Spiritual Care and Nursing: A Nurse's Contribution and Practice

HealthCare Chaplaincy Network™

SPIRITUAL CARE ASSOCIATION
Making Spiritual Care a Priority

CONTRIBUTORS

Rev. Brian P. Hughes, BCC, MDiv, MS
Chaplaincy Advocate, Researcher, and Consultant
HealthCare Chaplaincy Network

Cristy DeGregory, Ph.D., RN
Gerontologist
Clinical Assistant Professor
College of Nursing
University of South Carolina

Ronit Elk, Ph.D.
Co-Director, Palliative Care Initiative
Research Associate Professor
College of Nursing
University of South Carolina

Dennis Graham Ph.D., RN, ANP-BC
Adjunct Assistant Professor of Nursing
Barbara H. Hagan School of Nursing
Molloy College

Rev. Eric J. Hall, MDiv
President and CEO
HealthCare Chaplaincy Network
Spiritual Care Association

Judith Ressallat, RN, MSN, MPA

The close ties between spiritual motivations and the nursing field are demonstrated throughout the history of nursing.[1] During the European Middle Ages, nursing became popular as a vocation and cultural position for women and men[2], thanks in large part to the actions of the Catholic Church.[3] The Christian priests, nuns and sisters considered charity—working for the poor and infirm—as a mandate of their faith, and were consequently leaders in providing this care. It was both the ideal of acts of service and the association of nurses with the religious that formed the context within which modern nursing evolved.

Florence Nightingale is considered the mother of modern nursing. Many know her history of providing care to the wounded during the Crimean War, helping dramatically reduce infection rates by introducing basic hygiene in the wards near the frontlines. She ultimately became an advocate for compassionate care for the suffering throughout Europe, where she was consulted by kings, queens, and even the president of the U.S. Though at the time not deeply religious, on February 7, 1837, at age 17, she nevertheless experienced a kind of religious calling, which she attributed to God calling her to future service.[4] "Her religion gave her a strong sense of moral duty to help the poor and, over time, she held a growing belief that nursing was her God-given vocation."[5] She sought to find a way of service that echoed the charitable hospital work of the religious sisters she knew from her youth.[6] "One can argue, based on nursing's founder Florence Nightingale's statements in Notes on Nursing, that caring for the whole person—including one's spiritual needs—has been at the heart of the nursing discipline since its founding."[7] The "deep comfort" she sought to provide" emerges from Presence,"[8] a reference both to the divine presence of God with the suffering, as well as the embodiment a nurse can and should provide in caring for those who are ill.

Dame Cicely Saunders, "the mother of hospice care," was a nurse, social worker, physician and writer for whom religious faith was a central motivation as well. Living in England in the 1960s, and informed by the experience of the deaths of several of her patients and her own father, she sought to best understand how to care for those who were dying, which she saw as part of the life cycle, and, thus, part of life. She observed in one meaningful patient encounter that, "as the body becomes weaker, so the spirit becomes stronger."[9] In 1967, her own Christian faith inspired her to open, over the objections of many within the medical community, St. Christopher's—considered to be the first hospice. It helped to bridge teaching, clinical research, pain and symptom control, and compassionate care. Her creed of "living while dying" allowed for families to spend time with the dying, for pain to be controlled by medicines and discontinuation of painful treatments intended merely to prolong life, and prioritizing meaning making, spiritual and religious care, and life review.[10]

Nursing has long been associated with spirituality and meaning making, with alleviating suffering and healing if not curing. Many nurses understand their role to be caring for their "patients in their entirety and given their individuality . . . [and] in this meeting, in this area with those who are vulnerable and in pain, nurses can and must find space to achieve the spiritual care."[11] However, nurses often feel underequipped to provide spiritual care, struggle to articulate a functional or "actionable" definition of spirituality, and are "uncertain about what constitutes spiritual care."[12,13] Nurses often state that they consider spirituality to be important in the care of their patients, yet receive little formal training in the provision of spiritual care, mostly experience disincentives once they begin work clinically due to time constraints, and feel unprepared to do so as a result.[14,15,16,17,18,19,20,21]

Compassionate caring is central to good nursing care. Nursing can be understood as having a spiritual base to it, regardless of one's own religious affiliation or involvement, or that of the patients and families a nurse serves. Providing patient- and family-engaged care,[22] meaningful care means the patient is more than the diagnosis or prognosis, more than "the liver in room 315." A family photo on a patient's bedside table reminds the nurse that the "liver" comes surrounded by a living, breathing, broken, hopeful, scared, and scarred body of a person who has a mother and a father, perhaps some siblings or children or other family or friends, a vocation he or she considers important, and both struggles and victories that the person experiences and hopes to return to beyond this encounter. That patient in room 315 has fears, anxiety and hopes, and is seeking to make meaning in the midst of what is most likely an unplanned and unwelcome interruption to daily life, with all of the intense drama that goes with that the person's health care journey. And the nurse is often the one with whom this patient spends the majority of time while in the health care setting.

When it comes to nursing, what is spiritual care? What can a nurse do to address the spiritual needs of a patient or family member? How is spirituality the same or different from religion, and what does a nurse do if the spirituality or religion of the individual differs significantly from his or her own spirituality or religion? When should a nurse refer a patient or family to a professional chaplain to provide in-depth spiritual care, versus being equipped and confident to address the spiritual issues the patient or family presents? Is it ever ok to pray with a patient, or to share the nurse's own faith and religious resources? These questions are all central to the discussion of spirituality and nursing care in the health care context, and will be discussed in this white paper.

> Nursing has long been associated with spirituality and meaning making, with alleviating suffering and healing if not curing.

DEFINITIONS

Within the nursing literature, interest in spirituality has increased exponentially in the last several decades. For example, on the literature review site PubMed, in the decade 1982-1991, there were merely seven articles addressing "spirituality & nursing," while in 2001-2011, there were 401. The same site showed only three articles for "religion & nursing" between 1982-1992, while it found 491 between 2001-2011.[23] Yet even with such a proliferation of articles seeking to address spirituality and religion within the context of the nursing literature, there has not been a consensus definition reached within the field. A concept analysis looking at spirituality in nursing found that there were four main themes: "(a) spirituality as religious systems of beliefs and values (spirituality = religion); (b) spiritual as life meaning, purpose, and connection with others; (c) spirituality as nonreligious systems of beliefs and values; and (d) spirituality as metaphysical or transcendental phenomena."[24] Another recent concept analysis led to a nursing definition of spirituality as "a way of being in the world in which a person feels a sense of connectedness to self, others, and/or a higher power or nature; a sense of meaning in life; and transcendence beyond self, everyday living, and suffering."[25] Reinert & Koenig, in looking at definitions of spirituality within the literature published between 2001-2011, found no fewer than 20 different definitions, with varying degrees of conflation of spirituality, religion, and mental health issues and language.[26] It is imperative to be clear about definitions as we begin our discussion about spiritual care and nursing within health care.[27]

"The biomedical model is not enough for understanding and caring for patients' suffering. Therefore, the perspective needs to be widened through a more open vision that includes our spiritual dimension."[28] While we will be using the definition for spirituality described below for the baseline of this paper, from within the nursing field literature, the closest definition to the one we will adopt for this paper is "a complex phenomenon that is part of the inner self, a connection with the outer self that includes the natural environment in which we live, and the connecting with a higher being."[29] An interdisciplinary panel of experts from around the world, representing medical,

psychological, and spiritual care providers, offered this consensus definition of spirituality, that we will use as baseline for the purposes of this paper: "Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices."[30] For many, this can be distilled down to, "What is it that helps me make meaning in my life?" or "What gives me purpose?" and "How do I experience relationships?"

This definition of spirituality is not the same as religion. Religion is defined as "a subset of spirituality, encompassing a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the sacred, the divine, God (in Western cultures), or ultimate truth, reality, or nirvana (in Eastern cultures)."[31] Religion may well be one way in which people express their spirituality, but it is not the only way. Religion, as opposed to spirituality, is more focused on systems or social institutions of people who share beliefs or values.[32] Research shows that clinical staff, including nurses, often conflate spirituality and religion.[33] Especially in the predominantly Christian West, it is important to recognize that not all people are religiously Christian, and many may well express their spirituality through a variety of different, and even disparate, religious means. "For example, people may find spiritual connections in relationships, in nature, or in a set of beliefs (such as the scientific method), and yet may not belong to a community of faith or institutional religious system."[34]

Specific to this paper, we will focus on spirituality as it is discussed within the field of health care, broadly defined as "the field concerned with the maintenance or restoration of health of the body or mind."[35] When we discuss spirituality, we are typically discussing the spirituality of the patient and the family, not the spirituality of the nurse or other health care professionals. We will discuss the nurse's own spirituality below, but this distinction is important to make now.

Health care is evolving to become explicitly patient- and family-engaged care. The National Academy of Medicine describes this as "care planned, delivered, managed, and continuously improved in active partnership with patients and their families (or care partners as defined by the patient) to ensure integration of their health and health care goals, preferences and values. It includes explicit and partnered determination of goals and care options, and it requires ongoing assessment of the care match with patient goals."[36] As Rev. Eric J. Hall describes it, "The patient is the source of control for their care. The care is customized, encourages patient participation and empowerment, and reflects the patient's needs, values and choices. Transparency between providers and patients, as well as between providers, is required. Families and friends are considered an essential part of the care team."[37] As such, one of the primary ethical principles in providing spiritual care to patients and families is the ethic of patient autonomy, from which the ideal of patient- and family-engaged care evolved. The spirituality of the patient and family should always be primary, not the spirituality or religion of the nurse (or the chaplain or any other health care provider).[38] Because of the power differential between the patient and nurse, it is never acceptable for a nurse, or any health care profession, including the professional chaplain, to proselytize or seek to convert a patient or family to his or her own religious or spiritual beliefs. Instead, the nurse should always seek to help empower the patient and family to discover their own spiritual and religious resources, and how those resources can help them in this time of crisis. This is true even when the faith of the patient is different from the faith of the nurse.[39] This demonstrates hospitality (note the root word – hospital) and respect for all spiritual and religious traditions. If the nurse encounters a situation where the levels of difference between the nurse and patient in religion, spirituality or culture are extreme to the point that the nurse does not feel equipped to address the spiritual needs of the patient, then the nurse should refer this patient to a spiritual care specialist, such as a board certified chaplain.

"Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices."

SPIRITUAL WELL-BEING

As the numbers of studies comparing decades of research demonstrate, the topic of spirituality has increasingly become a focus throughout health care. In the 2016 meeting of the American Medical Association's House of Delegates, referencing recent research demonstrating the positive impact the provision of spiritual care provides for both cost of care and patient satisfaction, physician leaders adopted a new policy "recognizing the importance of individual patient spirituality and its effect on health. Delegates also encouraged giving patients access to spiritual care services."[40] Patients and families prioritize spirituality within health care settings.[41] Studies have shown that 87 percent of patients call spirituality important in their lives,[42] whereas between 51 and 77 percent consider religion to be a high priority.[43,44] In one multi-institutional study, researchers found that "the majority of patients (77.9 percent), physicians (71.6 percent), and nurses (85.1 percent) believed that routine spiritual care would have a positive impact on patients."[45] "Since 1998, emotional and spiritual needs have ranked second on the National Inpatient Priority Index, a composite ranking of hospital performance and patient importance compiled from surveys of approximately 1.4 million patients."[46,47]

An international team of interprofessional thought leaders on spiritual care developed the following statements, identifying what health care professionals should know about spiritual care within health care:
1. "Spiritual care should be integral to any compassionate and patient [and family] centered health care system model of care.
2. Spiritual care models should be based on honoring the dignity of all people and on providing compassionate care.
3. Spiritual distress or religious struggle should be treated with the same intent and urgency as treatment for pain or any other medical or social problem.
4. Spirituality should be considered a patient vital sign. Just as pain is screened routinely, so should spiritual issues be a part of routine care. Institutional policies for spiritual history and screening must be integrated into intake policies and ongoing assessment of care.
5. Spiritual care models should be interdisciplinary and clinical settings should have a Clinical Pastoral Education-trained board certified chaplain as part of the interprofessional team."[48]

> Studies also reveal there is a strong positive relationship between spirituality and overall health and well-being.

Studies also reveal there is a strong positive relationship between spirituality and overall health and well-being.[49] The research relating to spirituality is best discussed on a continuum, from spiritual well-being (also called spiritual resilience) on the healthy end of the spectrum, through spiritual concerns, risk for spiritual distress, and spiritual distress/struggle to spiritual despair at the unhealthy end.[50,51] The Spiritual Well-Being Scale (FACIT-Sp) is one of the most utilized instruments in assessing this within the research, but does not translate well to the clinical setting.[52] We will discuss screening and assessing for spiritual distress more in depth below. NANDA International (NANDA-I), the international nursing diagnosis association, defines spiritual distress as "a state of suffering related to the impaired ability to experience meaning in life through connections with self, others, the world, or a superior being."[53] NANDA-I then continues by defining a patient who is at risk for spiritual distress as being "vulnerable to an impaired ability to experience and integrate meaning and purpose in life through connectedness within self, literature, nature, and/or a power greater than oneself, which may compromise health."[54] When a patient or family member is experiencing spiritual distress, that person's capacity for meaning making and coping in a healthy way with the intensity of the health care journey is compromised. That person's overall well-being and health can then be threatened.[55]

The prevalence of spiritual distress depends on the patient population being assessed: 28 percent of cancer inpatients,[56] 40.8 percent of cancer patients undergoing chemotherapy,[57] and even 65 percent of older inpatients[58] have been assessed as

experiencing spiritual distress. This means that many patients will be wrestling with meaning making or finding a purpose, most especially in relationship to their new or ongoing health care struggles. This may mean patients or families are having to redefine their understandings, assumptions and beliefs about themselves, mortality, God, the Divine or religion. In studies across a range of clinical settings, patients have reported they have struggles and needs of a spiritual nature.[59,60,61,62] Despite these many consistent findings, in one major study 72 percent of patients reported that they received little to no spiritual support from anyone on the clinical team.[63]

The clinical impact of spiritual distress also merits attention. Studies show that spiritual distress often has a negative impact on a patient's health. People who score higher for spiritual distress are more likely to experience pain, more likely to be depressed,[64] be at a higher risk of suicide,[65] have more clinically-impactful anxiety,[66] and have higher resting heart rates.[67] One research team summarized that "research indicates that spiritual struggles . . . are associated with greater psychological distress and diminished levels of well-being."[68]

At the other end of the spirituality continuum is spiritual well-being, defined as "an assertion of life in relationship with God, the self, others, the community, and the environment that nurtures and celebrates wholeness. People who appreciate spiritual well-being tend to feel alive, purposeful and satisfied."[69] "The World Health Organization (WHO) announced that a person's health needs should include spiritual well-being in addition to physical, mental and social domains."[70] Specific to nursing, NANDA-I defines readiness for enhanced spiritual well-being as: "A pattern of experiencing and integrating meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/ or a power greater than oneself, which can be strengthened."[71] We will discuss potential ways nurses can assess, diagnose, plan, implement and evaluate patients all along the spirituality continuum.

The provision, or lack thereof, of spiritual support to patients can have a strong impact on their overall health and well-being.[72] "For a large proportion of either medically ill or mental health patients, spirituality/religion may provide coping resources, enhance pain management, improve surgical outcomes, protect against depression, and reduce risk of substance abuse and suicide."[73] For example, a robust Dana-Farber Cancer Institute study demonstrates that patients who did not receive spiritual support spent less than a week on hospice, and were more likely to die while continuing to receive aggressive medical care in the critical care unit (ICU) when compared with patients who did receive spiritual support.[74] Another study from Memorial Sloan Kettering Cancer Center, this one of 3,585 hospitals, reveals that the provision of chaplaincy services is correlated with both lower death rates and higher hospice enrollment.[75] Several recent studies have also shown the potential positive impact of spiritual care on pain severity.[76,77] Patients and families can utilize spirituality as a positive and constructive coping strategy, with religious rituals, meditation, prayer and mindfulness among the various spiritual resources that can potentially be of use in helping patients cope with the intensity of their pain and suffering.

Providing proactive spiritual care to patients has been proven to have a positive impact on not just clinical outcomes and cost, but also patient satisfaction.[78] One recent study of more than 9,000 patients and families at Mount Sinai Hospital concludes that patients are more likely to recommend the hospital (according to both Press Ganey scores, one of the most well-known and respected patient satisfaction survey companies; and the Centers for Medicare and Medicaid's survey, called Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS).[79] Press Ganey's research, from more than 2 million patients in its worldwide database, demonstrates that the single most unmet need as it relates to overall patient satisfaction with the care a patient receives in a hospital is that the "staff addressed my emotional and spiritual needs."[80]

Finally, a recent study conducted by the University of Chicago-Pritzer School of Medicine finds that when spiritual issues of both patients and families are addressed, this positively impacts not only patient satisfaction, but it also serves to raise the trust patients and families express in the medical team providing them with care.[81] This trust can then, in turn, positively impact compliance, communication and collaboration between the clinical team and the patient and family – most concretely in plan of care and end-of-life family-physician conferences. Another study demonstrates that not only does patient satisfaction suffer when spiritual needs go unmet, but so does the patient's and family's satisfaction with the quality of the overall care received.[82]

SPIRITUAL CARE GENERALISTS AND SPECIALISTS

Though every health care professional, including nurses, can and should provide some basic levels of spiritual care, most are not well trained in the provision of spiritual care, and even fewer are comfortable attempting to do so.[83,84] In acute care health care today, spirituality is often glossed over as tangential to clinical care unless the patient is nearing the end of life; then, evidence has led clinicians in palliative care and hospice to prioritize spirituality, making it one of the foundational aspects of palliative and hospice care. One of the goals of this paper is to encourage nurses and other health care professionals to better integrate spiritual care into the entire spectrum of acute care, farther upstream from palliative care and end-of- life involvement. Most patients and families do not anticipate in-depth, specialized spiritual care from their nurses, but they do have a strong expectation for some basic spiritual care, including interventions such as active and empathic listening, proactively communicating, and expressing compassion.[85] A high percentage of patients have expressed a desire for their health care providers, including their nurses, to ask about and potentially discuss or address spiritual and religious concerns and issues.[86,87,88]

> Most patients and families do not anticipate in-depth, specialized spiritual care from their nurses, but they do have a strong expectation for some basic spiritual care, including interventions such as active and empathic listening, proactively communicating, and expressing compassion.

One of the most important discussions concerning spiritual care within nursing practice and health care in general is not just how to provide spiritual care, but who should provide it. Within medicine, there are both generalists and specialists. Rev. George Handzo states, "Every physician is taught something about cardiology, certainly including how to assess and at least preliminarily diagnose cardiac issues. The general internist will also be able to treat some number of these issues, especially in their less severe forms, without referring to a cardiologist. However, at some point for some patients, a referral will be necessary."[89] This same paradigm should also exist for spiritual care. Handzo and Harold Koenig, M.D., argue that health care needs both spiritual care generalists – physicians, nurses, social workers, etc. – as well as spiritual care specialists – board certified chaplains (BCCs).[90] Just as with the medical model, the spiritual care generalist—the nurse for the sake of this paper—is responsible for screening for spiritual concerns, as well as potentially taking a spiritual history, providing some basic spiritual care as needed, and then making appropriate referrals to the spiritual care specialist when more in-depth spiritual care is deemed necessary.[91]

It is important to be able to identify and differentiate the roles of the spiritual care generalist, often the health care provider working with a patient and family, and the role of the spiritual care specialist, the professional chaplain. For example, the professional chaplain may well note that a patient is in physical pain, and share this information with the bedside nurse or physician following a visit. But the chaplain does not seek to medically or pharmacologically address the pain, as this is beyond the scope of his or her spiritual care practice. So, too, a nurse can and should note that a patient is in spiritual distress, and refer that patient to the board certified chaplain for ongoing spiritual assessment and support, but should not be the primary person seeking to address spiritual distress.

SPIRITUAL CARE SCREENS, HISTORIES AND ASSESSMENTS

It can be helpful to view a model that helps visualize the interprofessional team as it relates to the spiritual needs of the patient and family. This diagram illustrates the flow in the health care setting of spiritual care for a patient and family, beginning with the spiritual screen upon admission, followed by the spiritual history, and then assessment as needed, all of which lead to a treatment plan and constructive outcomes. This is the team-approach to the assess, diagnosis, plan, implement, evaluate process commonly used in nursing. It is important to note the potential overlap in the role of the nurse, physician, and social worker, and the admissions personnel as it pertains to spiritual care.
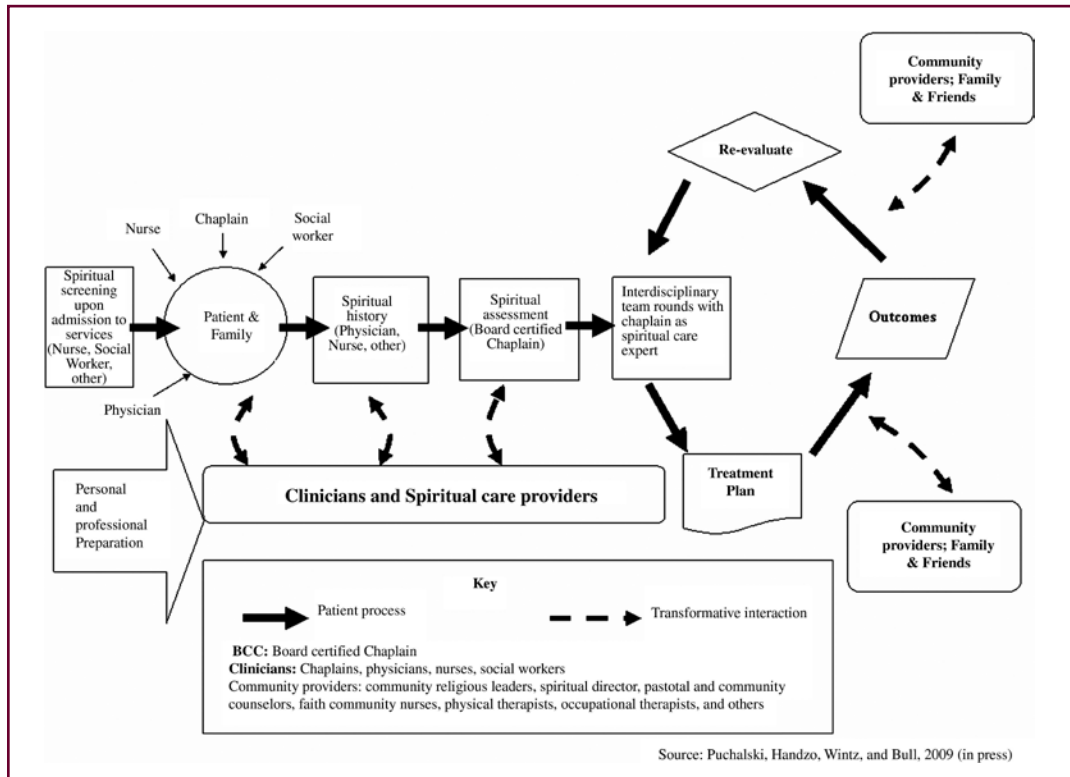
(above image from [92])

There are three distinct tools for health care providers to contribute to providing well-integrated spiritual care: the spiritual screen, the spiritual history, and the spiritual assessment. A different member of the clinical team will likely provide each, depending on the system within which one works. Though many organizations have various iterations of the three spiritual care tools and who uses each in the clinical setting, best practice is for an institution to have each tool distinct yet integrated. The nurse (and in other instances, the social worker or admissions personnel) performs the spiritual screen as a part of the nursing assessment done upon arrival to the unit within the electronic medical record, which gives the capability of triggering reports and referrals to the professional chaplain. Then the physician (and in some situations, the nurse or social worker) completes a spiritual history within the initial history and physical exam upon admission. And, when needed or referred, the board certified chaplain then provides an in-depth, expert spiritual assessment to address spiritual distress and other spiritual or religious needs of the patient and family—needs that have come to light through the spiritual screen and/or spiritual history. Many nurses will work within an institution that does not have each of these spiritual tools and processes, let alone the ownership of each, clearly differentiated and integrated. In this case, education, communication, and proactive discussion of the different tools and how they function within the system are essential. For example, when one organization recently recognized that the religious affiliation information about

patients was consistently inaccurate, upon doing a root cause analysis, it found that the omissions and errors for the majority of the patients were a result of a small percentage of the admissions personnel not following proper protocols and procedures. With some education and accountability, this process shifted from a liability to a strength for the institution.

Specifically, many institutions ask a question that is often assumed to be a spiritual care screen, but in reality create potential problems: the question at admission, "Would you like to see a chaplain?" The difficulty with this question is two-fold. The first is a result of the assumptions people bring when they hear the job title "chaplain." Many people assume a chaplain is there to help with death or specific religious rituals often associated with end of life and/or a specific religious tradition. Chaplains can and do provide much more in-depth and sophisticated care than only those functions, and this question creates the possibility that a patient's false assumptions about a chaplain's role may well create a missed opportunity for addressing a patient's spiritual distress. The second problem is that it creates a gatekeeping question, potentially preventing the chaplain from visiting the patient if that person had initially declined. As a patient's prognosis may change during hospitalization, or his or her spiritual needs and/or understanding of the chaplain's role may evolve (again, think of the analogy of physical pain, which everyone understands will not remain constant throughout a patient's admission), the person may well answer such a question differently on day two of admission than at the time of admission. If the patient has already declined such a visit at the time of admission, it creates unnecessary obstacles to spiritual care for the remainder of the hospitalization.

The spiritual screen is a tool that helps triage those patients or families with spiritual distress in order to refer to the chaplain. This is accomplished through "a few questions to elicit basic preferences and any obvious distress that warrants follow up, with minimal expertise and time required."[93] In the acute care setting, often the bedside nurse (or, in some institutions, the admissions personnel or social worker) completes the spiritual screen within the initial assessment upon arrival to a unit, as a triage level screen. This helps identify and diagnose the patients who may be experiencing spiritual distress to best develop a plan to address it clinically, including when and how to refer to the spiritual care specialist—the professional chaplain. The Rush Protocol is one of the most-utilized spiritual care screens, and the screening process look like this:

Spiritual Struggle Screening Protocol[94]

1. **Is religion or spirituality important to you as you cope with your illness?**
   If yes: *If no:*

2. **How much strength/comfort do you get from your religion/spirituality right now?**
   a) All that I need
   b) Somewhat less than I need
      • For 'a' or 'b' go to question 3
   c) Much less than I need
   d) None at all
      • for either 'c' or 'd', thank patient and order spiritual assessment

   2. **Has there ever been a time when religion and/or spirituality were important to you?**
   If yes: thank patient & order spiritual assessment
   If no: go to question 3 below

3. **Would you like a visit from the chaplain?**
   If yes: thank patient & order chaplain visit   *If no:* thank patient for their time

A spiritual history is somewhat similar, but would not be performed by admissions personnel. A nurse, advanced practice nurse, or physician should administer a spiritual history. As opposed to a spiritual screen, which looks at discovering and triaging spiritual distress for potential referral as needed to a spiritual care specialist, a spiritual history instead looks more in-depth at the spiritual and religious background of the patient, and seeks to ascertain what kind of support is potentially most helpful. The spiritual history may include not just what faith tradition the patient claims, but how involved the patient is within that tradition, and seeks to help the patient articulate how his or her faith may impact medical care while hospitalized. While there are several well-validated spiritual history instruments, including the HOPE[95] and SPIRIT[96] tools, Christina Puchalski, M.D., at the George Washington Institute for Spirituality and Health (GWISH), developed one called FICA, which has become one of the most utilized:[97]

F – Faith and belief
"Do you consider yourself spiritual or religious" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds with "No," the history-taker might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career or nature.

I – Importance
"What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"

C – Community
"Are you a part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

A – Address in care
"How would you like me, and the entire medical care team, to address these issues in your health care?"

An interdisciplinary and international committee of experts, chaired by Puchalski, makes the following recommendations for the spiritual screening and spiritual history process:

"1. All patients should receive a simple and time-efficient spiritual screening at the point of entry into the health care system and appropriate referrals as needed.
2. Health care providers should adopt and implement structured assessment tools to facilitate documentation of needs and evaluation of outcomes of treatment.
3. All staff members should be vigilant, sensitive and trained to recognize spiritual distress.
4. All health care professionals should be trained in doing a spiritual screening or history as part of their routine history and evaluation; unlicensed staff members should report all witnessed pain or spiritual distress.
5. Formal spiritual assessments should be made by a board certified chaplain who should document their assessment and communicate with the referring provider about their assessment and the plans of care.
6. Spiritual screenings, histories and assessments should be communicated and documented in patient records (e.g., charts, computerized databases, and shared during interprofessional rounds). Documentation should be placed in a centralized location for use by all clinicians. If a computerized patient database is available, spiritual histories and assessments should be included.
7. Follow-up spiritual histories or assessments should be conducted for all patients whose medical, psychosocial or spiritual condition changes and as part of routine follow-up in a medical history.
8. The chaplain should respond within 24 hours to a referral for spiritual assessment."[98]

Finally, the spiritual assessment should be completed only by the spiritual care specialist. A spiritual assessment is defined as "a detailed process of listening to, interpreting and evaluating spiritual needs and resources (significant expertise and often more time required). This should be completed by a board certified chaplain."[99] A professional chaplain's spiritual assessment should always be communicated clearly in the patient's chart. This may take different forms depending on the Electronic Medical Record (EMR) platform, but will likely have both checkboxes and free text entries. It may take the form of a SOAP note (Subjective, Objective, Assessment, Plan) or some other similar format (there are roughly 25+ spiritual assessment formats that have been published and reviewed, with varying levels of validity, specificity and clarity).[100] It can often be the case that the spiritual assessment ends up in an "ancillary notes" section of an EMR, which is then rarely read or reviewed by clinical staff following the chaplain's visit. Not all chaplains duplicate their written communication with direct oral communication with the nurse following a visit. Consequently, it would be helpful for the nurse to know where in the chart the spiritual assessment is electronically "filed," and to be consistently checking what the chaplain has written in that assessment, as it may well have a direct impact on the care of the patient. This is especially true in the critical care units, palliative care service, and nearing end of life.

As a brief aside, the professional chaplain is not synonymous with a community faith leader or clergy. Though most board certified chaplains are indeed ordained as clergy or faith leaders within their own religious community, they have also received much more training specific to the health care setting. A board certified chaplain must have completed an advanced degree, most commonly a three-year Master of Divinity or an equivalent. This is the same as most religious clergy. However, in addition to that, the board certified chaplain must also complete a medical residency-like clinical training, often Clinical Pastoral Education (CPE). With CPE, chaplaincy residents or interns learn about the clinical setting, medical ethics, cultural competence and humility, spiritual assessment, etc. Then they must become board certified through one of the major certifying bodies. The entire process, from beginning of the graduate degree to becoming a board certified chaplain, usually takes five or more years. This also means that most chaplains have the same basic level of training, and, like the local faith community leaders and clergy, most are ordained within their religious tradition. Professional chaplains then have additional training and certification to work in the "specialized" setting as a board certified chaplain. Board certified chaplains should be fully integrated on the interprofessional team, alongside the physicians, nurses, social workers, and other clinicians.

There are many nurses who may well work in an environment where there is not an employed professional chaplain available as a part of the interprofessional team. Research by Flannelly, Handzo, and Weaver shows that nearly two out of three hospitals employ chaplains.[101] This means that there are a significant portion of nurses who work for institutions that do not employ a spiritual care specialist—the board certified chaplain. For nurses in this circumstance, there are several approaches to ensuring that the patients in their care are receiving the best spiritual care and support possible.

One of the best long-term strategies would be for those working clinically to advocate for the hiring of competent, board certified chaplains to join the interprofessional team. This entire paper demonstrates the potential impact that proactive attention to spiritual care can have on patients, families, and the staff who serve them. Subsequently, when clinicians at an institution are seeking to encourage their administrations to hire spiritual care specialists in the form of board certified chaplains, they are working toward that goal of well-integrated whole-person patient- and family-engaged care.

Absent a chaplain integrated with the interprofessional team, nurses still have much to contribute to the spiritual care of the patients and families in their care. Nurses can and should focus on spiritual needs and spiritual care of their patients. Much like the fact that not every institution employs an entire fully-staffed and integrated palliative care team, so, too, an institution may not employ adequate chaplaincy staffing for addressing spiritual needs. Nurses in institutions without palliative care teams still provide the best end of life and pain management possible, through patient- and family-engaged care, continuing education in that field for the clinicians on staff, and staying abreast of the evidence for best practices concerning pain and end of life. The same, then, should be true for clinicians working in environments not staffed with chaplains. As this paper discusses in detail, nurses have many tools at their disposal to provide proactive spiritual care for patients. This may involve explicitly communicating compassion, active listening, and journeying with the patient through their health care experiences. The nurse should be sensitive to the spiritual impact of a hospitalization on the life of the patient and family, as well as the spiritual resources they bring to bear on their medical situations. It may also involve coordinating with local community faith leaders, with the patient's permission to avoid potential HIPAA violations, to provide some more in-depth spiritual support as needed.

WHAT CAN A NURSE DO TO PROVIDE SPIRITUAL CARE?

"There is confusion over the notion of spirituality and the nurse's role related to spiritual care."[102] Most nurses have had minimal training and education around providing spiritual care to their patients,[103] and often have even less comfort attempting to do so. It is not exclusively the duty of the nurse to assess and meet every spiritual need of every patient. As Florence Nightingale states in her Notes on Nursing: What It Is, and What It Is Not, "Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?"[104] Consequently, the nurse should always assess for spiritual need, provide basic spiritual support as needed, and refer when necessary. Nurses function with a process: to assess, then diagnosis, develop a plan, implement the plan, and then evaluate that plan's effectiveness. This section seeks to articulate what that process explicitly and concretely looks like for nurses who provide spiritual care as the spiritual care generalists. Research shows that most of what patients and families need from nurses, as it relates to spirituality and religion, is far more modest and achievable than many nurses assume. These same tools would be applicable for the nurse who works at institutions that do not provide a spiritual care specialist—the professional chaplain.

Patients yearn for an interpersonal, trusting relationship with their nurse, and this relationship is a prerequisite to revealing spiritual needs.[105] "Spiritual expressions such as love, hope and compassion constitute the most basic and universal approach to spiritual care and can be integrated into all aspects of nursing care."[106] Nurses in one study reported providing spiritual support to roughly half of their patients, with the specific interventions provided most frequently being empathy, listening, and psychological support.[107] Author Brené Brown writes, "Empathy has no script. There is no right way or wrong way to do it. It's simply listening. Holding space. Withholding judgment. Emotionally connecting, and communicating that incredibly healing message of 'you're not alone.'"[108] Nurses have communicated that their own motivations for providing spiritual care are more personal than organizational, meaning they want to connect and help their patients on a human level, more so than follow a checklist or institutional protocol.[109] Researcher Shane Sinclair explored the concept of compassion within health care specifically, and arrived at the definition of compassion as "a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action."[110] Each of

> "Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?"

these demonstrate the need for nurses to be able to connect at a human, interpersonal level with patients and families. "Compassionate care becomes the moral way of treating a person because the person is more than just an individual. Compassionate care becomes the means through which we address the needs of the whole person (physical, mental and spiritual) in the context of the larger community."[111] Nurses frequently see in their patients that, "Love goes very far beyond the physical person of the beloved. It finds its deepest meaning in his spiritual being, his inner self."[112]

Based on Sinclair's research, if you could hear the patients articulate what spiritual support they would want from you, their nurse, you would hear common sense encouragements, such as "Be kind. Be authentic. Be open. Be patient. Be accepting of the differences between you as the nurse and us, the patients and family. Seek to listen empathically. Demonstrate compassion always. Strive for empathy. Ask us about ourselves, our lives, our relationships, our faith, our religion—and not just to check it off some clinical checklist. Ask what gives us hope. Inquire about what it is we value. Know that we are trying, but we're not our best selves right now. For you, this is your every day at work, but for us, this is an unwelcome and frightening interruption into our everyday routine. We are scared. We don't know what to expect. We fear the worst. Try to understand us."

Often, nurses do not inquire into such personal and spiritual needs, fearing that, if they do, the patient may answer honestly, and have pressing needs that should be addressed, and for which nurses do not feel they have the time or bandwidth to tackle.[113,114] Consequently, a nurse may intentionally avoid anything that resembles such an inquiry, in a kind of clinical "don't ask, don't tell" scenario. If the nurse doesn't screen for spiritual needs, then the patient cannot overload the nurse, and the nurse can be clear to focus on what is perceived to be most important—the clinical biomedical daily needs of the patient. The nurse often does not have the time or emotional bandwidth to sit down, empathically and patiently hold the patient's hand, listening to all of his or her existential and spiritual struggles, and respond appropriately to an often messy and unpredictable exploration of the patient's fears, struggles and suffering. It may come as a relief to know that no one expects this of the nurse, not even the patient. Again, using the analogy of pain, if the nurse assesses the patient's pain, and it goes beyond what the nurse can do to address it in the moment—even if the primary obstacle is time—then the nurse can and should refer that patient to a pain specialist. The same is true about spiritual pain and spiritual needs. It is incumbent on the nurse to assess for spiritual distress. If the needs are such that offering empathic listening, kindness, and basic interpersonal support are insufficient, then this patient is the perfect patient to refer to the spiritual care specialist, the professional chaplain.

Specifically regarding the topic of praying with patients, there are some clinicians who love to do this and proactively seek out such opportunities, and others who shy away from it out of concern that it would be inappropriate or somehow too intimate. Studies have shown that nurses can often be comfortable praying with patients, with potential discomfort coming from a "cautious hesitancy," and a question about "to whose God are we praying?"[115,116] A good rule of thumb for this somewhat controversial discussion comes down to who initiates the request for the prayer. If a patient asks the nurse to pray for him or her, the best response might be, "Of course. What specifically would you like for me to be praying for?" This might be followed by something like, "Would you like for me to be praying for you throughout the day, or would you like to say a prayer together now?" That invites clarification, communicates respect for the patient, and allows the patient to determine what, when and who is involved in the prayer, which many consider to be an intimate shared action. It can also be helpful to ask the patient to pray first, and then to echo many of the sentiments and content of the patient's prayer if one prays with the patient. It is important to note that one should not pray "in the name of Jesus" for patients who are not Christian, and to be sensitive to and open to the priorities and

idiosyncrasies of the patient's faith tradition. If the nurse is uncomfortable saying a prayer with a patient, yet the patient asks to pray, this can be a good opportunity to make a referral to the professional chaplain and to communicate with the patient that "I don't usually pray with my patients directly. But I can call the chaplain, who does. And I will promise to be holding you in my thoughts and heart today and throughout your journey." This will satisfy the majority of those requesting a prayer and still allow for the nurse to maintain appropriate and healthy boundaries.

The Nursing Intervention Classification (NIC) has a constructive list of nursing care interventions to deal with spiritual distress specifically. These include, but are not limited to:

- Observe client for self-esteem, self-worth, feelings of futility, or hopelessness.
- Monitor support systems. Be aware of own belief systems and accept client's spirituality.
- Be physically present and available to help client determine religious and spiritual needs.
- Provide protected quiet time for meditation, prayer and relaxation.
- Help client make a list of important and unimportant issues.
- Ask how to be most helpful, then actively listen, and seek clarification.
- If client is comfortable with touch, hold client's hand or place hand gently on arm. Touch makes nonverbal communication more personal.
- Help client develop and accomplish short-term goals and tasks.
- Help client find a reason for living and be available for support.
- Listen to client's feelings about death. Be non-judgmental and allow time for grieving.
- Help client develop skills to deal with illness or lifestyle changes. Include client in planning of care.
- Provide appropriate religious materials, artifacts or music as requested.
- Provide privacy for client to pray with others or to be read to by members of own faith.
- See care plan for Readiness for Enhanced Spiritual Well-Being[117]

The Nursing Outcomes Classification (NOC) also then has a parallel list of desired contributing outcomes for providing these basic spiritual care support interventions with patients exhibiting spiritual distress:

- Dignified Dying
- Hope
- Spiritual Well-Being
- States conflicts or disturbances related to practice of belief system
- Discusses beliefs about spiritual issues
- States feelings of trust in self, God, or other belief systems
- Continues spiritual practices not detrimental to health
- Discusses feelings about death
- Displays a mood appropriate for the situation[118]

There are numerous spiritual care-related diagnoses, both detailed in NANDA-I's manual[119] and in subsequent discussion about them. The following is a list of potential diagnoses as presented by Puchalski and her colleagues[120]:

Diagnoses (primary)	Key feature from history	Example statements
Existential concerns	Lack of meaning Questions meaning about one's own existence Concern about afterlife Seeks spiritual assistance	"My life is meaningless." "I feel useless."
Abandonment by God or others	Lack of love, loneliness Not being remembered No sense of relatedness	"God has abandoned me." "No one comes by anymore."
Anger at God or others	Displaced anger toward religious representatives	"Why would God take my child . . . it's not fair."
Concerns about relationship with deity	Desires closeness to God, deepening relationship	"I want to have a deeper relationship with God."
Conflicted or challenged belief system	Verbalizes inner conflicts or questions about beliefs or faith Conflicts between religious beliefs and recommended treatments Questions moral or ethical implications of therapeutic regimen Expresses concern with life / death or belief system	"I am not sure if God is with me anymore." "I am not sure God would think it is ok for me to go through with this treatment."
Despair / hopelessness	Hopelessness about future health, life Despair as absolute hopelessness No hope for value in life	"Life is being cut short." "There is nothing left for me to live for."
Grief / loss	The feeling and process associated with the loss of a person, health, relationship	"I miss my loved one so much." "I wish I could run again."
Guilt / shame	Feeling that one has done something wrong or evil, somehow deserves current medical crisis Feeling that one is bad or evil	"I do not deserve to die pain-free."
Reconciliation	Need for forgiveness or reconciliation from self or others	"I need to be forgiven for what I did." "I would like my wife to forgive me."
Isolation	Separated from religious community or other	"Since moving to assisted living I am not able to go to my church anymore."
Religious-specific	Ritual needs Unable to perform usual religious practices	"I just can't pray anymore." "I need last rites."
Religious / spiritual struggle	Loss of faith or meaning Religious or spiritual beliefs or community not helping with coping	"What if all that I believe is not true?"

Finally, then, are some nursing-specific interventions that can be productive and comfortably used at the bedside in seeking to address spiritual concerns and issues. These may well feel "left-handed" at first, as many nurses have chosen to shy away from opening a potential can of worms about spiritual-related issues.[121] However, as you read through this cursory list of interventions, there may be several that nurses are already utilizing, and not necessarily charting or explicitly owning as such. Also from the efforts of Puchalski's team:[122]

Compassionate presence	Reflective listening, query about important life events	Support patient's sources of spiritual strength	Open-ended questions to elicit feelings
Inquiry about spiritual beliefs, values, & practices	Life review, listening to the patient's story	Continued presence and follow-up	Guided visualization for "meaningless pain"
Progressive relaxation exercise	Breathing practice or contemplation	Meaning-oriented therapy	Referral to spiritual care provider as indicated*
Use of story telling	Dignity-therapy & dignity-conserving therapy	Massage	Reconciliation with self or others
Spiritual support groups	Meditation	Sacred / spiritual readings or rituals	Yoga, tai chi
Exercise	Art therapy (music, art, dance)	Journaling	

* When referring to an outside community faith leader or clergy, it is best practice to also notify the chaplain. This allows for ongoing cultivation of relationships with community faith leaders and spiritual care providers at your institution.

A recent taxonomy of chaplaincy spiritual assessments and spiritual care interventions can also prove extremely helpful for nurses, both in better understanding the potential overlap of care provided by nurses and chaplains, and the language and nuance of professional chaplaincy care.[123] Appendix A has a one-page list of the chaplaincy taxonomy, articulating intended effects, methods and interventions.

SPIRITUALITY AS SELF-CARE FOR NURSES

Many nurses will articulate that they went into the field of nursing to be able to help people, often motivated by their personal religious or spiritual values.[124,125] Nurses are most often helper-type personalities, willing and able to go the extra mile to help those in need. The difficulty comes when the nurse provides a higher level of care for those he or she serves than for himself or herself. This can lead to compassion fatigue, burnout, vicarious traumatization, moral distress, and spiritual distress. Spirituality can be a healthy and constructive reservoir of resilience for nurses, from the disciplines of meditation, prayer, and religious ritual through to the relationships many create and maintain in their faith community.[126,127] There are many studies looking at religious and spiritual practices, and the potential positive impact these can have on nurses in helping to mitigate compassion fatigue and creating positive coping strategies around issues of self-care.[128]

St. Bernard of Clairvaux, a 12th century Christian monk, in his sermon Song of Songs, made the following statements about those in helping professions (he was speaking about priests and religious leaders, yet this applies just as well today to nurses and other health care providers):

> "The man who is wise, therefore, will see his life as more like a reservoir than a canal. The canal simultaneously pours out what it receives; the reservoir retains the water till it is filled, then discharges the overflow without loss to itself ... Today there are many in the Church who act like canals, the reservoirs are far too rare ... You too must learn to await this fullness before pouring out your gifts, do not try to be more generous than God."[129]

Today in nursing, there are many canals, and fewer reservoirs. Nurses should strive to be intentional about their own self-care, and function as a spiritual reservoir, helping from their own excess rather than from a place of depletion. Nurses find ways of coping with the intensity and stress of their daily work. It may be in eating, drinking, exercising, sexual activity, smoking or drugs, music, yoga, art, or other "outlets" that function as coping strategies. The key is in being intentional in finding constructive and healthy coping strategies. Many options arise from within the spiritual and religious disciplines that may prove helpful. "Nurses' spiritual health has a positive effect on nurses' professional commitment and caring."[130]

Nurses should mine their own spiritual heritage and/or religious traditions, and attempt to find meaningful, healthy coping strategies to help balance out the intensity of service they provide for those in their care. Balance is a key component. They may wish to consult with the professional chaplains at their own institution, finding ways to potentially partner in staff care and encourage discussions, strategizing, and implementation of proactive self-care strategies for the nursing staff. Programs like Tea for the Soul or a Blessing of Hands can help nurses reconnect with the reasons they went into nursing in the first place—which is often crowded out by the hustle, bustle and intensity of daily acute care nursing duties.

CONCLUSION

Florence Nightingale gave an excellent example to modern nurses as to the importance of providing whole-person, patient- and family-engaged care. This care moves beyond the biomedical model and incorporates meaning making, spirituality, and the patient's values and beliefs into his or her care. Nurses are spiritual care generalists, and in that role should seek to provide basic levels of spiritual care to the patients in their care. This involves the tools of spiritual screens and spiritual histories, but it is also as basic as providing spiritual care interventions such as being empathic, listening, and treating the patient as a fellow human with hopes, fears and values that are potentially impacted by hospitalization. Nurses should be able to diagnose spiritual distress, and know when and how to refer to the spiritual care specialists—the professional chaplains—in their health care settings.

Moving forward, one of the greatest and most urgent areas of need is for more proactive collaboration between researchers exploring spirituality in nursing practice and those from the professional chaplaincy community. The majority of nursing articles cited in this paper arise from research that is siloed, and does not involve the profession of chaplaincy, either those practicing alongside the clinical researchers or those involved in research in the field.

APPENDIX A: THE CHAPLAINCY TAXONOMY

Intended Effects	Methods	Interventions
Aligning care plan with patient's values	Accompany someone in their spiritual/religious practice outside your faith tradition	• Acknowledge current situation • Facilitate closure
Build relationship of care and support	Assist with finding purpose	• Acknowledge response to difficult experience • Facilitate communication
Convey a calming presence	Assist with spiritual/religious practices	• Active listening • Facilitate communication between patient and/or family member and care team
De-escalate emotionally charged situations	Collaborate with care team member	• Ask guided questions • Facilitate communication between patient/family member(s)
Demonstrate caring and concern	Demonstrate acceptance	• Ask guided questions about cultural and religious values • Facilitate decision making
Establish rapport and connectedness	Educate care team about cultural and religious values	• Ask guided questions about faith • Facilitate grief recovery groups
Faith affirmation	Encourage end of life review	• Ask guided questions about purpose • Facilitate life review
Helping someone feel comforted	Encourage self care	• Ask guided questions about the nature and presence of God • Facilitate preparing for end of life
Journeying with someone in the grief process	Encourage self reflection	• Ask questions to bring forth feelings • Facilitate spirituality groups
Lessen anxiety	Encourage sharing of feelings	• Assist patient with documenting choices • Facilitate understanding of limitations
Lessen someone's feelings of isolation	Encourage someone to recognize their strengths	• Assist patient with documenting values • Identify supportive relationship(s)
Meaning-Making	Encourage story-telling	• Assist someone with Advance Directives • Incorporate cultural and religious needs in plan of care
Mending broken relationships	Encouraging spiritual/religious practices	• Assist with determining decision maker • Invite someone to reminisce
Preserve dignity and respect	Explore cultural values	• Assist with identifying strengths • Perform a blessing
Promote a sense of peace	Explore ethical dilemmas	• Bless religious item(s) • Perform a religious rite or ritual
	Explore faith and values	• Blessing for care team member(s) • Pray
	Explore nature of God	• Communicate patient's needs/concerns to others • Prayer for healing
	Explore presence of God	• Conduct a memorial service • Provide a religious item(s)
	Explore quality of life	• Conduct a religious service • Provide access to a quiet place
	Explore spiritual/religious beliefs	• Connect someone with their faith community/clergy • Provide compassionate touch
	Explore values conflict	• Crisis intervention • Provide Grief Processing Session
	Exploring hope	• Discuss concerns • Provide grief resources
	Offer emotional support	• Discuss coping mechanism with someone • Provide hospitality
	Offer spiritual/religious support	• Discuss frustrations with someone • Provide religious music
	Offer support	• Discuss plan of care • Provide sacred reading(s)
	Setting boundaries	• Discuss spirituality/religion with someone • Provide spiritual/religious resources
		• Ethical consultation • Respond as chaplain to a defined crisis event
		• Explain chaplain role • Share words of hope and inspiration
		• Facilitate advance care planning • Share written prayer
		• Silent prayer

REFERENCES

1 Narayanasamy, Aru. "Learning spiritual dimensions of care from a historical perspective." Nurse Education Today 19.5 (1999): 386-395.
2 Thunderwolf, BSN, MSN, RN, Men in Nursing: A Historical Time Line http://allnurses.com/men-in-nursing/men-in-nursing-96326.html
3 Nursingschoolhub.com. http://www.nursingschoolhub.com/history-nursing/
4 Christianitytoday.com. http://bit.ly/2nGZXxp
5 Florence-nightingale.co.uk. http://www.florence-nightingale.co.uk/resources/biography/
6 O'Brien, Mary Elizabeth. A nurse's handbook of spiritual care: standing on holy ground. Jones & Bartlett Learning, 2004.
7 Reinert, Katia Garcia, and Harold G. Koenig. "Re-examining definitions of spirituality in nursing research." Journal of advanced nursing 69.12 (2013): 2622-2634. http://onlinelibrary.wiley.com/doi/10.1111/jan.12152/epdf
8 Drick, Carole Ann. "Deep comfort: the essence of nursing." Creative nursing 10.1 (2004): 8-10.
9 theguardian.com. https://www.theguardian.com/news/2005/jul/16/guardianobituaries.health
10 cicelysaundersinternationa.org. http://cicelysaundersinternational.org/dame-cicely-saunders/
11 Berenguer, S. M. A. C., & Pinto, S. M. D. O. "The competence for the spiritual care in nursing." Journal of Nursing UFPE on line, 10.6 (2016): 4974-4975. http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/9871/pdf_2065
12 Chew, Brendan WK, Lay Hwa Tiew, and Debra K. Creedy. "Acute care nurses' perceptions of spirituality and spiritual care: an exploratory study in Singapore." Journal of Clinical Nursing 25.17-18 (2016): 2520-2527.
13 Selby, Debbie, et al. "Patient versus health care provider perspectives on spirituality and spiritual care: the potential to miss the moment." Annals of Palliative Medicine (2017). http://apm.amegroups.com/article/download/13171/13547
14 Cetinkaya, Bengu, Arife Azak, and Sebahat Altundag Dundar. "Nurses' perceptions of spirituality and spiritual care." Australian Journal of Advanced Nursing, The 31.1 (2013): 5. http://www.ajan.com.au/Vol31/Issue1/1Azak.pdf
15 Grace, Kimmot Hanee, Caranto Lawrence, and David Juan Jose. "What the Spirit Receives, the Body Achieves: Spiritual Care of BSU Student Nurses." International Journal of Nursing Science 5.2 (2015): 53-59. http://article.sapub.org/10.5923.j.nursing.20150502.03.html
16 Chandramohan, Sandhya, and Raisuyah Bhagwan. "Utilization of spirituality and spiritual care in nursing practice in public hospitals in KwaZulu-Natal, South Africa." Religions 7.3 (2016): 23. http://www.mdpi.com/2077-1444/7/3/23/htm
17 Cooper, Katherine L., et al. "The impact of spiritual care education upon preparing undergraduate nursing students to provide spiritual care." Nurse education today 33.9 (2013): 1057-1061.
18 Austin, Philip Daniel, et al. "The Ability of Hospital Staff to Recognise and Meet Patients' Spiritual Needs: A Pilot Study." Journal for the Study of Spirituality 6.1 (2016): 20-37. http://bit.ly/2naEBad
19 Rogers, Melanie, and John Wattis. "Spirituality in nursing practice." Nursing Standard 29.39 (2015): 51-57. http://eprints.hud.ac.uk/24730/1/SpiritualityinNursingFebruary2015.pdf
20 Ali, Gulnar, John Wattis, and Michael Snowden. "Why are Spiritual Aspects of Care so hard to Address in Nursing Education?'A Literature Review (1993-2015)." International Journal of Multidisciplinary Comparative Studies 2.1 (2015): 7-31. http://bit.ly/2mRx51d
21 Ruder, Shirley. "Spirituality in nursing: nurses' perceptions about providing spiritual care." Home Healthcare Now 31.7 (2013): 356-367. http://bit.ly/2o1qdP7
22 Frampton, Susan B, et. al. "Harnessing evidence and experience to change culture: a guiding framework for patient and family engaged care." National Academy of Medicine. (2017): 1-38. http://bit.ly/2k14Xa2
23 Reinert, Katia Garcia, and Harold G. Koenig. "Re-examining definitions of spirituality in nursing research." Journal of advanced nursing 69.12 (2013): 2622-2634. http://onlinelibrary.wiley.com/doi/10.1111/jan.12152/epdf
24 Sessanna, Loralee, Deborah Finnell, and Mary Ann Jezewski. "Spirituality in nursing and health-related literature a concept analysis." Journal of Holistic Nursing 25.4 (2007): 252-262. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.978.3990&rep=rep1&type=pdf
25 Weathers, Elizabeth, Geraldine McCarthy, and Alice Coffey. "Concept analysis of spirituality: an evolutionary approach." Nurs Forum. doi. Vol. 10. 2015. http://www.ucc.ie/en/media/academic/medicineandhealth/graduateschool/ConceptAnalysisinNursingForum.pdf
26 Reinert, Katia Garcia, and Harold G. Koenig. "Re-examining definitions of spirituality in nursing research." Journal of advanced nursing 69.12 (2013): 2622-2634. http://onlinelibrary.wiley.com/doi/10.1111/jan.12152/epdf
27 Paley, John. "Spirituality and secularization: nursing and the sociology of religion." Journal of clinical nursing 17.2 (2008): 175-186. http://faith-health.org/wordpress/wp-content/uploads/278247221.pdf
28 Benito, Enric, Mónica Dones, and Javier Babero. "El acompañamiento espiritual en cuidados paliativos." Psicooncología 13.2-3 (2016): 367-384. http://revistas.ucm.es/index.php/PSIC/article/viewFile/54442/49745
29 Kociszewski, Cynthia. "A phenomenological pilot study of the nurses' experience providing spiritual care." Journal of Holistic Nursing 21.2 (2003): 131-148.
30 Puchalski, Christina M., et al. "Improving the spiritual dimension of whole person care: Reaching national and international consensus." Journal of Palliative Medicine 17.6 (2014): 642-656. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1429&context=smhs_medicine_facpubs
31 Koenig, Harold G. Medicine, religion, and health: Where science and spirituality meet. Templeton Foundation Press, 2008, p.11.
32 Emblen, Julia D. "Religion and spirituality defined according to current use in nursing literature." Journal of professional nursing 8.1 (1992): 41-47.
33 Chew, Brendan WK, Lay Hwa Tiew, and Debra K. Creedy. "Acute care nurses' perceptions of spirituality and spiritual care: an exploratory study in Singapore." Journal of Clinical Nursing 25.17-18 (2016): 2520-2527.
34 Hall, Eric. J., Hughes, Brian P., and Handzo, George H. Spiritual Care: What it means, why it matters in health care. HealthCare Chaplaincy Network (2016). https://www.healthcarechaplaincy.org/docs/about/spirituality.pdf
35 dictionary.com http://www.dictionary.com/browse/healthcare
36 Frampton, Susan B, et. al. "Harnessing evidence and experience to change culture: a guiding framework for patient and family engaged care." National Academy of Medicine. (2017): 1-38. http://bit.ly/2mMAEFb
37 email from HealthCare Chaplaincy Network, 9/1/2016.

38   Pesut, Barbara. "The development of nursing students' spirituality and spiritual care-giving." Nurse Education Today 22.2 (2002): 128-135.

39   see discussion of this issue in depth at: Fawcett, Tonks N., and Amy Noble. "The challenge of spiritual care in a multi faith society experienced as a Christian nurse." Journal of clinical nursing 13.2 (2004): 136-142.

40   wire.ama-assn.org. https://wire.ama-assn.org/ama-news/physicians-see-positive-role-spirituality-medicine

41   van de Geer, Joep, et al. "Training hospital staff on spiritual care in palliative care influences patient-reported outcomes: Results of a quasi-experimental study." Palliative Medicine (2016): 0269216316676648.

42   Hills, Judith, et al. "Spirituality and distress in palliative care consultation." Journal of Palliative Medicine 8.4 (2005): 782-788.

43   Balboni, Tracy A., et al. "Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life." Journal of Clinical Oncology 25.5 (2007): 555-560. http://ascopubs.org/doi/pdf/10.1200/JCO.2006.07.9046

44   Ehman, John W., et al. "Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill?." Archives of Internal Medicine 159.15 (1999): 1803-1806. http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1105624

45   Phelps, Andrea C., et al. "Addressing spirituality within the care of patients at the end of life: perspectives of patients with advanced cancer, oncologists, and oncology nurses." Journal of Clinical Oncology 30.20 (2012): 2538-2544. http://ascopubs.org/doi/pdf/10.1200/jco.2011.40.3766

46   Clark, Paul Alexander, Maxwell Drain, and Mary P. Malone. "Addressing patients' emotional and spiritual needs." The Joint Commission Journal on Quality and Safety 29.12 (2003): 659-670. http://hmablogs.hma.com/hmachaplains/files/2010/05/JCAHO-Journal-on-Spiritual-Care.pdf

47   McClung, Emily, Daniel H. Grossoehme, and Ann F. Jacobson. "Collaborating with chaplains to meet spiritual needs." Medsurg Nursing 15.3 (2006): 147. http://bit.ly/2bnX13E

48   Puchalski, Christina M., et al. "Improving the spiritual dimension of whole person care: Reaching national and international consensus." Journal of Palliative Medicine 17.6 (2014): 642-656. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1429&context=smhs_medicine_facpubs

49   Koenig, Harold G. "Religious attitudes and practices of hospitalized medically ill older adults." International journal of geriatric psychiatry 13.4 (1998): 213-224.

50   Peterman, Amy H., et al. "Measuring spiritual well-being in people with cancer: the functional assessment of chronic illness therapy—Spiritual Well-being Scale (FACIT-Sp)." Annals of behavioral medicine 24.1 (2002): 49-58.

51   Monod, Stefanie M., et al. "The spiritual distress assessment tool: an instrument to assess spiritual distress in hospitalised elderly persons." BMC geriatrics 10.1 (2010): 1. https://bmcgeriatr.biomedcentral.com/articles/10.1186/1471-2318-10-88

52   Ellison, L. L. (2006). The spiritual well-being scale. http://mds.marshall.edu/cgi/viewcontent.cgi?article=1008&context=co_faculty

53   kb.nanda.org http://kb.nanda.org/article/AA-00657/0/Defining-characteristics-of-spiritual-distress%3A-an-integrative-review.html

54   Diagnoses, N. N. (2003). Definitions & Clasification. Versión en español de la obra original en inglés. Madrid. Editorial Elsevier. p.374.

55   Monareng, Lydia V. "Spiritual nursing care: A concept analysis." curationis 35.1 (2012): 1-9. http://www.scielo.org.za/pdf/cura/v35n1/13.pdf

56   Blanchard, Judith H., Douglas A. Dunlap, and George Fitchett. "Screening for spiritual distress in the oncology inpatient: a quality improvement pilot project between nurses and chaplains." Journal of nursing management 20.8 (2012): 1076-1084.

57   Caldeira, Sílvia, et al. "Clinical validation of the nursing diagnosis spiritual distress in cancer patients undergoing chemotherapy." International journal of nursing knowledge (2015).

58   Monod, Stefanie, et al. "Validation of the Spiritual Distress Assessment Tool in older hospitalized patients." BMC geriatrics 12.1 (2012): 13. https://bmcgeriatr.biomedcentral.com/articles/10.1186/1471-2318-12-13

59   Astrow, Alan B., et al. "Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care?." Journal of Clinical Oncology 25.36 (2007): 5753-5757. http://ascopubs.org/doi/pdf/10.1200/JCO.2007.12.4362

60   Davison, Sara N., and Gian S. Jhangri. "Existential and supportive care needs among patients with chronic kidney disease." Journal of pain and symptom management 40.6 (2010): 838-843.

61   Fitchett, George, Laurel Arthur Burton, and Abigail B. Sivan. "The religious needs and resources of psychiatric inpatients." The Journal of Nervous and Mental Disease 185.5 (1997): 320-326.

62   Pearce, Michelle J., et al. "Unmet spiritual care needs impact emotional and spiritual well-being in advanced cancer patients." Supportive Care in Cancer 20.10 (2012): 2269-2276.

63   Balboni, Tracy A., et al. "Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life." Journal of Clinical Oncology 25.5 (2007): 555-560. http://ascopubs.org/doi/pdf/10.1200/JCO.2006.07.9046

64   Hui, David, et al. "The frequency and correlates of spiritual distress among patients with advanced cancer admitted to an acute palliative care unit." American Journal of Hospice and Palliative Medicine® 28.4 (2011): 264-270.

65   Kopacz, Marek S., et al. "Using a spiritual distress scale to assess suicide risk in veterans: An exploratory study." Pastoral Psychology 64.3 (2015): 381-390.

66   Abu-Raiya, Hisham, et al. "Robust links between religious/spiritual struggles, psychological distress, and well-being in a national sample of American adults." American Journal of Orthopsychiatry 85.6 (2015): 565.

67   Krause, Neal, Gail Ironson, and Kenneth I. Pargament. "Spiritual struggles and resting pulse rates: Does strong distress tolerance promote more effective coping?." Personality and Individual Differences 98 (2016): 261-265.

68   Krause, Neal, Gail Ironson, and Kenneth I. Pargament. "Spiritual struggles and resting pulse rates: Does strong distress tolerance promote more effective coping?." Personality and Individual Differences 98 (2016): 261-265.

69   Abbasi, Mojgan, et al. "Nursing students' spiritual well-being, spirituality and spiritual care." Iranian journal of nursing and midwifery research 19.3 (2014): 242. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4061623/

70   World Health Organization. Patient-Centered Health Care: A Policy Framework. (2007) World Health Organization: Western Pacific Region. http://www.wpro.who.int/health_services/people_at_the_centre_of_care/documents/ENG-PCIPolicyFramework.pdf

71   Diagnoses, N. N. (2003). Definitions & Clasification. Versión en español de la obra original en inglés. Madrid. Editorial Elsevier. p.361-362.

72   Mowat, Harriet. "The potential for efficacy of healthcare chaplaincy and spiritual care provision in the NHS (UK)." NHS Yorkshire and the Humber (2008).

73   Larson, David B., and Susan S. Larson. "Spirituality's potential relevance to physical and emotional health: a brief review of quantitative research." Journal of Psychology and Theology (2003).

74   Balboni, Tracy, et al. "Support of cancer patients' spiritual needs and associations with medical care costs at the end of life." Cancer 117.23 (2011): 5383-5391. http://onlinelibrary.wiley.com/doi/10.1002/cncr.26221/full

75   Flannelly, Kevin J., et al. "A national study of chaplaincy services and end-of-life outcomes." BMC palliative care 11.1 (2012): 10. https://bmcpalliatcare.biomedcentral.com/articles/10.1186/1472-684X-11-10

76   Cole, Brenda S. "Spiritually-focused psychotherapy for people diagnosed with cancer: A pilot outcome study." Mental Health, Religion & Culture 8.3 (2005): 217-226.

77   Wachholtz, Amy B., Michelle J. Pearce, and Harold Koenig. "Exploring the relationship between spirituality, coping, and pain." Journal of behavioral medicine 30.4 (2007): 311-318.

78   Johnson, Jeffrey R., et al. "The association of spiritual care providers' activities with family members' satisfaction with care after a death in the ICU." Critical care medicine 42.9 (2014): 1991. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4134753/

79   Marin, Deborah B., et al. "Relationship between chaplain visits and patient satisfaction." Journal of health care chaplaincy 21.1 (2015): 14-24. http://www.najc.org/pdf/reading/relationship_between_chaplain_visits_and_patient_satisfaction.pdf

80   Williams, Aimee. "What Do Patients Want That They're Not Getting? A Study of Patients from the United States, Canada, and Australia." Presented at the 5th International Conference of the Scientific Basis of Health Services, Washington DC: 2003.

81   Williams, Joshua A., et al. "Attention to inpatients' religious and spiritual concerns: Predictors and association with patient satisfaction." Journal of general internal medicine 26.11 (2011): 1265-1271. http://bit.ly/2njKhiC

82   Astrow, Alan B., et al. "Is failure to meet spiritual needs associated with cancer patients' perceptions of quality of care and their satisfaction with care?." Journal of Clinical Oncology 25.36 (2007): 5753-5757. http://ascopubs.org/doi/pdf/10.1200/JCO.2007.12.4362

83   Ruder, Shirley. "Spirituality in nursing: nurses' perceptions about providing spiritual care." Home Healthcare Now 31.7 (2013): 356-367. http://bit.ly/2o1qdP7

84   Balboni, Michael J., et al. "Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training." Journal of Clinical Oncology 31.4 (2012): 461-467. http://ascopubs.org/doi/pdf/10.1200/JCO.2012.44.6443

85   Sinclair, Shane, et al. "Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences." Palliative Medicine (2016): 1-11. http://journals.sagepub.com/doi/pdf/10.1177/0269216316663499

86   Daaleman, Timothy P., and Donald E. Nease Jr. "Patient attitudes regarding physician inquiry into spiritual and religious issues." Journal of Family Practice 39.6 (1994): 564-569.

87   Taylor, Elizabeth Johnston, and Iris Mamier. "Spiritual care nursing: what cancer patients and family caregivers want." Journal of Advanced Nursing 49.3 (2005): 260-267.

88   Phelps, Andrea C., et al. "Addressing spirituality within the care of patients at the end of life: perspectives of patients with advanced cancer, oncologists, and oncology nurses." Journal of Clinical Oncology 30.20 (2012): 2538-2544. http://ascopubs.org/doi/pdf/10.1200/jco.2011.40.3766

89   Handzoconsulting.com http://www.handzoconsulting.com/blog/2013/3/10/generalist-plus-specialist-spiritual-care.html

90   Handzo, Rev George, and Harold G. Koenig. "Spiritual care: whose job is it anyway?." Southern Medical Journal 97.12 (2004): 1242-1245.

91   Robinson, Mary R., et al. "Efficacy of training interprofessional spiritual care generalists." Journal of palliative medicine 19.8 (2016): 814-821.

92   Puchalski C, Ferrell B, Virani R, Otis-Green S, Baird P, Bull J, Chochinov H, Handzo G, Nelson-Becker H, Prince-Paul M, Pugliese K, Sulmasy D. (2009) Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference. Journal of Palliative Medicine, 12(November 10, 2009), p. 885-904. https://smhs.gwu.edu/gwish/sites/gwish/files/jpm.2009.pdf

93   Bowden, Jill, Murphy, Patricia, and Peery, Brent. "Using Screeners for Religious or Spiritual Struggle: Why, How, What?" Presented at the 2016 Association of Professional Chaplains' National Conference. Orlando, FL (2016).

94   Fitchett, George, and James L. Risk. "Screening for spiritual struggle." Journal of Pastoral Care & Counseling 63.1-2 (2009): 1-12. http://bishopandersonhouse.org/wp-content/uploads/2015/06/Spiritual-Screening.pdf

95   Anandarajah, Gowri, and Ellen Hight. "Spirituality and medical practice." American family physician 63.1 (2001): 81-88. http://courses.washington.edu/bh518/Articles/hopearticle.pdf

96   Maugans, Todd A. "The spiritual history." Archives of family medicine 5.1 (1996): 11-16.

97   Puchalski, Christina, and Anna L. Romer. "Taking a spiritual history allows clinicians to understand patients more fully." Journal of Palliative Medicine 3.1 (2000): 129-137.

98   Puchalski, Christina M., et al. "Improving the spiritual dimension of whole person care: Reaching national and international consensus." Journal of Palliative Medicine 17.6 (2014): 642-656. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1429&context=smhs_medicine_facpubs

99   Bowden, Jill, Murphy, Patricia, and Peery, Brent. "Using Screeners for Religious or Spiritual Struggle: Why, How, What?" Presented at the 2016 Association of Professional Chaplains' National Conference. Orlando, FL (2016).

100 Bowden, Jill, Murphy, Patricia, and Peery, Brent. "Using Screeners for Religious or Spiritual Struggle: Why, How, What?" Presented at the 2016 Association of Professional Chaplains' National Conference. Orlando, FL (2016).

101 Flannelly, Kevin J., George F. Handzo, and Andrew J. Weaver. "Factors affecting healthcare chaplaincy and the provision of pastoral care in the United States." Journal of Pastoral Care & Counseling 58.1-2 (2004): 127-130. http://bit.ly/2mq37VY

102 Narayanasamy, Aru, and Jan Owens. "A critical incident study of nurses' responses to the spiritual needs of their patients." Journal of advanced nursing 33.4 (2001): 446-455.

103 Cone, Pamela H., and Tove Giske. "Nurses' Comfort Level with Spiritual Assessment: A Study among Nurses Working in Diverse Healthcare Settings." Journal of Clinical Nursing (2016). http://bit.ly/2naHeZA

104 Nightingale, Florence. Notes on nursing: What it is, and what it is not. Lippincott Williams & Wilkins, 1992. http://www.latexedit.com/documents/Notes-on-nursing.pdf

105 Taylor, Elizabeth Johnston. "Client perspectives about nurse requisites for spiritual caregiving." Applied Nursing Research 20.1 (2007): 44-46.

106 Sawatzky, Rick, and Barbara Pesut. "Attributes of spiritual care in nursing practice." Journal of Holistic Nursing 23.1 (2005): 19-33. http://bit.ly/2nHdhld

107 Kalkim, Asli, Tulay Sagkal Midilli, and Ebru Baysal. "An investigation of the perceptions and practices of nursing students regarding spirituality and spiritual care." Religions 7.8 (2016): 101. http://www.mdpi.com/2077-1444/7/8/101/htm

108 redefineschoo.com. https://redefineschool.com/brene-brown-vulnerability/

109 Ramezani, Monir, et al. "Catalysts to Spiritual Care Delivery: A Content Analysis." Iranian Red Crescent Medical Journal 18.3 (2016). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4884212/pdf/ircmj-18-03-22420.pdf

110 Sinclair, Shane, et al. "Compassion in health care: An empirical model." Journal of pain and symptom management 51.2 (2016): 193-203. http://www.sciencedirect.com/science/article/pii/S0885392415005734

111 Von Dietze, Erich, and Angelica Orb. "Compassionate care: a moral dimension of nursing." Nursing Inquiry 7.3 (2000): 166-174.

112 Frankl, Viktor E. Man's Search for Meaning: The Importance of Spirituality. Beacon Press, 2006 (1946).

113 Caldeira, Sílvia, and Fiona Timmins. "Editorial: Time as presence and opportunity: The key to spiritual care in contemporary nursing practice." Journal of clinical nursing 24.17-18 (2015): 2355-2356. http://repositorio.ucp.pt/bitstream/10400.14/18487/1/2015_JCN.pdf

114 Balboni, Michael J., et al. "Nurse and physician barriers to spiritual care provision at the end of life." Journal of pain and symptom management 48.3 (2014): 400-410. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4569089/pdf/nihms720899.pdf

115 Minton, Mary E., Mary Isaacson, and Deborah Banik. "Prayer and the Registered Nurse (PRN): nurses' reports of ease and dis ease with patient initiated prayer request." Journal of advanced nursing 72.9 (2016): 2185-2195. http://bit.ly/2nHeCc0

116 Narayanasamy A (2014) The Challenges of Teaching and Learning Spirituality in Nursing. J Nurs Care 3: 189. https://www.researchgate.net/publication/287363273_The_Challenges_of_Teaching_and_Learning_Spirituality_in_Nursing

117 Nursinginterventionrationales.blogspot.com. http://nursinginterventionsrationales.blogspot.com/2013/07/spiritual-distress.html

118 Nursinginterventionrationales.blogspot.com. http://nursinginterventionsrationales.blogspot.com/2013/07/spiritual-distress.html

119 Diagnoses, N. N. (2003). Definitions & Clasification. Versión en español de la obra original en inglés. Madrid. Editorial Elsevier. p.374.

120 Puchalski, Christina M., et al. "Improving the spiritual dimension of whole person care: Reaching national and international consensus." Journal of Palliative Medicine 17.6 (2014): 642-656.
http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1429&context=smhs_medicine_facpubs

121 Balboni, Michael J., et al. "Nurse and physician barriers to spiritual care provision at the end of life." Journal of pain and symptom management 48.3 (2014): 400-410.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4569089/pdf/nihms720899.pdf

122 Puchalski, Christina M., et al. "Improving the spiritual dimension of whole person care: Reaching national and international consensus." Journal of Palliative Medicine 17.6 (2014): 642-656.
http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1429&context=smhs_medicine_facpubs

123 Massey, Kevin, et al. "What do I do? Developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care." BMC palliative care 14.1 (2015): 10. https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-015-0008-0

124 Mamier, Iris, et al. "Nurse Religiosity and the Provision of Spiritual Care." (2015).
http://www.nursinglibrary.org/vhl/bitstream/10755/602820/1/Mamier_STTI_2015_76398.pdf

125 Raingruber, Bonnie, and Terri Wolf. "Nurse perspectives regarding the meaningfulness of oncology nursing practice." Clinical journal of oncology nursing 19.3 (2015).

126 Ross, Linda, et al. "Student nurses perceptions of spirituality and competence in delivering spiritual care: a European pilot study." Nurse Education Today 34.5 (2014): 697-702. http://bit.ly/2nPjk44

127 White, Mary L. "Spirituality Self-Care Practices as a Mediator between Quality of Life and Depression." Religions 7.5 (2016): 54.
http://www.mdpi.com/2077-1444/7/5/54/htm

128 Pembroke, Neil. "Contributions from Christian ethics and Buddhist philosophy to the management of compassion fatigue in nurses." Nursing & health sciences (2015).

129 Sommerfeldt, John R. Bernard of Clairvaux on the Spirituality of Relationship. Paulist Press, 2004: 20.

130 Chiang, Yi-Chien, et al. "The impact of nurses' spiritual health on their attitudes toward spiritual care, professional commitment, and caring." Nursing outlook 64.3 (2016): 215-224. http://bit.ly/2mRvmZN

REPRINT PERMISSION

P. 9—Figure "Inpatient spiritual care implementation model" used with permission from Journal of Palliative Medicine.
    License No. 4071460277713

P. 11—The FICA Spiritual History Tool© is copyrighted and used with permission by Dr. Christina Puchalski.
    For more information and to potentially use the FICA Spiritual History Tool, please see:
    https://smhs.gwu.edu/gwish/clinical/fica

p.16—Table "Spiritual Concerns" used with permission from Journal of Palliative Medicine. License No. 4071460277713

p.17—Table "Examples of Spiritual Care Interventions" used with permission from Journal of Palliative Medicine.
    License No. 4071460277713