Aim. The aim of this paper is to propose a guideline for spiritual assessment and interventions explicitly for families, while considering each family member’s unique spirituality.

Background. Spirituality’s positive effect is pervasive in health care and in the lives of many families; therefore, there is a need to integrate spiritual assessment and interventions in total family care.

Discussion. The majority of published guidelines on spiritual assessment and interventions are designed predominantly for individuals. They fail to differentiate between individual and family spirituality or offer only brief discussions on family spirituality. Such guidelines are potentially problematic. They may lead nurses to focus only on individual spirituality and neglect to discern family unit spirituality or recognize the presence of conflicts in spiritual perspectives within the family. While other disciplines such as social work and family therapy have several guidelines/strategies to assess family spirituality, there is a dearth of such guidelines in the family health nursing and spirituality literature, in spite of the rhetoric about incorporating spirituality as part of total family assessment. As a beginning solution, guidelines are proposed for spiritual assessment and interventions for the family as a unit, and the category of spiritual interpretation to represent diagnosis is introduced. Case studies exemplify how to integrate the guideline, and illustrate elements that may favour specific interpretations which would guide the interventions.

Conclusion. As nurses continually strive to assist families with their health needs, they must also attend to their spiritual needs, as one cannot truly assess a family without assessing its spirituality.

Keywords: family health, nursing, spiritual assessment, spirituality

Introduction

In this paper, family spirituality is described as the search for meaning and purpose in life, meaningful relationships, individual family member spirituality, family values, beliefs, and practices, which may or may not be religiously based, and the ability to be transcendent (Sperry & Giblin 1996, Tanyi 2002). Family spirituality can be much broader than individual spirituality, as it encompasses individuals’ distinct spirituality and that of the family unit. The broadness of this description is consistent with the multi-dimensional and ambiguous nature of spirituality.

The family is defined here as two or more individuals who call themselves a family and are bonded together emotionally. They may or may not be biologically related or share physical space. Family is further defined as a single unit with interconnected parts (Friedman 1998, Wegner & Alexander 1999). Given the complex nature of spirituality, the intention in this paper is not to serve as a conclusive and definitive guide to spiritual assessment and interventions for families. Rather,
a beginning guideline is proposed in order to better equip nurses to provide and improve spiritual care. In accordance with this era of modern nursing and increased discourse on spirituality, this paper introduces the category of spiritual interpretation to represent diagnosis. Finally, the paper contributes to the literature on family health nursing and spirituality.

Background

Despite the lack of consensual definition of spirituality (MacLaren 2004), its positive effect pervades health care and is evident in the nursing literature. Therefore, providing spiritual care will remain an invaluable part of nursing, as nurses work with humans who are spiritual beings. Spirituality and religion are sometimes used interchangeably, but the two concepts are different, thus warranting a distinction. Religion involves an organized entity with established rules, practices, beliefs, and boundaries about a Higher Power or God to which individuals should adhere (Thoresen 1999). On the contrary, spirituality has been described as a personal journey and defined as:

the personal search for meaning and purpose in life, which may or may not be related to religion. It entails connection to self-chosen and/or religious beliefs, values, and practices that give meaning to life, thereby inspiring and motivating individuals to achieve their optimal being. This connection brings faith, hope, peace, and empowerment. The results are joy, forgiveness of oneself and others, awareness and acceptance of hardship and mortality, a heightened sense of physical and emotional well-being, and the ability to transcend beyond the infirmities of existence (Tanyi 2002, p. 506).

From the above definition, family spirituality may or may not be religiously based. While some families’ spiritual orientation may involve religion, others may view spirituality as related to the universe, environment, or significant relationships. Families with an atheist or agnostic orientation may also be spiritual. Whatever the spiritual orientation, families’ values, practices, beliefs are all part of their distinct spirituality, which may influence their functioning and help them manage crises (Walsh 1998).

The need to address family spirituality has been espoused by family health nursing writers (e.g. Friedman 1998, Wright & Leahey 2000). It is also clearly evident in the literature of various health professions, such as medicine (Maugans 1996, Walsh et al. 2002), clinical psychology (Frame 2000, Wolf & Stevens 2001), social work (Hodge 2000, 2001), and family therapy (Anderson & Worthen 1997, Rivett & Street 2001). While other disciplines such as social work and family therapy have several guidelines/strategies to assess family spirituality (e.g. Boyd-Franklin & Lockwood 1999, Frame 2000, Hodge 2000), there is a dearth of such guidelines in the family nursing and spirituality literature, in spite of the rhetoric to incorporate spirituality as part of total family assessment.

The majority of published guidelines in the nursing literature (e.g. Stoll 1979, Murray & Zentner 1989, Labun 1997) are predominately geared for assessing individual clients rather than families. They fail to distinguish between individual and family unit spirituality, or offer only brief discussions on family spirituality. Guidelines to assist the family health nurse with the spiritual dimension of care are timely and necessary in order to meet families’ holistic needs.

It could be argued that family health nurses may still employ the same guidelines as nurses working with individual clients. To an extent this approach is appropriate, but may pave the way for potential problems, as nurses may focus on only the individual’s spirituality, neglecting to discern the family’s spirituality as a unit. Guidelines exclusively for the family would better equip nurses to consciously approach the spiritual dimension from both the individual and family perspectives. It would alleviate the frustration of sorting through volumes of literature not specifically germane to assessing family spirituality. It would help nurses recognize conflicts between individual and family spirituality, and the impact on the individual’s health and family unit. Lastly, it would assist nurses to better organize spiritual data.

Spirituality: a powerful family resource

A few published studies have examined spirituality as a family phenomenon. Electronic database searches of CINAHL, PsycINFO, MEDLINE/PubMed, and ProQuest, in addition to manual searches of family journals such as Marital and Family Therapy, Family Relations, Marriage and Family Counselling, and Family Process over the last three decades yielded few studies in this area. The scant published studies reviewed for this paper were conducted in various countries; however, two from the United Kingdom (UK), three from Canada, and the remainder from the United States of America (USA) were pertinent to the paper’s focus. The ensuing section summarizes the studies that underscore the powerful effects of spirituality as an invaluable resource.

Spirituality can be expressed vertically via a relationship with God/Higher Power and/or horizontally via significant relationships with others or self (Stoll 1989). The families in the following studies expressed their spirituality both vertically, as they reported a relationship with God/Higher Power,
and horizontally, because of significant relationships with family members and others.

Spirituality is an important factor in facilitating healthy marital and family functioning (Giblin 1996). Research shows that spouses’ spiritual views and beliefs can decrease psychological stress and increase their sense of coherence (Mullen et al. 1993). A family’s spirituality can assist in maintaining normalcy, cohesion, and resilience in the midst of crises (Beavers & Hampson 1990, Leis et al. 1997, Boyd-Franklin & Lockwood 1999). It can expedite positive adjustment to the loss of a family member (Richards & Folkman 1997, Handsley 2001, Walsh et al. 2002), ameliorate difficulties associated with disabilities (Treloar 2002), help foster a deeper meaning and purpose in positive family events such as childbirth (Callister et al. 1999, Semenic et al. 2004), and contributes to satisfying, lasting marriages (Kaslow & Robison 1996).

Other findings show that families with strong spiritual orientations can effectively attenuate family caregivers’ burdens (Pierce 2001, Theis et al. 2003). In single-parent families, spiritual rituals such as prayers have been shown to provide solace and unity (Moriarty & Wagner 2004). Kloosterhouse and Ames’ (2002) study further highlights that families’ spiritual beliefs and practices can strengthen them and provide hope, meaning and purpose in their lives when dealing with stressors.

**Spiritual assessment**

The major goals of spiritual assessment are (1) to support and enhance families’ spiritual well-being and development; (2) to discern spiritual distress and its effect on overall family health; and (3) to ascertain ways to incorporate family spirituality when providing care. To capture the essential elements of spirituality and organize the assessment, nurses can utilize the guideline in Table 1 to categorize the data according to: meaning and purpose, strengths, relationships, beliefs, individual member’s spirituality, and family’s preference for spiritual care.

The initial step of a thorough spiritual assessment and intervention requires that nurses be comfortable with the topic and develop a trusting relationship with the family (Maugans 1996). One cannot precisely gauge when a nurse should establish a trusting relationship with a family as this depends on their interactions over a period of time. However, nurses’ actions, such as displaying genuine caring and concern, respecting families’ circumstances, and remaining non-judgemental can foster a healthy environment and expedite the development of a trusting relationship. In order to maintain the ethical aspects of spiritual care, nurses must remain open to families’ spiritual beliefs and perspectives, never imposing their personal beliefs or values on families. They also must explain the purpose of the assessment, how the information is used, and obtain families’ consent before consulting with spiritual leaders (Richards & Bergin 1997).

Before beginning the assessment, nurses must first attain family consent. Thereafter, the significance of spirituality in the family’s lives must be ascertained (Table 1). Answers to the example questions in Table 1 would provide insight about the family’s beliefs and strengths, and the influences of spirituality on their health. It would reveal the role of spirituality in family’s abilities to seek meaning and purpose in their lives, and shed light on the family’s sense of

<table>
<thead>
<tr>
<th>Table 1 Guideline to spiritual assessment for families</th>
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<tbody>
<tr>
<td><strong>Meaning and purpose</strong></td>
</tr>
<tr>
<td>Who or what does the family consider the most meaningful?</td>
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<tr>
<td>What gives the family meaning in their daily routines?</td>
</tr>
<tr>
<td>What gives the family peace, joy, and satisfaction?</td>
</tr>
<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>What gives the family strength?</td>
</tr>
<tr>
<td>What helps the family to deal with crises?</td>
</tr>
<tr>
<td>What does the family do in order to rebuild their strength?</td>
</tr>
<tr>
<td><strong>Relationships</strong></td>
</tr>
<tr>
<td>What do the family members like about their family?</td>
</tr>
<tr>
<td>Does the family have a relationship with God/Higher Power, universe, or other? If yes, how do they describe it?</td>
</tr>
<tr>
<td>Is the family involved in community-based spiritual activities? If yes, which ones?</td>
</tr>
<tr>
<td><strong>Beliefs</strong></td>
</tr>
<tr>
<td>What are the family’s beliefs? And what do these beliefs mean to their health?</td>
</tr>
<tr>
<td>Does the family practice rituals such as prayer, worship, or meditation?</td>
</tr>
<tr>
<td><strong>Individual family member spirituality</strong></td>
</tr>
<tr>
<td>How do family members express/describe their spirituality?</td>
</tr>
<tr>
<td>And what does this mean to their health?</td>
</tr>
<tr>
<td>Are there conflicts between family members because of their spiritual views?</td>
</tr>
<tr>
<td>If yes, what is the impact, if any, on the individual and family’s health?</td>
</tr>
<tr>
<td><strong>Family’s preference for spiritual care</strong></td>
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<tr>
<td>How does the family describe/express their spiritual views?</td>
</tr>
<tr>
<td>Can the family give examples of how nurses can integrate their spiritual views when working with them?</td>
</tr>
<tr>
<td>Does the family consider anyone their spiritual leader? And if necessary, can the spiritual leader be contacted to assist with providing care to the family?</td>
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These questions serve only as a guide to help nurses elicit spiritual information for each category. Nurses can, therefore, rephrase these questions according to the family’s understanding and expressions of their spirituality.
connectedness/disconnectedness, alerting nurses to potential sources of spiritual distress.

Although nurses should approach the family as a single unit, it is advantageous to collect data on each family member, as these data may reveal conflicts in spiritual views among family members, and the impact, if any, on the family unit and individuals’ health. Family responses on how to incorporate spirituality in their care would also add understanding to their unique spiritual needs.

Additionally, genograms and ecomaps are visual diagrammatic tools that can be used to assess family spirituality. A genogram is a three-generation family tree, which depicts a family’s history (Bowen 1980). Likewise, the spiritual genogram can be used to depict a three-generation picture of the family’s spiritual journey. Any event the family describes as spiritual should be outlined in the genogram. The process of completing the genogram can serve as a reflective tool for family members to evaluate their spirituality, as they understand and perceive it. It can also help to clarify questions about the family’s spirituality and to affirm their strengths (Massey & Adriana 1999, Hodge 2000, 2001). Ecomaps portray a family’s relationship with external systems such as health care or government, and the impact of these systems on the family. Information from the ecomap would help nurses to organize the family spiritual history and address legitimate spiritual issues (Frame 2000).

Spiritual needs may be difficult to discern; hence, nurses should observe family members’ non-verbal behaviours during the assessment. The home environment, including books or artwork, may also provide clues to family spirituality (Ross 1994).

Because spiritual distress may impede a family’s ability to manage conflicts and have a devastating effect on their wellbeing, nurses must be astute in discerning it and intervening quickly and appropriately (Table 2). Spiritual distress should be suspected if the family expresses a sense of hopelessness, abandonment, inner conflicts about their beliefs, and questions the meaning of their existence (Wilkinson 2000).

**Spiritual interventions**

The process of spiritual assessment is an effective intervention. It allows the family to openly discuss their spiritual strengths and legitimizes their abilities to manage life’s challenges (Hodge 2000). Nurses can, therefore, encourage families to draw upon this strength to manage other problems. Following the assessment, nurses would formulate an appropriate interpretation to guide the interventions in Table 2.

<table>
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<tr>
<th>Table 2 Guideline to spiritual interventions for families</th>
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<tr>
<td><strong>Spiritual support</strong></td>
</tr>
<tr>
<td>Be present and available to the family in a non-hurried manner</td>
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<tr>
<td>Respect the family’s spiritual orientation and support their practices</td>
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<tr>
<td>Encourage and support comments that reflect the family’s need for spiritual growth</td>
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<tr>
<td><strong>Spiritual well-being</strong></td>
</tr>
<tr>
<td>Support and encourage the family’s use of spiritual resources as desired</td>
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<tr>
<td>Assist the family in locating spiritual groups and resources in their community</td>
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<tr>
<td>Support, acknowledge, and applaud verbalized comments of peace, harmony, and satisfaction with family circumstances and relationships</td>
</tr>
<tr>
<td>Encourage continual spiritual growth</td>
</tr>
<tr>
<td><strong>Spiritual distress</strong></td>
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<tr>
<td>Attempt to determine the reason(s) for the distress, and support the family’s efforts to examine their beliefs and values</td>
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<tr>
<td>Acknowledge the family’s position, but if necessary, obtain their consent to consult with a spiritual leader of their preference</td>
</tr>
<tr>
<td>Provide research-based evidence to the family about the positive impacts of spirituality on family health and functioning</td>
</tr>
<tr>
<td>Continue to display empathy, acceptance, kindness in a non-judgemental manner</td>
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</tbody>
</table>


Due to the multi-dimensional and ambiguous nature of spirituality, the assessment and interventions may overlap into other categories. Nurses must, therefore, bear in mind each family’s unique situation.

The desired outcome for spiritual assessment and intervention is spiritual well-being. In this state, family members express satisfaction with their relationships, beliefs, circumstances, and display a strong sense of connectedness with each other, their God/Higher Power, universe, environment, and others (Wilkinson 2000). Evaluation criteria are verbalized comments from family members indicating (1) continuing spiritual growth; (2) feelings of connectedness and peace; (3) satisfaction with family circumstances, and improved sense of overall health and well-being.

**Case examples**

The ensuing fictitious case studies exemplify certain potential components within a family unit to favour an interpretation of spiritual support, wellbeing, or distress. While there are many other potential spiritual interpretations, these cases only underscore the major ones. As families’ circumstances change over time, spiritual interpretations are not permanent; they change to reflect a family’s state at any given time. The cases further illustrate how to integrate spiritual assessment, interpret data and implement appropriate interventions.
The Ntuba family

The Ntuba family consists of husband Henry, aged 50, wife Maggie aged 48, and Henry’s brother Evan, aged 37. Evan has acute kidney failure. He undergoes haemodialysis 3 days per week and has recently tested positive for tuberculosis (TB). He does not have active TB, but takes TB prophylaxis treatments. After completing this treatment, he will receive a new kidney.

The nurse discerns that this family’s spiritual orientation is religion based, Catholic, thus vertically connected to God. They report that God helps them deal with difficulties, such as Evan’s health. They engage in weekly family prayer and attend church regularly. They believe God is in charge of their lives and Evan’s health. This family displays a strong horizontal connection with one another, and they believe their purpose is to stay connected as a family unit. They deny any sense of anxiety about Evan’s health, exhibiting a deep sense of strength and peace. Each family member’s unique expression of spirituality is similar to other members (Augsberger 1986), and no conflicts are apparent. They agree that having a nurse who respects their spiritual views and prays for and with them is very important.

Upon collecting the information, nurses would organize and document the data under the Tables’ headings. As an example, the Ntuba family’s meaning and purpose is to stay connected; they believe in God; their strength comes from God; they have a strong horizontal relationship with each other and their church; no spiritual conflicts are present; and they prefer nurses to respect their spiritual views, and pray for and with them.

Nurses would then formulate the appropriate interpretation of continual spiritual well-being. This interpretation is appropriate for families that express satisfaction with their spiritual lives (Wilkinson 2000). In this case, the role of nurses is to encourage, acknowledge, and support the family in their spiritual journey, and incorporate the other interventions in Table 2.

The Ngoh family

The Ngoh family consists of Martin, aged 48, his wife Anna, aged 46, their son Phil, aged 16, and daughter Amy aged 18. Amy has hepatitis C, which she contracted following a blood transfusion. The nurse discovers that this has been a very close Protestant family. They usually resolved conflicts through open communication, bible study, church attendance, and prayer. Their spirituality is religion based, and their belief and faith in God has given them strength to manage crises.

Since Amy’s diagnosis of hepatitis C, the father has become withdrawn and openly verbalizes his anger towards God. He feels he is being punished and asks why God would allow such a thing to happen to their child and family. He no longer attends church or bible studies and communicates less with his family. His behaviours have a negative impact on the family’s health, creating tension in the household and destabilizing the family unit. The family prefers nurses to support their spirituality by displaying kindness, genuine caring and respect. With the exception of the father, family members share similarities in their spiritual views (Augsberger 1986).

In this case, nurses would document the appropriate interpretation of spiritual distress depicted by the father’s vertical disconnectedness with God and horizontal disconnectedness with family members. The initial nursing intervention would be to acknowledge the family’s situation in a non-judgemental manner, while gaining their trust. Thereafter, nurses would attempt to reach the father by reminding him how the family has effectively managed crises in the past through spiritual practices.

If nurses are unable to diffuse the distress or feels ill-equipped to handle the situation, they should ask the family’s permission to initiate a spiritual referral from a spiritual leader of their choice. If the family rejects the nurse’s initiation, the topic could be reintroduced at a later time. Nonetheless, nurses would continue to acknowledge and respect the family, while providing continual support, and implement the other interventions in Table 2.

The Wong family

The Wong family consists of Paul, aged 67, who has Diabetes Mellitus type 2, his wife Mary, aged 64 and their daughter, Maggie, aged 21. Paul’s laboratory tests are stable. However, nurses visit the family regularly for diabetic education and monitors Paul’s blood sugar levels, diet, and exercise. The nurse observes they are a spiritual family although they openly express their atheist. They have strong horizontal relationships with the external systems of health care, their neighbours, and extended family members; they show deep love and trust in one another. The vertical aspect of their spirituality is evident in their love for the universe; they often spend quiet moments enjoying nature. Faith in and commitment to all their vertical and horizontal relationships give them strength, enabling them to cope with Paul’s diabetes.

This family’s purpose is to remain supportive, connected, and loving to one another. They express inner peace and joy as a family unit. They want nurses to support their spirituality by showing genuine kindness while respecting their
What is already known about this topic

- Because humans are spiritual beings, all families are spiritual; spirituality is a vital resource that helps families manage crises and maintain equilibrium.
- The need to address family spirituality is espoused in the literature.
- There is a lack of guidelines to assist nurses with spiritual assessment and interventions explicitly for families.

What this paper adds

- When considering family spirituality, it is important to recognize the uniqueness of each family member's spirituality.
- A guideline is proposed for spiritual assessment and interventions for families as a beginning solution to the lack of such guidelines.
- A call is issued to family nursing writers, clinicians, and researchers to develop this proposed guideline.

Implications for nursing practice

After obtaining other healthcare information, the spiritual data should be collected next; this may be at the initial, second, or subsequent encounters with the family, provided a trusting relationship is established or beginning to be developed, and the family consents to it. The initial process of collecting healthcare data provides an excellent opportunity for nurses to introduce the spiritual aspect, because most healthcare history forms ask for religious affiliation. If the family is willing to discuss their religious affiliation, nurses may use this opportunity to broach the topic of spiritual assessment. The family’s response will tell nurses either to continue or to abandon the topic (McEvoy 2000). If the family appears interested but reluctant, nurses should nurture a trusting relationship with the family during subsequent encounters before reintroducing the topic.

If the family agrees, nurses must first explain the purpose of the assessment and how the information would be used. A thorough family assessment requires that data be collected from each family member (Wright & Leahey 2000). If all family members are not present, data from those not available can be obtained later. If time does not allow nurses to complete the entire assessment, data from one category (e.g. beliefs) can be obtained, and the rest completed at subsequent visits.

While a lack of educational preparation and time constraints are cited as barriers to providing spiritual care (McSherry 1998), other research suggests that nurses do in fact attend to families’ spiritual needs (Stiles 1990) regardless of these barriers. Therefore, Swinton’ (2001) argument that the issue of time constraints may represent how nurses prioritizes care may be operative; especially for nurses who desire to provide spiritual care, and do not perceive it as a burden (Walter 2002). While educational preparation is beneficial, the initial step in providing spiritual care is being comfortable with the topic regardless of a formal education (Maugans 1996).

The ideal setting for using this guideline is families’ homes, and so it is especially useful for family health nurses making home visits. However, the guideline is useful in almost all community settings, such as nursing homes and hospices, where nurses have frequent contact with families.

Patients with chronic illnesses are more likely to make frequent visits to their healthcare providers and develop trusting relationships with them; therefore, the guideline is also applicable for advanced practice nurses in clinic settings. In clinics, the guideline can be used during annual physicals, as more time is typically allotted for these visits. It is unlikely that nurses will meet the entire family during clinic visits. Nonetheless, the data can still be obtained and documented from one source, then expanded as nurses encounters other family members at different visits. This guideline would improve nurses’ understanding of families’ dynamics, and could reveal potential conflicts between spiritual beliefs and adherence to healthcare treatments; thus, it can be adapted to suit each family’s unique needs.

Conclusion

Use of this guideline would improve nurses’ understanding of family functioning, thereby enhancing communication and trust in nurses–family relationship. Spiritual care is ongoing with each family interaction, and spirituality is an important

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What is already known about this topic

What this paper adds

Implications for nursing practice

Conclusion
component of many families: its impact cannot be underestimated on the overall family health.

By attending to families’ spiritual needs, nurses would be promoting a comprehensive and holistic approach to healthcare delivery. Not examining the spiritual dimension of families would be ignoring a vital aspect of their overall health. In essence, one cannot truly assess a family’s health without examining its spirituality.

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