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Review

The Catalogue of Spiritual Care Instruments: A Scoping Review

Ricko Damberg Nissen [1,*], Erik Falkø [1], Dorte Toudal Viftrup [1], Elisabeth Assing Hvidt [1,2], Jens Søndergaard [1], Arndt Büssing [3], Johan Albert Wallin [1] and Niels Christian Hvidt [1,4]

1 Research Unit of General Practice, Department of Public Health, University of Southern Denmark, 5000 Odense, Denmark; EFalkoe@health.sdu.dk (E.F.); dviftrup@health.sdu.dk (D.T.V.); ehvidt@health.sdu.dk (E.A.H.); JSoendergaard@health.sdu.dk (J.S.); wallin@health.sdu.dk (J.A.W.); nchvidt@health.sdu.dk (N.C.H.)
2 Department for the Study of Culture, University of Southern Denmark, 5000 Odense, Denmark
3 Faculty of Health, Witten/Herdecke University, 58313 Herdecke, Germany; Arndt.Buessing@uni-wh.de
4 Academy of Geriatric Cancer Research, University of Southern Denmark, 5000 Odense, Denmark
* Correspondence: rnissen@health.sdu.dk

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Abstract: Spiritual care has been a growing focus in international healthcare research over the last decades. The approaches to spiritual care are many and derive from many different medical fields and different cultural contexts and often remain unknown across healthcare areas. This points to a potential knowledge gap between existing instruments and the knowledge and use of them cross-disciplinarily and cross-culturally, and thus best practice insights are not sufficiently shared. This article contributes to the growing field of spiritual care by providing an overview of the various approaches (henceforth instruments) to assess patients' spiritual needs in view of improving spiritual care. This was done through a scoping review method. The results of the review were collected and catalogued and presented here as 'The Catalogue of Spiritual Care Instruments'. The included instruments derive from a wide range of geographical contexts and healthcare areas and are aimed at patients and healthcare professionals alike, clearly showing that spiritual care is a focus in healthcare internationally. However, it also shows the difficulties of defining spiritual care, the importance of local contexts, and the difficulties of cross-cultural validity. The catalogue contains 182 entries and is available as an interactive platform for the further development of spiritual care internationally.

Keywords: spiritual care; spirituality; religion; existential; spiritual needs; scoping review

1. Introduction

This article contributes to the growing field of spiritual care in healthcare by providing an overview of the various approaches to assess the topic of spirituality and patients' spiritual needs in view of improving spiritual care. Through a scoping review, the various ways of identifying, assessing, and addressing spiritual/religious needs, resources, or distress of patients and providing care for these needs, were collected and catalogued. The result is presented here as 'The Catalogue of Spiritual Care Instruments'.

International studies show that healthcare professionals generally find spiritual care as an important aspect of healthcare and providing spiritual care should be included as part of patient-centered and holistic medicine (Taverna et al. 2019; Biro 2012; Monroe et al. 2003). However, healthcare professionals are rarely trained in identifying the spiritual needs or resources of their patients, and consequently spiritual care is at risk of being neglected or implemented in arbitrary and, more or less,

auto-didact ways (Austin et al. 2018; McSherry and Ross 2012; Taverna et al. 2019; Curl et al. 2012; Saguil and Phelps 2012). Furthermore, existing instruments/approaches (henceforth instruments) to spiritual care derive from many different medical fields and different cultural contexts (Mouch and Sonnega 2012) and may therefore remain unknown across healthcare areas. This points to a potential knowledge gap between existing instruments and the knowledge and use of them cross-disciplinarily and cross-culturally, and thus best practice insights (which might be very different and specific for different professions) are not sufficiently shared. Furthermore, research shows that patients feel their spiritual and religious needs are sometimes inadequately addressed by physicians and nurses, and sometimes not addressed at all, which may have negative consequences for quality, and even cost, of the care provided (Gijsberts et al. 2019; McSherry and Ross 2012; Balboni et al. 2011; Hodge and Horvath 2011; McCord et al. 2004).

Spiritual care and its place and role in healthcare has been a growing focus in international healthcare research. However, there is no international unified understanding of the concept of 'spirituality' (Blaber et al. 2015), nor is there a unified understanding of how this concept relates to 'existential' and 'religion' or how they all relate to health. Thus, there is no consensus on what spiritual care is or what it can be, and the result is that there are vastly divergent understandings of how to approach spiritual needs and how to provide spiritual care, and how it interconnects with and relates to patient-centered care (Steenfeldt et al. 2019; Vincensi 2019). Following (Moberg 2002), maybe this lack of unity in the understanding of (the word) spiritual is how it needs to be, as 'generic spirituality' does not exist and therefore spiritual care instruments need to be able to gauge spiritual and religious differences not only at a contextual level but also, and perhaps more importantly, at an individual level.

The present 'Catalogue of Spiritual Care Instruments' (henceforth the catalogue) adds to this discussion and development by suggesting a cross-disciplinary and cross-cultural overview and synthesis of spiritual care instruments. This, we hope, will promote both research in, and implementation of, spiritual care in practice. Furthermore, the catalogue will contribute to increasing the visibility of existing spiritual care instruments within a broader context of healthcare, both cross-disciplinarily and cross-culturally, hereby increasing access to instruments in relation to various patient populations, healthcare professionals, and clinical settings. In addition, the catalogue will promote international discussions within research and clinical practice about the meaning, role, function, and potential of the spiritual, existential, and religious aspects of human life in relation to health. The catalogue is available online as an interactive platform to further interdisciplinary and cross-cultural visibility of spiritual care instruments and hereby contribute to the continued international development of spiritual care (see Appendix A).

Knowledge about the pros and cons of the different instruments included in the catalogue, their validity and reliability, their applicability in different populations, and their (cross-)cultural acceptability is important and relevant. Assessing spiritual needs or locating spiritual distress and providing spiritual care is an important undertaking and it should not be approached lightly but handled in a strict and professional manner. Therefore, it is imperative for the authors to stress that the catalogue should not be seen as representing valid instruments (see Section 6) to be picked off the shelf in the 'Shop of Spiritual Care Instruments' and implemented in any given context.

2. Aim

The aim of this study was to identify and catalogue spiritual care instruments, through a scoping review method, in order to increase the cross-disciplinary and cross-cultural visibility and accessibility of these instruments, and thereby contribute to the ongoing international development of spiritual care.

3. Spiritual Care, Spirituality, and Religion

In the present scoping review, we adopt a broad and inclusive understanding of spiritual care. Following the World Health Organization's (WHO) inclusion of spirituality as an integral part of health, we understand spiritual care as methods and standards to adequately meet the spiritual care

needs of patients (including both religious and non-religious aspects), as well as research aimed at understanding spiritual and religious coping mechanisms and developing spiritual care interventions. To many healthcare professionals, the provision of spiritual care signifies a certain way of being with the patient that is not easily put into formula. Spiritual care is mostly understood as a deepened and considerate way of being present with the patient and to respond to his/her needs and struggles; it is an attitude involving empathy, compassion, trust, and relationship-building (Steenfeldt et al. 2019), and in this way it interconnects with patient-centered care (Vincensi 2019). Without wanting to discredit these core caregiving attitudes in any way, we argue that spiritual caregiving can be advanced and qualified through relevant spiritual care instruments because of their potential for identifying spiritual needs, determining how to address such needs (treatment plan), and assisting in the actual provision of spiritual care.

Therefore, and to enable the inclusion rather than exclusion of instruments in the catalogue, we adopt an understanding of spiritual care as a (hypothetical) process spanning four phases: (1) 'identifying spiritual needs'; (2) 'deciding on appropriate intervention(s) (treatment plan)'; (3) 'providing spiritual care'; (4) 'evaluation'. The spiritual care instruments included in the catalogue can address one or several of these phases. We are not claiming that spiritual care necessarily includes all phases, nor do the four phases equal a definition of spiritual care. Rather, this was a (hypothetical) process that acted as a guideline in the process of including or excluding instruments, in combination with the 'criteria for inclusion' for the catalogue. At the same time, we acknowledge that real life is more complicated than what a model can encapsulate, which is why we made the process (hypothetical) in parenthesis. This is reflected in the catalogue by instruments included that are not strictly spiritual care instruments in the sense that they do not apply to phase (3) 'providing spiritual care'. However, seeing spiritual care as a process stretching beyond the actual provision of spiritual care, instruments are included that are implicating, or leading to, phase (3) 'providing spiritual care', thereby becoming part of spiritual care as a process. This will be brought up and exemplified in the discussion as we find it an important part of the continuous development of spiritual care. In providing spiritual care one instrument may not suffice to locate, provide, and encompass the needs of an individual patient (Büssing 2019).

In this study we do not discuss defining spirituality or religiosity. However, some words are needed in order to situate the concepts in relation to the understanding of spiritual care. We believe that the existential domain covers secular, spiritual, and religious meaning orientations interwoven (La Cour and Hvidt 2010; Nissen 2019). Following this, the distinction of what constitute these secular, spiritual, or religious existential orientations and needs in relation to the various instruments in the catalogue, was made by the authors of the individual instruments. As a result, there is no unity in understanding of the concepts, which may share similar general topics, but may differ in specific details. We understand this, however, as both a necessary and beneficial approach, as it enables the inclusion of instruments based on a wide and cross-culturally inclusive understanding, rather than excluding instruments based on a too-narrow cultural understanding; it also enables the inclusion of instruments from more secular contexts bordering between existential, spiritual, and religious orientations. Therefore, we understand existential as inevitably present but not sufficient for inclusion; the focus on either spirituality or religion or some concept of transcendence is required for inclusion in the catalogue. The consequence will undoubtedly be that some readers will find that instruments are missing, while others will find that some should have been excluded. In this way, we hope to stimulate the debate about what spiritual care is and what it can be.

After all, 'existential', 'spirituality', and 'religion' are merely words constructed to capture human experience (at the macro level), not necessarily capturing this experience at the (micro) individual level or cross-culturally (Bowman and Valk 2015; Mignolo 2011). What is important is remembering that there is a difference between spiritual care as an intervention, and what is potentially the Archimedean point of the individual worldview of the patient, around which everything else revolves (Nissen et al. 2018). Anthropology, sociology, and the study of religion have shown that human life

and experience are not reducible to, or containable in, the concepts we try to develop to describe the human worlds, and do not lend themselves to such simple descriptions (Descola 2014; Holbraad and Pedersen 2017). Thus, it is imperative that we continue to discuss these concepts between us as human beings in a global and interwoven world, in order to keep developing and providing the best spiritual care possible. It is our hope that this article and the forthcoming online version of the catalogue will contribute to further this work.

4. Method

A five-stage scoping review method was employed to conduct the review: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; (5) collating, summarizing, and reporting the results (Daudt et al. 2013; Levac et al. 2010; Arksey and O'Malley 2005).

Stage 1. Identifying the research question

An initial search was performed to get a preliminary idea of the amount and diversity of potential instruments and as part of the process of formulating the research question (aim). The aim was deliberately formulated in wide terms as part of the scoping review method, allowing instruments to be included rather than having to exclude instruments following the formulation of a too-narrow aim (Daudt et al. 2013).

Stage 2. Identifying relevant studies

Based on the initial search of stage 1, a refined master search string was constructed (Table 1). The master search was done in the databases PubMed, ATLA, and Scopus, which were found relevant and inclusive enough for this purpose. The search string was defined for PubMed and refined in order to accommodate the specifications of the databases ATLA and Scopus. The search was performed in PubMed on 5 June 2019, and in ATLA and Scopus on 7 June 2019. The results are listed in Table 1 (N = 9931). This was then supplemented by cross-checking with relevant reviews located within the search (Table 2). This strategy secured a comprehensive and wide approach to the literature search (Daudt et al. 2013).

Table 1. Search strings.

Search String PubMed (N = 4570)
(((patient reported outcome OR patient reported outcomes OR pro OR pros OR prom OR proms OR patient reported concerns OR electronic patient reported outcome OR electronic patient reported outcomes OR epros OR epro) AND (psychospiritual OR spiritual OR spirituality OR religion OR religions OR religious OR religiosity OR existential))) OR ((screening OR assessment* OR assessing OR model OR models OR schedule* OR scale OR scales OR index OR indexes OR questionnaire* OR question OR questions OR instruments OR interview* OR measure* OR intervention* OR history OR inventory OR inventories) AND (psychospiritual OR spiritual OR spirituality OR religion OR religions OR religious OR religiosity OR existential) AND (Validated OR Validation OR psychometrics OR psychological tests OR personality inventory OR personality inventories))
Search String ATLA (N = 2709)
(((patient reported outcome OR patient reported outcomes OR pro OR pros OR prom OR proms OR patient reported concerns OR electronic patient reported outcome OR electronic patient reported outcomes OR epros OR epro) AND (psychospiritual OR spiritual OR spirituality OR religion OR religions OR religious OR religiosity OR existential))) OR ((screening OR assessment* OR assessing OR model OR models OR schedule* OR scale OR scales OR index OR indexes OR questionnaire* OR question OR questions OR instruments OR interview* OR measure* OR intervention* OR history OR inventory OR inventories) AND (psychospiritual OR spiritual OR spirituality OR religion OR religions OR religious OR religiosity OR existential) AND (Validated OR Validation OR psychometrics OR psychological tests OR personality inventory OR personality inventories))
Search String Scopus (Refine Results to Medicine, Nursing, and Psychology) (N = 1131 + 1521)
((TITLE-ABS-KEY(Validated OR Validation OR psychometrics OR "psychological tests" OR "personality inventory" OR "personality inventories")) AND (TITLE-ABS-KEY(screening OR assessment* OR assessing OR model OR models OR schedule* OR scale OR scales OR index OR indexes OR questionnaire* OR question OR questions OR instruments OR interview* OR measure* OR intervention* OR history OR inventory OR inventories) AND (psychospiritual OR spiritual OR spirituality OR religion OR religions OR religious OR religiosity OR existential))) OR (TITLE-ABS-KEY("patient reported outcome" OR "patient reported outcomes" OR pro OR pros OR prom OR proms OR "patient reported concerns" OR "electronic patient reported outcome" OR "electronic patient reported outcomes" OR epros OR epro) AND (psychospiritual OR spiritual OR spirituality OR religion OR religions OR religious OR religiosity OR existential)) AND NOT INDEX(medline)
Total: 9931

Table 2. Included reviews (chronologically).

(Drummond and Carey 2019)	Assessing Spiritual Well-Being in Residential Aged Care: An Exploratory Review
(Gijsberts et al. 2019)	Spiritual Care in Palliative Care: A Systematic Review of the Recent European Literature
(Austin et al. 2018)	Measuring spirituality and religiosity in clinical settings—A scoping review of available instruments
(Pok and Kim 2014)	The Effects of Spiritual Interventions in Patients with Cancer: A Meta-Analysis
(Panzini et al. 2017)	Quality-of-life and spirituality
(Seddigh et al. 2016)	Questionnaires measuring patients' spiritual needs. A narrative review
(Cadge and Bandini 2015)	The evolution of spiritual assessment instruments in healthcare
(Lucchetti et al. 2013a)	Measuring spirituality and religiosity in clinical research. A systematic review of instruments available in the Portuguese language
(Lucchetti et al. 2013b)	Taking Spiritual History on Clinical Practice: A Systematic Review of Instruments
(Draper 2012)	An integrative review of spiritual assessment: implications for nursing management
(Monod et al. 2011)	Instruments measuring spirituality in clinical research: A systematic review
(Selman et al. 2011)	The Measurement of Spirituality in Palliative Care and the Content of Tools Validated Cross-Culturally: A Systematic Review
(Holloway et al. 2009)	Spiritual Care at the end of Life—A Review
(Lewis 2008)	Spiritual assessments in African Americans. A review of measures of spirituality used in health research
(Vivat 2008)	Measures of spiritual issues for palliative care patients: A literature review

Stage 3. Study and instrument selection

This comprehensive approach to an exhaustive literature search resulted in a substantial number of studies to screen (N = 9931) (Table 3). An expected result of the search string was that a substantial number of studies/articles turned out to be irrelevant (N = 8747). After the removal of duplicates and irrelevant studies, 646 studies remained. In order to secure the comprehensive approach of the scoping review methodology, we decided to divide the inclusion process in two parts: an initial inclusion (N = 646 studies) based on the 'initial criteria for inclusion of studies' (Table 4) and a final inclusion (N = 182 instruments) based on the 'final criteria for inclusion of instruments' (Table 4). This was done because the same instruments were mentioned in many of the 646 studies. The next step 'transferring focus from study to instrument' (Table 3) and the significant number of studies removed at this stage (N = 464) illustrate the notion that many instruments are mentioned in several studies, and this step focused on extracting the individual instruments and evaluating them in relation to the established 'final criteria for inclusion of instruments' (Table 4). In total, 182 instruments were located and included in the catalogue (Appendix A).

Table 3. Flow chart.

Studies imported for screening	9931		
		Duplicates removed	538
Studies screened	9393		
		Irrelevant	8747
Full texts assessed for eligibility	646		
Transferring focus from study to instrument		Studies/instruments excluded	464
Instruments included	182		

Table 4. Criteria for inclusion.

Initial criteria for inclusion of studies	Include or present an instrument. Have a focus on existential orientations and needs and include a focus on spirituality or religion. Be written in English.
Final criteria for inclusion of instruments	A unique instrument employed within healthcare with a focus on spirituality or religion. Aimed at patients * or healthcare professionals or has a research aspect in relation to health and spirituality or religion. Be written in English.
Criteria for exclusion	Quality of life questionnaires **

* The study includes instruments that are aimed at adult patients. ** Quality of life (QOL) questionnaires or surveys can in general all be said to be essentially existential.

Stage 4. Charting the data

Stage 3 of the methodological approach of the scoping review was interwoven with stage 4, in the understanding that discussing the criteria for final inclusion also was part of the process of identifying key issues and themes and determining the criteria/categories for charting the data (Table 5).

Table 5. Categories.

Instrument name and abbreviation Comment	Author and year	Target area	Target group	Approach	Origin and implementation

Categories in the Catalogue (Appendix A)

The aim of the catalogue is to provide an overview of existing instruments; therefore, the catalogue includes only general categories.

Instrument name and abbreviation

We chose to use the term 'instrument' exclusively regardless of whether the instrument is referred to as a tool, instrument, measure, questionnaire, patient reported outcome measure, or something else. This was done to keep a stringent approach in the catalogue.

Comment

We included a commentary subcategory. This briefly lays out the most central aspect of the instrument, including the focus on spirituality or religion.

Author and year

As a first priority we strived to refer to the original developers of the instruments. However, sometimes the original instrument have been revised (sometimes several times) and the revised versions are the ones in primary use and also (sometimes) the ones that include the spiritual or religious aspect. In such cases we may refer to the most recently revised versions.

Target area, target group, approach, and origin and implementation are introduced in the discussion.

Stage 5. Collating, summarizing, and reporting the results

The results were collated and summarized into the final catalogue presented in Section 5.

5. Results—The Catalogue of Spiritual Care Instruments

See Appendix A.

6. Discussion

The discussion will center on the category 'origin and implementation', including the language bias, and international cross-cultural collaboration. Hereafter the categories 'target area', 'target group', and 'approach' will be discussed, and followed by the understanding of spirituality and religion and the process of providing spiritual care. We include samples from the catalogue in order to exemplify.

The catalogue has a total of 182 entries (Appendix A). Following the scoping review method, aim, and criteria for inclusion, the included instruments represent a wide span and divergence, making it impossible to discuss the specific content of the individual instruments or make any thorough thematic analysis, although the instruments are in one sense or another united in the theme spiritual needs/care. Furthermore, we do not discuss quality assessment or whether the instruments are validated. We use the phrasing that the authors of the instruments used, be it 'validated', 'reliable', etc., without further comments. This is, of course, essential information, and making the catalogue available as an online forum bears the potential of enabling discussions of (cross-cultural) validity.

6.1. Origin and Implementation

The category 'origin and implementation' includes the country of origin and other countries where, to our knowledge, the instruments are, or have been, employed. The instruments will, most likely, be employed in other contexts that might be revealed by their users through the online catalogue.

Table 6 lists where the instruments originate and shows that an overwhelming majority of the instruments are from the USA (N = 103).

Table 6. Origin. USA, United States of America; ENG, England; GER, Germany;

Country	N	Country	N	Country	N	Country	N	Country	N	Country	N
USA	103	ESP	3	IND	2	POR	2	DEN	1	POL	1
ENG	10	JPN	3	IRN	2	SCO	2	GRE	1	RSA	1
GER	7	TWN	3	IRE	2	SUI	2	ISR	1	SPG	1
AUS	6	BRA	2	ITL	2	AUT	1	LEB	1	THA	1
CAN	5	EU	2	KOR	2	CHI	1	MLT	1	TUR	1
NED	4	HKG	2	NZL	2	CZE	1	NIG	1	Total	182

USA, United States of America; ENG, England, GER, Germany; AUS, Australia; CAN, Canada; NED, Netherland; ESP, Spain; JPN, Japan; TWN, Taiwan; BRA, Brazil; EU, European Union; HKG, Hong Kong, IND, India; IRN, Iran; IRE, Ireland; ITL, Italy; KOR, South Korea; NZL, New Zealand; POR, Portugal; SCO, Scotland; SUI, Suisse; AUT, Austria; CHI, Chile; CZE, Czech Republic; DEN, Denmark; GRE, Greece; ISR, Israel; LEB, Lebanon; MLT, Malta; NIG, Nigeria; POL, Poland; RSA, Republic of South Africa; SPG, Singapore; THA, Thailand; TUR, Turkey.

Multiple reasons can be put forward in relation to this finding, of which we will mention only a few. An inclusion criterion was that instruments should be written in English. This excludes an unknown number of instruments originating in other languages, which have not been translated into English. It will be necessary to enable instruments developed in other language areas to be brought to attention in the English language contexts from which this catalogue originates, in order to further the international exchange of research and best practice, and vice versa. A few instruments

originate from contexts outside the language criteria, with articles written in English, thereby giving an insight into these contexts. Examples are the 'Hope Scale for Korean Cancer Patients' (HC_KCP, Tae et al. 2017) and 'The Spiritual Pain Assessment Sheet' from Japan (SpiPas, Murata 2004). The number of instruments originating in languages outside of the inclusion criteria is 46. Although speculative, it seems reasonable to assume that many more instruments exist in other languages and may therefore not be known in English-speaking contexts.

Since 2001, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission on Accreditation of Healthcare Organizations 2001), the largest and most influential healthcare accrediting body in the United States, required that spiritual assessments be done in healthcare settings (Hodge 2006). An effect of this is that today more than 90% of medical schools include courses or content on spirituality and health, 70% with spirituality content in required courses (Koenig et al. 2010), which presumably has led to an increased focus in clinical practice. This could be an explanatory factor for the many instruments originating in the USA. A reflection of the JCAHO's decision might be seen in the catalogue where 63 out of 103 entries from the USA are from the period 2002–2019 (61.17%). This can also be seen in Table 7 which lists the instruments by number of instruments released per year (Table 7).

Table 7. Year of publication.

Year	N	Year	N	Year	N	Year	N	Year	N	Year	N	Year	N	Year	N
2019	3	2014	10	2009	9	2004	3	1999	3	1994	3	1989	3	1984	1
2018	4	2013	10	2008	8	2003	4	1998	3	1993	2	1988	2	1983	0
2017	10	2012	10	2007	6	2002	9	1997	2	1992	1	1987	1	1982	2
2016	8	2011	8	2006	9	2001	7	1996	6	1991	0	1986	1	1981	0
2015	7	2010	10	2005	9	2000	4	1995	3	1990	0	1985	0	1980	0
														1979	1
														Total	**182**

Table 8 lists the instruments by other geographical contexts where (to our knowledge) they have been implemented (Table 8). This enables a view of international collaboration. An example of a non-funded international collaboration is the Spiritual Needs Questionnaire (SpNQ, Büssing et al. 2018), which is in use in at least 16 non-English speaking countries (Table 8). The Cultural Formulation Interview (CFI, Aggarwal et al. 2013) is another example of an international collaboration. The CFI is also mentioned here because it is an example of an instrument that was not developed in the context of spiritual care. However, the way the CFI is structured, the way it encourages the patient to 'talk in his/her own words', and the interaction it initiates between the patient and healthcare professional, can assist in at least one of the above-mentioned four aspects in the process of spiritual care, namely (1) 'detecting spiritual distress'. In this way an instrument developed outside the context of spiritual care can implicitly include an aspect of spiritual care. Is this stretching what spiritual care is? Is it turning the CFI into something which was not the intention of the developers of the instrument? It could be but let us also bear in mind that it is arguably a question of whether the instrument can help the patient and the healthcare professional to identify spiritual needs and engage in spiritual care.

Related to international collaboration and exchange of best practice is the challenge of cross-cultural implementation of the instruments, since, according to Lunder et al. (2011), only few spiritual care approaches have been cross-culturally validated. This finding is supported by the catalogue, and cross-cultural validation must be stressed as necessary since religious, spiritual, and existential aspects are understood and experienced differently depending on the cultural setting (La Cour and Hvidt 2010). Research shows, for instance, that religious and spiritual issues can be difficult to approach in secular contexts where these issues predominantly belong to the private sphere and are not easily brought into focus in a healthcare context (Nissen et al. 2019; Hvidt et al. 2017).

Table 8. Implementation in other cultural contexts.

Instrument	Implemented in (II)	N	Instrument	II	N	Instrument	II	N
SpNQ GER	BRA, CHN, CRO, DEN, ESP, FAR, FRA, GRE, IND, IRN, ITL, LTH, MYS, NGA, POL, PRT, PAK, UK	18	**SBI-15R** USA	ISR, ITA, TUR	3	**NHS** USA	NOR	1
QLQ-SWB-32 EU	BRA, CHI, CRO, ESP, NED, ENG, FRE, GER, GRE, ICE, ITL, JAP, MEX, NOR, PER, POR, RUS	17	**SHAS** IND	BRA, ISR, LTU	3	**PSNAS** USA	TUR	1
DUREL USA	BRA, GER, CHN, DEN, ESP, IRN, JPN, KOR, NED, NOR, POR, ROU, SAU, THA	14	**SPS** USA	IRN, SPG, SWE	3	**PTGI** USA	CHN	1
Brief RCOPE USA	BRA, CZE, DEN, FRA, GRE, IRN, MEX, NED, PKS, POL, SWE	11	**HHI** USA	ITL, NOR	2	**RCS** NED	BEL	1
POS ENG	ARG, AUS, BWA, GER, KEN, MWI, RSA, TZA, ZMB, ZWE	10	**INSPIRIT** USA	BRA, POR	2	**RFIRSB** ENG	ITL	1
SHA USA	AUS, CHN, ESP, FRE, GER, ITL, POL, JPN, IND, PHL	10	**MI-RSWB** AUT	ENG, GER	2	**SCQ** POL	NED	1
SWB USA	BRA, CAN, IRN, ITL, JOR, KOR MYS, ESP, THA, TWN	10	**SCSRFQ** USA	BRA, POR	2	**SDS** TWN	BRA	1
CFI USA	CAN, DEN, IND, KEN, NED, NOR, PER, SWE	8	**SCS Scale** MLT	ENG, IRN	2	**SHALOM** AUS	IRN	1
SpREUK GER	Arabic, ENG, ESP, ISR, MYS, POL, POR	7	**SNAP** USA	BRA, CHN	2	**SIBS** USA	GRE	1
FACIT-Sp-12 USA	AUS, BRA, IND, JOR, KOR, POR	6	**WHOQOL SRPB,** WHO	SUI, ZWE	2	**SIWB** USA	TWN	1
RCOPE USA	BRA, CZE, FRA, GRE, POL	5	**ESRD** USA	CAN	1	**SNS** KOR	IRN	1
BMMRS USA	ETH, ITL, POR, IND	4	**FICA** USA	CAN	1	**SpIRIT** USA	CHN	1
DSES USA	BRA, DEN, POR	3	**JAREL SWBS** USA	TUR	1	**Spirit 8** RSA	UGA	1
MQLI USA	CHN, ESP, KOR	3	**MRS** USA	IRN	1	**TSRS** USA	BRA	1

SpNQ, Spiritual Needs Questionnaire; QLQ-SWB-32, QLQ Spiritual Wellbeing 32; DUREL, Duke University Religion Index; Brief RCOPE, Brief Religious Coping; POS, Palliative Care Outcome Scale; SHA, Spiritual Health Assessment Tool; SWB, Spiritual Wellbeing; SpREUK, Spiritual and Religious Attitudes in Dealing with Illness; Facit-Sp-12, Functional Assessment of Chronic Illness Therapy-Spiritual Wellbeing; Rcope; Religious Coping; BMMRS, Brief Multidimensional Measure of Religiousness/spirituality; DSES, Daily Spiritual Experience Scale; MQLI, Multicultural Quality of Life Index; SBI-15R, Systems of beliefs Inventory; SHAS, Spiritual Health Assessment Scale; SPS, Spiritual Perspectives Scale; HHI, Herth Hope Index; INSPIRIT, Index of Core Spiritual Experience; MI-RSWB, Multidimensional Inventory of Religious/Spiritual Well-Being; SCSFRQ, Santa Clara Strength of Religious Faith Questionnaire; SCS Scale, Spiritual Coping Strategies Scale; SNAP; Spiritual Needs Assessment for Patients; WHOQOLSRPB, World Health Organization Question of Life Spirituality, Religiousness, and Personal Beliefs; ESRD, End Stage Renal Disease Spiritual Beliefs Scale; FICA, Faith, Importance, Community, Address in care; Jarel SWBS, Jarel Spiritual Well-Being Scale; MRS, Mature Religiosity Scale; NHS, Nowotny Hope Scale; PSNAS, Patients Spiritual Needs Assessment Scale; PTGI, Post Traumatic Growth Inventory; RCS, Receptive Coping Scale; RFIRSB, Royal Free Interview for Religious and Spiritual Beliefs; SCQ, Spiritual Coping Questionnaire; SDS, Spiritual Distress Scale; SHALOM, Spiritual Health and Life-Orientation Measure; SIBS, Spiritual Involvement and Beliefs Scale; SIWB, Spirituality Index of Well-Being; SNS, Spiritual Needs Scale Korea; SpIRIT, Spiritual Interest Related to Illness Tool; Spirit 8; TSRS, Treatment Spirituality/Religiosity Scale.

International collaboration is also reflected in Table 8, where Brazil stands out as a country showing great interest in instruments developed outside the Brazilian context (N = 14). It must be noted that the information regarding implementation in other contexts is based on information gathered through the process of inclusion and has not been researched independently, wherefore the cross-cultural implementation is likely to be larger than documented here.

It should also be taken into consideration that a number of instruments were located in only one other context (N = 18), and that 42 instruments in total were located as implemented outside of the context of origin, leaving 140 instruments that (to our knowledge) were not 'exported' and implemented outside of the context of origin (and therefore not included in Table 8).

6.2. Target Area, Target Group, and Approach

The target area designates the healthcare contexts (i.e., specialist or subject area as described in the original articles), in which the instruments were developed and is not meant to state that the area is exclusive. The category also includes research.

The target group designates the primary person the instrument targets, primarily patient or healthcare professional. Healthcare professional refers to the general category of healthcare professionals, if specific areas are mentioned they are included, such as for instance nurse or chaplain. Approach designates the type of instrument, such as questionnaire or interview.

As summed up in Table 9, the instruments have been developed and employed in many different areas within healthcare. Some of the areas partly overlap depending on local definitions, such as areas related to oncology, chronic illness, critical illness, end-of-life, and terminal illness. The classifications are derived from the area the studies mention as the primary area. Some instruments were developed outside of healthcare but have been implemented in a healthcare context. A substantial number of instruments have been developed within palliative care, end-of-life, oncology, etc., which is to be expected as these are areas where spiritual distress naturally occur, let alone emerge from. Many instruments are applied in more than one area and many are applicable in both research and clinical practice, which is why the total of Table 9 (N = 277) is higher than the 182 instruments included in the catalogue. An example is the Multidimensional Inventory of Religious/Spiritual Well-Being (MI-RSWB) (Unterrainer et al. 2010).

Table 9. Target area.

Health Area	N	Health Area	N	Health Area	N	Health Area	N
Acute care	1	Drug abuse	8	Heart failure	2	Pastoral care	7
Acute illness	1	End-of-life	6	Human immunodeficiency virus (HIV)	1	Psychiatry	7
Chronic illness	13	End stage renal disease	1	Mental health	11	Psychology	8
Chronic physical disability	1	General health	46	Nursing	15	Research	64
Critical illness	3	General practice	2	Oncology	34	Terminal illness	2
Dementia	1	Geriatric	10	Palliative care	33		
						Total	**277**

The MI-RSWB was developed in Austria within psychology of religion as an instrument for the general measure of religious/spiritual well-being for research purposes, bearing over into clinical practice as part of diagnostics in psychotherapy, and thereby included in both the research category and psychology category. This places MI-RSWB as part of phase (1) 'detecting spiritual distress' in the process of spiritual care. MI-RSWB is also an example of international influences because MI-RSWB, to some extent, builds on (is inspired by) the developments and conceptualizations from the USA made by Pargament et al. (2011) and Ellison and Paloutzian (1982). MI-RSWB was developed in an Austrian context and translated for use in the UK to further facilitate research (Unterrainer et al. 2012).

From the perspective of the category, target group, the instruments are, in one way or another, aimed at patients and from this perspective all instruments should have patients noted in the target group category. Even if the instrument is aimed at training healthcare professionals in providing spiritual care, the patients are still the final target. The category becomes relevant, however, when considering it in relation to the online catalogue. Table 10 shows the target group category sorted by nurse, a feature in the online catalogue, enabling better flexibility in this aspect and potentially assisting in bridgebuilding between healthcare professionals' competences, attitudes, etc., which may be different from patients' expectations, needs, coping strategies, etc.

We limited the approach category to include the primary approach of the instruments. The vast majority of the instruments are structured as questionnaires as shown in Table 11. Some of the

instruments take more than one approach, such as for instance, Integrated Narrative Nursing (INN, Artioli et al. 2017). INN is based on a questionnaire, followed by an interview, and then an integration with the narrated stories of the patients themselves. The category framework (Table 11) includes a variety of approaches such as the Bio-Psycho Social-Spiritual Model (BPSSM), developed at the University of Nevada (2000).

Table 10. Target group focus: Nurse.

Abbreviation	Target Group	Year, Origin	Abbreviation	Target Group	Year, Origin
2Q-Sam	Nurse	2018, USA	**PCM**	Nurse	2006, USA
BSS	Nurse	2009, USA	**SAS**	Nurse	1993, USA
CSAT	Nurse	2007, USA	**SAS**	Nurse	2015, CAN
GASN	Nurse	2000, USA	**SDS**	Nurse	2005, TWN
GSA	Nurse	1979, USA	**SHI**	Nurse	1992, IRE
GSWS	Nurse	2008, USA	**SpiPas**	Nurse	2006, JPN
INN	Nurse	2017, ITL	**SR**	Nurse	2010, UK
JAREL SWBS	Nurse	1996, USA	**SS**	Nurse	2005, USA
Mor-Vast	Nurse	2006, USA	**SWBQ**	Nurse	2002, AUS

2Q-SAM, 2 Question Spiritual Holistic Assessment Model; BSS, Brief Serenity Scale; CSAT, Client Spiritual Assessment Tool; GASN, Guidelines for the Assessment of Spiritual Needs; GSA, Guidelines for Spiritual Assessment; GSWS, Geriatric Spiritual Well-Being Scale; INN, Integrated Narrative Nursing; Jarel SWBS, JAREL Spiritual Well-Being Scale; Mor-Vast, Moral Authority, Vocational, Aesthetic, Social, and Transcendent Model; PCM, Principle Components Model; SAS, Spiritual Assessment Scale; SAS, Spiritual Assessment System; SDS, Spiritual Distress Scale; SHI, Spiritual Health Inventory; SpiPas, Spiritual Pain Assessment Sheet; SR, Spiritual Reminiscence; SS, Spirituality Scale; SWBQ, Spiritual Well-Being Questionnaire.

Table 11. Approach.

Approach	Questionnaire	Framework	Interview	Dialogue	
Number	131	20	19	12	
Total					**182**

The BPSSM is an educational program that teaches how to assess spiritual needs and how to incorporate spiritual considerations and needs of patients into the formulation of treatment plans. The framework category also includes models that include schematic presentation as part of the wider framework of the process of spiritual care (see above). Dialogue is understood as dialogue between either the patient and healthcare professional or as part of a group dialogue in a session involving persons/patients. Dialogue is seen as more informal and unstructured than interview.

6.3. Spiritual Care as a Process

The understanding of spiritual care as a (hypothetical) process consisting of (at least) four phases illustrates firstly that providing spiritual care is not a question of 'just' making an intervention by using an instrument. Several instruments may be necessary (Büssing 2019) and looking at spiritual care as a process highlights how the health professional's personal empathy towards the patient is important in identifying spiritual distress or needs, and how to proceed with providing spiritual care, and including existential, spiritual, and religious aspects as part of patient-centered care (Vincensi 2019). Secondly, the understanding of spiritual care as a process illustrates how instruments 'by themselves' may not be perceived as a spiritual care instrument at all. One cannot say, for example, that the Herth Hope Scale (HHI, Herth 1988/1991) is a spiritual care instrument per se. The HHI is designed to measure hope and does so through a 12-item, 4-point Likert scale questionnaire. The questions are existentially oriented with items such as "I have deep inner strength" or "I just know there is hope". There is only one question directly related to religion/spirituality "I have a faith that gives me comfort". The 4-point Likert scale answers range from "Never applies to me" to "Often applies to me". This question on faith and the Likert scale answer may not necessarily lead the healthcare professional to question the

patient further in relation to identifying spiritual distress (phase 1) and a potential need for spiritual care, but then again, it might. Clearly, to detect spiritual distress and set things in motion in order to provide the best spiritual care possible for the patient, depends on the healthcare professional and the above-mentioned empathy and attitude towards spiritual care.

Examples of instruments positioned in the other phases are: phase (1) 'identifying spiritual distress/the need for spiritual care', Connecto (Fletcher 2016); phase (3) 'providing spiritual care', Open Invite Model of Exploring Spiritual Needs (Open Invite, Saguil and Phelps 2012); phase (4) 'evaluation', Lothian Chaplaincy Patient Reported Outcome Measure (LCPROM, NHS Lothian 2012). Spiritual Assessment and Intervention Model (Spiritual Aim, Shields et al. 2014) is an example of a framework encompassing all four (hypothetical) phases of the process of spiritual care. It is designed for chaplains to assess individual unmet spiritual needs, devise and implement a plan for addressing this, and evaluate the outcome of the intervention.

Understanding spiritual care as a process enables the inclusion of instruments in the catalogue such as the above-mentioned HHI, but also instruments positioned where the existential, spiritual, and religious interweave. It could be argued that it would make a clearer and stronger catalogue to completely exclude any secular existential focus and exclusively center on the spiritual and religious aspects. However, this would lead to the exclusion of instruments developed in more secular grounded contexts, and thereby exclude instruments that deal with the spiritual and religious in post-secular environments where the religious/spiritual may be approached through a secular vocabulary (Nissen et al. 2018). This also bears into cross-cultural discussions of what spirituality is and different understandings of the concept. This can be exemplified in the catalogue by instruments developed in religious contexts such as Brazil, where the Intrinsic Religiosity Inventory (IRI, Taunay et al. 2011) is aimed to assess intrinsic religiosity in relation to the impact of religion on both physical and mental health. In a more secular context, the Mature Religiosity Scale (MRS, De Vries-Schot et al. 2012) from the Netherlands, addresses religiosity but is aimed directly at Christian patients. Thereby, two different groundings of different instruments enable a similar focus, and further discussion from a cross-cultural perspective would enable best practice results to be more easily shared internationally.

The inclusive understanding of secular existential, spiritual, and religious also makes the catalogue relevant cross-culturally by including different culturally based understandings of existential, spiritual, and religious and of what spiritual care is and can be. The Existential Communication in General Practice (EMAP, Assing Hvidt et al. 2017) is an example of an instrument developed in a secular (and non-English speaking) context and grounded in an approach to existential themes, where religious or spiritual topics are seen as private areas, and approaching these topics "should be kept in a normalizing tone so as to facilitate disclosure and avoid feelings of shyness, shame or of being different" (Assing Hvidt et al. 2017, p. 264). The EMAP is also one of the few examples of instruments developed in or aimed at general practice.

As illustrated through this discussion, the catalogued instruments that this review has identified represent many understandings of what spiritual care is, what it can be, how to provide it, and how it interconnects with and relates to patient-centered care (Steenfeldt et al. 2019; Vincensi 2019), all of which are central in the continuing development of spiritual care.

7. Perspectives, Limitations, and the Online Catalogue

There are many areas of debate and questions that a catalogue of this kind opens, and there are limitations as well. It is our hope that the online platform version of the catalogue will stimulate these debates, and thereby contribute to the ongoing development of spiritual care.

In the following the perspectives and limitations of the catalogue are discussed.

The catalogue clearly shows that a plentitude of instruments exist that can be applied in the process of providing spiritual care; by looking at spiritual care as a process, it has also been shown that instruments that may not have been aimed specifically at spiritual care can be useful and applicable as part of spiritual care.

It is a limitation of the catalogue in its present form that the validation status of the individual instruments was not considered. Instead we used the wording of the articles (see above). This is a limitation that the online version must address also in relation to cross-cultural validation approaches and standards. With a clear approach to international validation the online catalogue will increase its usefulness and relevance.

Another limitation is the language bias, as the included instruments are primarily developed in English-speaking contexts. However, by openly addressing this as a limitation, we see it as an opportunity for non-English researchers and healthcare professionals to contribute with their knowledge in order to enable spiritual care to become a crosslinguistic and cross-cultural endeavor, to overcome the linguistic bias, and to 'decolonize' (Mignolo 2011) the concept 'spirituality' as a European construct, thereby individualizing the concept in order to assist in overcoming difficulties that spiritual care faces in cross-cultural healthcare contexts (Nissen et al. 2019; Hvidt et al. 2017).

A limitation of the catalogue in its current form is that it does not open debate within the category target group, which includes both patients and healthcare professionals. The online interactive version will enable better flexibility in this aspect and potentially assist in bridgebuilding between healthcare professionals' competences, attitudes, etc., which may differ from patients´ expectations, needs, coping strategies, etc.

The catalogue, Appendix A, can potentially enable and further cross-disciplinary contact between healthcare disciplines, such as for instance oncology and palliative care, and between healthcare professionals such as physicians, nurses, and chaplains, and in this way contribute with added value to clinical practice. The same can be said from a research perspective. With the catalogue in written form only this is a limitation as the catalogue cannot be exhaustive in the information given and it is not possible to enable direct contact between various cultural or clinical settings. The online version of the catalogue as an online interactive platform, will remedy this. It is especially this feature we believe will make the catalogue useful in an international and cross-cultural context.

8. Conclusions

The aim of this study was, through a scoping review method, to identify spiritual care instruments, in order to increase the cross-disciplinary and cross-cultural visibility and accessibility of these instruments, and thereby to contribute to ongoing international development of spiritual care. Looking at spiritual care as a process enabled a wide inclusion of instruments from multiple healthcare areas relevant for multiple disciplines, healthcare professionals, and research. It was found that cross-cultural accessibility, language bias, and cross-cultural validation are difficult areas to approach and these areas need attention in order to further international collaboration towards best practice. It is the ambition of the online version of the catalogue to assist in this work. However, with 182 instruments located and included in the catalogue it is clear that spiritual care is an area of focus with great potential for international development and collaboration.

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Appendix A The Catalogue of Spiritual Care Instruments

Online: www.faith-health.org/catalogue.

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