

CHAPTER 3

Nursing Assessment of Spiritual Needs

The healer has to keep striving for . . . the space . . . in which healer and patient can reach out to each other as travelers sharing the same broken human condition.

Henri J. M. Nouwen, *Reaching Out*, 1986, p. 93

When you view nursing as a vocation, it helps you to assess the patient as a whole. You know, to really think about what their needs are physically, mentally, and spiritually. You see the whole person and are able to help them better by doing that; by assessing everything that's going on.

Terri, Team Leader on a Pediatric Unit

The first step in planning spiritual care for one who is ill is conducting a needs assessment; this may be done formally in the context of nursing research, or informally through interaction with the patient and family. The ill individual's level of spiritual development and religious tradition and practice are important variables to be explored. In this chapter, tools to assess spiritual and religious beliefs and needs are presented; these tools were developed through nursing research with persons living with a variety of illness conditions. Nursing diagnoses related to alterations in spirituality, derived from patient assessment, are examined, and selected nursing studies in which patients' spiritual and religious beliefs and needs were identified are described.

► Nursing Assessment

During the past few decades, nursing assessment of hospitalized patients' problems and needs has become increasingly more sophisticated. Assessment tools vary depending on the care setting, for example, intensive care versus a general care unit; nevertheless, today's nursing assessment instruments are much more detailed than the medical model-oriented database forms of the past. Recently nurses' comfort

level in conducting assessment of patients' spiritual needs has also received significant attention (Taylor, 2013, p. 178). Although it is admitted that some nurses may feel uncomfortable or unprepared to discuss spiritual or religious topics with patients (Ameling & Povilonis, 2001; Brush & Daly, 2000), a systematic approach to assessing spiritual well-being is recommended (Govier, 2000). In addition to assessing physiologic parameters, caregivers also assess psychological and sociological factors that may impact patients' illness conditions. A significant weakness, however, among many contemporary nursing assessment tools is the lack of evaluation of a patient's spiritual needs. Frequently, the spiritual assessment is reflected in a single question asking the religious affiliation of the individual. The assumption is that the patient's spiritual care can then be turned over to a hospital chaplain assigned to minister to persons of that religious tradition.

Although the important role of the hospital chaplain is in no way devalued, the nurse, if he or she is to provide holistic care, should have first-hand knowledge of the spiritual practices and needs of a patient. If no detailed spiritual assessment is carried out, such information, even if revealed during a chaplain's visit, might never be communicated to the nursing staff. A patient may, however, reveal a spiritual problem or concern in some depth to the primary nurse during an assessment at the bedside. In health-care facilities with well-functioning departments of spiritual ministry, excellent communication often takes place between pastoral caregivers and nursing staff. This is the ideal. In such situations, chaplains attend nursing care conferences and share in holistic health planning for patients. If the nursing staff has performed a spiritual assessment, this information, combined with the chaplain's insight and advice, can serve to round out the spiritual dimension of the holistic health-care plan.

In the contemporary era of home health care, assessment of a patient's spiritual beliefs and needs is also critical to developing a holistic home nursing care plan. Frequently the home care patient experiencing or recuperating from illness is isolated from sources of spiritual support such as attendance at worship services and interaction with other members of a church or faith group. In such a case, the home health-care nurse may be able to assist the patient in verbalizing his or her spiritual or religious needs; the nurse can then offer creative strategies for meeting those needs. The nurse may also provide a bridge between the patient and family and their church, recommending counseling from an ordained pastoral caregiver if this seems warranted.

Nursing authors continue to discuss the importance of assessing patients' spiritual needs (Young & Koopsen, 2011, pp. 149–152), as well as the value of continuing to develop spiritual assessment tools (Power, 2006). The need for spiritual assessment is identified specifically for such populations as intensive care unit (ICU) and coronary care unit (CCU) patients (Timmins & Kelly, 2008) and families of those who are ill (Tanyi, 2006). Assessment of the spiritual needs of terminally ill patients is a current concern for palliative care nurses (Smyth & Allen, 2011).

In light of current understanding of the need to evaluate patients' spiritual concerns, a number of recently developed spiritual assessment tools, appropriate for nurses' use with patient populations, are currently being proposed and tested. Some of these include: the "Hope Tool" (Blaber, Jones, & Willis, 2015); the "Spiritual Health Scale" (Hsiao, Chiang, Lee, & Han, 2013); the "FACIT-SP Spiritual Well-Being Scale" (Haugen, 2014); and the "Two Stage Spiritual Assessment in Health Care Settings" instrument (Hodge, 2015).

► **The Joint Commission Mandate on Assessment of Spiritual Needs**

During the past several decades, The Joint Commission (formerly the Joint Commission for Accreditation of Healthcare Organizations) has recognized the importance of spiritual and religious beliefs and traditions for persons who are ill or disabled. This concern is reflected in The Joint Commission's standards relating to spiritual assessment and spiritual care both for those who are hospitalized (Standard R1.1.3.5) and those living in nursing homes (Standard PE1.1.5.1) (The Joint Commission, 2003). The Joint Commission's standards "reflect the need to recognize and meet the spiritual needs of patients" (Sanders, 2002, p. 107).

The Joint Commission has "acknowledged that patients' psychosocial, spiritual and cultural values affect how they respond to care and has addressed spirituality and emotional well-being as aspects of patient care" (Clark, Drain, & Malone, 2003, p. 659). Standards refer to both spiritual services and pastoral care for health-care patients (p. 659). Care of patients' spiritual needs is now considered central to care provided in health-care organizations, which The Joint Commission recommends "(1) acknowledge patients' rights to spiritual care and (2) provide for these needs through pastoral care and a diversity of services that may be offered by certified, ordained or lay individuals" (La Pierre, 2003, p. 219).

The Joint Commission website suggests that assessment of patients' spiritual needs should be carried out not only to determine religious denomination, but also to identify spiritual and religious beliefs and practices, especially as related to coping with illness or disability. Some questions to be included in a spiritual assessment include: "Who or what provides the patient with strength and hope?"; "Does the patient use prayer in (his/her) life?"; "What type of spiritual/religious support does the patient desire?"; "What does dying mean to the patient?"; "Is there a role of church/synagogue in the patient's life?"; and "How does faith help the patient cope with illness?" (The Joint Commission, 2008).

The importance of the identified Joint Commission standard for the patient's spiritual assessment continues to be supported in contemporary health care-related chapters and articles (Hodge, 2006; Young & Koopsen, 2011). It is now understood that nurses must be involved in patients' spiritual care in the United States as "the Joint Commission (formerly JCAHO) requires spiritual assessment as part of health care" (Pesut, Fowler, Reimer-Kirkham, Taylor, & Sawatzky, 2009, p. 342).

► **HIPAA Regulations and Spiritual Assessment**

As noted, The Joint Commission, which accredits health-care organizations, has essentially mandated that nurses pay attention to patients' spiritual needs. Staff nurses, as members of the health-care team, have access to records for the patients under their care, and thus it seems that the confidentiality dimension (privacy standards) of the Health Insurance Portability and Accountability Act (HIPAA) should not be a concern. The HIPAA regulations may, however, impact patients' spiritual needs/care indirectly by limiting access to patients' personal clergy person or pastoral care provider.

In an article published in the newsletter of the Lutheran Services in America, one pastor complained that since the advent of HIPAA his access to general information about hospitalized parishioners has been limited. He observed that before HIPAA he was “able to provide better pastoral care when [he] could see the entire patient list” (2004, p. 1).

The situation appears to be somewhat different for the minister who is a hospital chaplain. In a series of three articles in consecutive issues of the *Association of Professional Chaplains (APC) News*, the authors raised the topic of HIPAA’s impact on hospital chaplains and their clinical pastoral education (CPE) students (White, 2003; White & Pierce, 2002a, 2002b). The conclusion seemed to be that patient records would be available and accessible to these pastoral care providers as they were, in fact, clinically trained members of the health-care team with responsibility for patients’ spiritual care. A distinction in title was suggested by the president and CEO of the National Association of Catholic Chaplains (NACC) as follows: “The chaplain is a health care professional; the clergyperson is a religious leader; the chaplain tends to the spiritual needs of all the patients; the clergyperson tends to the religious needs of his or her congregants” (Driscoll, 2003, p. 4). Thus, it seems that a pastoral care provider’s role description might significantly impact his or her access to patient records as controlled by HIPAA regulations.

Spiritual Development

Central to assessing a patient’s spirituality is a basic knowledge of the spiritual development of the human person. A number of theories attempt to track spiritual development; significant among these is James Fowler’s paradigm set forth in his book *Stages of Faith Development* (1981). Fowler’s theory, encompassing seven stages of faith development, emerged from data generated from research with persons across the life span from 3.5 to 84 years of age.

Fowler (1981) described faith as “not always religious in its content or context” (p. 4). He explained that faith has to do with one’s finding coherence in life, with seeing oneself in relation to others “against a background of shared meaning and purpose” (p. 4). Faith is viewed as deeper and more personal than organized religion, as relating to one’s transcendent values and relationship with a higher power, or God. Although Fowler admitted that more research needs to be done, his work demonstrated a preliminary pattern of relationships between the stages of faith development and chronological age. Fowler’s seven faith stages and their approximate corresponding age categories are as follows:

1. Undifferentiated Faith is a “prestage” (infancy) in which the seeds of trust, courage, hope, and love are joined to combat such issues as possible “inconsistency and abandonment in the infant’s environment” (p. 121). This faith stage has particular relevance for the maternal–infant nurse concerned with issues of parental–infant bonding.
2. Intuitive–Projective Faith (3–6 years) is an imitative “fantasy-filled” period in which a young child is strongly influenced by “examples, moods, actions and stories of the visible faith of primarily related adults” (p. 133). Pediatric nurses, especially those working with chronically or terminally ill children, will find guidance for dealing with the child’s spiritual and emotional needs from Fowler’s conceptualization of this stage.

3. Mythic–Literal Faith (7–12 years) is described as the time when the child begins to internalize “stories, beliefs and observances that symbolize belonging to his or her own faith community” (p. 149). In working with slightly older pediatric patients, the concept of mythic–literal faith can help the nurse to support the child’s participation in rites, rituals, and/or worship services of his or her tradition, which may provide support and comfort in illness.
4. Synthetic–Conventional Faith (13–20 years) describes the adolescent’s experiences outside the family unit: at school, at work, with peers, and from the media and religion. Faith provides a “basis for identity and outlook” (p. 172). Fowler’s definition of this faith stage provides an understanding of how the ill adolescent may relate to both internal (family) and external (peer) support and interaction during a crisis situation.
5. Individuative–Reflective Faith (21–30 years) identifies a period during which the young adult begins to claim a faith identity no longer defined by “the composite of one’s roles or meanings to others” (p. 182). This is a time of personal creativity and individualism that has important implications for the nurse, including patient autonomy in planning care for the ill young adult patient.
6. Conjunctive Faith (31–40 years) is a time of opening to the voices of one’s “deeper self” and the development of one’s social conscience (p. 198). Nurses caring for patients in this faith stage must be sensitive to the adult’s more mature spirituality, especially in relation to finding meaning in his or her illness.
7. Universalizing Faith (40 years and above) is described by Fowler as a culmination of the work of all of the previous faith stages, a time of relating to the “imperatives of absolute love and justice” toward all humankind (p. 200). Nurses need to be aware that patients may vary significantly in terms of degree of accomplishing the imperatives of this final stage. Assessing approximately where the mature adult patient is, related to such faith, will help in understanding both the patient’s response to an illness condition and his or her need for external support in coping with the crisis.

Although a nurse may not be able to identify every patient’s stage of faith development chronologically, Fowler’s theory with its approximate age-associated categorization does present some guidelines to assist in broadly estimating a patient’s level of spiritual development.

► Nursing Assessment of Spiritual Needs

The Spiritual Assessment Scale

In their fundamentals of nursing text, Taylor, Lillis, and LeMone (1993) asserted that assessment of a patient’s spirituality should be considered part of any “comprehensive nursing history” because, they reasoned, “a person’s spirituality and religious beliefs have the potential to influence every aspect of being” (p. 1173). Although an initial spiritual assessment or history can provide baseline information regarding a patient’s spirituality, it is important to remember that spiritual needs may change, or new

spiritual concerns may arise during an illness experience. And, because a patient may find it difficult to discuss spiritual problems, the nurse is advised to look for signs of possible spiritual distress such as “sudden changes in spiritual practices [rejection, neglect, fanatical devotion]; mood changes [frequent crying, depression, apathy, anger]; sudden interest in spiritual matters [reading religious books or watching religious programs on television, visits to clergy]; and disturbed sleep” (Taylor, Lillis, & LeMone, 1993, p. 1174).

Nurse researchers Sessanna, Finnell, Undershill, Chang, and Peng assert that “Assessing spiritual needs and preferences is an essential and critical aspect of holistic and multidisciplinary patient care practice” (2011, p. 1692). The authors admit, however, that “conceptual and operational definitions of spirituality vary greatly among nursing and health related literature” (p. 1692). They found that the concept of “religiosity” was often included in the ostensible measuring of “spirituality.”

One set of questions describing a patient’s spirituality that may be included as part of a nursing history are those contained in the spiritual history guide developed by Ruth Stoll (1979). The guide is divided into four subsections or “areas of concern”: “The person’s concept of God or deity; the person’s source of strength and hope; the significance of religious practices and rituals to the person; and the person’s perceived relationship between his spiritual beliefs and his state of health” (p. 1574). Some standardized spiritual assessment tools created by nurses include the Spiritual Perspective Scale, which measures adult spiritual views (Reed, 1991); Kerrigan and Harkulich’s Spiritual Assessment Tool, developed to identify the spiritual needs of nursing home residents (1993); the JAREL Spiritual Well-Being Scale, a tool to assess the spiritual attitudes of older adults (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1996); Puchalski’s “Spiritual History,” which includes four domains: “Faith, Importance, Community, and Address” (2000, p. 129); the multidimensional “Spiritual Needs Survey,” which includes seven major constructs: “belonging, meaning, hope, the sacred, morality, beauty, and acceptance of dying” (Galek, Flannelly, Vane, & Galek, 2005, p. 62); the spiritual assessment model, including focus on one’s “spiritual belief system, personal spirituality, integration/involvement in a spiritual community, ritualized practices and restrictions, implications for care and terminal events planned (advanced directives)” (Dameron, 2005, p. 16); the “Serenity Scale,” which measures spirituality and well-being and has three subscales that explore “acceptance, inner haven and trust” (Kreitzer, Gross, Waleekhachonloet, Reilly-Spong, & Byrd, 2009); and the “Spiritual Care Inventory,” which measures nurses’ attitudes toward and behaviors in providing patients’ spiritual care (Burkhart, Schmidt, & Hogan, 2011).

The author’s standardized instrument to assess adult, cognitively aware individuals’ spiritual beliefs and practices, entitled the “Spiritual Assessment Guide,” was initially developed and published in 1982 (O’Brien, 1982a, pp. 99–102). The 53-item tool contained 6 subscales: General Spiritual Beliefs, Personal Spiritual Beliefs, Identification with Institutionalized Religion, Spiritual/Religious Support Systems, Spiritual/Religious Rituals, and Spiritual Deficit/Distress. Items contained in the instrument were derived from content analysis of qualitative data generated in interviews with 126 chronically ill hemodialysis patients. The patients had been asked to discuss their spiritual beliefs, practices, concerns, and needs in relation to living with a long-term life-threatening illness. It was admitted at the time of construction that this early version of the tool, which contains a mix of both closed- and open-ended questions, was more detailed than appropriate for nursing use in short-term care

but could prove valuable in nursing research on the spiritual beliefs and behaviors of the chronically ill patient.

During the past two decades, the Spiritual Assessment Guide has been revised several times and selected items were used in research with such populations as nursing home residents (O'Brien, 1989), persons living with HIV and AIDS (O'Brien, 1992, 1995; O'Brien & Pfeifer, 1993), and the homebound elderly (Brennan, 1994).

The Spiritual Assessment Guide has recently been significantly revised again and retitled the Spiritual Assessment Scale (SAS). The standardized instrument, which measures the construct of Spiritual Well-Being, now contains 21 items organized into 3 subscales: Personal Faith (PF), 7 items; Religious Practice (RP), 7 items; and Spiritual Contentment (SC), 7 items. In its newly abbreviated form, the SAS, which takes approximately 3 to 4 minutes to complete, can be used by practicing nurses in the health-care setting, as well as being employed as a research instrument. The tool, as revised, will provide nursing staff and nurse researchers with a broad overview of a patient's personal faith beliefs, the type of spiritual support he or she receives from religious practices, and the type and degree of spiritual contentment/distress the patient is currently experiencing. The 21-item scale is organized with Likert-type scale response categories (SA—Strongly Agree, A—Agree, U—Uncertain, D—Disagree, SD—Strongly Disagree) following each item to facilitate administration; the appropriate categories may be checked by the patient or read aloud and marked by the nurse if a patient is unable to write.*

Validity and Reliability of the SAS

The construct measured by the SAS, Spiritual Well-Being, includes the dimensions of both spirituality and religiousness, or “religiosity,” operationally defined in terms of three discrete concepts: Personal Faith, Religious Practice, and Spiritual Contentment.

Spiritual Well-Being

The term *spiritual well-being* is described historically as having emerged following a 1971 White House Conference on Aging. Sociologist of religion David Moberg (1979) identified spiritual well-being as relating to the “wellness or health of the totality of the inner resources of people, the ultimate concerns around which all other values are focused, the central philosophy of life that guides conduct, and the meaning-giving center of human life which influences all individual and social behavior” (p. 2). The concept of hope is central to a number of definitions of spiritual well-being. In a discussion of holistic nursing care, spiritual well-being is described as “an integrating aspect of human wholeness, characterized by meaning and hope” (Clark, Cross, Deane, & Lowry, 1991, p. 68). Lindberg, Hunter, and Kruszewski (1994) included “the need to feel hopeful about one’s destiny” (p. 110) in a litany of patient needs related to spiritual well-being; and Droege (1991), in discussing the “faith factor” in healing, suggested that when an individual does not experience spiritual well-being, serious “spiritual maladies” may occur, such as “depression, loneliness, existential anxiety and meaninglessness” (p. 13).

*The Spiritual Assessment Scale does assume belief in a Supreme Being, or God.

Most notions of spiritual well-being also contain some reference to philosophy of life and transcendence. Blaikie and Kelson (1979) described spiritual well-being as “that type of existential well being which incorporates some reference to the supernatural, the sacred or the transcendental” (p. 137); and Barker observed that spiritual well-being is “to be in communication, in communion with that which goes beyond oneself in order to be whole in oneself” (1979, p. 154). For the Christian, spiritual well-being is identified as “a right relationship of the person to God, and, following that, a right relationship to neighbor and self” (Christy & Lyon, 1979, p. 98).

Spirituality is generally identified as being related to issues of transcendence and ultimate life goals. Nurse theorist Barbara Dossey (1989) explained spirituality as encompassing “values, meanings, and purpose” in life; it includes belief in the existence of a “higher authority”; and it may or may not involve “organized religion” (p. 24). O’Brien (1989), in reporting on research with the chronically ill, suggested that spirituality is a broad concept relating to transcendence [God]; to the “non-material forces or elements within man [or woman]; spirituality is that which inspires in one the desire to transcend the realm of the material” (p. 88).

Religiousness, or “religiosity,” as it is sometimes identified in the sociological literature, refers to religious affiliation and/or practice. Kaufman (1979) described religiousness as “the degree to which religious beliefs, attitudes and behaviors permeate the life of an individual” (p. 237). In their classic work of 1968, Stark and Glock identified five primary elements of religiousness: belief, religious practice (ritual, devotional), religious experience, religious knowledge, and consequence of religious practice on day-to-day living.

The “spirituality” dimension of spiritual well-being is measured in terms of the concepts of Personal Faith and Spiritual Contentment; the “religiousness” element of the construct is reflected in the concept of Religious Practice.

► Personal Faith

Personal faith, as a component concept of the spiritual well-being construct, has been described as “a personal relationship with God on whose strength and sureness one can literally stake one’s life” (Fatula, 1993, p. 379). Personal faith is a reflection of an individual’s transcendent values and philosophy of life.

Religious Practice

Religious practice is primarily operationalized in terms of religious rituals such as attendance at formal group worship services, private prayer and meditation, reading of spiritual books and articles, and/or the carrying out of such activities as volunteer work or almsgiving.

Spiritual Contentment

Spiritual contentment, the opposite of spiritual distress, is likened to spiritual peace (Johnson, 1992), a concept whose correlates include “living in the now of God’s love,” “accepting the ultimate strength of God,” knowledge that all are “children of God,” knowing that “God is in control,” and “finding peace in God’s love and

forgiveness” (pp. 12–13). When an individual reports minimal to no notable spiritual distress, he or she may be considered to be in a state of “spiritual contentment.”

Construct Validity of the SAS

In research with young adults, David Moberg (1979) identified eight correlates or characteristics of spiritual well-being: Peace with God (PG), Inner Peace (IP), Faith in Christ (God) (FG), Good Morals (GM), Faith in People (FP), Helping Others (HO), Good Health (GH), and Being Successful (BS) (p. 8). Moberg reported that study participants placed greatest importance on the concepts Peace with God, Inner Peace, and Faith in Christ. The majority of respondents believed that Good Health and Being Successful were not critical elements to spiritual well-being. Those persons, however, who did not seem to possess spiritual well-being were reported as being “more likely to interpret these [health and success] as essential or most likely to be present” with overall spiritual well-being (Moberg, 1979, p. 9).

The SAS, developed to assess spiritual well-being, was constructed to broadly reflect Moberg’s eight correlates. In some cases a liberal interpretation of the characteristic was accepted; for example, Faith in Christ is understood also as Faith in God, to include the tradition of the non-Christian believer; Good Health, which Moberg described as physical, may also include good mental health, for the person whose body is suffering the ravages of illness; and Being Successful may relate to an individual’s positive feeling about self related to the strength of his or her spiritual beliefs.

The SAS items relate to Moberg’s conceptualization of spiritual well-being as follows: Peace with God—item 2; Inner Peace—items 13, 14; Faith in God/Christ—items 1, 3, 5, 6; Good Morals—items 8, 9; Faith in People—items 7 (also GH), 11, 12; Helping Others—item 10; Good Health—item 7 (also FP); Being Successful—item 4.

Construct validity of the SAS is also derived, in part, from the association of individual items with James Fowler’s conceptualization of the stages of faith development (1981, p. 113), proceeding from the prestage, infancy (Undifferentiated Faith), to the late adult stage (Universalizing Faith): Prestage (trust, courage, hope, and love): items 3, 6

Stage 1 (child learns examples of faith from related adults): items 11, 12

Stage 2 (internalization of stories of one’s own faith community): items 1, 4

Stages 3 and 4 (religious faith as a basis for identity and world outlook): items 2, 5

Stage 5 (conjunctive faith): items 7, 13, 14

Stage 6 (universalizing faith; one recognizes imperatives of love and justice toward all humankind): items 8, 9, 10*

*SAS items 15–21 assessing spiritual contentment/spiritual distress explore negative or lack of negative experiences associated with Moberg’s correlates of Inner Peace and Faith in God.

*SAS items 15–21 assessing spiritual contentment/spiritual distress explore negative or lack of negative experiences associated with Fowler’s stages of faith development; focus is placed especially on internalization of trust and hope (stage 1) and the development of one’s personal reflective faith (stage 5).

Content Validity of the SAS

Content validity of the SAS was established through submission of the revised items to a panel of experts in the area of spirituality and health/illness. Following the expert judges' review, certain tool items were modified and/or reworded.

Reliability of the SAS

Reliability of the newly revised 21-item SAS was determined through administration to a sample population of 179 chronically ill persons who agreed to respond to the tool items for the purpose of statistical analysis.

The sample group, employed for the purpose of establishing instrument reliability, consisted of 36 men and 143 women. One hundred thirty-eight members of the group (76%) were Roman Catholic; 34 were Protestant; 3 were Jewish; and 4 identified no specific religious belief system. Sixty-three persons attended church services weekly; 26 individuals attended daily church services; and 6 persons reported never going to church or synagogue. The mean age of the sample group was 49 years, with ages ranging from 19 to 89. Seventy-seven persons were single; 79 individuals were married. The participants were well educated, with 70.3 percent reporting some level of college education; the range was from 16.2 percent with 2 years of college or AA degrees to 5 percent who had achieved an MD or PhD.

Selected occupations of the sample group members included physician, nurse, teacher, social worker, secretary, pastoral minister, nursing aide, counselor, engineer, chaplain, and speech pathologist. Some examples of the chronic illnesses reported by the study population, as categorized by body system, included gastrointestinal—ulcer, gastroesophageal reflux disease (GERD), colitis, esophageal cancer, colorectal cancer; genitourinary—end-stage renal disease (ESRD), nephritis, polycystic kidneys; cardiovascular—hypertension, rheumatic heart disease, prolapsed mitral valve, pernicious anemia; respiratory—chronic obstructive pulmonary disease (COPD), asthma, lung cancer, emphysema; neurologic—brain cancer, epilepsy; musculoskeletal—osteoarthritis, osteoporosis, arthritis, multiple sclerosis; gynecological—uterine cancer, breast cancer, ovarian tumors, herpes; psychiatric—chronic depression, bipolar disease, transient amnesia, bulimia/anorexia.

Statistical reliability was calculated for a sample of 171 cases (11 cases were deleted because of missing data). Items 15–21, comprising a subscale measuring the degree of spiritual distress, were recorded in the opposite direction to reflect the concept of Spiritual Contentment.

Cronbach's alpha coefficients for the overall SAS and the subscales Personal Faith (PF), Religious Practice (RP), and Spiritual Contentment (SC) demonstrated statistically significant reliability for the instrument, both in regard to the overall tool and its subscales as examined individually:

SPIRITUAL ASSESSMENT SCALE (SAS)—21 ITEMS

Alpha coefficient = 0.92

Personal Faith (PF)—7 items

Alpha coefficient = 0.89

Religious Practice (RP)—7 items

Alpha coefficient = 0.89

Spiritual Contentment (SC)—7 items

Alpha coefficient = 0.76

Mean total scale and subscale scores reflected a sample population with a strongly positive sense of spiritual well-being. The overall mean SAS score was 91.7, out of a possible total scale score of 105. The subscales reflected a similar pattern with a PF subscale mean of 32.2 (possible total subscale score of 35); and RP and SC subscale means of 29.7 and 29.6, respectively (possible total scores of 35 for each subscale).

Spiritual Assessment Scale

Instructions: Please check the response category that best identifies your personal belief about the item (response categories: SA—Strongly Agree; A—Agree; U—Uncertain; D—Disagree; SD—Strongly Disagree).

A. Personal Faith

1. There is a Supreme Being, or God, who created humankind and who cares for all creatures.
SA _____ A _____ U _____ D _____ SD _____
2. I am at peace with God.
SA _____ A _____ U _____ D _____ SD _____
3. I feel confident that God is watching over me.
SA _____ A _____ U _____ D _____ SD _____
4. I receive strength and comfort from my spiritual beliefs.
SA _____ A _____ U _____ D _____ SD _____
5. I believe that God is interested in all the activities of my life.
SA _____ A _____ U _____ D _____ SD _____
6. I trust that God will take care of the future.
SA _____ A _____ U _____ D _____ SD _____
7. My spiritual beliefs support a positive image of myself and of others, as members of God's family.
SA _____ A _____ U _____ D _____ SD _____

B. Religious Practice

8. Belonging to a church or faith group is an important part of my life.
SA _____ A _____ U _____ D _____ SD _____
9. I am strengthened by participation in religious worship services.
SA _____ A _____ U _____ D _____ SD _____
10. I find satisfaction in religiously motivated activities other than attending worship services, for example, volunteer work or being kind to others.
SA _____ A _____ U _____ D _____ SD _____
11. I am supported by relationships with friends or family members who share my religious beliefs.
SA _____ A _____ U _____ D _____ SD _____
12. I receive comfort and support from a spiritual companion, for example, a pastoral caregiver or friend.
SA _____ A _____ U _____ D _____ SD _____
13. My relationship with God is strengthened by personal prayer.
SA _____ A _____ U _____ D _____ SD _____
14. I am helped to communicate with God by reading or thinking about religious or spiritual things.
SA _____ A _____ U _____ D _____ SD _____

C. Spiritual Contentment

15. I experience pain associated with my spiritual beliefs.
SA _____ A _____ U _____ D _____ SD _____
16. I feel “far away” from God.
SA _____ A _____ U _____ D _____ SD _____
17. I am afraid that God might not take care of my needs.
SA _____ A _____ U _____ D _____ SD _____
18. I have done some things for which I fear God may not forgive me.
SA _____ A _____ U _____ D _____ SD _____
19. I get angry at God for allowing “bad things” to happen to me, or to people I care about.
SA _____ A _____ U _____ D _____ SD _____
20. I feel that I have lost God’s love.
SA _____ A _____ U _____ D _____ SD _____
21. I believe that there is no hope of obtaining God’s love.
SA _____ A _____ U _____ D _____ SD _____

► Nursing Diagnoses: Alterations in Spiritual Integrity

Nursing diagnoses are currently used in selected health-care facilities to label those patient conditions whose treatment falls within the purview of the nurse. From early in the nursing diagnosis movement, spiritual issues have been addressed with such diagnoses as “alterations in faith” (Gebbie, 1976; Gebbie & Lavin, 1975) and “nursing diagnoses related to spiritual distress” (Campbell, 1978). This concern for the identification of patients’ spiritual needs and deficits has continued among contemporary theorists of nursing diagnosis. The nursing diagnosis “high risk for spiritual distress related to confrontation with the unknown” was described by Holloway in 1993. Two other diagnoses related to faith beliefs, “potential for spiritual well-being” and “spiritual distress,” were identified in 1994 by the North American Nursing Diagnosis Association (Brennan, 1994, p. 852). The potential for spiritual well-being is associated with “the process of an individual’s developing an unfolding of mystery through harmonious interconnections that spring from inner strength”; “spiritual distress is a disruption of the life principle that pervades a person’s entire being and that integrates and transcends one’s biological and physiological nature” (Brennan, 1994, p. 852). A recently advanced nursing diagnosis for human response in the domain of spirituality is that of “enhanced spirituality” (Cavendish et al., 2000).

As contemporary nurses become more involved with diagnosis and intervention in the spiritual arena, some basic knowledge of the beliefs and behaviors associated with the major religious cultures is essential (Engebretson, 1996). This information will allow nurses to accurately identify and address significant spiritual needs and problems exhibited or reported by their patients.

Seven nursing diagnoses related to “alterations in spiritual integrity,” which were identified from the author’s research (1982a) on spirituality and life-threatening illness, include:

“Spiritual Pain, as evidenced by expressions of discomfort or suffering relative to one’s relationship with God; verbalization of feelings of having a void or lack of

spiritual fulfillment, and/or a lack of peace in terms of one's relationship to one's creator" (O'Brien, 1982a, p. 106). A terminally ill patient, experiencing such "spiritual pain," may verbalize a fear that he or she has not lived "according to God's will"; this concern is exacerbated as the possibility of imminent death approaches.

"Spiritual Alienation, as evidenced by expressions of loneliness, or the feeling that God seems very far away and remote from one's everyday life; verbalization that one has to depend upon oneself in times of trial or need; and/or a negative attitude toward receiving any comfort or help from God" (O'Brien, 1982a, p. 106). Often, a chronically ill person expresses frustration in terms of closeness to God during sickness; the comment may be heard: "Where is God when I need Him most?"

"Spiritual Anxiety, as evidenced by an expression of fear of God's wrath and punishment; fear that God might not take care of one, either immediately or in the future; and/or worry that God is displeased with one's behavior" (O'Brien, 1982a, p. 106). Some cultural groups entertain a concept, although not held by all members of the culture, that illness may be a "punishment" from God for real or imagined faults or failures.

"Spiritual Guilt, as evidenced by expressions suggesting that one has failed to do the things which he or she should have done in life, and/or done things which were not pleasing to God; articulation of concerns about the 'kind' of life one has lived" (O'Brien, 1982a, p. 106). Certain individuals, especially those schooled in more fundamentalist religious traditions, experience "guilt" related to their perceived failure to follow God's will, as they understand it. This "guilt" frequently is exacerbated during times of physical or psychological illness.

"Spiritual Anger, as evidenced by expressions of frustration, anguish or outrage at God for having allowed illness or other trials; comments about the 'unfairness' of God; and/or negative remarks about institutionalized religion and its ministers or spiritual caregivers" (O'Brien, 1982a, p. 107). Family members of those who are ill may express anger at God for allowing a loved one to suffer.

"Spiritual Loss, as evidenced by expression of feelings of having temporarily lost or terminated the love of God; fear that one's relationship with God has been threatened; and/or a feeling of emptiness with regard to spiritual things" (O'Brien, 1982a, p. 107). A sense of "spiritual loss" may frequently be associated with psychological depression; for an individual who feels useless and powerless, there may also be a resultant feeling of alienation from anything or any person perceived as good, such as God.

"Spiritual Despair, as evidenced by expressions suggesting that there is no hope of ever having a relationship with God, or of pleasing Him; and/or a feeling that God no longer can or does care for one" (O'Brien, 1982a, p. 107). Although spiritual despair is generally rare among believers, such a diagnosis may be associated with serious psychiatric disorders. If such thoughts or feeling are expressed by a patient, the nurse needs to be alerted, also, to the potential for suicidal ideation or possible behavior.

► Spirituality and Nursing Research

Although clinical nursing research efforts in the area of spirituality and nursing practice have not been extensive, some nurse investigators have addressed the spiritual needs of particular patient groups. Examples include Soeken and Carson (1987), "Responding to the Spiritual Needs of the Chronically Ill"; Clifford and Gruca (1987), "Facilitating

Spiritual Care in the Rehabilitation Setting”; Reed (1991), “Preferences for Spiritually Related Nursing Interventions Among Terminally Ill and Nonterminally Ill Hospitalized Adults and Well Adults”; Toth (1992), “Faith in Recovery: Spiritual Support After an Acute M.I.”; Highfield (1992), “Spiritual Health of Oncology Patients”; Mickley, Soeken, and Belcher (1992), “Spiritual Well-Being, Religiousness, and Hope Among Women with Breast Cancer”; Harris et al. (1995), “The Role of Religion in Heart-Transplant Recipients’ Long-Term Health and Well-Being”; Smith (1995), “Power and Spirituality in Polio Survivors: A Study Based on Roger’s Science”; Twibell, Wieseke, Marine, and Schoger (1996), “Spiritual and Coping Needs of Critically Ill Patients: Validation of Nursing Diagnoses”; and Post-White et al. (1996), “Hope, Spirituality, Sense of Coherence, and Quality of Life in Patients with Cancer.”

Nursing studies, especially those in the arena of chronic illness, have frequently included the concepts of spirituality, religion, and/or religiosity (religious practice) as key variables in a larger matrix. Some examples include the author’s research with chronic renal failure patients, migrant farmworkers, nursing home residents, and persons living with HIV infection and AIDS. Brief examples of the studies are described here; more detailed qualitative data elicited in the research can illustrate instances of spiritual need and spiritual care.

Study Title: Religious Faith and Adaptation to Maintenance Hemodialysis

The purpose of this study was to examine the relationship between religious faith and adaptation to chronic renal failure (CRF) and its treatment regimen of maintenance hemodialysis. The religious faith question represented one variable in a multivariate study of adaptation to renal disease and dialysis. The study subjects consisted of 126 adult hemodialysis patients who were interviewed first to obtain baseline data and again in a three-year follow-up, when 63 of the original sample were identified (O’Brien, 1982c, p. 75).

Study Title: Spirituality and Health Beliefs and Practices of Migrant Farmworkers

The research consisted of an exploratory descriptive qualitative study of the overall health attitudes and behaviors of a sample group of Mexican American migrant farmworkers. Central to the study was an examination of the spirituality and religious beliefs of the population, as related to health/illness beliefs and practices. The methods of data collection were observation and focused interview. During the three-month data collection phase of the study, the investigator attended many of the group’s religious services and rituals, including weekly Spanish Masses, evening Mass in migrant camps, Baptisms, First Communion services, a Mass of departure as the migrants moved from one work setting to another, and a “coming of age” religious service for a teenage girl. The author visited several Mexican American religious shrines and interviewed three practitioners of folk religion/medicine. Focused interviews were also conducted with 125 adult migrant workers in three Midwestern states (O’Brien, 1982b, p. 13).

Study Title: Spiritual Beliefs and Behaviors of the Institutionalized Elderly

The purpose of this exploratory case study, conducted over a two-year period, was to examine and describe the overall institutional nursing home setting, as well as the patterns of attitude and behavior exhibited by the residents, family members, medical and nursing caregivers, and ancillary staff. A key variable of interest was spirituality, or the spiritual perceptions, attitudes, behaviors, and needs of the residents. The nursing home studied was a 230-bed residential facility that provided three levels of care: skilled, semiskilled, and domiciliary. The author collected data by means of direct and participant observation, as well as through focused interviews with staff, family members, and 71 alert and cognitively aware residents (62 women and 9 men). Variables of particular interest related to the spiritual/religious attitudes, experiences, and practices of the residents. Selected data on religion and spirituality are presented as excerpted from verbatim interview transcripts (O'Brien, 1989, p. 47).

Study Title: Religious Faith and Living with HIV Infection

Personal faith beliefs, as well as the support of an individual's church group or religious denomination, were examined in a study of coping response in HIV infection. The overall aim of the longitudinal project was to establish a database of physical, psychosocial, and spiritual needs associated with HIV infection, from which appropriate caregiving strategies could be derived. The study population consisted initially of 133 men and 3 women, all of whom were categorized within the CDC IV classification: "Constitutional Disease, Secondary Infections, Secondary Cancers, or Other Conditions Related to HIV Infection." A number had diagnoses of AIDS. A subgroup of 41 men with HIV/AIDS was followed over a five-year period, as long-term survivors of the infection. Data were collected by both quantitative (interview schedule) and qualitative (tape-recorded focused interview) measures. Data on the relationship of religion and spirituality revealed the importance of personal faith beliefs and church affiliation in coping with HIV (O'Brien, 1992, 1995).

Although not all nurses may or must feel comfortable in providing spiritual care, the assessment of a patient's spiritual needs is a professional responsibility. Contemporary holistic health care mandates attention to the problems and concerns of the spirit as well as to those of the body and mind. In carrying out an assessment of the patient's spiritual well-being, a nurse may glean information important to supporting the medical and nursing therapies planned for the ill person. Following a spiritual assessment, appropriate spiritual or religious interventions may be provided either by the nurse or through referral to a designated pastoral caregiver.

► References

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- Ameling, A., & Povilonis, M. (2001). Spirituality, meaning, mental health and nursing. *Journal of Psychosocial Nursing & Mental Health Services*, 39(4), 15–20.
- Barker, E. (1979). Whose service is perfect freedom. In D. O. Moberg (Ed.), *Spiritual well-being: Sociological perspectives* (pp. 153–171). Washington, DC: University Press of America.

- Blaber, M., Jones, J., & Willis, D. (2015). Spiritual care: Which is the best assessment tool? *Journal of Palliative Nursing*, 21(9), 430–438.
- Blaikie, N. W., & Kelson, G. P. (1979). Locating self and giving meaning to existence. In D. O. Moberg (Ed.), *Spiritual well-being: Sociological perspectives* (pp. 133–151). Washington, DC: University Press of America.
- Brennan, M. R. (1994). *Spirituality in the homebound elderly* (Unpublished doctoral dissertation). The Catholic University of America. Ann Arbor, MI.
- Brush, B. L., & Daly, P. R. (2000). Assessing spirituality in primary care practice: Is there time? *Clinical Excellence for Nurse Practitioners*, 4(2), 67–71.
- Burkhart, L., Schmidt, L., & Hogan, N. (2011). Development and psychometric testing of the spiritual care inventory. *Journal of Advanced Nursing*, 67(11), 2463–2472.
- Campbell, C. (1978). *Nursing diagnosis and intervention in nursing practice*. New York, NY: Wiley.
- Cavendish, R., Luise, B. K., Horne, K., Bauer, M., Medefindt, J., Gallo, M. A., . . . Kutza, T. (2000). Opportunities for enhanced spirituality relevant to well adults. *Nursing Diagnosis*, 11(4), 151–163.
- Christy, R. D., & Lyon, D. (1979). Sociological perspectives on personhood. In D. O. Moberg (Ed.), *Spiritual well-being: Sociological perspectives* (pp. 91–98). Washington, DC: University Press of America.
- Clark, C. C., Cross, J. R., Deane, D. M., & Lowry, L. W. (1991). Spirituality: Integral to quality care. *Holistic Nursing Process*, 3(1), 67–76.
- Clark, P., Drain, M., & Malone, M. (2003). Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety*, 29(12), 659–670.
- Clifford, M., & Gruca, J. (1987). Facilitating spiritual care in the rehabilitation setting. *Rehabilitation Nursing*, 12(6), 331–333.
- Dameron, C. (2005). Spiritual assessment made easy . . . with acronyms. *Journal of Christian Nursing*, 22(1), 14–16.
- Dossey, B. M. (1989). The transpersonal self and states of consciousness. In B. M. Dossey, L. Keegan, L. G. Kolkmeier, & C. E. Guzzetta (Eds.), *Holistic health promotion* (pp. 23–35). Rockville, MD: Aspen.
- Driscoll, J. (2003). HIPAA: Calling the question. *Vision*, 13(5), 4–5.
- Droege, T. (1991). *The faith factor in healing*. Philadelphia, PA: Trinity Press International.
- Engelbreton, J. (1996). Considerations in diagnosing in the spiritual domain. *Nursing Diagnosis*, 7(3), 100–107.
- Fatula, M. A. (1993). Faith. In M. Downey (Ed.), *The new dictionary of Catholic spirituality* (pp. 379–390). Collegeville, MN: The Liturgical Press.
- Fowler, J. W. (1981). *Stages of faith development*. New York, NY: HarperCollins.
- Galek, K., Flannelly, K., Vane, A., & Galek, R. (2005). Assessing a patient's spiritual needs: A comprehensive instrument. *Holistic Nursing Practice*, 19(2), 62–69.
- Gebbie, K. M. (1976). *Summary of the second national conference, classification of nursing diagnoses*. St. Louis, MO: C. V. Mosby.
- Gebbie, K. M., & Lavin, M. A. (1975). *Classification of nursing diagnoses, proceeds of the first national conference*. St. Louis, MO: C. V. Mosby.
- Govier, I. (2000). Spiritual care in nursing: A systematic approach. *Nursing Standard*, 14(17), 32–36.
- Harris, R. C., Dew, M. A., Lee, A., Amaya, M., Bushes, L., Rettz, D., & Coleman, G. (1995). The role of religion in heart-transplant recipients' long-term health and well-being. *Journal of Religion and Health*, 34(1), 17–32.
- Haugan, G. (2014). The FACIT-SP spiritual well-being scale: An investigation of the dimensionality, reliability and construct validity in a cognitively intact nursing home population. *Scandinavian Journal of Caring*, 29(1), 152–164.

- Highfield, M. (1992). Spiritual health of oncology patients. *Cancer Nursing, 15*(1), 1–8.
- Hodge, D. R. (2013). Administering a two-stage assessment in healthcare settings: A necessary component of ethical and effective care. *Journal of Nursing Management, 23*(1), 37–38.
- Hodge, D. R. (2006). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. *Social Work, 51*(4), 317–326.
- Holloway, N. M. (1993). *Medical surgical care planning* (2nd ed.). Springhouse, PA: Springhouse Corporation.
- Hsiao, Y., Chiang, Y., Lee, H., & Han, C. (2013). Psychometric testing of the properties of the Spiritual Health Care Scale Short Form. *Journal of Clinical Nursing, 22*(21/22), 2981–2990.
- Hungelmann, J., Kenkel-Rossi, E., Klassen, L., & Stollenwerk, R. (1996). Focus on spiritual well-being: Harmonious interconnectedness of mind-body-spirit—Use of the JAREL spiritual well-being scale. *Geriatric Nursing, 17*(6), 262–266.
- Johnson, R. P. (1992). *Body, mind, spirit: Trapping the healing power within you*. Liguori, MO: Liguori.
- Joint Commission. (2003). *Comprehensive accreditation annual for hospitals: The official handbook*. Oakbrook Terrace, IL: The Joint Commission.
- Joint Commission. (2008). *Standards FAQ details: Spiritual assessment*. Retrieved from http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=290&ProgramId=1
- Kaufman, J. H. (1979). Social correlates of spiritual maturity among North American Mennonites. In D. O. Moberg (Ed.), *Spiritual well-being: Sociological perspectives* (pp. 237–254). Washington, DC: University of America Press.
- Kerrigan, R., & Harkulich, J. T. (1993). A spiritual tool. *Health Progress, 74*(5), 46–49.
- Kreitzer, M. J., Gross, C., Waleekhachonloet, O., Reilly-Spong, M., & Byrd, M. (2009). The brief serenity scale: A psychometric analysis of a measure of spirituality and well-being. *Journal of Holistic Nursing, 27*(1), 7–16.
- LaPierre, L. (2003). JCAHO safeguards spiritual care. *Holistic Nursing Practice, 17*(4), 219.
- Lindberg, J. B., Hunter, M. L., & Kruszewski, A. Z. (1994). *Introduction to nursing: Concepts, issues and opportunities*. Philadelphia, PA: J. B. Lippincott.
- Lutheran Services in America. (2004, July). Intersections of HIPPA and pastoral care. *Q & A, Lutheran Services in America Newsletter, 1*.
- Mickley, J., Soeken, K., & Belcher, A. (1992). Spiritual well-being, religiousness and hope among women with breast cancer. *Image, 24*(4), 267–272.
- Moberg, D. O. (Ed.). (1979). The development of social indicators of spiritual well-being and quality of life. In *Spiritual well-being: Sociological perspectives* (pp. 1–13). Washington, DC: University of America Press.
- North American Nursing Diagnosis Association (NANDA). (1994). *NANDA, nursing diagnoses: Definitions and classification, 1995–1996*. Philadelphia, PA: Author.
- Nouwen, H. J. M. (1986). *Reaching out*. New York, NY: Doubleday.
- O'Brien, M. E. (1982a). The need for spiritual integrity. In H. Yura & M. Walsh (Eds.), *Human needs and the nursing process* (Vol. 2, pp. 82–115). Norwalk, CT: Appleton-Century-Crofts.
- O'Brien, M. E. (1982b, April). Pragmatic survivalism: Behavior patterns affecting low level wellness among minority group members. *Advances in Nursing Science, 4*(3), 13–26.
- O'Brien, M. E. (1982c). Religious faith and adjustment to long-term hemodialysis. *Journal of Religion and Health, 21*(1), 68–80.
- O'Brien, M. E. (1989). *Anatomy of a nursing home: A new view of resident life*. Owings Mills, MD: National Health Publishing.
- O'Brien, M. E. (1992). *Living with HIV: Experiment in courage*. Westport, CT: Auburn House.

- O'Brien, M. E. (1995). *The AIDS challenge: Breaking through the boundaries*. Westport, CT: Auburn House.
- O'Brien, M. E., & Pfeifer, W. G. (1993). Nursing care of persons infected with HIV. In M. Maas, K. Buckwalter, & M. Titler (Eds.), *Nursing clinics of North America*, 23(2), 303–315.
- Pesut, B., Fowler, M., Reimer-Kirkham, S., Taylor, E., & Sawatzky, R. (2009). Particularizing spirituality in points of tension: Enriching the discourse. *Nursing Inquiry*, 16(4), 337–346.
- Post-White, J., Ceronsky, C., Kreitzer, M. J., Nickelson, K., Drew, D., Mackey, K. W., . . . & Gutknecht, S. (1996). Hope, spirituality, sense of coherence, and quality of life in patients with cancer. *Oncology Nursing Forum*, 23(10), 1571–1579.
- Power, J. (2006). Spiritual assessment: Developing an assessment tool. *Nursing Older People*, 18(2), 16–18.
- Puchalski, C. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine*, 3(1), 129–137.
- Reed, P. G. (1991). Preferences for spiritually related nursing interventions among terminally ill and nonterminally ill hospitalized adults and well adults. *Applied Nursing Research*, 4(3), 122–128.
- Sanders, C. (2002). Challenges for spiritual care-giving in the millennium. *Contemporary Nurse*, 12(2), 107.
- Sessanna, L., Finnell, D., Underhill, M., Chang, Y., & Peng, H. (2011). Measures assessing spirituality as more than religiosity: A methodological review of nursing and health-related literature. *Journal of Advanced Nursing*, 67(8), 1677–1694.
- Smith, D. W. (1995). Power and spirituality in polio survivors: A study based on Roger's science. *Nursing Science Quarterly*, 8(3), 133–139.
- Smyth, T., & Allen, S. (2001). Nurses' experiences assessing the spirituality of terminally ill patients in acute clinical practice. *International Journal of Palliative Care Nursing*, 17(7), 337–343.
- Soeken, K., & Carson, V. B. (1987). Responding to the spiritual needs of the chronically ill. *Nursing Clinics of North America*, 22(3), 603–611.
- Stark, R., & Glock, C. (1968). *American piety: The nature of religious commitment*. Berkeley, CA: University of California Press.
- Stoll, R. I. (1979). Guidelines for spiritual assessment. *American Journal of Nursing*, 79(9), 1574–1577.
- Tanyi, R. A. (2006). Spirituality and family nursing: Spiritual assessment and interventions for families. *Journal of Advanced Nursing*, 53(3), 287–294.
- Taylor, E. J. (2013). New Zealand hospice nurses' self-rated comfort in conducting spiritual assessment. *International Journal of Palliative Nursing*, 19(4), 178–185.
- Taylor, C., Lillis, C., & LeMone, P. (1993). *Fundamentals of nursing: The art and science of nursing care* (2nd ed.). Philadelphia, PA: J. B. Lippincott.
- Timmins, R., & Kelly, J. (2008). Spiritual assessment in intensive and cardiac care nursing. *Nursing in Critical Care*, 13(3), 124–131.
- Toth, J. C. (1992). Faith in recovery: Spiritual support after an acute M.I. *Journal of Christian Nursing*, 9(4), 28–31.
- Twibell, R. S., Wieseke, A. W., Marine, M., & Schoger, J. (1996). Spiritual and coping needs of critically ill patients: Validation of nursing diagnoses. *Dimensions of Critical Care Nursing*, 15(5), 245–253.
- White, L. (2003). Pastoral care providers are members of the health care team in accordance with the regulations of the Department of Health and Human Services. *APC News*, 6(1), 1–2.
- White, L., & Pierce, R. (2002a). HIPPA regulations raise questions for chaplains. *APC (Association of Professional Chaplains) News*, 5(1), 1–2.
- White, L., & Pierce, R. (2002b). HIPPA regulations impact on visitation by clergy, lay ministers and faith group representatives. *APC News*, 5(3), 1–2.
- Young, C., & Koopsen, C. (2011). *Spirituality, health and healing: An integrative approach*. Sudbury, MA: Jones & Bartlett Learning.