

Nursing spiritual assessment instruments in adult patients: a narrative literature review

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Abstract. *Background and aim of the work:* Spiritual care in nursing is a critical part of providing holistic care. Whilst patients might desire spiritual care and value the opportunities that nurses take to engage with them to meet their spiritual needs, research suggests that nurses do not consistently engage in spiritual care with their patients. To identify instruments available to nurses to assess spirituality in different patient groups and highlight the characteristics and psychometric properties of these instruments. *Method:* A narrative literature review of the relevant literature published after 2008 was carried out in CINAHL, PsycINFO, MEDLINE and Google scholar databases in October 2020. Narrative review synthesized key findings and grouped instruments into macro areas by content. *Results:* After the screening, based on inclusion criteria, 31 articles were identified. 17 instruments were identified and divided into 4 macro areas: wellbeing (N = 4), attitude (N = 5) needs (N = 6) and multiple domains (N = 2). *Conclusions:* This review enables an increased awareness of the variety of instruments available to aid spiritual care and therefore increase their use within nurse clinical practice. The widening of the patient group to be considered (i.e., non-oncological) may have a significant impact on the practice, causing professionals to reflect on the necessity to investigate spiritual needs even at an early stage of a disease process. Future studies should aim to test reliability and validity of existing instruments rather than develop further ones. (www.actabiomedica.it)

Key words: spirituality, spiritual assessment, nursing, oncological patients, spiritual needs, narrative review, instruments

Introduction

There is much debate within the research literature on how spirituality and religiosity can be defined (1; 2). For example, Puchalski, Vitillo, Hull and Reller (3) describe spirituality as a concept incorporating the seeking of meaning, purpose and transcendence, in relation to the self, to others and expressing this spirituality through beliefs, practices and traditions. Similarly, a recent concept analysis identifies three common elements within spirituality: 'Transcendence'; 'Connectedness to others, nature or a higher power'; and 'Meaning in life' (4). These elements also

feature in the eight domains of spirituality identified by the World Health Organisation (WHO) in its international measure of spiritual wellbeing (5). These domains include: connectedness to a spiritual being or force; meaning of life; awe, wholeness and integration; spiritual strength; inner peace/serenity/harmony; hope and optimism, and faith. It becomes apparent therefore that spirituality is a highly individualized phenomenon with variations depending upon the individual's culture and view of the world (6).

Regardless of the conceptualization or definition of spirituality, spiritual wellbeing has been associated with a variety of health and wellbeing benefits includ-

ing a greater tolerance of physical and emotional stress and management of illness (7), lower levels of anxiety and pain (8) as well as lower risk of suicide and depression (7). Subsequently, the spiritual part of life is recognized internationally as having an important role to play in health, well-being and quality of life (5; 9; 10; 11). As such, spiritual care features within health-care policy and guidance internationally (12), including in relation to the provision of nursing care (13; 14; 15), which is recognized by many professional nursing organizations e.g. The Nursing and Midwifery Council (NMC) The American Nurses Association (ANA) and the International Council of Nurses. Numerous patients benefit have been observed coming from spiritual care provision as an improved assessment and care for terminally ill patients of disease (16), facilitating a more rapid recovery (17) as well as reduced levels of spiritual distress (18). Subsequently, if patients' spiritual needs are not met, there is an increased risk of adverse psychological outcomes including a reduction in quality of life, increased risk of developing depression and a reduction in the perception of spiritual peace (19). Nurses are in an ideal position to assist patients with spiritual care due to their close working with patients throughout the day (20). However, whilst patients might desire assistance with spiritual care (21) and value the opportunities that nurses take to engage with them to meet their spiritual needs (22) research suggests that nurses do not consistently engage in spiritual care with their patients or assess their spiritual needs (23; 24).

Reasons for the inconsistent provision of spiritual care for patients are likely to be varied and multifaceted, but there is suggestion that many professionals often feel underprepared, lacking both skill and confidence in this area (2; 25; 26). There is also said to be confusion amongst nurses over their role in spiritual care provision (27; 28). Student and qualified nurses are aware of the importance of providing spiritual care and are hindered by a lack of education about how best to implement such care. It has been suggested that the religiosity of individual nurses or their training institutions seems to be of less importance than training in spiritual care interventions (24). In keeping with this there is suggestion that advances of medical technology throughout the 20th century have led to an in-

creased focus on scientific and technical skills within nursing care (29) with some authors suggesting that spiritual care is regarded as low on the list of patient needs (30). Notably a lack of agreed definition over spirituality and a lack of clear explanation of spiritual distress can contribute nurses not providing spiritual care (31). It has been proposed that all staff should be able to provide patients with a basic level of spiritual support and care (30). It is vitally important then to operationalize spirituality in order to identify all of the patient's needs and assess the effectiveness of care. To achieve this, it is necessary to identify the instruments available for use with patients in order to assess their spirituality and identify factors that may influence their spiritual wellbeing. Therefore, to improve the precision of assessment, new scales are being developed by different research groups. Knowing how these questionnaires are made, their strengths and weaknesses, and their theoretical bases can provide the groundwork for creating future measures and revising existing ones if applicable (33).

Aims

The review aims to collect the most recent and scientifically validated instruments to assess adult patients' spirituality, in order to create a manageable database of instruments that can be used according to different patients' individual needs.

Rather than merely identifying available instruments for spiritual assessment, we feel it is important to establish the reliability and validity of instruments that assess spirituality, as it is noted that instruments that have an empirical basis are more likely to result in measures that accurately and reliably represent the area of interest and decrease the likelihood of author biases (34).

The objectives of the review were to: I) Identify instruments used to measure spiritual constructs in different categories of patients; II) Categorize these instruments according to different spiritual measures; III) Highlight instruments' characteristics and psychometric properties.

Method

Design and search methods

A narrative review was carried out. The searches were conducted using CINAHL, PsycINFO, MEDLINE and Google scholar databases, using various combinations of the following keywords: “spirituality OR spiritual Well-Being” AND “tools OR measures OR assessment OR instruments OR scales” AND “nursing OR holistic care”. In addition, titles and abstracts were searched in PubMed for spirituality or spiritual well-being to ensure a comprehensive retrieval of citations for studies not caught by the MeSH search for spirituality. The database search strategy followed a standardized format designed for MEDLINE and adapted for the other databases used. The search was conducted in October 2020.

Quality appraisal

To be included in the review, articles had to meet the following criteria which formed the review protocol: (1) were published in peer-reviewed journals; (2) written in English; (3) published between 2008–2020; (4) consider spirituality assessment, spiritual needs and spiritual care; (5) concerning “patients” or “nurse(s)”; (6) with consideration of an adult population.

Titles and abstracts were viewed: the appropriate articles reviewed, and the inappropriate were discarded. Appropriate articles had the measures used noted and any other appropriate measures which were outlined in the article were noted down and followed up via reference list. These instruments were then considered for their suitability for the assessment of spiritual patient needs or behaviours or issues related to the spirituality of nurses (which may therefore impact upon the spiritual care of patients). Where original reliability measures (e.g. Cronbach alpha) were not given within the original study searches were made for the use of the scale in other articles to obtain indicative measures.

Data abstraction

Three reviewers independently extracted data using a pre-designed table. Descriptive variables were

compiled, which included the year of publication, country of origin and study type. The measure was described (number of items and definition of dimensions) and the applicability norms were noted. The following data were extracted from each instrument: name, aims, macro area according to content, mode of rating, number of items, target population, dimensions of items, and psychometric properties.

Synthesis

A descriptive analysis and synthesis of the results was conducted in order to describe each instrument. We divided instruments into macro areas according to their content and highlighted the characteristics and psychometric properties of each. The synthesis of these results is presented in Table 1.

Results

17 scales were identified inherent to the evaluation of patients’ spirituality. Since the scales can measure different facets of spirituality according to their underlying paradigm, we divided them into macro areas according to their content. The areas are: Wellbeing (W; N=4), Attitude (A; N=5), and Needs (N; N=6). One additional section outlines Qualitative Tools assessing multiple domains (QT; N=2). Finally, an exhaustive summary of the scales psychometric properties is reported at the end of the results section, in Table 1.

(1) The AMEN (Affirm, Meet, Educate, No Matter What; 35) is a conversational protocol that aims to help providers to remain engaged with patients and their families during challenging conversations that involve patients’ religious beliefs in response to a poor prognosis. It guides the conversation in order to make it collaborative rather than adversarial. In doing so, it reportedly helps to preserve the patient’s hope, dignity and faith whilst also explaining the medical issues. The four dimensions guide the provider in: Affirming the patient’s belief (Affirm); Meeting the patient or family member where they are (Meet); Educating from their role as a medical provider (Educate); Assuring the patient and family you are committed to them (No matter what).

(2) The Brief Serenity Scale (36) is a shorter version of the original 44 item Serenity Scale, developed in the work with patients who have survived organ failure and subsequent organ transplantation and face chronic health problems. The scale is formed of items most strongly related to the underlying concept of se-

renity, conceptualised as the spiritual experience of inner peace that is independent of external events. This 22-item brief version includes all of the items from the largest of Roberts and Aspy's original factors (37), except Belonging, Contentment or Cognitive Restructuring.

Table 1. Description and psychometric properties of the scales

N.	Instrument	Macro Area	Mode of rating	N items	Target populations	Domains / dimensions	Scale – categorical, rating / scale, n of points / yes, no	Psychometric properties – alpha
1	Affirm, Meet, Educate, No Matter What (AMEN) (Cooper, Ferguson, Bodurtha & Smith, 2014).	QT	Interview	4 items	Oncology patients and relatives	Affirm the patient's belief; Meet the patient or family member where they are; Educate from your role as a medical provider; No matter what; assure the patient and family you are committed to them	N/A	N/A
2	Brief Serenity Scale (Kreitzer, Gross, Walekhachonloet, Reilly-Spong & Byrd, 2009)	A	Survey	22 items	Organ transplant patients	Inner Haven Trust Acceptance	5-points Likert scale	Overall .95 Inner Haven .94 Trust .88 Acceptance .89
3	The Elders' Spiritual Health Scale (ESHS) (Ajamzibada, Foroughanb, Shahboulaghic, Rafieyd & Rassoulie, 2019)	W	Survey	20 items	Elder patients	Spiritual Belief Centricity of God Altruism Spiritual contact Purposefulness of life	5-points Likert scale	Overall .89 Lowest .70 Highest .84
4	Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being (FACIT-Sp), (Peterman, Fitchett, Brady, Hernandez & Cella, 2002).	W	Survey	12 items	Cancer patient	Meaning, Peace, and Faith	5-points Likert scale	Overall .87 Meaning .78 Peace .83 Faith .84

(continued)

Table 1 (continued). Description and psychometric properties of the scales

N.	Instrument	Macro Area	Mode of rating	N items	Target populations	Domains / dimensions	Scale – categorical, rating / scale, n of points / yes, no	Psychometric properties – alpha
5	The FICA Spiritual History Tool (Kra-kowiak & Fopka-Kowalczyk, 2015).	QT	Interview	4 main items	Patients	F – Faith and Be-lief – assessing types of beliefs and faiths patient holds I – Importance, - how important is spirituality to them C – Community – if they are part of a spiri-tual community and exploring this A – Address in Care – how to address these needs in patient care	N/A	N/A
6	GES Questionnaire (Benito, Oliver, Galiana, Barreto, Pascual, Gomis, & Barbero, 2014).	A	Survey	8 items	Palliative care pa-tients	Intrapersonalspiritual-ity Interpersonalspiritual-ity Transpersonalspiritu-ality	Likert scale	Overall .72
7	The South Afri-can Spirituality Scale (SASS)(van Rensburg, 2020)	A	Survey	32 items	South African population	Beyond Awareness Meaning Others Journey Connection	5-points Likert Scale	All subscales > .7
8	Spiritual Attitude and Involvement List (SAIL; Meezenbroek, Garssen, van den Berg, Tuytel, van Dierendonck, Visser & Schaufeli, 2011)	A	Survey	26 items	Cancer patients	Meaningfulness Trust Acceptance Caring for others Connectedness with nature Transcendent Experi-ences Spiritual Activities	6-point Likert scale	Subscales ranging from .73 to .86

(continued)

Table 1 (continued). Description and psychometric properties of the scales

N.	Instrument	Macro Area	Mode of rating	N items	Target populations	Domains / dimensions	Scale – categorical, rating / scale, n of points / yes, no	Psychometric properties – alpha
9	Spiritual Care Needs Inventory (SCNI; Wu, Koo, Liao, Chen & Yeh, 2016).	N	Survey	21 items	Acute care hospital patients	Meaning and hope Caring and respect	5-point Likert scale	Meaning and hope .96 Caring and respect .91
10	The Spirituality Instrument-27© (SpI-27©)(Weathers, Coffey, McSherry & McCarthy, 2020)	N	Survey	27 items	Chronic illness patients	Connectedness with others Self-Transcendence Self-Cognisance Conservationism Connectedness with a Higher Power	5-point Likert scale	Overall .90 Subscales ranging from .82 to .91
11	The Spiritual Needs Assessment for Patients (SNAP) (Sharma, Astrow, Texeira & Sulmasy, 2012)	N	Survey	23 items	Cancer patients	Psychosocial needs Spiritual needs Religious needs	4-point Likert scale	Overall .96 Subscales ranging from .74 to .93
12	The Spiritual Needs Inventory (SNI; Hermann, 2006)	N	Survey	17 items	Hospice cancerous dying patients	Outlook, Inspiration, Spiritual Activities, Religion, Community	5-point Likert scale	Overall .85
13	Spiritual Interests Related to Illness Tool (SpIRIT; Taylor, 2006)	A	Survey	42 items	White Christian Cancer patients and caregivers	Needing positive perspective, Needing relationship with God, Giving love to others, Receiving love from others Reviewing beliefs Finding Meaning Practicing religion Preparing for death	5-point Likert scale	Overall .95 Subscales ranging from .76 to .96

(continued)

Table 1 (continued). Description and psychometric properties of the scales

N.	Instrument	Macro Area	Mode of rating	N items	Target populations	Domains / dimensions	Scale – categorical, rating / scale, n of points / yes, no	Psychometric properties – alpha
14	Spiritual Needs Questionnaire (SpNQ; Büssing, Balzat & Heusser, 2010)	N	Survey	19 items	Patients	Religious needs Existential needs Inner peace Actively giving	4-point Likert scale	Overall .93 Subscales ranging from .74 to .88
15	Spiritual Need Scale (SNS; Yong , Kim , Han & Puchalski, 2008)	N	Survey	26 items	Korean hospitalized patients	Love and connection Hope and peace Meaning and purpose Relationship with God Acceptance of dying	5-point Likert scale	Overall .92
16	Thai Spiritual Well-being Assessment Tool for Elders with Chronic Illnesses (TSWBATECI) (Unsanit, Sunsern, Kunsongkeit, O'Brien & McMullen, 2012).	W	Survey	41 items	chronically ill elders	Happiness in life Acceptance of chronic illness Life equilibrium Passion for life Self-transcendence Optimistic personality Purpose in life Willingness to forgive	5-point Likert scale	Overall .97
17	The Spiritual well-being subscale of the Quality of Life-Cancer Survivor (QOL-CS) measure (Ferrell, Hassey, & Grant, 1995).	W	Survey	6 items	Breast and gynaecological cancer patients	Salience of spirituality and religion	10-point Likert scale	Overall .8

Legend: QT= Qualitative tool; A=Attitude; W= Wellbeing; N=Needs

Confirmatory Factor Analysis revealed 3 distinct factors: Acceptance (10 items) e.g. “I accept situations that I cannot change”; “I am forgiving of myself for past mistakes”; Inner Haven (8 items) e.g. “I am aware of inner peace”; “I am aware of an inner source of comfort, strength, and security”; Trust (4 items) e.g.

“I see the good in painful events that have happened to me”; “I trust that everything happens as it should”. Items are measured on a 5-point response scale which ranges from 1 (never) to 5 (always). Internal consistency was high (Cronbach’s alpha = .95). According to the authors, The Brief Serenity Scale may capture a

dimension of spirituality - a state of acceptance, inner haven and trust - that is distinct from other spirituality instruments that tap more into spiritual values or religious beliefs, orientation and practices. The instrument can be empirically used to measure whether spiritual interventions offered by nurses to patients (e.g., prayer, meditation, reading of spiritual texts) contribute to a state of inner peace. It is an easily administered instrument and the brevity of this version is such that it will not contribute to participant burden. Therefore, this instrument may complement other instruments of spiritual health and well-being as well as serve as a unique and distinct measure of the outcomes of spiritual care.

(3) The Elders' Spiritual Health Scale (ESHS; 38), intends to measure the level of spiritual health of elder patients. It was developed and validated on Iranian population. The ESHS consists of 20 items and 5 sub-scales comprising: Spiritual belief (5 items); Centricity of God (5 items); Altruism (4 items); Spiritual conduct (4 items); Purposefulness of life (2 items). No examples of the items were available in the validation study. This scale has good internal consistency (0.89) and the highest internal consistency coefficient (0.84) is related to the sub-scale "centricity of God", and the lowest (0.70) is related to "spiritual conduct".

(4) The Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp; 39), intends to provide an inclusive measure of spirituality applicable in research with people who have chronic and/or life-threatening illnesses, and to describe aspects of spirituality and/or faith that contribute to well-being with content not limited to any one religious or spiritual tradition. Translated and linguistically validated in 14 languages, the FACIT-Sp-12 comprises two subscales—one measuring a sense of Meaning and Peace (8 items) e.g. "I feel peaceful"; "I have trouble feeling peace of mind"; and the other assessing the role of Faith in illness (4 items) e.g. "I find comfort in my faith or spiritual beliefs"; "I find strength in my faith or spiritual beliefs". It also produces a total score for spiritual well-being. However, Haugan (40) noted that a 3-factor-construct version (where the subscales of meaning and peace constitute

distinct factors) is psychometrically superior. It consists of 12 items rated on a 5-point Likert type scale. Internal consistency was high (Overall = .87; Meaning = .78; Peace = .83; Faith = .84). It is considered to be the most well-validated instrument for the assessment of a patient's current spiritual state (41).

(5) The FICA Spiritual History Tool (42) is designed for the evaluation of spiritual experience of persons at the end of their life. FICA is a qualitative scale in the form of an open questionnaire which allows individuals to freely answer questions about their beliefs, spirituality, and the importance of spiritual beliefs in dealing with the situation of the disease. Four subscales are presented in the form of open questions:

- F – Faith and Belief – assessing types of beliefs and faiths patient holds: "Do you consider yourself spiritual or religious?" or "Is spirituality something important to you" or "Do you have spiritual beliefs that help you cope with stress/ difficult times?" (Contextualize to reason for visit if it is not the routine history). If the patient responds "No," the health care provider might ask, "What gives your life meaning?"
- I – Importance - how important is spirituality to them: "What importance does your spirituality have in our life? Has your spirituality influenced how you take care of yourself, your health?"
- C – Community – if they are part of a spiritual community and exploring this: "Are you part of a spiritual community?" Communities such as churches, temples, or a group of like-minded friends, family. "Is this of support to you and how?"
- A – Address in Care – how to address these needs in patient care: "How would you like me, your healthcare provider, to address these issues in your healthcare?"

(6) SECPAL Spirituality Group Questionnaire (Grupo de Espiritualidad de la SECPAL (GES) Questionnaire; 43), is designed to assess spiritual resources and needs. It was formulated from a task force comprising physicians, nurses, psychologists, social workers, theologians, anthropologists, and volunteers. The GES Questionnaire comprises six open questions

to facilitate the patient's trusting revelation of his/her biography and inner world, followed by eight items assessing spirituality as a general factor and the three spirituality dimensions: Intrapersonal, Interpersonal, and Transpersonal. It has been validated on a sample of one hundred and eight Spanish patients with cancer. The confirmatory Factor Analysis confirmed the three-factor model. The questionnaire is available in English and Spanish.

(7) The South African Spirituality Scale (SASS; 44), intends to assess spirituality in clinical settings across the heterogeneous spectrum of South African cultural, religious and faith traditions. It was validated on a sample of University students in South Africa. It is composed of 32 items equally distributed on six factors: Beyond (8 items) e.g. "I am aware of a reality beyond my everyday existence"; Awareness (6 items) e.g. "I am aware of my thoughts about everyday life experiences"; Meaning (6 items) e.g. "I understand the meaning of my everyday existence"; Others (4 items) e.g. "I am aware of my personal relation to the significant other person(s) in my life"; Journey (5 items) e.g. "I make sense of challenging life situations"; Connection (3 items) e.g. "I am connected to my physical environment". The internal consistency for each of the scales, examined using Cronbach's alpha, is adequate with all alphas > .7.

(8) The Spiritual Attitude and Involvement List (SAIL; 45) assesses spirituality amongst both those who are religious and those who are not, via 7 subscales represented by 26 items: Meaningfulness (3 items) e.g. "I know what position is in life", "I experience the things I do as meaningful"; Trust (4 items) e.g. "I approach the world with trust", "In difficult times, I maintain my inner peace"; Acceptance (4 items) e.g. "I accept that I am not in full control of the course of my life"; Caring for Others (4 items) e.g. "It is important to me that I can do things for others"; Connectedness with Nature (2 items) e.g. "When I am in nature, I feel a strong sense of connection"; Transcendent Experiences (5 items) e.g. "I have had experiences in which all things seemed to be part of a greater whole"; Spiritual Activities (4 items) e.g. "There is a God or higher power in my life that gives me guidance". Each item

is scored on a range from 1 to 6. The scale was developed over a series of phases and tested with a variety of populations including students, adults with and without a spiritual orientation, as well as curatively treated cancer patients and palliative cancer patients. Good psychometric properties are reported across numerous populations.

(9) The Spiritual Care Needs Inventory (SCNI; 46; in 33), is designed to assess spiritual care needs in acute care hospital patients with different religious beliefs and validated on 1,351 adult acute care patients in a medical Centre in Taiwan. The SCNI principal components analysis revealed two components: "Meaning and hope" and "Caring and respect", which together accounted for 66.2% of the total variance. In the subscales patients indicated if these aspects were 'not needed at all' to 'strongly needed' on a 5 points response scale. Meaning and hope (14 items) contains items as 'Guidance to being at peace with the world' 'Guidance to use art and creativity for self-expression; Caring and respect (7 items) contains items as 'Supporting and reassuring me' 'Interacting with me (e.g., chat, talking)'.

(10) The Spirituality Instrument-27© (SpI-27©; 47), intends to measure a set of mixed needs of religious and non-religious people. It was validated on a population of 249 individuals with chronic illness via web. It consists of 27 items composing 5 dimensions: Connectedness with others (9 items) e.g. "I have a general sense of belonging e.g. to society, to the world"; Self-Transcendence (9 items) e.g. "I am able to accept death as a part of life"; Self-Cognition (4 items) e.g. "I try to understand who I am"; Conservationism (3 items) e.g. "I am concerned about the earth being destroyed"; Connectedness with a Higher Power (2 items) e.g. "I pray to a Higher Power if something is bothering me". Cronbach's alpha coefficients ranged from 0.823 to 0.911 for the five factors, and 0.904 for the overall scale.

(11) The Spiritual Needs Assessment for Patients (SNAP) (48; in 33), is designed to identify unmet spiritual needs in cancer patients. It was developed from literature review, clinical and pastoral evaluation, and

cognitive pre-testing. It was validated in ambulatory oncology clinics which serve a wide mix of different ethnic groups including Orthodox, Catholics, African Americans, and recent immigrants from China, the Middle East, Poland, Russia, Mexico, and the Caribbean. All of the participants were English speakers. The SNAP covers: Psychosocial needs (5 items) e.g. 'Getting in touch with other patients with similar illnesses?'; Spiritual needs (13 items) e.g. 'Finding meaning in your experience of illness?'; Religious needs (5 items) e.g. 'Visits from clergy of your faith community'. Responses were categorized on the following ordinal scale: 'very much,' 'somewhat,' 'not very much,' and 'not at all.'

(12) The Spiritual Needs Inventory (SNI; 49; in 33), is an instrument designed to assess spiritual needs of patients near the end of life. The items were developed from a qualitative study on spiritual needs of dying patients. A principal component factor analysis with a promax oblique rotation identified a five-factor solution. The SNI describes 17 needs as activities, thoughts, or experiences (e.g. 'In order to live my life fully I need to: Sing/listen to inspirational music'), rating of these items (Never, Rarely, Sometimes, Frequently, Always). Respondents then indicated whether they considered this activity to be a spiritual need (Yes / No) and 'Is this need being met in your life now?' (Yes/ No). Items cover Outlook (5 items) e.g. 'Laugh'; 'Think happy thoughts'; Inspiration (4 items) e.g. 'Sing/listen to music'; 'Talk with someone about religious/spiritual issues'; Spiritual Activities (3 items) e.g. 'Read inspirational material'; 'Use phrases from a religious text'; Religion (2 items) 'Pray'; 'Go to religious services'; Community (3 items) e.g. 'Be with family'; 'Have information about family and friends'.

(13) The Spiritual Interests Related to Illness Tool (SpIRIT; in 33; 50), is intended to measure spiritual needs. 42 items were clustered together in 8 categories and given 5-point Likert response options (1 = not at all through 5 = a great deal): Needing positive perspective (6 item), e.g. "Tell others about the good things in my life"; Needing relationship with God (6 items) e.g. "Get right with God"; Giving love to others (5 items) e.g. "Have my/my loved one's nurse help me satisfy

these spiritual interests"; Receiving love from others (4 items) e.g. "Be with others I consider to be family"; Reviewing beliefs (5 items) e.g. "Think about whether my beliefs about God are correct"; Finding meaning (7 item) e.g. "Try to make life count"; Practicing religion (6 items) e.g. "Have quiet time to reflect or meditate"; Preparing for death (4 items) e.g. "Make sure my/my loved one's personal business is in order". This instrument was formulated in the USA considering the spiritual needs of both patients with a cancer diagnosis and their caregivers. The measure is a self-report instrument with questions focused on "how important is it now to..." and ended with "how important is it to have my (or my love one's) nurse help me to satisfy these spiritual interests?"

(14) The Spiritual Needs Questionnaire (SpNQ; 51; in 52) is a 19-item scale appropriate for use with adults who have chronic disease. All items were scored with respect to the self-ascribed importance on a 4-point scale from disagreement to agreement (0 - not at all; 1 - somewhat; 2 - very; 3 - extremely). It assesses four primary dimensions 'Religious Needs', 'Existential Needs', 'Inner Peace' and 'Actively Giving'. Via its use of non-exclusive religious terminology, it is appropriate for a variety of faith types. A factor analysis gives a Cronbach alpha of .93, with the four factors explaining 37% of the variance amongst patients with chronic pain conditions or cancer. The 'Religious Needs' domain (6 items) e.g. "someone prays for you", "pray with someone", considered aspects such as prayer either with others or alone, or participation at a religious ceremony. The 'need for Inner Peace' domain (5 items) e.g. "talk with others about my fears and worries" considered several areas including discussing fears and anxieties with others, the need to spend prolonged periods of time in places of quietness and peace as well as finding inner peace. The 'Existential Needs' domain (5 items) e.g. "find meaning in illness and/or suffering", "dissolve open aspects of your life" and was reflective in nature considering meaning in life and of suffering, as well as considering the possibility of life after death. The 'Actively Giving' domain (3 items) e.g. "turn to someone in a loving attitude", "solace someone" considered providing solace to another as well as receiving support from others.

(15) The Spiritual Need Scale (SNS; 53; in 33) was originally developed in Korea, and devised to assess the spiritual needs of patients experiencing cancer. This 26 item, 5 point Likert scale (from 1=not at all to 5=a great deal) assessed five domains: 'Love and connection' (2 items) e.g. "to talk to someone who will listen to me"; 'Hope and peace' (5 items) e.g. "to have hope despite my current pain"; 'Meaning and purpose' (7 items); 'Relationship with God' (5 items) e.g. "to participate in religious rituals and service"; 'Acceptance of dying' (7 items) e.g. "To be in charge of my life in the face of death.". 'Love and connection' represented a need for a person to listen and for a person who cares to be present, whilst 'Hope and peace', considered the needs patients held around understanding, forgiveness and peace as well as the types of needs patients have for understanding their future life. 'Relationship with God' covered various aspects of interaction with God and activities that enabled this interaction e.g. reading of scriptures. 'Meaning and purpose' considered items such as attempting to understand why one should go through the period of illness. 'Acceptance of dying' involved a variety of aspects related to dying such as behaviours associated with the acceptance of death, their emotional response to death and their reflections on dying. This measure was formed following literature reviewing and interviews with patients and reports a reliability of 0.92, with factor analysis revealing that these five factors accounted for 62.9% of the variance.

(16) The Thai Spiritual Well-being Assessment Tool for Elders with Chronic Illnesses (TSWBATE-CI) (54), is designed to assess spiritual well-being as a form of dynamic energy bringing meaning and direction to the individual, considering its role in helping chronically ill elderly deal with health care issues. It was developed from qualitative data obtained via literature review, focus groups and individual interviews with elders with chronic illnesses, of Buddhist, Islamic or Christian faith. The final confirmatory factor analysis identified an eight factor model: 'Happiness in life' (7 items) e.g. "Your life is perfect and you don't need anything else"; 'Acceptance of chronic illness' (6 items) e.g. "You feel angry when you suffer from the symptoms and effects of your chronic illness"; 'Life equilibrium' (5 items) e.g. "You can live with conflict"; 'Pas-

sion for life' (6 items) e.g. "Life is valuable; you want to keep it even though you experience suffering from your chronic illness"; 'Self-transcendence' (5 items) e.g. "You like doing anything for the sufferer/beggar"; 'Optimistic personality' (5 items) e.g. "Your chronic illness helps to make you understand the truth and nature of life"; 'A purpose in life' (4 items) e.g. "Doing more good things"; 'Willingness to forgive' (3 items) e.g. "Your chronic illness makes you forgive yourself for your mistakes". A five-point rating scale was developed to measure the level agreement/disagreement with each item. The description and scores for the possible responses ranged from: 0 = "Strongly disagree" to 4 = "Strongly agree."

(17) The Spiritual well-being subscale of the Quality of Life-Cancer Survivor (QOL-CS) measure (55; in 56), is a monofactorial survey formed of 6 items intended for use with patients who have cancer. Respondents rate themselves along an interval rating scale ranging from 0 (not at all important) to 10 (very important) for each item. The spirituality facet of the quality of life scale considers the salience of both spirituality and religion with good psychometric properties. It was originally employed with 686 cancer survivors, with the spirituality scale test-retest reliability of 0.90.

Discussion

Within contemporary healthcare, the World Health Organisation (WHO) recognizes that human well-being is formed of a balance of emotional, mental, physical, social and spiritual states. Equilibrium in these states reportedly permits the individual to reach and maintain their personal potential in life. Spiritual care is increasingly recognized as a fundamental part of nursing care and is assessed via a variety of instruments. This review identified seventeen scales intended to assess the spiritual needs of patients. These instruments were divided into macro areas according to their content: wellbeing (N= 4), attitude (N= 5), and needs (N =6). One additional section contained qualitative tools assessing different domains (N =2). This division is important because the grouping of the scales accord-

ing to their content allows the practitioner to choose the appropriate instrument according to patient need. However, spiritual evaluation must also consider physical, psychological, emotional, social and cultural components. This article presents the psychometric properties of the seventeen scales studied: all of them were found to hold good levels of reliability. It was observed that the Thai Spiritual Well-being Assessment Tool for Elders with Chronic Illnesses (TSWBATECI) reported the highest psychometric results. This measure assessed spiritual wellbeing, defined as a form of dynamic energy bringing meaning and direction to the individual, through the 8 domains listed above. TSWBATECI therefore appears to be a valid instrument for assessing spiritual well-being of elderly Thais with chronic illnesses. However, because the culture of aging in Thailand likely differs from Western cultures, this scale does not necessarily incorporate the spiritual needs of individuals within Western culture. Selman et al., (57) for example note how spirituality is often culture specific.

A review of the measures of spiritual issues in palliative care patients by Vivat (58) identified the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (FACIT-Sp) as the only instrument that had been validated cross-culturally (cited in 57).

Finally, even though the FACIT-Sp does not have the highest psychometric properties, up to date it seems to be the best instrument to assess spirituality in a transversal population.

The other instrument we highlighted here, also if they have good or even better psychometric properties when compared to FACIT-Sp, seem to fit only specific target populations or in terms of culture and religion, or in terms of age.

These instruments could, then, be used when dealing with patients that perfectly fit the target identified by the instrument.

Because of the methodological limitations in the search strategy within our review, a number of instruments may have been missed: only two search terms were used in database searches ("cancer" and "spiritu*"), and no other methods were used in the search strategy to identify relevant instruments. For this reason, further research into validation of spiritual instruments in diverse cultural contexts is needed. Development

of spiritual scales must take into account the different traditional religions and spirituality that is not expressed in religious categories. One construct can be measured by different factors in different cultures and because of cultural differences and the relationship between spiritual needs and culture, it is recommended that questionnaires are designed to be culture-specific (56). Furthermore, depending on the culture in which the questionnaire is used, the priority of needs may change. It is always necessary to re-evaluate the ways to meet spiritual needs, to make them personalized and adaptable to the patient. We suggest that evaluation instruments alone are not the best way to assess a patient's needs. Therefore, active listening is an important role of the nurse, emphasising the importance of training in the recognition and assessment of spiritual needs. We also maintain that an in-depth study is needed to take into consideration the spiritual questions and concerns not only of patients, but also of caregivers, including nurses, because of their important influence on the patients that they care for.

Conclusion

In this review we intended to offer nurses an in-depth study of the latest assessment scales of spirituality for their patients, highlighting the content and psychometric properties of these instruments. In the analysis of the scales reported in the review, we have observed that the instruments are formed and used according to specific cultural and ethnic contexts. This review leads us to suggest that future studies should focus on the perception of the need for spirituality in different cultures and ethnic groups, to then enable the adaptation of the measurement instruments, and to test the reliability and validity of existing instruments in different cultural contexts. We also believe that it is necessary to consider the spirituality of professionals and caregivers (which also links closely to culture and ethnicity) to take into account the spiritual issues and concerns of caregivers, due to their important influence on the spiritual dimension of the patient.

The measures outlined above provide a series of relevant implications for health professionals. Whilst this review did not aim to analyse ways of using the

spirituality assessment scales, we believe that the first and perhaps most important clinical implication is that these scales may provide practical support for the delivery of spiritual care and assessment. We anticipate that this review will enable an increased awareness of the variety of instruments that are available to aid spiritual care and therefore increase their use within clinical practice. We hope that via increased awareness of these instruments nurses are able to identify the ones that are most suitable for their individual practice based on the patient's clinical presentation, the patient's culture and ethnicity, and ultimately the unique needs and desires of each patient.

Since spiritual care has been identified in the literature as a vital aspect of a good nursing care, we hope that this contribution will assist professionals to become more aware of their expertise and attitude towards spirituality, and to request, if necessary, specific training in this area.

It is interesting to note that even though most of the scales we found consider patients who have cancer and patients reaching the end of life, we have also identified in the literature instruments that evaluate the spiritual dimension in non-oncological patients and those not necessarily in the end of life phase. We believe that this widening of the patient group to be considered may have a significant impact on the practice of spiritual care provision, causing professionals to reflect on the necessity to investigate spiritual needs even at an early stage of a disease process.

Furthermore, there is evidence within the scientific literature that health professionals may experience reluctance to provide spiritual care to their patients, or even to underestimate the patient's need for spirituality. We hope that the use of these scales can reduce the perception of difficulty in assessing a patient's spiritual needs.

Conflict of interest: Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article

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