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Development and validation of the Chinese Version of Spiritual Interests Related Illness Tool for patients with cancer in Taiwan



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A B S T R A C T

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Patients with cancer

Purpose: The purpose of the study was to develop and validate the Chinese Version of Spiritual Interests Related Illness Tool (C-SpIRIT) for patients with cancer in Taiwan.

Methods: Translation, adaptation, and content validation were performed based on the 44-item Spiritual Interests Related Illness Tool. The psychometric validation was conducted based on 260 participants who were recruited from the oncology outpatient clinic of a medical center in southern Taiwan. The data were analyzed using exploratory factor analysis, Cronbach's alpha, and Pearson's correlations.

Results: Five subscales (related to beliefs/religion, positive attitudes toward life, love to/from others, seeking for the meaning of life, and peaceful mind) were extracted from an exploratory factor analysis. The five subscales (with 21 items) accounted for 50.43% of the variance. The evidence based on concurrent validity was supported by a significant correlation ($r = 0.95$) between the 33-item C-SpIRIT and the 21-item C-SpIRIT. Cronbach's α values (0.73–0.88) demonstrated internal item consistency of the C-SpIRIT.

Conclusions: This preliminary 21-item and 5-factor constructed C-SpIRIT demonstrated a valid and reliable instrument to assess the spiritual needs of patients with cancer in Taiwan. In addition, it is a handy tool for oncology nursing practitioners to gauge their patients' spiritual needs.

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Introduction

Spiritual needs can be defined as the search for nature, meaning of individual's life, and purpose of being alive; it does not only limited to religious oriented domain, but also non-religious oriented domain (Hodge and Horvath, 2011; Narayanasamy, 2007; Taylor and Ferszt, 1990). Satisfying the spiritual needs of patients with cancer can support them facing the horror of death, ease the discomforts and uncertainty during treatment process, and thus enhance their inner peace and meaning of life (Pearce et al., 2012; Reed, 1992). Therefore, satisfaction of spiritual needs is a significant indicator of quality of life for patients with cancer (WHOQOL SRPB

Group, 2006). Performing a simple spiritual-needs assessment can be an initial step of building up a nurse-patient rapport and an effective intervention to obtain spiritual-related resources (Eldridge, 2007; Puchalski and Ferrell, 2010). Thus, the capabilities of assessing spiritual needs and providing spiritual care are critical competences for nurses who take care of patients with cancer (American Association of Colleague Nursing, 1997).

The incident and prevalent rates of cancer had surged drastically in Taiwan, and it had been the leading cause of death for the past three decades (Ministry of Health and Welfare (2013)). Therefore, Taiwanese nurses may consider spiritual care as a fundamental skill while caring patients with cancer. However, spiritual needs were rarely addressed during nursing skill training and education in Taiwan (McSherry and Jamison, 2012).

Hsiao et al. (2010) conducted a qualitative study on spiritual needs of 33 patients with lung cancer underwent outpatient chemotherapy or radiation therapy in Taiwan. They categorized spiritual needs into four themes: (1) providing hope to survive and spiritual peace, (2) the satisfaction of meaning of life and dignity,

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(3) the experiences of love and be loved, and (4) the support of facing death issues willingly. British scholars [Nixon and Narayanasamy \(2010\)](#) explored spiritual needs of 21 neurosurgical inpatients with brain tumor, using in-depth qualitative interview technique. They categorized spiritual needs into several sections, i.e. family support, emotional support, religious needs, need for connection/loneliness/depression, need to talk, reassurance, plan for the future/sense of normality, solitude, and thoughts about meaning of life. [Nixon and Narayanasamy \(2010\)](#) asserted that their results offered practical nursing strategies for satisfying cancer patients' spiritual needs.

[Taylor \(2003\)](#) developed a 44-item Spiritual Interests Related to Illness Tool (SpIRIT) to measure the satisfaction of spiritual needs of patients with cancer and their families. The eight dimensions of the 44-item SpIRIT were: needing positive perspective, needing relationships with God, giving love to others, receiving love from others, reevaluating beliefs, seeking for the meaning of life, practicing religion, and preparing for death. In addition, the eight categories were extracted by maximum transformation matrix method of exploratory factor analysis: relating to God (9 items), giving love to others (6 items), receiving love and spiritual support (6 items), seeking for the meaning of life (5 items), maintaining positive perspective (5 items), preparing for death (4 items), reevaluating beliefs and life (4 items), asking "whys" (3 items). A 5-point Likert scale was used, and the score of each category was calculated by the summation of item scores divided by the numbers of the category (with Chrobach's alpha coefficients ranged from 0.76 to 0.96); thus the higher the score, the higher the spiritual needs for the specific category. Taylor's instrument ([2006](#)) was a valid and reliable tool of assessing spiritual needs of patients with cancer, which encompassed [Hsiao's \(2010\)](#) qualitative study results of patients with lung cancer. Therefore, we intended to establish a Chinese Version of spiritual needs measurement tool for Taiwanese patients with cancer, on the basis of [Taylor's \(2006\)](#) instrument.

The purpose of the study was to develop and validate the Chinese Version of Spiritual Interests Related Illness Tool (C-SpIRIT) for patients with cancer in Taiwan. Specific objectives were to examine content validity, construct validity, concurrent validity, and internal consistency reliability of the C-SpIRIT. A reliable and valid assessment tool of spiritual needs for patients with cancer is essential, and nurses are able to develop practical caring plans to satisfy patients' spiritual needs accordingly.

Methods

The process of this study was organized by translation, adaptation, content validation and psychometric evaluation.

Phase 1 – Translation, adaptation and content validation

The 5-step decentering method applied in this study was intended to achieve semantic and conceptual equivalence between the English and Chinese versions of the SpIRIT.

Step 1: Bilingual expert forward translation

Two bilingual oncology experts fluent in reading, speaking, writing, and understanding both Chinese and English were invited to translate the SpIRIT from English into Chinese, independently ([Wild et al., 2005](#)). They were asked to submit their independent translation work to the first and corresponding authors. Then the authors and translators discussed and examined any unclear translations separately.

Step 2: Translation committee approach

A translation committee was organized to evaluate and reach semantic equivalence of the initial C-SpIRIT ([Wild et al., 2005](#)). This translation committee was composed of five bilingual experts (i.e., two nursing professors, a nursing graduated student, a pastor, and an English teacher) fluent in reading, speaking, writing and understanding both Chinese and English. The original English version used various Christian terminologies; therefore a pastor was invited in this committee. In order to prevent any judgment bias derived from the interactions between translators and reviewers, the committee members evaluated the translation equivalence between the initial C-SpIRIT and original English version independently.

Translation Equivalence Questionnaire and Translation Validity Index (TVI) were used to evaluate the translation equivalence between the initial and original versions of SpIRIT ([Tang and Dixon, 2002](#)). TVI was calculated by the average ratings of the experts for each item, and it reflected the extent of agreement among the experts. The resulting proportion of items presented the rating of equivalence. Items with TVI below 0.80 indicated unacceptable level of translation validity and were revised by the original translators. The process continued until all the items were above 0.80 agreements ([Tang and Dixon, 2002](#)).

Step 3: Monolingual lay target population review

In order to assess how accurately the connotative meaning was captured in the C-SpIRIT, five cancer patients were asked to serve as monolingual reviewers to evaluate the understandability of the second version of the C-SpIRIT independently. The Monolingual Reviewer Questionnaire, developed for the C-SpIRIT specifically, was used to evaluate and rate the understandability of the translated version. The Monolingual Reviewer Questionnaire was a 2-point score ('0' = 'disagree, and '1' = 'agree'). The average score less than 0.80 implied unacceptable level of understandability. In addition, reviewers were asked to comment on their thoughts about what each item intended to ask.

Step 4: Validation and cultural adaptation (item-level content validity)

Six additional experts (i.e., four nursing professors, a senior registered nurse of cancer caring, and an oncologist) were recruited to assess the validity (i.e., the degree of applicability and comprehensibility) of each item's content addressed the domain of concepts of the instrument independently ([Waltz et al., 2005](#)).

The Content Validity Questionnaire was a 4-point Likert's scale for experts to evaluate the applicability and comprehensibility of each item ([Lynn, 1986](#)). The Item-level content validity index (CVI) was calculated by the experts' average ratings for each individual item, which reflected the extent of agreement among the experts. CVI below 0.83 denoted unacceptable level of content validity ([Lynn, 1986](#); [Polit and Beck, 2006](#); [Waltz et al., 2005](#)).

Step 5: Pretesting

Extra ten cancer patients from the outpatient oncology department at a medical center in southern Taiwan were recruited to evaluate the quality and comprehension of the second version of C-SpIRIT and verify the simplicity of administration. We conducted 30 min interview with patients individually, which were audio-recorded and transcribed for detecting problems with the instrument, and thereby reduced measurement errors.

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