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# Development of a Spiritual Self-Care Practice Scale

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**Background and Purpose:** Development of a valid, reliable instrument to measure spiritual self-care practices of patients with heart failure. **Methods:** African American patients ( $N = 142$ ) with heart failure participated in the study. Spiritual advisors from several religious groups reviewed the Spiritual Self-Care Practices Scale (SSCPS) for content validity. Construct validity was determined using a principal components factor analysis. Reliability was established using Cronbach's alpha coefficients. **Results:** Religious advisors provided suggestions to improve content validity. Four factors consistent with spiritual practices (personal spiritual practices, spiritual practices, physical spiritual practices, and interpersonal spiritual practices) emerged from the factor analysis. The alpha coefficient was moderate at 0.64. **Conclusions:** Results indicated the SSCPS was reliable and valid for measuring spiritual self-care practices among African Americans with heart failure. Additional testing is needed to confirm results in other patient groups with chronic illnesses.

**Keywords:** spirituality; self-care; measures; nursing theory; practices

Spirituality profoundly affects human health and illness and contributes to quality of life. Nursing has traditionally been concerned with the human spirit as a focal point of the human condition across the lifespan. Nurses and other health care providers need to be aware of the relation between spirituality and patients' abilities to cope with life events. Researchers in the fields of theology, sociology, psychology, and medicine have examined spirituality, with these research studies providing substantial contributions to the continuing delineation of the construct (Como, 2007). With a growing interest in spirituality and health, several research efforts have focused on developing valid, reliable ways to measure spirituality-related concepts.

Spirituality is a particularly important element in the lives of people who have been diagnosed with chronic illnesses or injuries (Wittink, Joo, Lewis, & Barg, 2009). Definitions of spirituality are diverse and many instruments are available that combine measurements of both spiritual beliefs and spiritual practices.

A comprehensive review of literature was conducted to find an instrument that could be used to measure spiritual practices. Most of the available instruments were intended to measure religious beliefs, spiritual beliefs, and spiritual practices in combination. None of the identified surveys isolated spiritual self-care practices from beliefs. Some instruments also combined spirituality and well-being. In response to the identified need for a practice-focused tool, the Spiritual Self-Care Practices Scale (SSCPS) was developed by White (2010).

Understanding that spiritual beliefs and practices are distinct and may not be congruent, the authors developed a new instrument to measure what people do (spiritual practices) separate from what they believe. The authors' interest was in testing a midrange model of the relationships between spiritual practices in which people engage and self-care practices used to promote health and well-being. The conceptual framework has been presented elsewhere (White, Peters, & Schim, 2011). The purpose of this article is to describe the survey development process, initial testing, and psychometrics of the SSCPS that can be used to measure spiritual self-care practices.

## BACKGROUND AND CONCEPTUAL FRAMEWORK

### Spirituality

Defining spirituality is difficult for most people, with confusion also existing in academia. For example, Dessio et al. (2004) defined spirituality in terms of "a person's acknowledgment of, and relationship with, a higher being, but [spirituality] can also mean one's unique sense of connectedness to the self, others, and nature" (p. 189). Although many religious people consider themselves spiritual, spirituality is a broader concept that incorporates both religious and nonreligious practices (Dessio et al., 2004). For the purpose of the development of the SSCPS, spirituality is defined as *the beliefs a person holds related to their subjective sense of existential connectedness including beliefs that reflect relationships with others, acknowledge a higher power, recognize an individual's place in the world, and lead to spiritual practices* (White et al., 2011).

Three diverse, interrelated meanings (i.e., spiritual distress, spiritual needs, and spiritual well-being) underlie the concept of spirituality in the nursing discipline (Carson & Koenig, 2008). These aspects of spirituality are relevant for health promotion and health recovery. Spirituality can give meaning to the lives of healthy people, providing comfort in good times (Fosarelli, 2008) and sustaining a positive outlook during bad times. Spirituality can bring peacefulness, a reason for living, a sense of purpose, and a sense of harmony to individuals who are experiencing health crises (Katerndahl, 2008). For individuals who are ill or dying, increased spirituality and spiritual support can be important coping mechanisms (Creel & Tillman, 2008). Spirituality allows individuals with chronic pain to accept their condition and give meaning to their lives despite their pain (Sorajjakool, Thompson, Aveling, & Earl, 2006). Nurses need to understand the different manifestations of spirituality and fully understand through research how to use spiritual interventions effectively to provide nursing support during health and illness. Viewing spirituality and spiritual practices within a self-care deficit nursing theoretical perspective provides nurses with a framework by which to ensure a holistic approach for meeting the health care needs of patients and families (Orem, 2001).

### Spiritual Practices

Although spiritual beliefs and spiritual practices are mentioned frequently and used interchangeably in the literature, they are distinct concepts. Spiritual *beliefs* (e.g., acknowledging that God or another higher power is the ultimate healer, acknowledging God's powers, and abiding by divine laws to improve health) generally are within cognitive (thought) and affective (feeling) domains. In contrast, spiritual *practices* are primarily within the psychomotor (doing) domain and can be performed by an individual alone or in concert with

others. Examples of spiritual practices include prayer, worship, and meditation (Newlin, Knafl, & D'Eramo Melkus, 2002); going to church or another place of worship (Harvey, 2006); and interacting with others (Conner & Eller, 2004).

Adding to the complexity of distinguishing spiritual beliefs from practices is the observation that many established spiritual practices (e.g., prayer or meditation) are primarily cognitive processes in which the thinking, feeling, and doing of the activity are difficult to disentangle. Spiritual practices can influence the way individuals “. . . view themselves, the meaning in their lives, and their role in the world” (Rothman, 2009, p. 178). Conversely, individuals' spiritual beliefs influence their practices in complex ways.

Spiritual practices can include public participation or personal pursuits. Public participation can encompass activities such as theological study, group worship (Ryder, Wolpert, Orwig, Carter-Pokras, & Black, 2008), volunteering, or group exercise or rehabilitation classes. Personal pursuits can include prayer (Campbell & Ash, 2007); yoga (Chen et al., 2008); transcendental meditation (Jayadevappa et al., 2007); relaxation techniques (Chang et al., 2005); as well as engaging in healthy behaviors, relishing nature and the beauty embodied in it, and sustaining hope and positive attitudes even in times of stress. These pursuits can be done either alone or in groups.

### Self-Care

*Self-care* is defined as a “naturalistic decision making process involving the choice of behaviors that maintain physiologic stability (self-care maintenance) and the response to symptoms when they occur (self-care management)” (Riegel et al., 2004, p. 351). Self-care is situation and culture specific, involving the capacity to act and to make choices. Self-care is influenced by knowledge, skills, values, motivation, locus of control, and efficacy; and focuses on aspects of health care under individual control (Gantz, 1990). Actions and behaviors associated with self-care have been identified by Orem (2001) as types of operations to maintain human life, health, and well-being. These regulatory actions are influenced by age, stage of personal development, health state, environmental conditions, and effects of medical care. Some examples of specific self-care behaviors are following a therapeutic diet, engaging in exercise, and taking medications as prescribed.

### Spiritual Self-Care

White's theory of spirituality and spiritual self-care (WTSSSC) was derived from Orem (2001). In developing the middle-range theory, White achieved greater precision by separating spiritual beliefs (spirituality) from spiritual practices (spiritual self-care). Detailed description of this substruction and the WTSSSC are available elsewhere (White, 2010; White et al., 2011).

Spirituality allows individuals to engage in specific spiritual self-care practices. Spiritual self-care as defined in the WTSSSC is *the set of spirituality-based practices in which people engage to promote continued personal development and well-being in health and illness*. Spiritual self-care is based on an individual's mind/spirit/body connection, upbringing, moral and religious background, and life experiences that originate from faith, feelings, and emotions. Examples of spiritual self-care can include building social networks or volunteering (Liu et al., 2008), listening to inspirational music (Stake-Nilsson, Soderlund, Hultcrantz, & Unge, 2009), meditation (Delaney, 2005), and developing a sense of inner peace and quiet (Kreitzer, Gross, Waleekhachonloet, Reilly-Spong, & Byrd, 2009). Other examples of spiritual self-care include practicing yoga or Tai Chi; attending

religious services; reading sacred or inspirational texts; praying or mediating; hiking, walking, or otherwise enjoying nature; and developing or mending personal relationships. Whatever the spiritual self-care activity, the goal is to enhance spiritual well-being and improve overall health and well-being.

## PROCEDURE FOR DEVELOPMENT OF THE SSCPS

Study protocols were approved by the Wayne State University Human Investigation Committee and Internal Review Boards at the hospital system and individual practices. The researcher-developed SSCPS is a 36-item paper-and-pencil self-report questionnaire that was designed to measure the frequency with which participants practice spiritual self-care actions and behaviors.

## ITEM DEVELOPMENT

Potential items for the SSCPS were developed from a review of the relevant literature on spirituality and spiritual practices, discussion of the emerging middle-range theory, and brainstorming with both clinicians and spiritual leaders in the community. The items were rationally assigned to four subscales: personal spiritual behaviors, interpersonal spiritual behaviors, health-related spiritual behaviors, and physical activity spiritual behaviors. These four subscales were developed to capture a range of potential actions thought to be common spiritual practices in a middle-American, urban/suburban community. Thirty-eight items were considered for the initial version of the SSCPS. Because the measurement interest was in the frequency with which the spiritual actions and practices were performed, the instrument was designed using a 5-point Likert-type response set ranging from 1 for *never* to 5 for *always*. The tool was laid out as a matrix with individual items in numbered flush left rows and boxes for responses along the right margin. Although a matrix layout is considered to require relatively high literacy skills and potential loss of control over a survey's navigational path (Dillman, 2007), the authors opted for this format to minimize the length of the instrument and maximize parsimony. Concerns regarding literacy were addressed through the reading of items to participants, with the interviewer recording the responses. After initial construction, the tool was subjected to a three-phase evaluation process including (a) review by an expert panel, (b) pilot testing, and (c) psychometric testing using a larger sample. Each of these phases is described briefly.

### Phase 1: Expert Review

The preliminary SSCPS with 38 items was given to five local religious leaders to evaluate item content validity. Reviewers included a Jewish rabbi, an Episcopal pastor, a Muslim imam, a Lutheran minister, and a Roman Catholic priest. Although these experts do not represent every religious or spiritual perspective, they include the major traditions in this community. The religious leaders reviewed the survey items for representation of spiritual practices, clarity, readability, duplicated items, inclusiveness, and items for additional spiritual practices that should be added. Reviewers rated item relevance to *spiritual practices* using a 4-point scale ranging from 1 for *not spiritual* to 4 for *spiritual*. The first author reviewed comments and responses on the evaluations and made changes



when a consensus was achieved regarding removing an item or changing the wording to make it more reflective of spiritual practices. Two items (“Asking questions about medical orders” [duplicate item] and “Practicing Tai Chi”) were removed from the survey based on reviewer recommendations. In addition, the item “Reading” was changed to “Reading for Inspiration,” and “Wearing special clothing” had examples added (e.g., “yarmulke, burka, cross, star of David”) as reviewers suggested. The clergy group reached consensus on the inclusion of the revised instrument consisting of 36 items. This tool was then used in a pilot test to determine the usability of the instrument with people seeking the services of a physician.

## Phase 2: Pilot Test

Following approval from the Wayne State University Human Investigation Committee (WSU HIC), a pilot test of the 36-item revised SSCPS was completed with a convenience sample of 35 patients in a general practice medical office. The patients included 30 (85.7%) females and 5 (14.3%) males. The racial distribution of the pilot sample was White ( $n = 23$ , 65.7%), African American ( $n = 3$ , 8.6%), Asian/Pacific Islander ( $n = 7$ , 20.0%), and Hispanic ( $n = 2$ , 5.7%). The mean age of participants in the pilot test was 46.37 ( $SD = 8.70$ ) years, with a median age of 43 years. Participants ranged in age from 32 to 66 years. Pilot participants represent a more racially diverse sample than the more homogeneous African American sample selected in the larger study. However, on other aspects of demographics and diversity, the samples are similar. For the purpose of preliminary testing of the tool, the broader sample was appropriate.

Pilot participants were asked to comment on the ease of use of the new tool and the relevance of the items to spiritual practices to obtain feedback from lay (nonclergy) people in the community regarding face validity. No items were identified as problematic and no items were added or deleted in this phase.

The pilot participants completed both the new SSCPS and the established *Spirituality and Spiritual Care Rating Scale* (SSCRS; McSherry, Draper, & Kendrick, 2002) to allow estimation of criterion validity and to evaluate internal consistency of the SSCPS using Cronbach’s alpha coefficient. The SSCRS is a widely used valid and reliable instrument that measures spirituality beliefs and practices. Construct validity of the SSCRS was determined using a principal components factor analysis with a varimax rotation (McSherry et al., 2002). Four subscales emerged from the analysis accounting for 64% of the variance in spirituality and spiritual care. The internal consistency of SSCRS was reported as good ( $\alpha = 0.91$ ), although McSherry et al. (2002) indicated that the alpha coefficients for the individual subscales ranged from 0.65 to 0.77.

Responses on the new tool (SSCPS) and the SSCRS were correlated to determine the extent to which the instruments were measuring similar constructs. Correlation coefficients between the SSCPS and SSCRS were statistically significant ( $r = .37$ ,  $p = .027$ ) indicating adequate criterion validity. The SSCPS was found to have good internal consistency reliability on the pilot test with a Cronbach’s alpha coefficient of 0.92. The results of the pilot test provided support that the new instrument had good reliability and validity for use in research.

The final step in pilot testing the SSCPS was evaluation of reading level. Estimation using the Flesch-Kincaide readability index was at the eighth grade level. Of the 36 items, however, 34 were observed to be at a fourth grade reading level. Two items, “Following a special diet (e.g., Kosher, Halal, vegetarian)” and “Wearing special clothing or jewelry

(e.g., yarmulke, burka, cross, star of David)” included potentially unfamiliar polysyllabic words that increased the overall reading level substantially. However, these items were retained based on their importance in the overall purpose of the instrument. Participants in the pilot test did not report any difficulty understanding or responding to any of the 36 items presented.

## DESCRIPTION, ADMINISTRATION, AND SCORING

The SSCPS was administered to participants in outpatient clinics at the time of their medical appointments. Participants were given an information sheet and had opportunities to ask questions prior to completing a packet of survey tools that included the SSCPS. To ensure consistency in the survey administration, the first author, who was the principal investigator (PI) on the larger study, met individually with the participants and read all items to them, recording their responses on the forms. A small incentive payment (\$20) was provided to everyone who participated in any part of the survey.

Participants were asked to rate the frequency with which the actions and behaviors are practiced on a 5-point scale ranging from 1 for *not at all* to 5 for *always*.

To score the survey, the numeric ratings for items on each of four subscales are summed to obtain a total score for each subscale. Because the subscales differ regarding to the number of items, the total score for each subscale is then divided by the number of items included on that subscale to obtain mean scores. The use of mean scores allows results to be reported in the original unit of measurement (1–5) and provides a means of directly comparing the subscales.

## METHOD

### Participants

There were 142 African American patients diagnosed with heart failure participated in the larger study of African Americans with heart failure during which psychometrics of the SSCPS were evaluated (White & Schim, 2010). Study participants were seeking medical services in two outpatient clinics located in a large metropolitan area in the U.S. Midwest. The mean age of the participants was 56.82 ( $SD = 14.41$ ), with a median age of 56 years. Participants ranged from 18 to 91 years of age. The sample was split evenly between male (50%) and female (50%) respondents even though no effort was made to stratify by gender. All participants self-reported being African American. The number of years since diagnosis of heart failure ranged from 0 (newly diagnosed) to 55 years with a median of 2 years. The upper limit of 55 years was set by one participant who had been diagnosed at birth with a congenital heart defect. The mean number of years since diagnosis was 4.75 ( $SD = 7.89$ ) years. Sixty-seven (47.0%) of the participants had Stage D heart failure. Stage D is indicative of the most severe cardiac conditions according to the severity rating system used by the American Colleges of Cardiology and the American Heart Association (McCormick, 2007–2008). Most ( $n = 92$ , 65%) said they were Baptist in religious background, and most reported Baptist as their current religious affiliation ( $n = 79$ , 56%). Demographics for the sample are summarized in Table 1.

**TABLE 1. Frequency Distributions—Demographic Characteristics of the Sample ( $N = 142$ )**

Demographic Characteristics	<i>n</i>	Percentage
Gender		
Male	71	50.0
Female	71	50.0
Marital status		
Single, never married	61	43.3
Married	36	25.5
Widowed	18	12.8
Divorced	24	17.0
Living with partner	2	1.4
Educational level		
Less than high school	30	21.6
High school graduate/GED	56	40.3
Some college/technical school	30	21.6
Associate degree	12	8.6
Bachelor's degree	7	5.0
Graduate degree	4	2.9
Work status		
Working full time	23	16.5
Working part time	5	3.6
Retired	39	28.1
Retired, volunteering	2	1.4
Disabled	44	31.7
Other	26	18.7
Living arrangements		
Spouse	40	28.8
Children	25	18.0
Alone (independently)	43	30.9
Assisted living facility	2	1.4
Senior residence	1	0.7
Other family/friends	28	20.1

*Note.* Mean age 56.82 ( $SD = 14.41$ ) years, ranging from 18 to 91 years.



## RESULTS

### Factor Analysis

Ratings for the 36 items of the SSCPS obtained from the 142 participants were used in a principal components factor analysis using a varimax rotation. Four factors emerged from the factor analysis, including personal spiritual practices, spiritual practices, physical spiritual practices, and interpersonal spiritual practices. Personal spiritual practices included items that individuals do for themselves. Spiritual practices were actions associated with internal reflection. Physical spiritual practices encompassed involvement or participation in individual or group activities. The fourth factor to emerge was termed interpersonal spiritual practices because the items tended to involve interactions with others. To be retained on a factor, the item had to have a factor loading greater than or equal to .35 and not load highly on more than one factor. The four factors explained 47% of the variance in spiritual self-care practices. Eigenvalues for each of the four factors were greater than 1.00, indicating that each factor was explaining a statistically significant amount of variance in the latent variable. One item, *Singing or listening to music*, did not load on any of the factors and was eliminated from further analyses. The results of the factor analysis are presented in Table 2.

Concurrent validity was examined by correlating the four subscales on the SSCPS with the four subscales (core spirituality, spiritual perspective/existential, personal application/humility, and acceptance/insight) of the *Spiritual Involvement and Belief's Scale—Revised* (SIBS—R; Hatch, Burg, Naberhaus, & Heilmich, 1998; Hatch, Spring, Ritz, & Burg, 2006). The SIBS—R has been tested extensively for validity and reliability by the scale authors. The correlations obtained between the SSCPS and the SIBS ranged from .72 for the relation between core spirituality and spiritual practices to .13 for acceptance/insight and physical spiritual practices. A summary of the correlations between the SSCPS and SIBS subscales is shown in Table 3.

To estimate the reliability of the SSCPS, internal consistency coefficients were obtained using Cronbach's alpha procedures. Results of these analyses indicated adequate to good internal consistency for each of the four subscales: personal self-care practices (0.89), spiritual practices (0.85), physical spiritual practices (0.69), and interpersonal spiritual practices (0.66). The alpha coefficient for the total scale was 0.91, indicating that the SSCPS has good internal consistency.

## DISCUSSION

The SSCPS was developed to measure spiritual self-care activities among people with chronic illnesses based on the proposition that such activities were linked to overall self-care and quality of life. The types of activities included on the survey included items from various common religious and spiritual traditions that reflected spiritual practices in everyday life.

The instrument was designed with input from different religious leaders and was pilot tested in a diverse population of patients visiting a general practitioner's office. Results of the pilot test provided initial support for the internal consistency of the items and pilot participants also provided comments regarding readability. Their comments also were considered in developing the final version that was used with African American patients diagnosed with heart failure.

**TABLE 2. Factor Analysis—Spiritual Self-Care Practices Scale**

Item	Factor 1	Factor 2	Factor 3	Factor 4
Personal spiritual self-care practices				
Making time for self	0.71			
Eating healthy foods	0.67			
Feeling at peace and/or in harmony	0.66			
Resting to regain health and energy	0.65			
Giving love to others	0.58			
Following medical orders	0.57			
Maintaining a sense of hope for the future	0.57			
Laughing	0.56			
Forgiving yourself	0.56			
Finding meaning in both good or bad situations	0.51			
Maintaining positive relationships	0.50			
Asking questions about medical orders	0.50			
Forgiving others	0.43			
Helping others	0.43			
Spiritual practices				
Attending religious services		0.75		
Contributing to a religious group		0.70		
Praying		0.68		
Consulting a spiritual advisor		0.66		
Living a moral life		0.59		
Meditating, contemplating, or reflecting		0.55		
Reading for inspiration		0.54		
Mending broken relationships		0.40		
Resolving conflicts		0.38		
Physical spiritual practices				
Engaging in physical activity			0.77	
Giving alms to the poor or doing other acts of charity			0.55	
Volunteering			0.54	
Hiking or walking			0.50	
Practicing yoga or tai-chi			0.36	

*(Continued)*

**TABLE 2. (Continued)**

Item	Factor 1	Factor 2	Factor 3	Factor 4
Interpersonal spiritual practices				
Following a special diet (e.g., Kosher, Halal, vegetarian)				0.66
Maintaining friendships				0.56
Being with family				0.52
Having a meaningful conversation with others				0.47
Receiving love from others				0.46
Being with friends				0.46
Wearing special clothing or jewelry (e.g., yarmulke, birka, cross, Star of David)				0.44
Percentage of explained variance	30.23	6.90	5.35	4.77
Eigenvalues	6.00	4.47	3.76	2.77
Cronbach's alpha coefficients	0.89	0.85	0.69	0.66

The construct validity of the SSCPS was supported using factor analysis. The results of this analysis produced four factors (personal spiritual practices, spiritual practices, physical spiritual practices, and interpersonal spiritual practices). Based on these encouraging preliminary findings, the SSCPS has good reliability and validity. The instrument has good concurrent validity based on the statistically significant positive correlations between the subscales of the new SSCPS and the established SIBS—R. However, additional research is needed to expand psychometric testing of the SSCPS. Future projects with different populations will guide refinement of instrument items for subsequent editions of the tool.

The survey was well received by both study participants and the clinicians who were providing treatment. Several participants who completed the study indicated that the survey items made them think differently about their lives and what they could do to manage health problems. The survey items suggested discussion topics for some participants that could be explored in greater depth. In response to the survey, some participants wanted to start a support group so that they could continue the positive dialogue that promoted their self-care, including aspects of spirituality. Unprompted, one clinic nurse said that she had observed better compliance among some participants in the study. Many patients expressed concerns about having a diagnosis of heart failure, often relating that they thought they had somehow caused their illness. After completing the survey, they felt better about their diagnoses and were willing to become more involved in their own care. Many participants expressed their appreciation for the opportunity to reflect on their personal spiritual self-care practices.

An interesting unexpected outcome of the study was the interest generated in talking about self-care practices and the role of spirituality in controlling and managing chronic conditions. As is often the case with measurement efforts in nursing, good assessment questions can also act as interventions by creating interest in and focus on aspects of knowledge, attitudes, and behaviors among those who are participating in the assessment.

**TABLE 3. Pearson Product Moment Correlations—Spiritual Self-Care Practices Scale and Spiritual Involvement and Belief's Scale—Revised**

	Spiritual Involvement and Belief's Scale—Revised									
	Core Spiritual Practices		Spiritual Perspective/ Existential		Personal Application/ Humility		Acceptance/ Insight		Spirituality— Total Score	
Spiritual Self-care Practices Scale	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Personal self-care practices	.44	<.001	.72	<.001	.47	<.001	.27	.001	.63	<.001
Spiritual practices	.51	<.001	.55	<.001	.39	<.001	.36	<.001	.58	<.001
Physical spiritual practices	.29	<.001	.36	<.001	.22	.010	.27	.001	.36	<.001
Interpersonal spiritual practices	.20	.019	.22	.011	.14	.106	.27	.002	.25	.003
Total spiritual practices	.46	<.001	.58	<.001	.38	<.001	.40	<.001	.58	<.001

## LIMITATIONS AND RECOMMENDATIONS FOR FURTHER STUDY

The initial testing of the SSCPS has been promising, although the survey has been used primarily with a sample of African Americans diagnosed with heart failure. Additional testing is needed to determine tool usability with people with heart failure from other racial/ethnic groups and for African Americans and others with chronic diagnoses beyond heart failure. Because items are tested with broader cultural and diagnostic groups, additional spiritual practices may be identified and added to the SSCPS. Inclusion of all possible spiritual practices is unrealistic for one instrument, but tailoring items for specific populations would be possible as part of an ongoing program of research.

Once the SSCPS is used and tested more broadly in research, it could be adapted for use as a clinical assessment tool. The full relationship between scale scores and patient chronic disease clinical outcomes has not yet been described. However, if the patterns observed to date continue, the SSCPS could be a helpful adjunct to nursing assessment. The items might also be useful as an intervention to structure patient and family teaching and coaching about ways to incorporate existing or new spiritual practices into self-care for health. This type of discussion could potentially promote the use of spiritual self-care in managing chronic illnesses and add an important, but often overlooked, element to nursing care.

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