

**Supplementary Table S1. Articles analyzed in this study**

Study [ref]	Sample	Statistics	Main findings
Berman, 2004 [35]	74 Baptist patients randomly selected from a list of 358 subjects, mean age 54 years, 89% were African Americans, 31 men and 43 women. Clinical data were modeled using the Karnofsky Index. Hoge Intrinsic Religiosity Scale, the Organizational Religious Activity Scale, the Non-organizational Religious Activity Scale, MSPSS, SWLS, SWMC, BDI, the Schwartz's Outcome scale, the Coping Scale were administered to the patients.	Multiple linear and logistic regression analysis	Religion was not associated with adherence to the treatment and with coping skills, while correlated with satisfaction with life, satisfaction with medical care, social support and psychosocial adjustment, BDI score, and employment.
Song, 2009 [36]	51 out of 101 African American patients took part into the study, 56.90% males, 43.10% females, mean age 57.78 ± 13.18 years. SPMSQ, DSI, SF-12, Self-Perception and Relationship Tool (concerning psycho-spiritual well-being) were administered to the patients	Chi-square test, Fisher's exact test, Mann-Whitney U-test, Lunneborg's formula and Monte Carlo estimation procedures for permutation tests	65% of the sample responded that they regularly followed religious practices, and 61% reported that spirituality was important in their lives. Religious involvement and importance of religion were not associated with treatment choice or preferences (end-of-life care planning <i>versus</i> life-sustaining treatment), as well as with clinical outcomes. Spirituality was instead associated with some goals in the end-of-life care scenario, with the acceptance of poorer health levels and with treatment choice. Subjects with higher spiritual well-being preferred to forgo dialysis. Spiritual well-being, and not spirituality and religiosity, correlated with ethnicity. Spirituality, spiritual well-being and religiosity behaved as different predictors of patient's preference. The correlation between these variables was rather modest
Spinale, 2008 [37]	Longitudinal study, investigating 166 CKD patients, 102 men and 64 women, 89.2% were African Americans, mean age 56.2±13.8 years. MSPSS and an <i>ad hoc</i> not fully validated scale about religiosity were administered	ANCOVA, Kaplan-Meier analysis, Spearman's correlation test, proportional hazards regression	Spirituality score was slight higher than religiosity score. 99 out of 166 original cohort subjects survived. Spirituality (but not religiosity, intended both as involvement in religious practices and as religious coping strategy) correlated with social support and psychosocial adjustment, and both spirituality and perceived social supported correlated with higher survival rate
Tanyi, 2003 [38]	86 patients (29 males, 57 females; mean age, 48.3 years, range 20-84 years) on peritoneal dialysis took part into the study. They were administered the 10-Question Survey assessing religious activity, BDI, SF-36	Chi-square test, ANOVA (analysis of variance) one-way, correlation analysis	75.6% of the sample took part regularly in religious practices. Men and high educated people reported weaker religious beliefs. Low religious dimension correlated with low quality of life score and with high depression score. High religious patients behaved as patients having no religious beliefs

Valcanti, 2012 [39]	123 CKD subjects on haemodialysis; 65 males (53%) and 58 females (47%), mean age 56±12.55 years, 103 Catholic, 19 Evangelical, 1 Spiritist. Brief-SRCOPE/SRC was administered	Spearman's correlation test, multiple linear regression analysis, ANOVA	No differences between spirituality and religiosity were found; the authors concluded that spiritual coping could not be simply considered as a non-religious form of coping. No differences among the different religious groups were found. 97% of the sample considered religion and spirituality as having an impact on their lives; 55% of the sample regularly attended the place of prayer and 98% usually prayed or meditated. Spirituality was related with gender (women reporting higher spirituality scores), age group (the lower this parameter the higher the negative religious coping score), treatment time, family income (the lower the score the higher the negative spiritual coping score). Most participants used religious and spiritual coping mechanisms as a strategy to face their disease, particularly younger women with a higher income, who regularly attended the church every week.
Theofilou, 2012 [40]	144 patients, 84 on haemodialysis (58.3%) and 60 on CAPD (41.7%), 86 men (59.7%) and 58 women (40.3%), mean age 60.6±14.9 years, decided to take part into the study. WHOWOL-BREF, MHLC, CES-D, GHQ-28, STAI were administered	Kolmogorov-Smirnov test, Pearson's rho correlation test, hierarchical regression analysis	No substantial differences were found between patients on haemodialysis and patients on peritoneal dialysis. Religiosity and spirituality positively correlated with internal health locus of control but negatively with depression, trait anxiety, somatic symptoms, anxiety, insomnia, social dysfunction, severe depression.
Reig-Ferrer, 2012 [41]	94 patients on haemodialysis, 65% males, mean age 67±13.4 years, range 33-86, 65% males. Clinical data were investigated and modeled using CCI, MILS, the COOP-WONCA questionnaire concerning patient's QoL were administered	Correlation analysis	Women and older patients tended to be more religious than the other subjects. SWB was significantly associated with various domains of quality of life, health status, happiness. There was no relationship between spirituality scores and co-morbidity, HD duration. Spirituality and religiosity tended to correlate.
Davison, 2010 [42]	253 CKD ESRD stage 4 and 5 patients out of 342 decided to take part into the study, mean age was 59.5±14.6 years. 81.5% were White, 148 were on haemodialysis, 24 on peritoneal dialysis, 81 on pre-dialysis. Clinical data were collected and modeled using CCI, KDQOL-SF, ESRD Spiritual Beliefs Scale, SPS, SWBS were administered to the patients	Multiple linear regression, Pearson's correlation test	These patients had substantial spiritual and supportive care needs. No differences in spirituality and religiosity scores were observed among the different dialysis groups (even if quality of life differed). There were no clear predictors of high spiritual or supportive care needs, highlighting the importance of evaluating all CKD patients for unmet needs. Spirituality and religiosity tended to behave differently, EWB scores being slight higher than RWB scores. RWB correlated with SPS, while the correlation between SPS and EWB was rather weak. Spirituality correlated with quality of life, while religiosity did not. Moreover, religiosity and spirituality did not correlate with each other. No differences in the correlation scores were found in the different ESRD stages. Age, time on dialysis, ethnicity, co-morbidities, diabetes status, biomarkers (such as hemoglobin and albumin) were not associated with spirituality and religiosity.

Martin, 2002 [43]	28 women who received kidney transplant, mean age was 44.36 ± 14.26 years, 64% Black. SPS, SWB were administered	Fisher's exact test, Kruskal-Wallis test, Mann-Whitney test, ANOVA	EWB and RWB correlated, indicating that women used religiosity and spirituality at the same way
Rambod, 2010 [44]	202 Muslim CKD patients on haemodialysis. 96 were males, 106 females. Mean age was 55.61±15.54 years, range from 20 to 86. PRQ-85, Ferrans and Powers Quality of Life index-dialysis	Chi-square, Spearman's rho correlation test	No distinction between religiosity and spirituality was applied by the researchers. There were a statistically significant relationship between perceived social support and psychological-spiritual sub-scale of quality of life questionnaire
O'Brien, 1982 [45]	3-years longitudinal study, investigating 126 CKD patients under haemodialysis at time zero and 63 patients at the conclusion of the survey, age in the range of 21-75 years. 69.1% were Protestants, 19.8% Catholics, 6.3% Jewish, 4.8% with no a specif religious identity. 25.4% were white, 74.6% were black. Interactional Behavior Scale (adapted from the Bridgford's Disability Self-Conception Inventory), Dean Alienation Scale were administered to the patients	This is a mixed study (both qualitative and quantitative); ANOVA one-way and content analysis were used	No difference was found among the different faiths as far as interactional behaviors and the quality of interaction were concerned. Subjects with no religious affiliation reported lower scores. A difference was found in the alienation scores (the Jewish patients reporting higher scores, while the Catholic ones lower scores). For most patients, the disease was considered a trial and a challenge. 73.8% of the patients considered religious beliefs as related to their acceptance of the disease and the treatment. This percentage rate was particularly high among the Catholics and the Protestants, but not among the Jewish subjects. Religious and spiritual beliefs correlated with psychosocial adjustment, lower alienation, an appropriate sick role behavior, acceptance of the disease and of the treatment, adherence, compliance (being the Catholics the most compliant, the non-religious the least compliant) and coping skills and strategies. The strength of the spiritual beliefs increased throughout the years (28.6%), as well as religious practices and attendance.
De Cássia Lopes Chaves, 2010 [46]	120 CKD patients, 61 females, 95 Catholics took part into the study. Spiritual needs were investigated through qualitative interviews	Cohen's kappa coefficient.	87 patients out of 120 considered religion having a profound impact on their life and disease. 27.5% of the patients reported impaired spirituality
Kao, 2009 [47]	633 CKD patients took part into the study, 281 men. They were administered the Royal Free Interview for Spiritual and Religious Beliefs, SF-36	Chi-square test, ANOVA, ANCOVA, Scheffé post-hoc test	Women had stronger beliefs, while less-educated patients had weaker beliefs. Patients with no or with strong spiritual beliefs had higher role physical and social functioning scores than patients with weak beliefs. Haemodialysis patients with no or strong spiritual beliefs had higher quality of life scores than those with weak spiritual beliefs. Spirituality scores correlated with quality of life and with social support. Absence of spiritual beliefs was interpreted as self-belief and self-confidence.

Kimmel, 2003 [48]	165 out of 190 haemodialysis patients, mean age 60.9 years, 52% males, 48% females, 63 white, 33.3% black. SWLS, MQOL, SBS, SNS were administered to the patients	Unpaired t-test, Pearson's correlation coefficients, ANOVA one-way, linear univariate and multivariate regression analysis	Pain was the most common symptom (21% of patients). There was an inverse relationship between reported number of symptoms and SWLS, MQOL scale score, and SIS. The SBS correlated with the MQOL scale score, SWLS, and SIS. African American had a higher spirituality scores than white subjects. Women were more religious than men. No clinical parameter correlated with any measure of QOL, spiritual beliefs, or social support
Lai, 2007 [49]	710 patients on haemodialysis, peritoneal dialysis or with transplanted kidney took part into the study. Clinical data were collected and modeled using GCS. Greyson's NDES, Royal Free Questionnaire, 10-Question Survey, Ring's WCEI, and BDI were administered	Chi-square test, t-test, Spearman rank correlation, Mann-Withney test	70 patients out of 710 (9.86%) reported at least one NDE, 21 patients referred more than 1 NDE, and 45 patients experienced 51 highly scored NDEs. 64.3% of patients having experienced NDE were women. Spirituality scores and religious practices and dimensions correlated with NDE scores. Spirituality correlated with motivation and psychosocial adjustment and social relationship
Welch, 1999 [50]	3-months longitudinal study investigating 79 CKD patients. QOL was administered to the patients.	Correlation analysis	No differences found among black and whites (comparing Black-reported scores with those Whites-reported ones in the literature). Poorer spiritual outcome was associated with younger age and higher education. Psychological/spiritual QOL was higher than health and functioning quality of life or other QOL domains
Weisbord, 2007 [51]	160 patients (82 White and 78 African American) out of 220. Neuro-psychological tests, BDI, CDI, DSI were administered	Chi-square test (with Bonferroni correction), Wilcoxon rank sum test, two sample Student's t-test, linear regression analysis, Pearson's correlation test, Spearman's correlation test	No differences were found between White and African American subjects as far as the burden of the disease, and the gravity of the symptoms were concerned. However African Americans described themselves as more religious and spiritual. Spirituality correlated with CDI, BDI scores and the correlation was stronger among the African American patients

Wechpradit, 2011 [52]	90 CAPD patients took part into the study. Pender's questionnaire about health promotion behaviors (using Bloom's scale for assessing the results) was administered	Chi-square test, Fisher's exact test, Pearson's correlation test	Spirituality played a role in improving the patient's quality of life
Davison, 2012 [53]	253 CKD patients (ESRD Stages 4-5) out of 342; 56.5% men, 81.5% white. Mean age: 59.5±14.6. They were on peritoneal dialysis/home haemodialysis/in-center haemodialysis/rural satellite haemodialysis. Clinical data were investigated and modeled using CCI. They were administered SWBS, PAIS, KDQOL-SF questionnaires. SWBS included items concerning both EWB SWB	ANOVA, chi-square test, correlation and regression analysis	No differences were found among peritoneal dialysis, home haemodialysis, in-center haemodialysis and rural satellite haemodialysis. Psychosocial adjustment was the main variable, exerting its effect mainly on mental health (and to a less extent on physical health), even though spiritual coping may play a role. In fact, EWB correlated with QOL, while SWB not
Ibrahim, 2012 [54]	274 patients, on haemodialysis (183 subjects) and on CAPD (91 individuals) took part into the survey, 51.5% males, 48.5% females, 52.2% Muslim, 29.2% Buddhist, 8.0% Hindu, 4.0% Christian, 6.6% other religious affiliations. IPQ-R, Religious Coping Strategies (an <i>ad hoc</i> questionnaire)	Pearson's correlation coefficients, multiple regression	Using the Common Sense model of self-regulation, the authors proved an impact of religious coping strategies on illness perception, perceived symptoms severity and quality of life the correlations between time since the diagnosis and the treatment, illness coherence and beliefs, personal control and regulation, and quality of life were buffered by religion.
Lucchetti, 2012 [55]	133 out of 205 haemodialysis patients; 60.9% white. Private and Social Religious Practice Scale, BAI, BDI, VAS for pain assessment, WHOQOL were administered to the patients	Linear regression	Depression and anxiety were common among haemodialysis patients. 82.3% of the sample prayed everyday. 73% of the population reported an increase in religiosity during the last 10 years. 63.1% of the patients believed that religiosity was very important for their recovery and 55.8% to their lives. For most patients these religious needs were often unmet: 29.5% of the subjects had ever been asked about their religious or spiritual beliefs by a doctor and 55.6% of the sample believed doctors should ask about their beliefs. Religiosity was correlated with higher quality of life scores, with psychosocial adjustment, with lower depression scores, but showed no correlation with anxiety
Patel, 2002 [56]	53 patients on haemodialysis, 30 women and 23 men, 86.8% were African Americans. Clinical data were investigated and modeled using Karnofsky Index. IEQ, SWLS, an <i>ad hoc</i> scale concerning Religious and Spiritual Beliefs, MSPSS, BDI, KDQOL were administered.	Unpaired t-tests, chi-square test, Pearson's correlation test	Religious beliefs are related to perception of depression, illness effects, social support, and QOL independently of medical aspects of illness. Religious beliefs may act as coping mechanisms for patients with ESRD
Weil, 2000 [57]	14 patients on dialysis accepted to take part into the study, 5 men and 9 women, 13 white, 1 African American, mean age was 62.5 years, range 43-81 years	Qualitative study	Spirituality was identified as a source of hope, and thus mediated acceptance of the treatment. Other sources of hope were family and friends

Kranenburg, 2005 [58]	61 patients, 57% males, 62% on haemodialysis, 33% CAPD, 5% on pre-dialysis, mean age 50. 5 patients were Muslim. EuroQOL, EQ-VAS were administered to the patients	Wilcoxon signed ranks test, McNemar test, paired samples t-test	Religiosity and spirituality were negative predictors of acceptance of xenotransplants in CKD patients
Davison, 2010 [59]	584 ESRD stage 4 and 5 patients out of 680, mean age 68.16±14.4 years. 238 were on pre-dialysis, 222 on haemodialysis, 73 on peritoneal dialysis, 51 having received a transplanted organ, 80.5% was white.	Qualitative study	13.5% of the sample reported to rely on spiritual advisors as their end-of-life care preferences. 27.2% of the patients reported pastoral needs, 13.4% of the sample advocated spiritual care as fundamental.
Davison, 2006 [60]	24 out of 25 patients on haemodialysis and on peritoneal dialysis, 12 women and 12 men, mean age 64 years (range 44-88 years) decided to take part into the study. Most patients were white, only 1 was Aboriginal	Qualitative ethnographic study	Spirituality helped the patients in advance care planning (APC), alleviating anxiety, fear and tension, preparing them for death, modulating social relationships and behaviors moreover, spirituality could be linked with Locus of Control (LOC). Facing religiosity could be an added value in shared decision making
Tanyi, 2008 [61]	16 women out of 25, age in the range 29-77 years, 11 African Americans, 2 Protestants, 3 Catholics, 3 Christians, 3 Baptists, 1 Jewish, Lutheran, Seventh Day Adventist, Pentecostal, and non denominational	Qualitative study, Colaizzi's methodology	Spirituality contributed to acceptance of the disease and of the treatment, fortification, a better understanding of the patient's experience and emotion modulation
Parker, 2003 [62]	46 patients, 16 on haemodialysis, 8 on peritoneal dialysis, 24 men and 22 women, mean age 51.6±10.8 years. Ferrans and Powers QLI questionnaire, EES were administered	Mann-Whitney U-test, Kruskal-Wallis test, regression analysis	Spirituality score was higher among haemodialysis patients than among subjects treated with peritoneal dialysis. Spirituality correlated with global functioning and sleep disorders
Yang, 2008 [64]	861 patients on haemodialysis. PSQI and the Royal Free Questionnaire were administered to the patients	Correlation analysis	Good sleepers did not statistically differ from poor sleeper. Religious and spiritual activity scores did not correlate with global PSQI score. However, patients who exercised religious beliefs more strongly reported less sleep disorders and trouble in daytime dysfunction
Laws, 2000 [68]	53 of 69 patients took part into the study. Clinical and laboratory data were collected and modeled using Daugirdas's equation, SGA and Karnofsky's index. Campbell's IGA, IGWB, OLS were administered to the patients	Student t-test, Kruskal-Wallis test, Wilcoxon test, multiple regression analysis	64% of patients were well nourished, while 23% of the subjects were moderately malnourished, and 13% were severely malnourished. Malnutrition correlated with poorer subjective quality and spirituality score. There was a statistically significant correlation between some clinical parameters (such as, nutritional assessment, mid arm muscle circumference, MAMC) and religiosity
Finkelstein, 2007 [69]	200 ESRD patients on both haemodialysis and peritoneal dialysis. Clinical data were modeled using CCI. SWBQ, BDI, SF-36 were administered	Correlation analysis	Spirituality did not correlate with co-morbidities, patient age and patient's compliance. It correlated with quality of life, global functioning and BDI score. No differences between haemodialysis and peritoneal dialysis groups

Schwartz, 2005 [70]	21-days longitudinal study, investigating 175 CKD patients out of 184, 98 males, 67 females, 152 White (86.9%), 103 Catholic, 52 Christian, 3 Jewish, 1 Buddhist, 9 other. Folstein's Mini-Mental Status Exam, MVQOLI-R, MSAS, Ryff's Psychological Well-being measure short-form questionnaires were administered to the patients	Pearson's correlation test, regression analysis	Differences in distress between individuals were associated with the severity of the symptoms, the functioning and the well-being. Changes in global distress for one individual over time were associated primarily with the symptom severity and spirituality. The majority of the patients indicated that spiritual practice was very important to them, only 10 patients reported no interest in spirituality
Ko, 2007 [71]	117 out of 131 patients on haemodialysis, 65 males and 47 females, mean age 55.5±16.9 years, 79.5% Christian (15 Roman Catholic, 45 Protestant, 29 other Christian faith). 9 were atheist, 7 Muslim, other 7 Hindu, Buddhist, Sikh or other. Clinical and laboratory data were investigated and modeled using Daugirdas formula. RBS, the Royal Free Interview, KDQOL were administered	Chi-square test, Pearson's correlation test, independent sample t-tests, ANOVA one-way	105 of the 112 (94%) subjects considered themselves religious, spiritual or both. No differences among the different religious groups and between religious and spiritual groups. KDQOL negatively correlated with spirituality score. No correlations were found between mental health, emotional well-being or social functioning and spirituality score. BUN and creatinine values statistically differed between religious and non religious groups, but no other correlations (age, gender, ethnicity) were found. A correlation was found between spirituality score and survival rate (speculatively, this could be mediated by a sense of hopelessness)
Foster, 1973 [72]	2-years longitudinal study, investigating 21 CKD patients under haemodialysis, 9 Roman Catholic, 11 Protestant and 1 Jewish subjects. Clinical data were modeled using Karnofsky index. Miller-Quinlan Boundary Image Test, the Rotter's Internal and External Locus of Control questionnaire, the Mood adjective Check-list, the fusion-boundary dimensions of the patients body image questionnaire, CMI, and a battery of neuro-psychological tests were administered to the patients	Unpaired Student's t-test, Chi-square test with Yates correction, product-moment correlation analysis	After two years, all the Roman Catholic patients survived, while only 6 of the Protestants and the only Jewish died. Religion had a significant impact on survival rate, despite the small size of the studied sample. No other correlations with social, clinical and demographic parameters were observed. Other parameters which instead resulted significant were: psychiatric profile of the patients, parental presence and assistance versus loss and bereavement, low blood urea nitrogen levels, serum chloride, and scores reported in the Miller-Quinlan Boundary Image Test. Creatinine levels did not prove statistically significant
Greenberg, 1975 [73]	7 patients decided to take part into the study, age in the range 29-61 years, 4 males, 3 females, 1 Baptist, 1 Jewish, the other Roman Catholic, 6 white, 1 black	Qualitative study	Emotional reaction to the disease varied from fear, shock, disbelief, to resigned acceptance of it. Religion was used as a way for coping and dealing with death and with its associated existential anxiety. Other coping strategies were a defensive style and denial. Apparently, Catholic affiliation was associated with a slight higher 2-years survival rate
Elliott, 2012 [74]	27 out of about 120 eligible dialysis patients were interviewed, mean age 80.6 years (range 70-100), 15 men and 12 women	Qualitative study	83% of the sample considered himself/herself as spiritual or religious. Several patients described the dialysis as a gift from God and reported their spiritual beliefs having an impact on their choice of following the treatment. The main categories related to spirituality were: help in finding a meaning in life, modulation of psychosocial relationship, distress coping

Breckenridge, 1997 [75]	22 CKD patients (6 on CAPD, the others 16 on haemodialysis) decided to take part into the study, 13 males, 9 females, mean age was 53.8 years, range 29-69 years, 17 African American, 5 white	Qualitative study	Spiritual beliefs were important for the patients (dialysis was considered a blessing) and were integrated in a Neuman system model by the care-givers, in order to ensure a holistic nursing. The Neuman system included physiological, psychological, sociocultural, developmental and spiritual treatment
Baldree, 1982 [76]	35 patients on haemodialysis out of 160 eligible subjects and of 38 selected individuals, 19 females, 16 males, 19 black, 13 white, 3 Hispanic, mean age 42.2 years, range 21-60 years. A rating scale concerning physiological and psychosocial stressors and a coping scale developed by Jalowiec and Powers were administered	Chi-square test, Spearman's rank test, Pearson's correlation coefficient	Using the theory of stressors, the author found that praying and trusting in God could be used as an effective affect-oriented coping strategy. Indeed, it was one of the seven most used coping strategies (together with hope, maintaining control, thinking differently, looking objectively at the situation, accepting the situation, worrying)
Walton, 2002 [77]	11 patients, 4 men and 7 women, age in the range 36-78 years, decided to take part in the study. 10 patients were white, one was American Indian. Patients belong to many religious groups, from Judeo-Christian, Jehovah's witness, Mormon to a non institutionalized creed (3 patients)	Qualitative narrative study	The author used the Glaserian method of constant comparative grounded theory analysis and found that religion helped the patients to find a balance. Spirituality related with the following dimensions: thinking of mortality, coping with the disease, accepting the treatment, reframing. The author found also other categories, such as receiving and giving back, the presence of God
Tanyi, 2006 [78]	16 women on haemodialysis accepted to be interviewed	Qualitative study	Spirituality was used to mobilize inner resources, to build relationships by 83% of the interviewed subjects. They underlined the importance of integrating spirituality and religiosity in the frame of a holistic nursing care
Tanyi, 2003 [79]	65 women on haemodialysis out of 70 (mean age 57.54±14.77 years, range 24-82), 41.5% white, 47.7% African American, 40 Protestant, 11 Catholic. PAIS-SR, SWBS, an ad hoc questionnaire concerning self-perceived health were administered	Chi-square test, t-test, Pearson's product moment correlation analysis	RWB score followed a bimodal distribution, while EWB score followed a genuine Gaussian pattern, with RWB score being higher than EWB. SWB correlated with psychosocial adjustment, psychological distress adjustment. EWB correlated with social adjustment but to a weaker extent. Using Roy's adaptation model, the authors confirmed the importance of spirituality and religiosity as adaptation strategy
Caress, 2001 [80]	405 patients took part in this cross-sectional study, 155 on pre-dialysis, 103 on haemodialysis, and 147 with a transplanted kidney	Chi-square test	Using Lipowski theory and categories, the authors found that 3 patients (all Evangelical Christians) referred that they felt themselves closer to God. Also in other patients, religiosity and spirituality had a positive impact
Shah, 2006 [81]	50 out 52 patients, 52% men, 48% women, 64% African American, 32% Caucasian, mean age was 49 ± 11.7 years, range 25-71 years. An <i>ad hoc</i> modified QOL-scale QLS, IEQ, MSPSS, BDI, SWLS were administered to the patients	Pearson's correlation coefficient	Perception of a better QOL correlated with lower depression score and illness effects and with perception of greater social support and satisfaction with life. Perception of QOL did not correlate with age, time since transplantation, creatinine, hemoglobin or albumin levels



Matthews, 2001 [88]	This is a randomized survey, investigating 95 adult haemodialysis subjects with ESRD, mean age was 49 years, 58% males, 68% African American 13% Haitian, 11% Cuban and Hispanic, 8% White, Protestant or Baptist 71.6%, Catholic 13.7%, with no religious affiliation 4.2%. 47 randomly selected subjects were told they would have received intercessory prayer, and the other 48 positive visualization. Later, the sample was randomly subdivided in 3 subgroups, the first receiving the expected treatment, the second receiving the other kind of treatment, the third receiving no treatment at all. SF-36, BDI, BSI, Belief in Prayer/Positive Visualization Questionnaire were administered to the patients	This 2x3 factorial study made use of chi-square test, ANOVA and post-hoc Bonferroni test, ANCOVA	Subjects who expected to receive intercessory prayer reported higher QOL scores than those who expected to receive positive visualization. A reduction of state and trait anxiety was also observed. No other statistically significant main effects or interactions were found. In conclusion, expectancy of an intercessory prayer was more effective than that the very prayer itself
---------------------	---	--	--

BAI, Beck Anxiety Inventory; BDI, Beck Depression Inventory; Brief-SRCOPE/SRC, Short Spiritual Religious Coping Scale; BSI, Brief Symptom Inventory; CAPD, Continuous Ambulatory Peritoneal Dialysis; CCI, Charlson Co-morbidity Index; CDI, Cognitive Depression Index; CES-D, Center for Epidemiological Studies Depression; CKD, Chronic Kidney Disease; CMI, Cornell Medical Index; DSI, Dialysis Symptom Index; ESRD, End-Stage Renal Disease; ESS, Epworth Sleepiness Scale; EWB, Existential Well-Being; GCS, Glasgow Coma Scale; GHQ-28, General Health Questionnaire 28; IEQ, Illness Effects Questionnaire; IGA, Index of General Affect; IGWB, Index of General Well-Being; IPQ-R, Illness Perception Questionnaire Revised; KDQOL-SF, Kidney Dialysis Quality Of Life Short Form; MILS, Meaning In Life Scale; MQOL, McGill Quality Of Life; MSAS, Memorial Symptom Assessment Scale; MSPSS, Multidimensional Scale of Perceived Support; MVQOLI-R, Missoula-VITAS Quality Of Life Index Revised; NDE, Near-Death Experience; NDES, Near-Death Experience Scale; OLS, Overall Life Satisfaction; PAIS, Psychological Adjustment to Illness Scale; PRQ-85, Personal Resources Questionnaire 85; PSQI, Pittsburgh Sleep Quality Index; QLI, Quality of Life Index; QLS, Quality of Life Scale Score; RBS, Religious Beliefs Scale; SBS, Spiritual Beliefs Scale; SF-12 Short Form 12; SF-36, Short-Form 36; SGA, Subjective Global Assessment; SNS, Support Network Scale; SPMSQ, Short Portable Mental Status Questionnaire; SPS, Spiritual Perspective Scale; STAI, State-Trait Anxiety, SWB, Spiritual Well-Being; SWBQ, Spiritual Well-Being Questionnaire; SWBS, Spiritual Well-Being Scale; SWLS, Satisfaction With Life Scale; SWMC, Satisfaction With Medical Care; VAS, Visual Analog Scale; WCEI, Weighted Core Experience Index.