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Assessment of Spiritual distress in oncology patients: A survey using the SpiDiScl

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Abstract

Background: Spiritual Distress (SD), the inability to find meaning and connection with self, others or a higher power, is a major concern among cancer patients. Few Indian studies have assessed SD, with none using the SpiDiScl, a tool designed in Hindi language to measure spiritual distress.

Aim: To assess spiritual distress in a cross-section of Indian cancer patients.

Method: 101 adult, cancer patients in a cancer centre of the National Capital Region were selected for the study. Their SD was assessed using the SpiDiScl. Their age, diagnosis and socioeconomic status using the BG Prasad Socio-Economic Status Classification were noted. Statistical analysis was conducted using IBM SPSS Software Version 2.

Result: The participants reported moderate levels of SD (M = 36.8) with highest levels in patients with rectal cancer (M=45.31) and lung cancer (M=40.63), and in those from lower socioeconomic background (M=41.7).

Conclusion: These findings highlight the need for integrating culturally appropriate spiritual assessment into routine care of Indian oncology patients, with the help of appropriate tools and the need for properly trained staff, counsellors and spiritual guides.

Keywords: India, Oncology, Spiritual Assessment, Spiritual Distress

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Introduction

Cancer is one of the most feared diseases of mankind. Also known as malignancy or neoplasm, it is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow uncontrollably, go beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs, in a process called 'metastasizing'. It is the second leading cause of death globally, responsible for approximately 9.6 million deaths, or 1 in 6 deaths, in 2018 (World Health Organization, 2024). According to estimates by the Global Cancer Observatory, there were 19.3 million cancer cases worldwide in 2020 (Sung et al., 2020). The cancer burden continues to grow globally, exerting tremendous physical, emotional and financial strain on individuals, families, communities and health systems (World Health Organization, 2025). Being diagnosed with cancer profoundly affects multiple aspects of an individual's life: physical, psychological, economic, social, and spiritual (Aziz & Rowland, 2003). The impact of a cancer diagnosis is felt on every aspect of life: physical, economic, social, psychological, and spiritual (Aziz & Rowland, 2003). Psychological distress is very commonly present throughout the course of this illness. High levels of distress can be a feature of impaired mental health or depression and anxiety and this has been consistently linked to a range of adverse physical health outcomes, including accelerated aging, cognitive decline, and mortality especially from cardiovascular causes (Zhu et al., 2022). All these factors affect the quality of life (QoL) of patients and their families with proven mutual relationship between physical and psychological distress in cancer patients (Kim & Kwon, 2007).

Spirituality

Spirituality is described as a broad concept encompassing values, meaning, and purpose; love, caring, wisdom, and compassion and the existence of a higher authority that heals the body-mind-spirit; and may or may not involve organized religion (Dossey, 1989). Baldacchino defined it as the bio-psycho-social religious aspects of care that unite different aspects of care into one whole (Baldacchino, 2008).

Spiritual practices relate positively with survival, lower blood pressure, faster recovery from depression; with improved quality of life, cooperativeness and lower inter leukine 6 levels (Dhar et al., 2013). They also help people deal with bereavement and other tragedies with lesser anxiety or depression (Dhar et al., 2013). Most (85% to 90%) cancer patients have reported in studies that they are spiritual, and spirituality is an important part of their life while 78% found spirituality important in coping with cancer (Xing et al., 2018). Spirituality can enhance self-care and balance, and improve well-being (Rani, 2023), give meaning to difficult experiences, reduce hopelessness, existential suffering, depression, and aid faster recovery from it. (Breitbart et al., 2000; Doolittle & Farrell, 2004; Grant et al., 2004; Koenig et al., 1992; McClain et al., 2003). A complex and non-linear

relationship has been observed between spiritual health the aspects of mental health, quality of life, and burnout, potentially affected by emotional regulation (Akbari & Hossaini, 2018).

It is also important to differentiate spirituality from religiosity. Spirituality means connection with a higher power or the world while religion refers to an organised way of worship with laid down beliefs, rites and rituals (Tiwari, 2023). Spirituality is a broader concept, which includes the personal quest for understanding answers to ultimate questions about life, life meaning, and relationship with the sacred or transcendent (Lucchetti et al., 2021). According to this, an individual could have high levels of spirituality even with low levels of religiousness (Klimasiński et al., 2022; Lucchetti et al., 2021; McSherry, 2000; Narayanasamy, 2001).

Religion is highly culturally determined (NDA: How Culture Affects Religion, 2022). On the other hand, spirituality is considered a universal human capacity, usually—but not necessarily—associated with and expressed in religious practice (Lepherd, 2014). Most individuals consider themselves both spiritual and religious; some may consider themselves religious but not spiritual; others, including some atheists or agnostics, may consider themselves spiritual but not religious (McSherry, 2000). For instance, in a sample of 369 representative cancer outpatients in New York City, 6% identified themselves as agnostic or atheist, 29% attended religious services weekly; and 66% represented themselves as spiritual but not religious (Astrow et al., 2007).

In the Handbook of Religion and Health, which deliberates over the extensive research conducted between 1900 and 2000 on religion and its relationship with various mental and physical health outcomes, authors found religious and spiritual involvement to be commonly associated with better mental health outcomes, such as lower levels of depression, anxiety, and suicide (Koenig et al., 2001). Spiritual beliefs can also help people deal with bereavement and other tragedies in a better way with less resultant anxiety or depression (Dhar et al., 2013).

Spiritual Distress (SD)

Spiritual Distress (SD) is defined as impairment in the ability to experience a sense of meaning and purpose in life through connectedness with self, others, or a higher power (Schultz et al., 2017). SD may result from the belief that cancer is a punishment by God, may accompany the question “why me?” and may involve loss of faith (Puchalski et al., 2004). Many people have these thoughts, but a few become obsessed with them and score high on a general measure of religious and spiritual distress (such as the negative subscale of the Religious Coping Scale) (National Cancer Institute (US), 2003). High levels of SD may contribute to poorer health and psychosocial outcomes. Structured interviews conducted with 70 women, reported that 38.6% were experiencing spiritual distress (Caldeira et al., 2016). A study on

advanced cancer patients found that 50 of 113 patients, i.e., 44% had spiritual distress (Hui et al., 2010). Similarly, an Indian study on cancer patients found 17.4% of the sample to be spiritually distressed with 36.2% clinging to divine support (Gielen et al., 2017). Another Indian research on terminally ill patients with focus on the emotional, psycho-social, religious, and existential aspects found that 72% wished for their spiritual needs to be met (Mathew & Kunnath, 2024). With the highest scores for psychosocial needs and acceptance of dying at the lowest, majority of them had a strong desire for connection with their family (Mathew & Kunnath, 2024). These findings also highlighted that needs were related to the patients' cultures. A muti-centric study across five Asian countries which analysed effect of socioeconomic status on end-of-life suffering in advanced cancer patients observed that lower education and economic status were linked to greater psychological, social, and spiritual suffering (Malhotra et al., 2020). Thus, in order to be managed effectively, SD needs to be assessed properly.

Assessment of Spiritual Distress

Many spiritual assessment tools have been developed by various care providers- chaplains, nurses, social workers, and physicians. These vary in scope and style from simple questionnaires about religious preference to detailed spiritual history obtained by chaplains. A conversational approach with open-ended questions allows patients to express their spiritual beliefs most fully and the assessment can be tailored to the patient, situation, and environment.

A systematic review of twenty-five spiritual assessment instruments from various fields found the 5 highest scoring assessments to be the HOPE (Hope, Organized religion, Personal spirituality, and Effects on medical care), FICA (Faith, Importance/Influence, Community, and Address), FAITH, SPIRITual History, and the Royal College of Psychiatrists (Lucchetti et al., 2013). The choice depends on focus of evaluation (religious practice or spiritual well-being/distress), purpose (e.g., screening vs. evaluation as part of care of all patients), modality of the assessment (interview or questionnaire) and feasibility (staff and patient burden) (Lucchetti et al., 2013). Interestingly, evidence shows that very few patients find such assessments intrusive or distressing, and simply asking about spirituality may enhance the patient's desire for further exploration making the line between assessment and intervention hazy (National Cancer Institute (US), 2003).

Since spiritual concerns are considered important by patients especially at the end of life, many wish for health professionals to attend to their spiritual needs (Sulmasy 2002; Gall & Cornblat, 2002; Kappeli, 2005; True et al., 2005; Gall et al., 2008). Patients have reported the need for it in many earlier studies, showing that most of them are willing to discuss their spiritual beliefs with their healthcare providers. In one study conducted in the waiting room of 5 family medicine practices, 83% of patients were willing

to discuss spiritual beliefs (63% depending on the situation and 20% always) (McCord et al., 2004). It also highlighted the circumstances that decide whether patients are willing to discuss their beliefs. The severity of illness is important as the three most common situations were when patients were "very seriously ill with the possibility of dying," "suffering from an ongoing, long-term, serious illness," and "just diagnosed with a serious illness," (McCord et al., 2004). The 3 main reasons for patients wanting to have a spiritual discussion were "so that the doctor can understand how your beliefs influence how you deal with being sick," "so that the doctor can understand you better," and "so that the doctor would understand how you make decisions,", indicating their wishes for being understood by their healthcare providers (Henry et al., 2024; McCord et al., 2004). A cross-sectional survey of one hundred forty-one primary care patients comparing rural and urban patients showed that between 38.3 and 49.1% of patients desired a clinical spiritual assessment but were rarely asked about their religious or spiritual beliefs (Fuchs et al., 2021). A study of 456 patients from 6 academic medical centre clinics found that 33% of patients would like to be asked about their religious beliefs in a routine office visit, with the number increasing to 40% for hospitalized patients and 70% of those who were dying (MacLean et al., 2003). Another study noted that 77% inpatients sought spiritual support from their physicians (King & Bushwick, 1994). According to a national survey conducted by the George H. Gallup International Institute in USA, around 40% individuals considered it crucial that their physician addresses spiritual issues if they were seriously ill (Gallup, 1997). Similarly, research with one hundred seventy-seven patients visiting a pulmonary clinic found that two-thirds of patients would welcome a question about spiritual or religious beliefs if they became gravely ill (Ehman et al., 1999). It has been suggested consistently, that greater the severity of illness, the more willing patients are to discuss their spirituality. It was also identified that, for the patient, being valued, recognising one's family, and discussing values were vital spiritual care needs (Ordons et al., 2018).

Serious illness often makes patients explore existential and spiritual meanings. One may re-examine existing beliefs. Hence it becomes essential that the healthcare provider be prepared to take on the responsibility of addressing spiritual and existential concerns the patient or their family may bring up. Terminally ill patients are more susceptible to greater psychological distress if spiritual well-being is not maintained (Bauer-Wu et al., 2017). It is therefore a priority for palliative care practitioners to develop this sense of well-being and ease suffering of patients, while being sensitive to the religious-cultural beliefs of the patients and their families (Bauer-Wu et al., 2017).

Standardized assessment measures that can be used include Duke Religious Index (DRI), Systems of Belief Inventory (SBI-15R), Brief

Measure of Religious Coping (RCOPE), Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being (FACIT-Sp), and Spiritual Transformation Scale (STS), whereas interviewing tools include The SPIRITual History, and FICA (National Cancer Institute (US), 2003). Although many scales are available in English, only one scale- the SpiDiScl has been translated and validated for use in India (Gielen et al. 2022) This tool was therefore selected for studying the level of distress in the present study.

A pilot study, conducted by Rotary Cancer Hospital, All India Institute of Medical Sciences (AIIMS), New Delhi, to assess the "total pain" in cancer patients in the Indian context, found that psycho-social pain contributed to approximately 68% of total pain, out of which spiritual pain comprised 17% of the whole (Singh et al., 2023). Meeting the psycho-social and spiritual needs is an important part of cancer management.

Two studies from AIIMS, New Delhi describe the prevalence and nature of spiritual distress. (Gielen et al., 2016) and the most common signs of spiritual distress in Indian cancer patients enrolled for palliative care (Bhatnagar et al., 2017). There have been no further studies to assess SD and none using the SpiDiScl since its publication in 2022. Hence, this topic was chosen to address this gap in knowledge about spiritual distress in Indian cancer patients.

Method

Study Design

This was a quantitative, cross-sectional study.

Participants

The subjects were 101 adult, cancer patients in a cancer centre of the NCR selected using a pre-set criteria with purposive sampling method. Initially, 110 patients were enrolled but 9 dropped out later. Inclusion Criteria: Willing, adult cancer patients between 35 - 50 years age, who could understand and communicate in Hindi. Exclusion criteria: Patients with uncontrolled symptoms that prevented proper assessment, comorbid psychiatric conditions, cancer remission, or inability to communicate in Hindi.

Tools Used

1. The SpiDiScl –

The SpiDiScl is a 16-item scale; a tool designed to assess spiritual distress. The validity of the Spiritual Distress Scale for Hindi speaking palliative care patients in India was tested using a non-experimental cross-sectional sample survey design with 400 cancer patients enrolled in the palliative care unit of AIIMS, New Delhi. The scale's internal consistency is very good (Cronbach's Alpha 0.85) and the finding of significant negative correlations between SpiDiScl and both FACIT-Sp-12 ($R = –0.16$, $P = 0.001$) and WHOQOL-BREF ($R = –0.27$, $P < 0.001$) confirmed convergent validity. The highly significant association ($R = 0.75$, $P < 0.001$) of the scores on assessments 2 weeks apart confirmed test-retest reliability, making the SpiDiScl a reliable and valid measure to assess

spiritual distress in research among Hindi speaking patients in India.

The spiritual distress score is calculated by coding the answers as 1 for 'sahmat'/'agree' and 0 for 'asahmat'/'disagree', and multiplying the mean score of all responses by 100. Neutral responses are not coded and are not considered while calculating the distress score. The final score will fall between 0 and 100, with a higher score indicating more substantial spiritual distress.

2. B. G. Prasad Socio-Economic Status (SES) Classification for the Year 2023 – First developed in 1961 and modified over the years, this scale calculates SES using per capita monthly income, obtained by dividing total monthly family income by number of family members (Akram et al., 2023). According to this scale, revised in 2023, the SE status is classified into the following groups, according to the per capita income per person/per month in the following groups:

Social class: I Upper class- above Rs 8763/month; II upper middle Class- Rs 4381.5–8675.3/month, III middle class- Rs 2630–4294/month, IV lower middle class- Rs 1314.5–2541.27 /month, V lower class - less than Rs 1314.5 /month (Akram et al., 2023).

Procedure

Data was collected from the outpatient wing of a cancer hospital in National Capital Region (NCR) after due permission. A total of 101 patients were selected and after basic socio-demographic details, SD was assessed using the SpiDiScl. They were given printed information sheets in Hindi; the aim and procedures of research were explained and any questions answered. After taking voluntary, informed, written consent for participation and publication, data was collected. Once data collection was completed, responses were systematically recorded, anonymized and stored. Statistical analysis was carried out using IBM SPSS Software Version 2.

Ethical Considerations

Ethics approval was obtained from the institutional ethics committee. Informed, written consent was obtained for participation and publication of anonymized data from all individual participants included in the study. The participants were informed about the study's purpose and procedure. They were assured that participation was optional and would not affect their treatment. They were informed that they had the right to withdraw at any point during the study. Furthermore, data was anonymised to protect participants' identity and maintain confidentiality.

Data Analysis

Data analysis was carried out using IBM SPSS Software Version 2. Descriptive statistics were utilized to assess levels of SD and related factors in the sample.

Result

Sociodemographic data

1. Number of participants: There were a total of 101 participants.
2. Age group: Age was between 35 - 50 years.
3. Religion: There were 6 Muslim and 95 Hindu participants
4. Cancer Diagnoses: There were 28 lung cancer, 26 Genito-urinary, 16 breast, 12 rectal, 9 stomach, 5 head and neck malignancy, and 5 multiple myeloma cases in the sample.
5. Socio-economic status: 31 participants reported belonging to lower SE background, with 22 from lower-middle, 32 from middle and 16 from upper middle background.

Level of SD: The Overall mean SD was 36.8 indicating moderate levels of SD in the sample (Table 1). The standard deviation was 20.76.

Table 1

Spiritual Distress

N	Mean	SD	Range	Minimum	Maximum
101	36.80	20.76	100.00	0.00	100.00

Note. N = sample size; SD = standard deviation.

Levels of SD by diagnosis: Maximum SD was seen in the patients with rectal cancer (M=45.31) followed by lung cancer (M=40.63) (Table 2). Minimum SD was reported by stomach cancer cases (M=25.89).

Table 2

Spiritual distress by diagnoses

Cancer Type	N	Mean	Median	Mode	SD	Range	Minimum	Maximum
Stomach	9	25.89	37.50	0.00	23.51	56.25	0.00	56.25
Multiple Myeloma	5	28.75	31.25	31.25	14.39	37.50	12.50	50.00
Lung	28	40.63	37.50	62.50	18.36	56.25	12.50	68.75
Head & Neck	5	28.75	25.00	6.25[a]	21.01	56.25	6.25	62.50
Genitourinary	26	35.58	37.50	37.50	20.52	68.75	0.00	68.75
Breast	16	36.72	37.50	31.25[a]	17.06	75.00	0.00	75.00
Rectal	12	45.31	53.13	56.25	28.96	100.00	0.00	100.00

Note. N = sample size; SD = standard deviation.
[a] Multiple modes exist. The smallest value is shown.

Levels of SD by Socio-economic status:
The highest level of spiritual distress (M=41.7) was found among participants from lower socioeconomic background, closely followed by upper-middle background (M=41.4) (Table 3).

Table 3

Spiritual distress by socio-economic status

Group	N	Mean	SD	Range	Min	Max
Lower	31	41.73	20.18	100.00	0.00	100.00
Lower Middle	22	32.10	23.57	75.00	0.00	75.00
Middle	32	34.77	20.01	68.75	0.00	68.75
Upper Middle	16	41.41	19.08	62.50	0.00	62.50

Note. N = sample size; SD = standard deviation.

Discussion

The findings of moderate levels of SD in cancer patients support the hypothesis and are similar to those of earlier researchers who found spiritual distress to be common in oncology patients. Gielen et al's cross-sectional survey of

400 cancer patients in a tertiary cancer hospital in New Delhi, using the same scale, found the mean SD level to be 37.1, very close to the findings of this study. (Gielen et al., 2022). Signs of potential spiritual distress were found by another study of 300 patients where the authors had recommended spiritual history taking with reference to the nuances in the multi-cultural and multi-religious society in the Indian context (Bhatnagar et al., 2017).

It is documented that patients with lung cancer report higher levels of distress (Zabora et al., 2001) than patients with other types of cancer. However, the present study found the highest level of SD in rectal cancer with lung cancer at a close second. The SD in lower SE background was highest, similar to the findings of another Indian study from Hyderabad which reported SD levels highest in those from lower SE background and religious minorities (Jacob et al., 2019). This finding is also supported by the muti-centric research by Malhotra et al. which noted that advanced cancer patients from lower education and economic status tended to experience greater psychological, social, as well as spiritual suffering (Malhotra et al., 2020).

According to a single group study, providing spiritual care can considerably improve patients' and caregivers' overall and spiritual well-being (Sankhe et al., 2016). Even though healthcare providers understand the need for spiritual care in oncology, they find themselves ill equipped to handle it (Ghorbani et al., 2021) and patients report that medical professionals provide it infrequently (Varner-Perez et al., 2024) This highlights the need for providers to be aware of effective assessment tools as well as interventions. It is a challenge to develop and implement training programmes for spiritual care. A clinical guideline of spiritual care has been developed with 84 evidence-based recommendations that can be used by healthcare providers (Moosavi et al., 2020). It is also recommended that assessment for spiritual care needs and screening for SD should be a part of oncology care. The SpiDiScl is a useful tool for Indian population. It is easy to use in research and is simple enough to be used by literate patients for self-reporting too. It could further be adapted for clinical use over time.

There are many effective interventions that could be helpful in managing SD. Therapeutic strategies specifically targeting spirituality have been suggested for improving well-being, as well as mental and physical health outcomes, decreasing pain and improving QOL (De Bernardin Gonçalves et al., 2017; De Diego-Cordero et al., 2022; Tutzer et al., 2023). A recent practice-based evidence study suggested effectiveness of spiritually integrated psychotherapies (SIPs) in supporting holistic recovery of those who struggle with religious faith and/or spirituality, using interventions such as spiritual assessment, religious attachment and discussing self-control (Currier et al., 2024). An integrative review of 59 articles to select useful nursing spiritual care interventions found religious and spiritual beliefs to be associated

with active rather than passive coping and emphasised on the exploration of spiritual perspectives, a healing presence, therapeutic use of 'self', an intuitive sense, patient-centeredness, meaning-centred interventions, spiritually nurturing environments, and documenting and evaluating spiritual care as effective (Ghorbani et al, 2021). Recent reviews found small to large decrease in depression and anxiety through cognitive- behavioural, mindfulness-based stress relief (MBSR) and meaning-based interventions and dignity-based approaches (Von Blanckenburg & Leppin, 2018). Traditional MBSR which is based on Buddhist spiritual philosophy, teaches non-judgmental attitude, acceptance, and relaxation by focusing on the awareness of breath (Hulett & Armer, 2016). Yoga and meditation involve stretching, awareness of each moment, giving up strong attachment to beliefs, thoughts and feelings, to promote emotional balance and well-being (Ludwig, 2008). Movement-meditative-breathing interventions (Qigong, Tai Chi) help spiritual transformation through mindfulness and self-awareness (Piedmont et al., 2009). Integrative Cancer Therapies include progressive muscle relaxation (focused sensory awareness of individual muscle groups with meditation and deep breathing) and guided imagery (mentally imagining desired objects or outcomes) and have been found effective in improving QoL, mood, emotional expression, and decreasing social conformity for better symptom control, positive health behaviors and life changes (Hulett & Armer, 2016). It has been noted that Tai chi enhances self-healing and yoga alters the stress response associated with thoughts and emotions, thus reducing psychological distress (Hulett & Armer, 2016). A meta-analysis of randomized controlled trials to compare effect of spiritual interventions with usual care or other psychosocial interventions found that spiritual interventions may improve spiritual well-being and QoL, and reduce depression, anxiety, and hopelessness in cancer (Xing et al., 2018). The use of the Spiritual Care Assessment and Intervention (SCAI) framework by board certified chaplains was shown to be effective in improving spiritual well-being, QoL, depression, anxiety and religious coping (Varner-Perez et al., 2024). A systematic review of spiritual interventions for colorectal cancer showed psychoeducation, cognitive behavioural therapy, mindfulness, social intervention, and spiritual counselling effective in improving coping skills, hope, daily functioning, QoL, anxiety and survival rates (Okere et al,.2024). Another spiritual-care intervention "In dialogue with your life story" was found effective in increasing ego-integrity significantly while decreasing despair and anxiety (Liefbroer et al., 2025). An RCT to test effectiveness of a 'Compassion-Centered Spiritual Health Intervention' which promotes more inclusive, confident, and other-oriented language for better spiritual support in a pluralistic religious landscape has been shown to decrease depression among inpatients (Mascaro et al., 2025). Therefore, addressing the psycho-

social and spiritual needs of patients is an integral part of medical management.

This study assessed the SD in a sample of population in India using the SpiDiScl, building up evidence for presence of SD in this group and to highlight the need for assessment of spiritual needs in Indian oncology patients. The SciDiScl, which has been used has already been validated in India, has short and simple items, so that the patients find it easy to understand and answer. Data-analysis is also straightforward.

Limitations

It was a time-limited study so more variables could not be included. The population was limited to one cancer hospital in the NCR, making it less representative of other geographical areas.

Future Research Directions

In future, this tool can be used for multi - centric studies with a bigger sample to study patients with other diseases or to examine relations of SD with more variables. Longitudinal studies can be conducted to assess effectiveness of the interventions listed above. The SpiDiScl can also be translated into other Indian languages for wider use.

Conclusion

The present study shows the presence of spiritual distress in oncology patients in India, found to be more in rectal and lung cancers, and in lower socio-economic group. In India, SD can be assessed with the SpiDiScl, an easy-to-use tool, that is convenient to conduct on Hindi speaking population. This study highlights the need for integrating spiritual care into the routine assessment and care of Indian oncology patients. It is, first and foremost, important for care providers to be aware of this aspect of emotional pain in order to be able to recognise and assess it. Only then can they provide the spiritual care patients need, with the help of properly trained staff, counsellors and spiritual guides. It is recommended that culturally appropriate, evidence based, effective interventions for spiritual care be given through education and training of healthcare workers and spiritual guides, which can go a long way in providing holistic care for these patients.

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Author contributions

Conceptualization, Divyani Butola.; methodology, Seema Singh, Divyani Butola.; software, Divyani Butola.; formal analysis, Divyani Butola, Seema Singh.; investigation, Divyani Butola.; resources, Divyani Butola.; data curation, Divyani Butola.; writing—original draft preparation, Divyani Butola writing—review and editing, Divyani Butola, Seema Singh.; visualization, Divyani Butola.; supervision, Seema Singh.; project administration, Seema Singh. All authors have read and agreed to the published version of the manuscript.

Competing interests

The authors declare no competing interests.

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