Original Article

ACTA

Validation of the nursing diagnosis Spiritual Anguish: analysis by experts*

Validação do diagnóstico de enfermagem Angústia Espiritual: análise por especialistas

Validación del diagnóstico de enfermería Angustia Espiritual: análisis por especialistas

Erika de Cássia Lopes Chaves[1], Emília Campos de Carvalho[2], Vanderlei José Hass[3]

ABSTRACT

Objective: To validate the nursing diagnosis *Spiritual anguish*. **Methods**: Using the methodological framework proposed by Fehring was utilized a semi-structured questionnaire answered by a sample of 72 nurses, to evaluate the title, definition and defining characteristics of the diagnosis *Spiritual anguish*, as well as the classification in the Taxonomy II North American Nursing Diagnosis Association. **Results:** The best area to classify the studied diagnosis according to the expert nurses was the Domain 10; however the Domain classes need to be reviewed. *Spirituality impaired* proved to be a fitting title for the investigated concept. The validation identified seven defining characteristics as important indicators of clinical diagnosis; the feature - is not interested in nature - was considered little relevant. The total score of diagnosis was 0.72, therefore was considered validated. **Conclusion:** The new proposal submitted to explaining the phenomenon under study was considered relevant. This study may provide insight to validate clinically, diagnostics investigated.
Keywords: Nursing diagnosis;Spirituality; Validation studies

RESUMO

Objetivo: Realizar a validação de conteúdo do diagnóstico de enfermagem *Angústia espiritual*. **Métodos**: Utilizando o referencial metodológico proposto por Fehring, foi empregado um questionário semi-estruturado, respondido por uma amostra de 72 enfermeiros, para avaliação do título, definição e características definidoras do diagnóstico *Angústia espiritual*, bem como, sua disposição na Taxonomia II da North American Nursing Diagnosis Association. **Resultados**: O melhor domínio para classificação do diagnóstico em estudo, segundo os enfermeiros peritos, é o Domínio 10; no entanto, suas classes requerem revisão. *Espiritualidade prejudicada* demonstrou ser um título adequado ao conceito investigado. A validação das características definidoras identificou sete delas como importantes indicadores clínicos do diagnóstico e apenas a característica *não se interessa pela natureza* foi considerada pouco relevante. O escore total do diagnóstico foi 0,72, sendo, portanto, considerado validado. **Conclusão**: Uma nova proposta apresentada ao fenômeno em estudo foi considerada pertinente. Este estudo pode oferecer subsídios para a validação clínica do diagnóstico investigado.
Descritores: Diagnóstico de enfermagem; Espiritualidade; Estudos de validação

RESUMEN

Objetivo: Realizar la validación de contenido del diagnóstico de enfermería *Angustia espiritual*. **Métodos**: Utilizando el marco metodológico propuesto por Fehring, fue empleado un cuestionario semi-estructurado, respondido por una muestra de 72 enfermeros, para evaluar el título, definición y características definidoras del diagnóstico *Angustia espiritual*, así como, la clasificación en la Taxonomía II de la North *American Nursing Diagnosis Association*. **Resultados**: El mejor dominio para la clasificación del diagnóstico en estudio, según los enfermeros peritos, es el Dominio 10; sin embargo, sus clases requieren revisión. La *Espiritualidad perjudicada* demostró ser un título adecuado para el concepto investigado. La validación de las características definidoras identificó siete de ellas como importantes indicadores clínicos del diagnóstico y apenas la característica *no se interesa por la naturaleza* fue considerada poco relevante. El puntaje total del diagnóstico fue 0,72, siendo, por tanto, considerado validado. **Conclusión**: La nueva propuesta presentada para el fenómeno en estudio fue considerada pertinente. Este estudio puede ofrecer subsidios para la validación clínica del diagnóstico investigado.
Descriptores: Diagnóstico de enfermería; Espiritualidad; Estudios de validación

---

* *Extracted from the dissertation: Review of nursing diagnosis: Spiritual Distress defended at the University of São Paulo, College of Nursing USP – Ribeirão Preto (SP), Brazil.*

[1] *PhD, Professor at the Federal University at Alfenas – Minas Gerais. UNIFAL-MG, Brazil*
[2] *Full Professor at University of São Paulo at Ribeirão Preto, College of Nursing – USP – Ribeirão Preto (SP), Brazil.*
[3] *PhD, Professor, PRODOC/CAPES fellowship, University of São Paulo at Ribeirão Preto, College of Nursing - USP – Ribeirão Preto (SP), Brazil.*

Corresponding Author: **Emília Campos de Carvalho**
Av. Bandeirantes, 3900 - Monte Alegre - Ribeirão Preto - São Paulo (SP), Brazil.
Cep: 14040-902 E-mail: ecdcava@usp.br

Received article **06/03/2009** and accepted **30/04/2009**

INTRODUCTION

The nursing diagnosis Spiritual distress proposed by the North American Nursing Diagnosis Association (NANDA) in 1980 describes the responses of individuals to disorders encompassing spirituality[1-2]. In practice, however, nurses rarely use this diagnosis even though the importance of the body-mind-spirit relationship is acknowledged in holistic care[3-5].

For nurses, the development of diagnoses encompassing "spirituality" poses the challenge of interpreting the spiritual behavior of patients. The difficulty is in the fact that these diagnoses share some defining characteristics and have a high level of abstraction. Moreover, there has been little consensus reached in the literature in relation to its definition.

An integrative review concerning spiritual distress[6] was carried out to identify the concept proposed in the literature for the phenomenon and the clinical indicators that evidence its presence. Complementing what has been proposed by NANDA[7], the authors show that spiritual distress refers to an impaired sense concerning meaning and purpose in life and an inability to connect and transcend. These authors also observed divergences in the presentation of defining characteristics. The main one refers to the grouping of these characteristics, which were distributed in the NANDA Taxonomy II according to the individuals' system of connection, restricting the description of the phenomenon, which also involves an altered perception of transcendence and meaning and purpose in life[6].

In relation to the diagnosis title attributed by NANDA, a study[5] using the steps of Walker and Avant for conceptual analysis, presents important guidance for its understanding, in which the expression "spiritual distress" is identified as the manifestation of spiritual impairment. In this context, the title impaired spirituality can better describe the losses experienced in the human spiritual dimension since the use of spirituality as a diagnostic concept, supported by the descriptor impaired, can broaden the possibility of new diagnoses in this dimension and even improve those already existent[8-9].

The need to review the organization of this diagnosis in the classification system proposed by NANDA has also been observed. Despite the fact that the domain used by the Taxonomy II to present the diagnosis is focused on the spiritual dimension, the classes composing it seem not to involve all the constructs that describe the phenomenon[10].

Based on these reflections, this study verified the relevance of the proposal to review the nursing diagnosis Spiritual distress with experts, whose modifications are highlighted (*italics*) as follow:

Domain: Life Principles

Class: Value/Belief/Action congruence, *connection, transcendence and meaning/purpose in life*

Title: *Impaired spirituality*

Definition: Inability to experience and integrate meaning and purpose in life, *transcendence and connection with oneself, with God/Power Greater than Self, with others and with the world around.*

Defining Characteristics: Express alienation *or isolation*; *Question suffering; Express altered behavior*: anger; Inability to express creativity; Express lack of meaning/*purpose* in life; Express lack of serenity; Express *altered behavior: cries*; Express lack of courage; Express lack of hope; Express *guilt*; *Refuse interactions with significant others*; *Express being abandoned; Feeling of regret; Requests spiritual assistance;* Inability to experience *transcendence*; *Present disorders in the system of beliefs or relationship with God;* Express having anger toward God; Express lack of love; *Express despair* and Disinterest in nature.

This study aimed to validate the content of the nursing diagnosis spiritual distress through a comparison of the diagnosis structure proposed by the NANDA Taxonomy II with the changes and complementation proposed in this study.

METHOD

The model of Diagnostic Content Validation proposed by Fehring[11-13] was used as the methodological framework in which the following procedures were established: selection of experts; experts identify the relevance of defining characteristics of the studied diagnosis: its title, definitions of title and class, and inclusion of the diagnosis in the proposed domains and classes; computation of scores for each defining characteristic and computation of the diagnosis' total score.

Selection and characterization of experts

A total of 72 nursing experts participated in the study and composed a convenience sample. Literature[13] recommendations were followed during the sample selection: experts should achieve a minimum score of five points obtained through specific criteria that reveal they have mastered the field and nature of the study.

The experts were selected from groups of research in nursing diagnoses and/or spirituality, in scientific events in the field and through a search in the Lattes platform in the National Council for Scientific and Technological Development portal.

Data collection and analysis

An instrument containing the changes and additions proposed in the study of the nursing diagnosis spiritual distress and its structure presented by the NANDA Taxonomy II was developed. It permitted analyzing and judging both proposals and allowed nurses to indicate the relevance of each.

This semi-structured questionnaire was developed so as to permit the characterization of the experts and their judgment concerning the diagnosis classification, its definition and title. A five-point Likert scale was used by the experts to evaluate the relevance of each defining characteristic: 1: not relevant; 2: little relevant; 3: somewhat relevant; 4: very relevant; and 5: very much relevant. According to the methodological framework[11-13] it was possible to identify the attribution of weight given to each defining characteristic according to the level of relevance conferred by experts and computation of weighted averages obtained by the sum of weights attributed to each response and divided by the total number of answers.

Defining characteristics were classified based on these averages according to their scores: Core characteristics (scores equal or higher than 0.80), Secondary characteristics (scores between 0.50 and

0.79) and Little relevant characteristics (scores equal or lower than 0.50).

The diagnosis' total score (total DTC) was also computed. It consists of the sum of scores of each characteristic divided by the total number of defining characteristics, though not considering those characteristics that obtained scores lower or equal to 0.50. Only the diagnoses with scores higher than 0.60 are considered validated[12].

The data collection instrument was submitted to a refining process with a view to evaluate its clarity, objectivity and coverage in relation to what is proposed to be identified. After this refinement, the instrument was sent by e-mail to 72 nurses. A free and informed consent form was sent by mail with a sealed and addressed envelope so participants would be able to return the form.

Data were analyzed through the Statistical Package for the Social Sciences (SPSS) version 15.0 in which descriptive analysis was employed concerning the relevance of the diagnosis in relation to its class and domain in the NANDA Taxonomy II as well as the appropriateness of its definition for its respective title. Potential divergences among experts according to their fields were also observed through the Chi-square test (X2) for nominal variables and the Mann Whitney test for continuous variables. A significant p-value less than or equal to 5% was considered ($p \leq 0.05$).

Complying with the Resolution N. 196/96 that regulates research with human subjects, this study was approved by the Human Research Ethics Committee at the University of São Paulo at Ribeirão Preto (Process CEP-EERP/USP – 0810/2007).

RESULTS

Characterization of participants

The professional experience of the 72 experts varied between 20 and 30 years with an average of 21 years and 47 months. The participants' fields of work varied, though 31 (43.1%) experts worked both in care delivery and in teaching and research. There was a predominance of doctors (45.8%), followed by master degrees (37.5%), associate professors (9.7%) and professors with post-doctoral experience (6.9%). The production of research addressing nursing diagnoses and also content relevant to the studied field was observed in 61 (84.7%) experts.

A range from 6 to 12 points with average and median of 8 ± 1.5 points was observed in the experts' scores. Among the 72 nurses, 39 (54.2%) reported experience with nursing diagnosis and spirituality and 33 (45.8%) reported experience only with nursing diagnosis. Nonetheless, the majority (55.0%) of those who did not have complementary training in the field of spirituality reported identifying the nursing diagnosis •spiritual distress in their clinical practice. Hence, the nurses were distributed into two groups: group A (experts with experience only in nursing diagnosis) and group B (experts with experience in nursing diagnosis and spirituality). Group B scored higher than group A with a statistically significant difference ($p<0.001$).

Classification of the nursing diagnosis Spiritual distress

The experts investigated which would be the best position of the studied diagnosis in the classification proposed by the NANDA Taxonomy II[7]. Twenty-four experts from group A and 26 from group B selected domain 10 – Life principles (Table 1). Thus, 50 experts opted for domain 10 against 12 who opted for some other domain. Responses from both groups were homogeneous (X2 test, p=0.359).

Five experts chose more than one domain (including Domain 10) and five did not know which domain was the most appropriate one, reporting they were unsure between two or more domains, that is, for 10 (13.8%) experts the classification of the diagnosis includes aspects from more than one domain.

In relation to the best class to include the studied diagnosis, both the group with experience only in diagnosis and those with experience also in spirituality indicated the need to enlarge *Class 3* of Domain 10 of the NANDA Taxonomy II[7]. There was no statistically significant difference in the opinions of the two groups of experts (X2 Test, p=0.685). Therefore, 58 experts opted for the modified class that describes congruence between values, beliefs, actions, connection, transcendence and meaning/ purpose in life (table 2).

Diagnosis title and concept

After describing the definition of the nursing diagnosis

Table 1 – Opinion of experts regarding the best domain for the classification of the nursing diagnosis Spiritual distress. Ribeirão Preto, SP, Brazil 2008

Domain	Experts				Total	
	Group A*		Group B**			
	n	%	n	%	n	%
Health Promotion	-	-	1	2.6	1	1.4
Perception/Cognition	1	3.0	2	5.1	3	4.2
Self-perception	1	3.0	2	5.1	3	4.2
Coping/ Tolerance to stress	1	3.0	1	2.6	2	2.8
Life Principles	24	72.7	26	66.7	50	69.4
Comfort	1	3.0	2	5.1	3	4.2
Chose more than one option	-	-	5	12.8	5	6.9
Did not know	5	15.2	-	-	5	6.9
Total	**33**	**100**	**39**	**100**	**72**	**100**

*Experts with experience in nursing diagnosis (n= 33)
** Experts with experience in nursing diagnosis and spirituality (n=39)

proposed by NANDA[7] and the suggestion to modify its conceptual description, nurses were asked to judge which definition better represented the studied diagnosis. Results show that 75% agreed with the change of definition, confirming that the description of the diagnosis by NANDA[7] does not fully represent the phenomenon, with no statistically significant difference between the answers of the two groups (X2 Test, p=0.757) (Table 3).

Fifty experts agreed with the change of the diagnosis denomination, while 21 did not. There was no statistically significant difference between the two groups of experts (X2 Test, p=0.692); 69.4% of the experts judged that Impaired spirituality is a more appropriate designation to describe disorders in spirituality than Spiritual distress (Table 4).

Defining characteristics validity

In relation to the relevance of each defining characteristic, seven were considered "core characteristics" and therefore, according to the experts, these clinical indicators should be present in the identification of the diagnosis. Twelve characteristics were considered secondary and only the characteristic Disinterest in nature, which obtained a score lower than 0.50, was identified as little relevant for the studied diagnosis and requires further research (Table 5).

The defining characteristic: Express altered behavior: anger was considered little relevant to the diagnosis (score=0.50) only by group A and was considered a relevant characteristic (score=0.57), though a secondary one, by group B. Thus the global average (0.53) obtained by this characteristic enabled it to be considered validated, since these statistical tests did not present statistically significant differences between both groups of experts (p= 0.203) (Table 5).

Despite the fact that the experts with experience only in nursing diagnosis assigned weights lower than those assigned

Table 2 – Opinion of experts regarding the best class to include the nursing diagnosis spiritual distress. Ribeirão Preto, SP, Brazil 2008

Domain	Experts					
	Group A*		Group B**		Total	
	n	%	n	%	n	%
Beliefs	1	3.0	-	-	1	1.4
Congruence between Values/Beliefs/Action	4	12.1	5	12.8	9	12.5
Congruence between values, beliefs, sense of connection, transcendence and meaning/purpose in life	25	75.8	33	84.6	58	80.5
Chose more than one option	-	-	1	2.6	1	1.4
Did not know	3	9.1	-	-	3	4.2
Total	**33**	**100**	**39**	**100**	**72**	**100**

*Experts with experience in nursing diagnosis (n= 33)
** Experts with experience in nursing diagnosis and spirituality (n=39)

Table 3 – Experts' responses regarding the changing of definition of the nursing diagnosis Spiritual distress. Ribeirão Preto, SP, Brazil 2008

Opinion regarding changing of the definition of the diagnosis	Experts				Total	
	Group A*		Group B*			
	n	%	n	%	n	%
Agree	26	78.8	28	71.8	54	75.0
Do not agree	7	21.2	9	23.0	16	22.2
Do not know	-	-	2	5.1	2	2.8
Total	**33**	**100**	**39**	**100**	**72**	**100**

*Experts with experience in nursing diagnosis (n= 33)
** Experts with experience in nursing diagnosis and spirituality (n=39)

Table 4 – Responses of experts regarding changing the title of the nursing diagnosis Spiritual distress. Ribeirão Preto, SP, Brazil 2008

Opinion regarding changing the title of the diagnosis	Experts				Total	
	Group A*		Group B**			
	n	%	n	%	n	%
Agree	24	72.7	26	66.7	50	69.4
Do not agree	9	27.3	12	30.8	21	29.2
Do not know	-	-	1	2.6	1	1.4
Total	**33**	**100**	**39**	**100**	**72**	**100**

*Experts with experience in nursing diagnosis (n= 33)
** Experts with experience in nursing diagnosis and spirituality (n=39)

Table 5 – Defining characteristics of the nursing diagnosis Spiritual distress according to the scores assigned by experts. Ribeirão Preto, São Paulo, Brazil 2008

Defining characteristics	weighted		General average	p-value***
	Group A*	Group B**		
Present disorders or concern in relation to system of beliefs and/or relationship with God	0.90	0.87	0.89	0.86
Express having anger toward God	0.87	0.88	0.88	0.935
Express lack of meaning/purpose in life	0.88	0.86	0.87	0.775
Inability to experience the transcendent	0.80	0.83	0.82	0.570
Express alienation or isolation	0.77	0.86	0.82	**0.024**
Question suffering	0.76	0.85	0.81	0.137
Express lack of serenity	0.76	0.83	0.80	0.072
Express despair	0.76	0.78	0.77	0.583
Request spiritual assistance	0.81	0.72	0.76	0.351
Express lack of hope	0.67	0.77	0.73	0.092
Express lack of love	0.63	0.73	0.69	0.095
Express being abandoned	0.65	0.72	0.69	0.129
Express guilt	0.61	0.67	0.64	0.376
Refuses interactions with significant ones	0.54	0.72	0.64	**0.007**
Express altered behavior: cry	0.58	0.60	0.60	0.948
Express lack of courage	0.53	0.62	0.58	0.177
Inability to express creativity	0.53	0.63	0.59	0.146
Feeling of regret	0.56	0.60	0.58	0.617
Express altered behavior: anger	0.50	0.57	0.53	0.203
Disinterest in nature	0.43	0.48	0.46	0.420

*Experts with experience in nursing diagnosis (n= 33)
** Experts with experience in nursing diagnosis and spirituality (n=39)
***Mann Whitney

by experts with experience both in nursing diagnosis and spirituality (Table 5) to almost all defining characteristics, statistically significant differences were found only regarding the defining characteristics Refuse interaction with significant others (p= 0.007) and Express alienation or isolation (p= 0.024). Hence, experts with experience both in nursing diagnosis and spirituality consider these characteristics to be more representative of the diagnosis than do the remaining experts.

One new characteristic was suggested during the validation process: Express sense of temporality, which was conceptualized as "the state in which the individual confides having left unresolved situations and does not have time to fix them; reports that time takes anxiously too long to pass in face of distress and too fast in face of proximity of death." New studies are required so as to indicate the relevance of this characteristic to the diagnosis.

Based on the score of each defining characteristic and excluding those that obtained scores lower than 0.50 (Table 5), the total score of the nursing diagnosis Spiritual distress was computed, whose result was 0.72 and therefore was considered validated[11].

DISCUSSION

The study of nursing diagnoses is necessary to maintain and improve the base of evidence of the NANDA taxonomy II and also to ground nurses' clinical practice, since these diagnoses support both the establishment of nursing interventions and their evaluation *per se*[14]. The diagnoses should be validated and, when necessary, reformulated.

The organization of the diagnosis in a classification system is a significant factor of analysis given its importance for research, since the study of a nursing diagnosis requires one to have a clear understanding of its hierarchical structure and classification with its three levels (domains, classes and diagnoses)[15]. The inclusion of the nursing diagnosis in the study of Domain 10 was considered relevant for the study's experts, corroborating Engebretson[1], who states that the spiritual domain should reflect a philosophy of life, a view of the world, as a person knows and seeks meaning for life. The classes that compose such a domain require improvement from a conceptual point of view, since they do not seem to include all the dimensions involving spirituality.

The experts considered the NANDA proposal to modify the title of the diagnosis to be appropriate, which corroborated the studies of authors[8-9] who emphasize the need to develop a nursing vocabulary for the responses of patients to the spiritual dimension, justifying the importance of conceptualizing spirituality as continuous and the view that nursing diagnoses have little application in clinical practice as they are presented by NANDA. Therefore, the new title impaired spirituality might enlarge the diagnostic possibilities for the dimension of spirituality and make the nomenclature more flexible.

The diagnostic concept is the main element of diagnostic declaration[7], and therefore should have a clear and effective definition that facilitates communication not only among the nursing team members but also with other professionals and clients. The definition proposed in this study for the studied

nursing diagnosis reinforces the idea that spirituality is a multidimensional phenomenon[16-19]. In this context, the obtained results corroborate the conceptual analysis identified in the literature[19], in which spiritual distress is conceptualized as loss in the constructs that describe the spiritual human dimension.

The signs and symptoms of the diagnosis Impaired spirituality are manifested as losses in the combination of any of the constructs identified in the diagnosis concept. However, these are manifestations that include cognitive, affective and behavioral aspects that vary in degree and intensity according to each individual[5], which make its clinical validation with patients presenting this diagnosis necessary.

Nonetheless, it is expected that the considered core defining characteristics are presented in the clientele to be studied, which are: Express disorder or concern in relation to system of beliefs and/or God, Express having anger toward God, Express lack of meaning/purpose in life, Inability to experience the transcendent, Express alienation or isolation, Question distress and Express lack of serenity. In contrast, the remaining defining characteristics may or not be defined in the clinical validation.

When the global score, obtained through the set of the diagnosis defining characteristics, is satisfactory in this type of validation, it reinforces the need for a clinical validation of the proposed diagnosis.

CONCLUSION

Nurses ought to understand what spirituality means for individuals and how significant events, such as a disease, affect it, so that they can deal with disorders affecting this human dimension in clinical practice since the evaluation of spiritual intervention should be included in holistic care. Hence, accurate identification of the nursing diagnosis of spiritual distress permits its appropriate use in clinical practice.

A group of experts validated a new proposal for spiritual distress in this study with a view to contribute to the improvement of the diagnosis presented by NANDA, given the importance of having a language capable of communicating disorders in individuals' spirituality, which are certainly difficult to describe and/or define. Given the study's findings, we conclude that the title that better describes the studied phenomenon is *impaired spirituality* and its definition should portray potential loss both in the sense of meaning and purpose in life and in the ability of individuals to transcend and connect with themselves, with God/Power Greater than Self, with others and the world.

The best domain to classify the studied diagnosis is Domain 10 – Life Principles as proposed by NANDA taxonomy II. However, class 3 needs to be enlarged or a new class that represents congruence between values, beliefs, actions, connection, transcendence and meaning/purpose in life should be created.

The lack of experts to interpret the spiritual responses of individuals limits the generalization of results, which also occurs due to the diagnosis' abstract nature and its defining characteristics. Further studies should confirm the perception of spiritual responses of patients, their family members and nurses. Similar studies reinforce the inclusion of spiritual care in the nursing practice and can support further research addressing the validation of nursing diagnoses.

REFERENCES

1. Engebretson J. Considerations in diagnosing in the spiritual domain. Nurs Diagn. 1996;7(3):100-7.
2. Mohr WK. Spiritual issues in psychiatric care. Perspect Psychiatr Care. 2006;42(3):174-83.
3. Heliker D. Reevaluation of a nursing diagnosis: spiritual distress. Nurs Forum. 1992;27(4):15-20.
4. Twibell RS, Wieseke AW, Marine M, Schoger J. Spiritual and coping needs of critically ill patients: validation of nursing diagnoses. Dimens Crit Care Nurs. 1996;15(5):245-53.
5. Villagomeza LR. Spiritual distress in adult cancer patients: toward conceptual clarity. Holistic Nurs Pract. 2005;19(6):285-94.
6. Chaves ECL, Carvalho EC, Goyatá SL, Galvão CM. Angústia espiritual: revisão integrativa da literatura. Online Braz J Nurs (Online). 2008;7(2). OBJN [Internet] 2008; 7(2): Disponível em: http://www.uff.br/objnursing/index.php/nursing/article/view/j.1676-4285.2008.1551/358 .
7. North American nursing Diagnosis Association. Diagnósticos de enfermagem da NANDA: definições e classificação 2007-2008. Porto Alegre: Artmed; 2008.
8. Cavendish R, Luise BK, Horne K, Bauer M, Medefindt J, et al. Opportunities for enhanced spirituality relevant to well adults. Nurs Diagn. 2000;11(4):151-63.
9. Cavendish R, Luise BK, Horne K, Bauer M, Gallo MA, et al. Opportunities for enhanced spirituality relevant to well adults. Nurs Diagn. 2001;12(3):77-90.
10. Chaves ECL. Revisão do diagnóstico de enfermagem angústia espiritual [tese]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo; 2008.
11. Fehring RJ. Validation diagnostic labels: standardized methodology. In: Hurley M, editor. Classification of nursing diagnosis: proceeding of the sixth conference. St. Louis: Mosby; 1986. p.183-90.
12. Fehring RJ. Methods to validate nursing diagnoses. Heart Lung. 1987;16(6 Pt 1):625-9.
13. Fehring RJ. The Fehring model. In: Carroll-Johnson RM, Paquette M. Classification of nursing diagnosis: proceedings of the tenth conference. Philadelphia: Lippincott Williams & Wilkins; 1994. p. 55-7.
14. Chaves ECL, Carvalho EC, Rossi LA. Validação de diagnósticos de enfermagem: tipos, modelos e componentes validados. Rev Eletrônica Enferm. [Internet] 2008;10(2):513-5. Disponível em: http://www.fen.ufg.br/revista/v10/n2/v10n1a22.htm
15. Hoskins LM. Taxonomy Committee Report. Nurs Diagn. 2002;13(1):67-8.
16. Miner-Williams D. Putting a puzzle together: making spirituality meaningful for nursing using an evolving theoretical framework. J Clin Nurs. 2006;15(7):811-21.

17. Chiu L, Emblen JD, Van Hofwegen L, Sawatzky R, Meyerhoff H. An integrative review of the concept of spirituality in the health sciences. West J Nurs Res. 2004;26(4):405-28.
18. Delgado C. A discussion of the concept of spirituality. Nurs Sci Q. 2005;18(2):157-62.
19. Villagomeza LR. Mending broken hearts: the role of spirituality in cardiac illness: a research synthesis, 1991-2004. Holist Nurs Pract. 2006;20(4):169-86.