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SPECIAL REPORT

Validation of the Italian version of the spirituality and spiritual care rating scale (SSCRS-ita)

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Abstract

Purpose: To translate and validate the Italian version of the Spirituality and Spiritual Care Rating Scale (SSCRS-ita).

Methods: A single-center cross-sectional study was performed from October 15 to November 15, 2019 in a public hospital in Milan, Italy. The scale was drafted using the back-translation method. Prior to administration, the Italian version of the scale was assessed for content validity and retest stability by calculating the content validity index. Internal consistency was investigated by calculating Cronbach's alpha coefficient, test-retest stability by Spearman's rho coefficient.

Findings: A total $n = 337$ nurses participated in the survey by correctly completing the scale. The Kaiser–Meyer–Olkin test (0.81) and Bartlett's test of sphericity ($p < 0.001$) confirmed the adequacy of the sample to conduct exploratory factor analysis (EFA). The factorial model of EFA without rotation and then with nonorthogonal Promax rotation confirmed the presence of the four constructs identified by the original author.

Conclusions: SSCRS-ita showed promising psychometric properties in terms of validity and reliability. The results of this study, together with the lack of in-depth studies in the Italian health and educational panorama, suggest the need to develop an educational pathway which, starting from the curricula of basic training and continuing with the updating of nursing staff, is dedicated to the detection of the spiritual needs of the patient.

Implications for nursing practice: The SSCRS-ita is the first validated Italian tool concerning the consideration of the needs of spirituality and spiritual care in healthcare contexts; the possibility to use this tool is the first step towards a better integration of the mentioned dimensions of care in a nursing care qualitative perspective in Italy.

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KEYWORDS
spirituality, spiritual care, nursing, SSCR, validation

Abstract

Purpose: Tradurre e validare la versione italiana della Spirituality and Spiritual Care Rating Scale (SSCRS-ita).

Methods: È stato effettuato uno studio trasversale monocentrico dal 15 ottobre al 15 novembre 2019 in un ospedale pubblico di Milano, in Italia. La scala è stata redatta utilizzando il metodo della back-translation. Prima della somministrazione, sono state valutate la validità di contenuto e la stabilità di retest della versione italiana della scala calcolando il Content Validity Index. La consistenza interna è stata studiata calcolando il coefficiente alfa di Cronbach, la stabilità test-retest con il coefficiente rho di Spearman.

Results: Un totale di n. = 337 infermieri ha partecipato all'indagine completando correttamente lo strumento. Il test Kaiser-Meyer-Olkin (0,81) e il test di sfericità di Bartlett ($p < 0{,}001$) hanno confermato l'adeguatezza del campione per condurre l'analisi fattoriale esplorativa (EFA). Il modello fattoriale di EFA senza rotazione e poi con rotazione Promax non ortogonale ha confermato la presenza dei 4 costrutti identificati dall'autore originale.

Conclusions: La SSCRS-ita ha mostrato proprietà psicometriche promettenti in termini di validità e affidabilità. I risultati di questo studio, insieme alla mancanza di studi approfonditi nel panorama sanitario ed educativo italiano, suggeriscono la necessità di sviluppare un percorso educativo che, partendo dai curricula della formazione di base e proseguendo con l'aggiornamento del personale infermieristico, sia dedicato alla rilevazione dei bisogni spirituali del paziente.

Implications for nursing practice: La SSCRS-ita è il primo strumento italiano validato riguardante la considerazione dei bisogni di spiritualità e assistenza spirituale nei contesti di assistenza sanitaria; la possibilità di utilizzare questo strumento è il primo passo verso una migliore integrazione delle dimensioni di assistenza menzionate in una prospettiva qualitativa dell'assistenza infermieristica qualitativa.

INTRODUCTION

In the last few decades considerable attention has been given to the delivery of spiritual care and the role spirituality may have on patient care. These aspects are related to nursing in a much deeper way than just a historical-religious heritage. Their consideration is inherent in the most important theories of nursing, starting with V. Henderson (1897–1996), M. Rogers (1914–1994), M. Gordon (1931–2015), and Florence Nightingale (1820–1910), who came to define how the person should be cared for offering a global perspective and in reciprocal connection with the various physical/biological, psychological, social, cultural, and "spiritual" components (Nightingale, 2020). More recently, the Human Becoming Theory by Rosmarie Parse (1938) also emphasized the human becoming with a bio-psycho-social-spiritual framework to which nurses could align with in order to help individuals use their personal talents and meet their potential (Parse, 1992). Currently, the interconnection between spirituality, spiritual care needs and nursing is not merely theoretical but considered an unequivocal part of the nursing profession and the North American Nursing Diagnosis Association Manual (Herdman & Kamitsuru, 2018) includes it in the class "Congruence of actions related to values and beliefs".

BACKGROUND

Globally, the attention of researchers to spirituality and spiritual nursing has been increasing in recent years, although there is still a certain lack of standardization in the conceptualization and evaluation of spiritual nursing. Notwithstanding these considerations, the importance of spiritual care appears to be underestimated and underreported by nurses (Hawthorne & Gordon, 2020) although the international literature indicate it as a component of quality of care (Ghorbani et al., 2021). This could be partly due to the lack of concept standardization, therefore pointing to the need for dedicated assessment tools (Harrad et al., 2019).

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In Europe, attention to spirituality and patient care is so high that, in addition to the creation of assessment tools (McSherry et al., 2002) a specific network (EPICC Network, McSherry et al., 2020) has been created to promote the practice of evidence-based spiritual care throughout Europe, bringing together all the major experts in the field and focusing much of its work on educating nursing students to consider spirituality and spiritual care (Giske et al., 2022; Ross et al., 2014, 2016).

Italy has always been characterized by the presence of a strong religiosity both in the historical evolution of health care (Celeri Bellotti & Destrebecq, 2013) and in the political-cultural aspects of the country (Garelli, 2014); one would expect a wide consideration of the spirituality and spiritual care needs of patients, yet, to date, training programs do not specifically consider the spiritual dimension of nursing care and there is no validated evaluation scale that assesses these elements. As a result, the literature suggests spiritual care being part of the "missed care" phenomenon (Chaboyer et al., 2021). Therefore, it is of undisputed importance to validate a suitable instrument in Italian for the purposes already expressed. Currently, we did not find many validated instruments suitable for this purpose, apparently the most widely used instrument, internationally, seems to be the Spirituality and Spiritual Care Rating Scale (McSherry et al., 2002).

DESIGN

A single-center cross-sectional study was conducted in a public hospital trust in Milan, Italy. A total of 419 nurses were enrolled from 23 different wards and six department (internal medicine, surgical, cardiorespiratory, oncohaematological, hepato-gastric-metabolic, emergency), without defining exclusion criteria. Data collection was conducted from October 15 to November 15, 2019. The information form regarding the aims and methods of the project, the request for consent to participate and the survey instrument were printed and given directly to the nursing staff who, after completion, placed them in a special binder that was then collected by a researcher.

METHOD

The Italian version of the scale was produced using the back-translation method (Brislin, 1970; Ozolins et al., 2020). The translation of the original instrument into Italian was carried out independently by two nurses, tutors of the nursing degree course at the University of Milan with certified knowledge of the English language. The comparison of the two translations allowed the drafting of a shared final version (SSCRS-ita) which was subsequently retranslated independently by native English teacher and sent back to the original author to confirm adherence to the original instrument.

Prior to administration, the SSCRS-ita was assessed for content validity and retest stability by calculating the Content Validity Index (Polit & Beck, 2006). Eight experienced nurses (with overall working experience $\geq$ 10 years) from different departments were contacted individually and asked for their opinion on the appropriateness of the items on a 10-point Likert scale (1 = not at all relevant/10 = very relevant), the need to make any changes to one or more items, and clarity and comprehensibility of the instrument as a whole. On the basis of the answers provided, content validity was investigated by calculating the Content Validity Index of the scale (S-CVI). In order to investigate the stability of the scale, it was administered in two stages (1 week apart) to a nonrandomized sample consisting of the first 35 nurses who joined the project.

The scale

The tool comprises of two sections. The first part is the Spirituality and Spiritual Care Rating Scale -ita (Table 1) and includes 17 items that in the original version were divided into four subscales: "spirituality", "spiritual care", "religiosity", and "personalized care". The answers are structured according to a 5-point Likert scale (totally disagree–totally agree). The second section investigates sociodemographic information (age, gender, religious beliefs) and occupational information (length of service, educational qualification, continuing education, contract, and shift work).

Ethical considerations

Data were collected anonymously and processed by the authors in accordance with current Italian legislation and the principles of the Declaration of Helsinki. Participants provided their explicit consent to participation necessary for access to the survey instrument. The research was conducted with the authorization of the nurse manager and the hospital board, protocol n. 0025050.

Statistical analysis

Descriptive statistics were used to analyze the sociodemographic and professional characteristics of the sample. The content validity of the Italian version of the scale was tested by calculating the Content Validity Index of each item (I-CVI) and of the scale as a whole (S-CVI), considering acceptable value of S-CVI $\geq$ 0.90 (Polit & Beck, 2006). Internal consistency was investigated by calculating Cronbach's alpha coefficient, test-retest stability through Spearman's rho coefficient. For all analyses conducted, the significance threshold was set at 0.05. All calculations were performed with SAS® 9.0 software (SAS Inc., Cary, USA).

RESULTS

Four hundred nineteen nurses were invited to participate; a total of 337 nurses completed the survey by correctly completing the scale

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TABLE 1 The SSCR-ita scale

Spirituality And Spiritual Care Rating Scale (SSCRS) – ita
Versione italiana a cura di Mauro Parozzi, Francesco Miseroni, Stefano Terzoni, Università degli studi di Milano.

Per ciascuna domanda, si prega di cerchiare una sola risposta che rifletta al meglio il grado di accordo o disaccordo con ciascuna affermazione.

a) Credo che gli infermieri possono fornire assistenza spirituale organizzando una visita da parte del cappellano ospedaliero o del leader religioso del paziente, se richiesto.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

b) Credo che gli infermieri possano fornire assistenza spirituale mostrando gentilezza, preoccupazione e allegria durante l'assistenza.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

c) Credo che la spiritualità riguardi il bisogno di perdonare ed essere perdonati.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

d) Credo che la spiritualità riguardi solo il fatto di recarsi in chiesa o nel luogo di culto.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

e) Credo che la spiritualità non riguardi la fede in Dio o in un essere supremo.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

f) Credo che la spiritualità sia trovare un significato negli eventi buoni e cattivi della vita.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

g) Credo che gli infermieri possano fornire assistenza spirituale trascorrendo tempo con un paziente per dargli supporto e rassicurazione, soprattutto nel momento del bisogno.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

h) Credo che gli infermieri possano fornire assistenza spirituale permettendo al paziente di trovare un significato e un fine nella loro malattia.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

i) Credo che la spiritualità riguardi il fatto di avere un senso di speranza nella vita.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

j) Credo che la spiritualità abbia a che fare con il modo in cui si conduce la propria vita qui e adesso.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

k) Credo che gli infermieri possano fornire assistenza spirituale ascoltando il paziente e dandogli il tempo di discutere e esplorare le loro paure, ansie e problemi.
* Fortemente in Disaccordo * Disaccordo *Incerto * D'accordo * Fortemente in Accordo

(response rate 80.42%). Missing data responses were not included in the analysis.

Sociodemographic and professional characteristics

Of those who participated, 64.69% were females (*n* = 218) and mostly aged between 20 and 29 years old (*n* = 99, 29.37%). Of those who participated, 259 nurses (76.85%) had a bachelor's degree or equivalent, 16 had a master's degree (4.75%); 47 had a first level advanced course degree (13.95%) and one had a second level advanced course degree.

Regarding the years of work experience, the most representative group was between 1 and 5 years (*n* = 94, 27.89%), followed by the most senior nurses (20 years, *n* = 82, 24.33%). 311 persons (92.28%) worked full-time, 26 (7.72%) part-time; 205 (60.83%) were shift workers. Table 2 summarizes the characteristics of the sample.

Of the 337 nurses who participated 252 (74.77%) said they had a religious belief, 98 of whom were religionist (38.89%). By the Pearson's chi-square test, there were no significant differences in the number of believers as a function of the variables gender ($p = 0.08$), age ($p = 0.66$), educational qualification ($p = 0.53$), years of work ($p = 0.14$), and working hours ($p = 0.56$). On the other hand, the percentage of people with a religion in the female gender was significantly higher than in the male gender (34.94% vs 20.17%, $p = 0.01$).

Content and face validity of the SSCRS-ita

Eight tutor nurses with more than 10 years of work experience were involved in the content and face validity process. All nurses involved had a Master's degree, two had a PhD in nursing sciences, one was doctoral student; the other five nurse had advanced postgraduate training in different settings. The eight expert nurses received an email containing the information regarding the purpose of the project and the Italian version of the SSCRS scale translated through the back-translation method; each nurse evaluated the relevance of each item attributing to it a score from 1 ("not at all relevant") to 10 ("very relevant"); this allowed to calculate the Content Validity Index of each single item (I-CVI) and the Content Validity Index of the scale as a whole (S-CVI). All 17 items obtained an I-CVI > 0.80; the instrument as a whole obtained a Content Validity Index (S-CVI) of 0.92; no unclear items or items requiring modification or clarification were reported.

Construct validity of the SSCRS-ita

The Kaiser–Meyer–Olkin measure (0.81) and Bartlett's test of sphericity ($p < 0.001$) confirmed the adequacy of the sample for conducting exploratory factor analysis (EFA). The factorial pattern of the EFA without rotation and then with non-orthogonal Promax rotation confirmed

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TABLE 2 Nurses sociodemographic characteristics

Variable	N (%)
Gender	
Male	119 (35.31)
Female	218 (64.69)
Age	
20–29	99 (29.38)
30–39	97 (28.78)
40–49	68 (20.18)
50–59	64 (18.99)
⇒60	9 (2.67)
Work experience (years)	
<1	26 (7.72)
1–5	94 (27.89)
6–10	52 (15.43)
11–15	42 (12.46)
16–20	41 (12.17)
>20	82 (24.33)
Shift worker	
Yes	205 (60.83)
No	132 (39.17)
Religious beliefs	
Yes	252 (74.78)
No	85 (25.22)

the presence of the four constructs identified by the original author (McSherry et al., 2002). All items presented factor loadings above Stevens' cut-off = 0.4 (Stevens, 2012). The SSCRS-ita explained 58.49% of the overall variance (Table 3).

Internal consistency

The Cronbach's alpha coefficient was 0.70; the repeated analysis by eliminating progressively each item, did not show significant variations of the coefficient (range [0.69;0.72]). The analysis of each domain showed the following values of Cronbach's alpha: spirituality = 0.69, spiritual care = 0.73, religiosity = 0.65, and personalized care = 0.71.

Test-retest stability

The above mentioned 35 nurses filled the SSCRS-ita again after one week confirming the absence of personal, professional, and organizational changes in the workplace compared to the first compilation; the results obtained (rho = 0.89, $p < 0.001$) confirmed the stability of the instrument.

TABLE 3 Factor loadings for four factors of SSCRS-ita

N	#	Spirituality	Spiritual care	Religiosity	Personalized care
1	A	0.034	**0.617**	0.133	0.005
2	B	0.059	**0.749**	0.171	0.172
3	C	**0.689**	0.018	0.028	0.126
4	D	0.101	0.024	**0.746**	0.198
5	E	0.093	0.132	**0.801**	0.063
6	F	**0.723**	0.078	0.119	0.069
7	G	0.040	**0.703**	0.120	0.028
8	H	**0.603**	0.076	0.078	0.009
9	I	**0.699**	0.023	0.034	0.006
10	J	**0.598**	0.087	0.081	0.056
11	K	0.001	**0.677**	0.012	0.014
12	L	**0.643**	0.036	0.005	0.012
13	M	0.030	0.056	**0.725**	0.122
14	N	0.024	**0.608**	0.034	0.032
15	O	0.045	0.059	0.036	**0.737**
16	P	0.061	0.043	**0.796**	0.122
17	Q	0.087	0.088	0.132	**0.799**
	α	**0.69**	**0.73**	**0.65**	**0.71**

Item comprised in each subscale are bold.

DISCUSSION

The SSCRS-ita showed good psychometric properties. Overall, our data highlight the validity and stability of our version. The excellent score on the Content Validity Index confirms the original concept that all aspects explored are highly relevant and pertinent to the framing of the construct. The scale was tested on a large sample and the response rate was high, which allows us to conclude that the results are undoubtedly representative of the population examined, however, the study was conducted in only one hospital and this limitation undoubtedly supports the need for further study in other settings. The structure of the original scale was maintained in the Italian version, which also showed an overall satisfactory internal consistency in each of the domains that emerged. In particular, the exploratory factor analysis confirmed the four constructs identified by the original author (spirituality, spiritual care, religiosity, personalized care).

The factorial loadings of the SSCR-Ita faithfully reflect those of the original SSCR in the groupings with the only real exception of item "E" which in the analysis of the original scale constituted the only loading of a fifth factor (later eliminated) and which in our analyses was placed in Factor 3 (religiosity). Still in the analyses of the original scale, item "C" showed a low weighting in both Factor 1 and Factor 2 while in the SSCR-ita it was placed firmly in Factor 1. Finally, the original factorial analysis showed the need to consider the factorial loadings of Item "N" under both Factor 2 (lowest value) and Factor 4 (highest value) while in the SSCR-ita analyses it was only under Factor 2; this, however, could be due to a slightly smaller sample size than that of the original scale.

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Analyzing the constructs described in each domain of the scale, the six variables of the 'Spirituality' subscale explore aspects concerning life and existence, and in particular, the need to find meaning and purpose in life and during periods of illness or hospitalization. These concepts appear to be effectively useful in the overall framing of the person as they allow to contextualize behaviours and states of mind to which one often tends to give only modest importance (Jacobs, 2018).

The variables described in the subscale "spiritual care" seem to identify the main concepts characterizing spiritual care, such as listening skills, time management, respect for privacy and dignity, as well as evidence of qualities such as kindness and care for the person being cared for; these results, moreover, are in line with other contemporary work (Carretta et al., 2017; Karaca & Durna, 2019) who have identified them as key elements in patient satisfaction.

Nurses' awareness that these principles are associated with spiritual care is undoubtedly the starting point for the improvement of holistic nursing (Southard, 2020); further work aimed at exploring the perception of Italian nurses is needed.

The four variables grouped by the third factor would seem to confirm the idea already found in the literature that spirituality is not a concept associated only with religion but also a universal concept, able to unify people, therefore also atheists and agnostics (Domingo-Osle & Domingo, 2020; McSherry et al., 2002; Mcsherry & Jamieson, 2011). The presence of this factor also confirms that religiosity is indeed a separate construct to be distinguished from spirituality.

Two variables loaded on the fourth factor which seems to measure an aspect of spirituality, that of personalized care, through which a person's own beliefs, values, morals, and relationships are brought into play. These are all characteristics that are inherently unique to each individual (Erden Melikoğlu et al., 2021).

CONCLUSIONS

A holistic approach, which is typical of the nursing profession, requires careful evaluation of all the nursing needs potentially involved: physical, psychological, emotional and sociocultural conditions; understanding the attitudes toward spirituality is a fundamental step, within the nursing student's educational program, which can influence clinical internship experiences and shape future nursing practice (Bollo et al., 2019). Assessment of the spiritual needs of the individual and the impact that the spirituality of each human being has on every single dimension of the person and on the nursing care plan should also be taken into; for these reasons, the assessment of the spiritual dimension is an essential step in the process of nursing care to better and more thoroughly identify the specific needs of patients and their caregivers. Especially when facing long periods of illness, permanent disabilities, and adverse prognoses, specific needs emerge in patients, such as the need to find meaning and purpose in life; the elements of spirituality, spiritual care, religiosity, and personalized care are essential to help these people and their families embrace their opportunities and potential in the best possible way, in the time they still can be together.

The Italian version of the SSCRS has shown promising psychometric properties in terms of validity and reliability and is therefore a useful tool for assessing the different constructs that characterize spirituality and spiritual care by providing a clear structure from which to obtain a deeper understanding of the concepts. The factors extracted confirm the original structure suggesting the presence of several main components of spirituality that may be universally transferable to all individuals.

The results of this study, together with the lack of in-depth studies within the Italian health and educational panorama, suggest the need to develop an educational pathway which, starting from the curricula of basic training and continuing with the updating of nursing staff, is dedicated to the detection of the spiritual needs of the patient, an essential element for developing adequate and appropriate care responses.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

No ethical approval is required for this study.

AUTHOR CONTRIBUTIONS

Stefano Terzoni, Agostino D'Antuono, and Wilfred Mcsherry provided methodological support to the study.

Mauro Parozzi, Stefano Terzoni, Francesco Miseroni, Laura Di Prisco, Paolo Ferrara, and Agostino D'Antuono performed the study and drafted the manuscript.

Wilfred Mcsherry, Stefano Terzoni, and Mauro Parozzi revised the manuscript.

Stefano Terzoni, Mauro Parozzi, and Agostino D'Antuono performed the statistical analysis.

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