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R E S E A R C H P A P E R

Translation and adaptation of the Spirituality and Spiritual Care Rating Scale in Portuguese palliative care nurses

Tradução e adaptação da *Spirituality and Spiritual Care Rating Scale* em enfermeiros portugueses de cuidados paliativos
Traducción y adaptación de la *Spirituality and Spiritual Care Rating Scale* en enfermeros portugueses de cuidados paliativos

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Abstract

Theoretical framework: The knowledge on spirituality in Nursing has increased in Portugal, but there is still low evidence on the nurses' perception of this dimension of care, as well as limited instruments in portuguese which allow measuring related phenomena. The Spirituality and Spiritual Care Rating Scale (SSCRS) allows assessing the nurses' perception of spirituality and spiritual care.
Objectives: To translate, adapt and validate the SSCRS into portuguese in a sample of portuguese palliative care nurses.
Methodology: Methodological study using a sample composed of 94 palliative care nurses.
Results: The original structure of the 17-item scale was maintained during the scale validation process. A Cronbach's alpha between 0.59 and 0.69 in the subscales and 0.76 in the total scale was obtained. These values are indicators of the scale's reasonable reliability to be used in the population under study.
Conclusion: The portuguese version of the SSCRS proved to be a reliable scale with content validity to assess the nurses' perception of spirituality and spiritual care.

Keywords: spirituality; palliative care; Nursing; validation studies.

Resumo

Enquadramento: O conhecimento acerca da espiritualidade em Enfermagem tem-se evidenciado em Portugal, mas ainda é escassa a evidência acerca da perceção desta dimensão nos enfermeiros, bem como a disponibilidade de instrumentos na língua portuguesa que permitam medir fenómenos relacionados. A *Spirituality and Spiritual Care Rating Scale* (SSCRS) permite avaliar a perceção dos enfermeiros face à espiritualidade e ao cuidado espiritual.
Objetivos: Traduzir, adaptar e validar a SSCRS para português, numa população de enfermeiros portugueses de cuidados paliativos.
Metodologia: Estudo metodológico, numa amostra de 94 enfermeiros de cuidados paliativos.
Resultados: No processo de validação da escala, optou-se por manter a estrutura da escala original com os 17 itens. Obteve-se um alfa de *Cronbach* entre 0,59 e 0,69 nas subescalas e de 0,76 na escala global. Estes valores são indicadores que a escala tem fidelidade razoável para a população em estudo.
Conclusão: A versão portuguesa da SSCRS revela ser uma escala fiável e com validade de conteúdo para avaliar a perceção dos enfermeiros face à espiritualidade e ao cuidado espiritual.

Palavras-chave: espiritualidade; cuidados paliativos; Enfermagem; estudos de validação.

Resumen

Marco contextual: El conocimiento de la espiritualidad en enfermería ha aumentado en Portugal, sin embargo aún hay pocas pruebas acerca de la percepción de esta dimensión en los enfermeros, así como poca disponibilidad de instrumentos en portugués para medir los fenómenos relacionados. La Spirituality and Spiritual Care Rating Scale (SSCRS) permite evaluar la percepción de los enfermeros sobre la espiritualidad y la atención espiritual.
Objetivos: Traducir, adaptar y validar la SSCRS al portugués en una población de enfermeros portugueses de cuidados paliativos.
Metodología: Estudio metodológico en una muestra de 94 enfermeros de cuidados paliativos.
Resultados: En el proceso de validación de la escala, se optó por mantener la estructura de la escala original con 17 ítems. Se obtuvo un alfa de Cronbach entre 0.59 y 0.69 en las subescalas y de 0.76 en la escala global. Estos valores son indicadores de que la escala tiene una fidelidad razonable para la población en estudio.
Conclusión: La versión portuguesa de la SSCRS demuestra ser una escala fiable y con validez de contenido para evaluar la percepción de los enfermeros acerca de la espiritualidad y la atención espiritual.

Palabras clave: espiritualidad; cuidados paliativos; Enfermería; estudios de validación.

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Introduction

Spirituality is a dimension of life that makes each person unique and singular. It is a universal dimension, since it is present in everyone's life and invokes feelings such as love, faith, hope and trust. The word *spirituality* derives from the word *spirit* that "relates to the unique spirit of an individual that is their life force, the essence and energy of their being. It is this force that develops in an individual the ability to transcend the natural laws and orders of this life, allowing access to a mysterious or transcendent dimension. The *spirit* drives and motivates individuals to find meaning and purpose, allowing expression in all aspects and experiences of life, especially in times of crisis" (McSherry, 2006, p. 45).

The nurse is the health care professional who provides care on a 24 hours basis and, therefore, enjoys a favourable position to develop a closer and more significant interpersonal relationship with the patient. Such relationship supports the provision of Nursing care. Spiritual care, which is defined as the attitude of caring for patients in an integral and individual way, helping them find their spiritual well-being, is only possible within the scope of this relational context (Caldeira, 2011). However, nurses feel a lack of preparation to provide spiritual care (Caldeira & Narayanasamy, 2011) and consider spirituality to be a subjective concept (McSherry, 2006).

In Portugal, the scientific dissemination on this topic is relatively recent and scarce (Caldeira, Castelo Branco, & Vieira, 2011) and there is no instrument available to assess the nurses' perception of this phenomenon. This concern becomes particularly important in palliative care settings, where spirituality assumes a key position in the well-being of palliative patients so that they may live as actively as possible until the time of their death (Hill, Paice, Cameron, & Shott, 2005).

Within the scope of the development of the master's dissertation in palliative care, it was considered relevant to explore the perception of nurses working in Portuguese Palliative Care Units in relation to spirituality and spiritual care, through the translation and linguistic and cultural adaptation of the Spirituality and Spiritual Care Rating Scale (SSCRS). Hence, the objective of the study was to analyse the psychometric properties of the SSCRS, thus enabling its use in Portugal.

Background

There are currently many definitions of spirituality, as well as several studies that allow expanding research in the subject under analysis. Spirituality is understood as the vital life force which integrates biological, psychological and social components, and may or not include religious components according to the individual belief system (Baldacchino, 2011). The concept of spirituality is more abstract than that of religion and covers areas such as the meaning of life, love, relationships, personal values, individuality, inner peace, and tranquillity (Narayanasamy, 2001). Spirituality is universal and present in all people. Religious beliefs are not a prerequisite of spirituality and an individual may becomes more spiritually aware during a *time of need* (McSherry, 2006).

Considering that each individual seeks spirituality according to his/her beliefs and values, this dimension emphasises the uniqueness of human beings, which is reflected in their way of being and living life.

Spiritual care integrates the nurses' skills and should not be an option, but a duty inherent in their professional practice. However, it becomes essential for nurses to develop the necessary skills to promote this type of care, as is the case for the development of other skills. According to Narayanasamy (2001), self-awareness and communication skills, such as knowing how to listen to the patient and building trust relationships, are forms of addressing the patient's spiritual needs.

Addressing the spirituality of palliative patients assumes a vital role, since "spiritual issues frequently become more relevant at the end of life" (Gijsberts, 2011, p. 852). According to the World Health Organization (2002), palliative care aims at providing the best possible quality of life for patients with severe illness and limited prognosis. The prevention and relief of suffering become particularly relevant, not only at the physical level, but also at the psychosocial and spiritual levels. It is often at this stage that the person constantly looks for inner peace, which is a reflection of the relationship with both the self and others. When confronted with death, human beings seem to experience a greater need to find the meaning and purpose of their lives.

According to the National Consensus Project for Quality Palliative Care (2009), spiritual care is an

essential prerequisite for quality in palliative care and both the spiritual and existential dimensions should be systematically assessed and based upon the best available evidence. Taking into account that the care receiver unit is composed of the patient and his/her family/significant person, it is absolutely necessary to involve the family in spiritual care, because only then it is possible to relieve the palliative patient from spiritual suffering. "Spiritual care should help patients and families find a meaning, and promote a sense of connection and peace in the face of suffering or death" (Hanson, 2008, p. 908). It is in finding spiritual peace that the relationship between the patient and his/her family is exalted and its true meaning is found.
Bearing in mind the importance of spirituality in palliative care, the validation of the SSCRS will allow us understand the perception of Portuguese nurses working in palliative care about spirituality and spiritual care. The assessment of the nurses' perception refers to their opinions and ideas and an understanding of the dimensions addressed (Houaiss & Villar, 2003). Therefore, after being validated, the instrument will contribute to understanding the nurses' perception of spirituality and spiritual care.

The Spirituality and Spiritual Care Rating Scale

Although spirituality is one of the most important dimensions of human life, particularly at the end of life, its assessment continues to be difficult and complex. Aware of this difficulty, Wilfred McSherry developed the Spirituality and Spiritual Care Rating Scale (SSCRS), in 1997, in the United Kingdom, to identify the nurses' perceptions of spirituality and spiritual care, in an attempt to understand in greater detail the reasons for the neglect of spiritual attention. In the construction of the scale, 1029 questionnaires were applied to nurses from several professional categories and specialties of the UK National Health Service. The response rate was 53%, which corresponded to a sample of 559 nurses (McSherry, Draper, & Kendrik, 2002).
For the construction of the instrument, and following further research, the author found nine areas related to spirituality: hope, meaning and purpose, forgiveness, beliefs and values, spiritual care, relationships, belief in a God or deity, morality, and creativity/self-expression (McSherry et al., 2002).
The original instrument (Figure 1) is composed of 17 items on a Likert-type scale and has a global Cronbach's alpha coefficient of 0.64. It explores 4 factors (Factor V was deleted for having only one item):
- Factor I - Spirituality (items F, H, I, J, L);
- Factor II - Spiritual Care (items A, B, G, K, N);
- Factor III - Religiosity (items D, M, P);
- Factor IV - Personalised Care (items N, O, Q).

Methodology

This study was carried out with the purpose of providing an instrument in portuguese that assessed the nurses' perception of spirituality and spiritual care. It is a methodological study, in which the original instrument was translated and culturally validated to portuguese and, subsequently, its psychometric properties were analysed.

Selection of participants

The population was composed of nurses working in the Palliative Care Units and Intra-Hospital Teams for Support in Palliative Care, established by the Portuguese Government and recognised by the Portuguese Association of Palliative Care.
With the purpose of analysing the construct using factor analysis, we followed the recommendation of Ribeiro (2010) regarding sample size. Each item should, therefore, include approximately five to 10 participants. Since the instrument under analysis was composed of 17 items, a sample size between 85 and 170 nurses was estimated.
The directors of the abovementioned units and teams were contacted. They were explained the objectives of the study and asked to convey them to the nurses in their units/teams. After this contact, an initial sample of 159 nurses was obtained.
Later on, the head nurses (liaison people between the researcher and the sample population) were also asked to provide the participants' e-mail addresses so that the questionnaire link could be sent to them for completion.
Not all nurses who consented to participate in this study answered the questionnaire. Hence, the final sample consisted of 94 nurses.
All participants were asked to give their informed consent and the anonymity and confidentiality of the answers were ensured (it should be noted that,

after the questionnaires were sent, it was no longer possible to identify the nurses). Permission was also obtained from the author of the original version of the SSCRS, not only for its use but also for its study and validation.

Linguistic and conceptual equivalence

In a first step, the linguistic and cultural equivalence of the SSCRS for the portuguese population was performed through translation, back-translation, panel of judges and pretest (Ribeiro, 2010), as summarised in Figure 1.

Two translations of the original scale (from english into portuguese) were performed by two independent, bilingual and professional translators, who were explained the purpose of the instrument to be validated. No information was exchanged between the translators throughout the translation process. The discrepancies found in the translations were subsequently discussed between the researcher and both translators. The discussion resulted in the 1st portuguese version of the SSCRS.

In a second phase, the portuguese version was back-translated (from portuguese into english). This process was carried out by two other independent, bilingual and professional translators who, in turn, were unaware of the original scale. The versions obtained were then sent to the author of the original scale, who validated one translation as the most accurate one, compared to the original instrument. portuguese version is here designated as the second portuguese version of the SSCRS.

In a third phase, the instrument was assessed by a panel of judges composed of one linguistics teacher and three nurses (one expert in scale validation methodology, one researcher in spirituality and scale translation, and one master in palliative care). The panel was explained the purpose of their evaluation and asked to verify whether the concepts used were common to both cultures (portuguese and english). This resulted in the 3rd portuguese version of the SSCRS. This version was submitted to a pretest by means of an electronic questionnaire. The questionnaire was sent by email to four nurses who worked on a Palliative Care Unit at the time of the study. The pretest aimed at ensuring that the format and design of the questionnaire, instructions for completion, understanding of the different items, and receptiveness and adherence to their content did not affect the results. According to the suggestions presented, some changes were made: issues were added related to the characterisation of the sample (type of academic qualifications, employment contract and, should participants attend future training sessions in spiritual care, the topics that they considered important to be addressed). After these changes were introduced, the 4th version of the SSCRS was obtained (which included questions related to demographic data and was equivalent to the questionnaire).

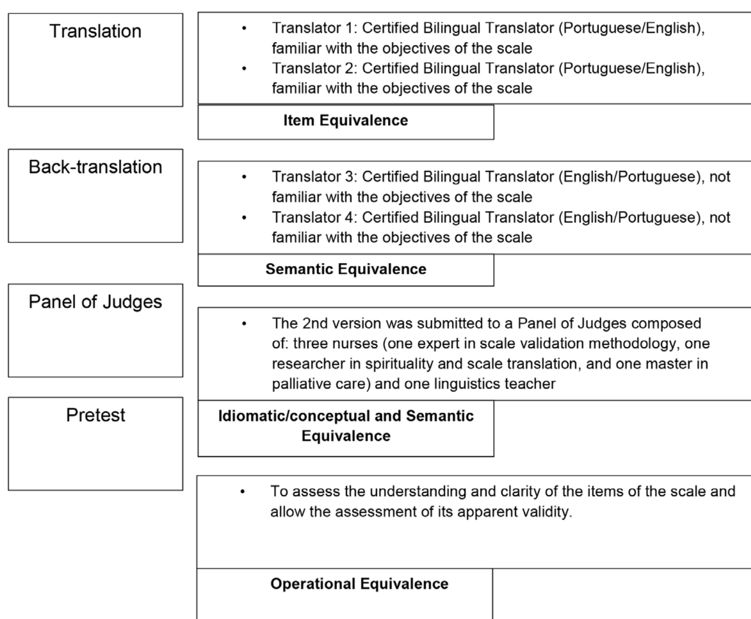

Figure 1. Cross-cultural adaptation process of the Spirituality and Spiritual Care Rating Scale (SSCRS - EN).

Results

Once the linguistic and conceptual equivalence was achieved, the *Spirituality and Spiritual Care Rating Scale* - portuguese version was obtained (Figure 2).

Para cada alínea, por favor, assinale a resposta que melhor refletir o seu nível de acordo ou desacordo com a afirmação.

Discordo totalmente	Discordo	Não sei	Concordo	Concordo plenamente

ITEMS

a)	Acredito que os enfermeiros podem proporcionar cuidados espirituais ao providenciarem a visita do padre do hospital ou do representante da religião do doente, se solicitado pelo mesmo.
b)	Acredito que os enfermeiros podem proporcionar cuidados espirituais ao mostrarem simpatia, preocupação e boa disposição quando prestam os cuidados.
c)	Acredito que a espiritualidade está relacionada com a necessidade de perdoar e ser perdoado.
d)	Acredito que a espiritualidade envolve apenas a ida à Igreja/Local de Culto.
e)	Acredito que a espiritualidade não está relacionada com a crença e a fé em Deus ou numa Entidade Superior.
f)	Acredito que a espiritualidade está relacionada com encontrar um significado nos bons e maus momentos da vida.
g)	Acredito que os enfermeiros podem proporcionar cuidados espirituais ao disponibilizarem tempo com o doente, dando-lhe apoio e conforto especialmente em situações de necessidade.
h)	Acredito que os enfermeiros podem proporcionar cuidados espirituais ao ajudar o doente a encontrar um significado e um propósito para a sua doença.
i)	Acredito que a espiritualidade está relacionada com o sentimento de esperança na vida.
j)	Acredito que a espiritualidade está relacionada com a forma como cada pessoa vive a sua vida aqui e agora.
k)	Acredito que os enfermeiros podem proporcionar cuidados espirituais ao escutarem e ao disponibilizarem tempo para os doentes falarem e explorarem os seus medos, ansiedades e problemas.
l)	Acredito que a espiritualidade é uma força unificadora que permite a uma pessoa estar em paz consigo e com o mundo.
m)	Acredito que a espiritualidade exclui áreas como a arte, a criatividade e a expressão própria.
n)	Acredito que os enfermeiros podem proporcionar cuidados espirituais respeitando a privacidade, dignidade e as crenças religiosas e culturais do doente.
o)	Acredito que a espiritualidade envolve amizades e relações interpessoais.
p)	Acredito que a espiritualidade não se aplica a ateus ou agnósticos.
q)	Acredito que a espiritualidade inclui os princípios morais de cada um.

Figure 2. Spirituality and Spiritual Care Rating Scale - portuguese version.

Sample characterisation

Most participants were aged between 21 and 39 years (80%), had academic qualifications below the master's degree (73%), worked full-time (80%), on shifts (80%), and had between two and six years of professional experience (73%). It was found that not all nurses who consented to participate in this study answered the questionnaire. Hence, the final sample consisted of 94 nurses, which corresponded to a response rate of 59%.

Psychometric properties

Upon the completion of the linguistic and cultural adaptation process, the psychometric properties of the instrument under study were analysed, namely their validity and reliability.

Construct validity

An exploratory factor analysis was initially performed using the principal components analysis with varimax rotation, following the procedure adopted by the authors of the original scale (McSherry et al., 2002). Factors with eigenvalues greater than one and weights higher than 0.40 were retained. Similar to the validation process of the original version, five factors were found in the first phase. However, the model found in this study did not divide the items in the same way as the original version, grouping them as follows: Factor I (items B, A, G, O, L), Factor II (items D, P, N, K, C), Factor III (items I, F, H), Factor IV (items Q, J, M), and Factor V (E). Finally, similar to the original version, the last factor was deleted for having only one item. However, taking into account the process of content analysis and validity developed by the author, we believe the division of items in the original version to be more correct.

Therefore, with this type of analysis, the construct validity was not demonstrated in this study. However, in view of the authors' logical organisation of items, we chose to maintain the original structure and study its internal consistency.

Reliability

The reliability of a test is associated with the accuracy and consistency of results (Ribeiro, 2010).

Based on the analysis of the original scale structure, the Cronbach's alpha was calculated, since it allows assessing the homogeneity between the scale items (internal consistency).

Initially, the alpha value of each sub-scale was calculated. Item (d) - *Acredito que a espiritualidade envolve apenas a ida à Igreja/Local de Culto* and item (q) - *Acredito que a espiritualidade inclui os princípios morais de cada um* were removed from the factors Religiosity and Personalised Care, respectively, for negatively influencing the internal consistency of the dimensions. However, it was found that, even if both items were deleted, that would not greatly affect the scale's total alpha value and, therefore, the decision was made to keep the 17 items (Table 1). The scale' alpha value was 0.76.

Table 1
Reliability of the original factors

	α	Mean inter-item correlation	Item-total correlation range	α if item deleted
Spirituality	0.66	0.276	0.299-0.542	
Item (f)				0.65
Item (h)				0.53
Item (i)				0.60
Item (j)				0.62
Item (l)				0.60
Spiritual care	0.69	0.346	0.313-0.613	
Item (a)				0.70
Item (b)				0.66
Item (g)				0.58
Item (k)				0.62
Item (n)				0.65
Religiosity	0.64	0.380	0.348-0.578	
Item (d)				0.69
Item (m)				0.47
Item (p)				0.33
Personalised care	0.59	0.33	0.289-0.497	
Item (n)				0.35
Item (o)				0.49
Item (q)				0.64
Spirituality and Total Care	0.76	0.187	0.011-0.644	
Item (a)				0.76
Item (b)				0.77
Item (c)				0.75
Item (d)				0.75
Item (e)				0.79
Item (f)				0.76
Item (g)				0.73
Item (h)				0.73
Item (i)				0.75
Item (j)				0.74
Item (k)				0.73
Item (l)				0.73
Item (m)				0.74
Item (n)				0.73
Item (o)				0.74
Item (p)				0.73
Item (q)				0.75

Discussion

After the analysis of data and the study of the scale's psychometric properties of the scale, the portuguese version showed a total Cronbach's alpha higher than the original version of McSherry et al. (2002) (α=0.76 versus α=0.64). Despite the fact that the value of internal consistency obtained in the Spirituality factor was equal to the one found by the author (α=0.66), the other factors did not follow the same pattern. The portuguese version showed Cronbach's alpha values higher than those of the original version regarding Religiosity (α=0.69 versus α=0.55) and Personalised Care (α=0.64 versus α=0.48) factors. However, in the Spiritual Care factor, this value was slightly lower

than the one found in the original version (α=0.69 versus α=0.73).
In addition to the original study, another study was found in which the authors analysed the scale's total internal consistency and obtained a Cronbach's alpha of 0.85 (Khoshknab, Mazaheri, Maddah, & Rahgozar, 2010). However, the authors did not analyse the internal consistency of the various dimensions. Although similar in terms of the number of participants, the sample in the study of Khoshknab et al. (2010) differed from that of the present study, particularly regarding gender distribution (in the first sample, a more homogeneous distribution was observed) and academic qualifications, which were slightly lower in the study of Khoshknab et al. (2010). The differences obtained between both studies may derive from this fact. Wong, Lee, and Lee (2008) mentioned that the influence of both academic qualifications and gender should be taken into account in the analysis of spirituality and spiritual care.
In another study of McSherry and Jamieson (2011), the Cronbach's alpha was 0.80, which was also higher than the one found in the portuguese version. However, this study was conducted in several countries, in a sample that was 43 times higher (n = 4054 nurses), this difference being enough to improve internal consistency. It should also be highlighted that the sample of this international study included a wide range of religions and a higher percentage of people with no religion than the present study.
The present study showed a statistically significant correlation between the various scale dimensions and also between each dimension and the total scale, the latter being not too high. This fact demonstrates that, similarly to the original version, the various dimensions did not overlap; rather, they are correlated.
As regards the reliability analysis of the SSCRS (portuguese version), it may be concluded that the scale showed not only good total internal consistency but also good internal consistency in the various dimensions considered. In addition, taking into account the process of linguistic equivalence and the conceptual agreement among the panel of judges, the content validity of the scale also seemed to be appropriate.
Even though the results support the use of the portuguese version of the scale and, therefore, the continuity of research in this field, it is important to apply the instrument to wider and more diversified samples, preferably to probability samples. Despite the efforts made, it was not possible for us to contact, in due time, all Portuguese Palliative Care Units and Intra-Hospital Teams for Support in Palliative Care, which became a limitation for the composition of the sample and, therefore, the study.

Conclusion

Both the method adopted and the data obtained in this study were acceptable, thus it can be concluded that the SSCRS - portuguese version has reasonable psychometric characteristics. Considering the internal consistency of the scale, its reliability proved to be satisfactory for it to be used in descriptive studies. Therefore, we suggest the development of further studies using larger and more diversified samples, so as to ensure and consolidate the psychometric properties of the scale.
The portuguese version of the SSCRS may provide an incentive for further studies and is, therefore, an added value not only for the study of spirituality but also for clinical practice and the quality of Nursing care. This scale, which allows assessing the nurses' perception of spirituality and spiritual care, may be an important starting point to raise awareness. On the one hand, it helps nurses reflect on their own spirituality and, on the other hand, makes them more aware of the importance of spiritual care.

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