Fleck MP. Quality-of-life and spirituality. *Int Rev Psychiatry*. 2017;29(3):263–82.
158. Albers G, Echteld MA, de Vet HC, Onwuteaka-Philipsen BD, van der Linden MH, Deliens L. Content and spiritual items of quality-of-life instruments appropriate for use in palliative care: a review. *J Pain Symptom Manage*. 2010;40(2):290–300.
159. Saroglou V. Believing, bonding, behaving, and belonging: The Big Four religious dimensions and cultural variation. *J Cross-Cult Psychol*. 2011;42(8):1320–40.
160. Koenig HG, Büssing A. The Duke University Religion Index (DUREL): A five-item measure for use in epidemiological studies. *Religions*. 2010;1(1):78–85.
161. Chirico F. Spiritual well-being in the 21st century: it's time to review the current WHO's health definition. *J Health Soc Sci*. 2016;1(1):11–6.
162. Lu J, Lo C-L, Bang NM, Romero D. A critical review of spiritual well-being scales: Implications for research, practice, and education in rehabilitation counseling. *Rehabil Couns Bull*. 2019;62(3):144–56.
163. Brandstätter M, Baumann U, Borasio GD, Fegg MJ. Systematic review of meaning in life assessment instruments. *Psychooncology*. 2012;21(10):1034–52.
164. Büssing A, Balzat HJ, Heusser P. Spiritual needs of patients with chronic pain diseases and cancer - validation of the spiritual needs questionnaire. *Eur J Med Res*. 2010;15(6):266–73.
165. Büssing A, Koenig HG. The BENEFIT through spirituality/religiosity scale—a 6-item measure for use in health outcome studies. *Int J Psychiatry Med*. 2008;38(4):493–506.
166. Büssing A, Ostermann T, Matthiessen PF. Distinct expressions of vital spirituality: The ASP Questionnaire as an explorative research tool. *J Relig Health*. 2007;46(2):267–86.
167. Büssing A, Ostermann T, Matthiessen PF. Role of religion and spirituality in medical patients: confirmatory results with the SpREUK questionnaire. *Health Qual Life Outcomes*. 2005;3:10.
168. Büssing A. The Spiritual Needs Questionnaire in research and clinical application: A summary of findings. *J Relig Health*. 2021;60(5):3732–48.
169. Zinnbauer BJ, Pargament KI. Religiousness and spirituality. In: Paloutzian RF, Park CL, editors. *Handbook of the psychology of religion and spirituality*. New York: The Guilford Press; 2005. pp. 21–42.

170. Stripp TA. Qualitative Testing of Questionnaires on Existential, Spiritual, and Religious Constructs: Epistemological Reflections. Religions. 2025;16(2):216.

171. Saunders C. The evolution of palliative care. J R Soc Med. 2001;94(9):430–2.

Figures

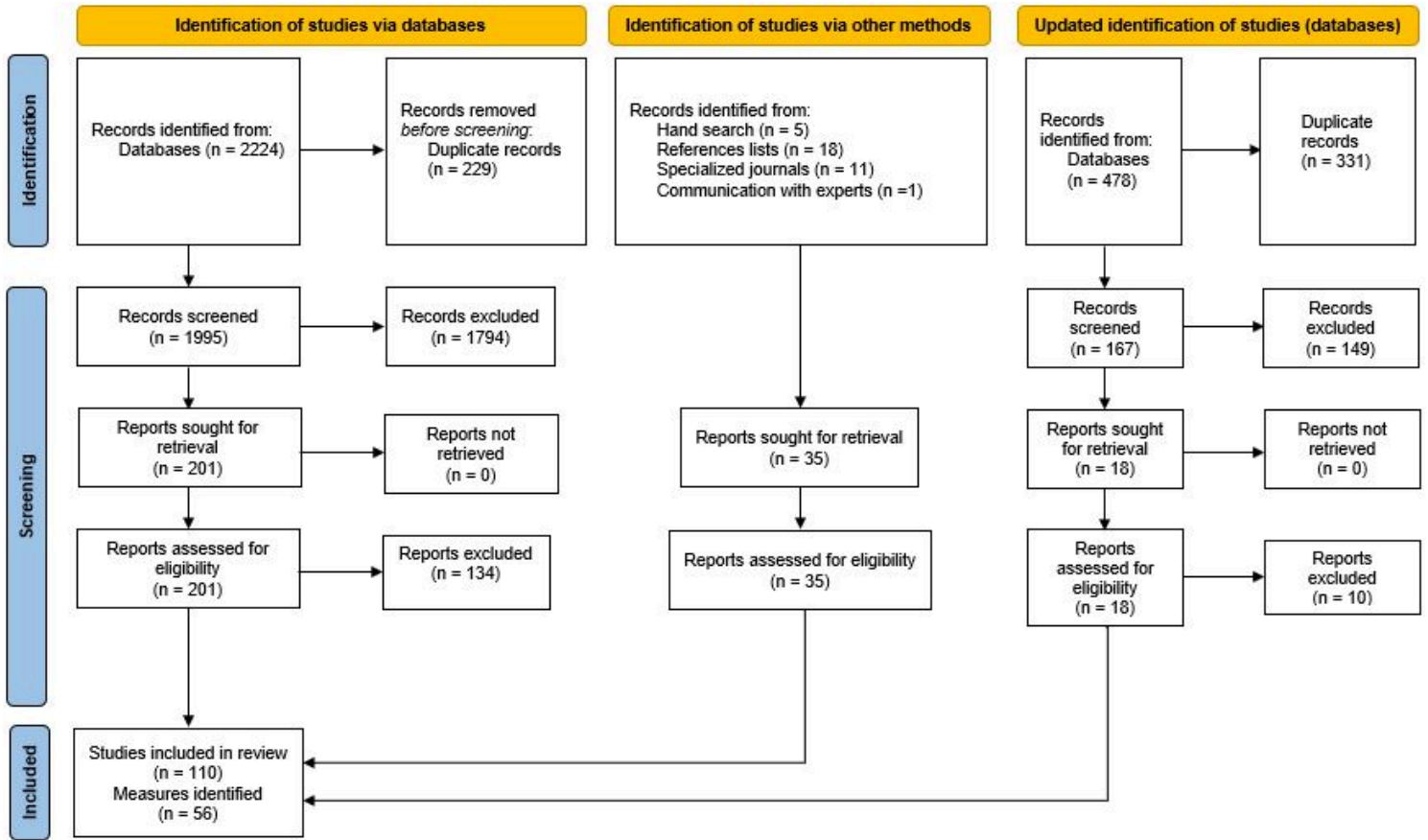


Figure 1

PRISMA flow diagram of the review process.

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- [1.png](#)
- [SupplementaryTable1reviewedv31.docx](#)