Original Article

Development and Validation of a New Tool for the Assessment and Spiritual Care of Palliative Care Patients

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Abstract

Context. Spiritual assessment tools and interventions based on holistic approaches are needed to promote healing. Such tools must be adapted to the wide cultural backgrounds of contemporary Western society.

Objectives. To develop and validate a new brief measure, simultaneously featuring clinical applicability and adequate psychometric properties. The tool uses six initial questions to establish a climate of trust with patients before they complete an eight-item, five-point Likert scale. The questionnaire is based on a model of spirituality generated by the Spanish Society of Palliative Care (SECPAL) Task Force on Spiritual Care (Grupo de Espiritualidad de la SECPAL), which aims to recognize, share, and assess the spiritual resources and needs of palliative care patients.

Methods. Multidisciplinary professionals from 15 palliative care teams across Spain interviewed 108 patients using the Grupo de Espiritualidad de la SECPAL questionnaire. Confirmatory factor analysis techniques were used to study the new tool factor structure and reliability. Additionally, concurrent criterion validity coefficients were estimated considering spiritual well-being, anxiety, depression, resilience, and symptoms. Descriptive statistics on questionnaire applicability were reported.

Results. Analyses supported a three-factor structure (intrapersonal, interpersonal, transpersonal) with an underlying second-order factor representing a spirituality construct. Adequate reliability results and evidence for construct validity were obtained.

Conclusion. The new questionnaire, based on empirical research and bedside experience, showed good psychometric properties and clinical applicability.
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Key Words
Palliative care, spiritual care, spirituality, assessment, questionnaire validation, structural equation modeling

Introduction

The assessment of spirituality in palliative care is a central issue in many cultures.[1–3] Spirituality has been identified as an important resource for patients that helps them address distress when facing disease.[4,5] In this context, patients suffering spiritually have indicated that their suffering aggravated their physical/emotional symptoms. Spiritual well-being has been clearly shown to be linked with lower levels of anxiety and depression.[6] Assessing spiritual needs and resources as well as spiritual care is imperative to care for the whole person.

A variety of spirituality instruments have been developed and widely used in the past years, such as the Palliative Care Outcome Scale,[7] the Existential Meaning Scale,[8] the Functional Assessment of Chronic Illness Therapy-Spiritual Well Being (FACIT-Sp) tool,[9] the Ironson-Woods Spirituality/Religiousness Index Short Form,[10] the World Health Organization's Quality of Life Measure Spiritual Religious and Personal Beliefs,[11] and, more recently, the Spiritual Needs Assessment for Patients.[12]

The tools for available measuring spirituality in the palliative care context have several problems. Information about the psychometric properties of the instruments is scarce. There is a lack of precision in definitions as well as illusory spiritual health, ceiling effects, social desirability, and bias.[13] Despite the need to assess spiritual outcomes in palliative care, as Selman et al.[4] recently stated, little is known about the properties of the tools currently used to do so. Some critics have highlighted cultural bias and the lack of cross-cultural validations in these instrument[4,13,14] because most of them have been developed in the U.S. Caucasian populations.[4] As spirituality is embedded within culture,[15,16] the exclusion of the target population from the tool development process may lead to a misfit between the spirituality approach embedded in the measure and the approach of the respondent population,[4] which in turn leads to an uncritical transference of concepts between cultures.[17] The researchers' diverse goals, together with the assumption that their interpretation of spirituality can be applied universally—when in fact it is based on evaluative criteria of particular groups—make cross-cultural application of the existing tools not recommended.

Furthermore, in Mediterranean cultures, family relationships play an important role not only in life but also when dealing with death. The progressive secularization of Spanish society in recent decades and the current weak religious practice, along with the high frequency of agnosticism among health professionals, inspired a questionnaire based on issues that were considered more inherently spiritual. Religious beliefs and practices are avoided to facilitate the exploration of spiritual resources and needs, which, according to this model, are still at the core of every human being. We based the new instrument on the assertion by Mount et al.[18] that "humans are intrinsically spiritual because all persons are in relationships with themselves, others, nature, and the significant or sacred." Accordingly, the questionnaire is built on three axes: interpersonal, intrapersonal, and transpersonal. We try to reflect this cultural trait in our context. In fact, among the few instruments validated transculturally,[19] only the psychometric properties of the Palliative Care Outcome Scale have been studied in the Spanish palliative care context,[20] although there are Spanish version of some of the other instruments.

The Spanish Society of Palliative Care (SECPAL) created a Task Force on Spiritual Care (Grupo de Espiritualidad de la SECPAL [GES]), which emerged out of the need identified by palliative care professionals to find a conceptual framework for coping with patient's suffering by working through their spiritual needs and resources. Its first step was to develop a humanistic, integrative, and conceptual model of suffering, spirituality, and spiritual care, integrating bibliographic research, traditional wisdom, and clinical experience.

The task force worked on the definition of a clinical approach to suffering and spiritual care for the Spanish context.[21] A second step was the implementation of nationwide residential training workshops on spiritual care for clinicians.[22] Finally, a model for the assessment of spiritual resources and needs was developed, resulting in the construction of the instrument with clinicians. The questionnaire was developed in light of some of the aforementioned limitations, trying to improve on the psychometric properties of the existing tools.

We sought consensus among a task force comprising physicians, nurses, psychologists, social workers, theologians, anthropologists, and volunteers. We started from what the literature reveals as spirituality's most relevant dimensions;[5,23–29] the most significant aspects of relationships with ourselves (need for meaning and coherence), with others (harmony in our relationships with people we care most for and the need to feel loved and to love) and transcendence (the need to have hope and the sense of belonging) were defined.

Based on this process and on clinical experience, the aim of this research was to evaluate the reliability, validity, acceptability, and feasibility of a new brief assessment and intervention questionnaire for use in spiritual care in palliative care settings, taking into account the cultural framework.

Methods

Development of the Scale

Focus groups of palliative care experts and professionals developed the items of the new measurement instrument. After the focus groups, and consultation with methodologists, the proposed items were reduced to eight, as shown in Appendix I.

Design and Procedure

A cross-sectional, multicenter study was implemented. A pilot study was carried out in Mallorca and Barcelona. In a second phase, an open invitation to participate was offered throughout the network of Spanish palliative care professionals to those previously aware of the SECPAL spiritual model framework. Those willing to take part participated in monitored questionnaire completion and interviews across the 15 participating sites (Appendix II, available at jpsmjournal.com).

Participants

Data were collected between June and December 2011, after verifying the inclusion criteria detailed in Table 1. In this social context, questions posed in the questionnaire can only be addressed when the patient is aware of his/her disease status. Therefore, inclusion criteria had to be very restrictive. Although there are no data from all the teams who interviewed patients, it is estimated that the patients interviewed represent less than 25% of those seen in this period. Participants were interviewed with the protocol provided and surveyed by the research team, which emphasized the attitudes of trust, intimacy, and respect when interviewing.

One hundred eight patients participated, 48.1% of whom were men. Their ages ranged from 41 to 94 years, with a mean ± SD age of 68.09 ± 12.7, and 85% presented with a diagnosis of cancer. Regarding marital status, 50.5% were married or had a partner, 20.8% were widows/widowers, 14.9% were divorced, and

Table 1
Inclusion Criteria

A. Adult patients (18 years or older).
B. Presence of advanced terminal disease according to WHO/SECPAL criteria for palliative care.
C. To have comprehension ability to understand subjective measures (assessed with the Spanish version of SPMSQ).[a,b]
D. To be aware of diagnosis and occasionally express the possibility of dying (scores equal to or greater than 3 as assessed by Ellershaw's scale).[c]
E. Participants agreed to be interviewed and signed the questionnaire's informed consent.

WHO = World Health Organization; SECPAL = Spanish Society of Palliative Care.
[a]Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. J Am Geriatr Soc 1975; 23:433–441.
[b]Martínez de la Iglesia J, Dueñas R, Onís MC, et al. Adaptación y validación al castellano del cuestionario de Pfeiffer (SPMSQ) para detectar la existencia de deterioro cognitivo en personas mayores de 65 años [Spanish adaptation and validation of the Pfeiffer questionnaire (SPMSQ) to detect the presence of cognitive impairment in people over 65 years.]. Med Clin 2001; 117:129-134.
[c]Ellershaw JE, Peat SJ, Boys LC. Assessing the effectiveness of a hospital palliative care team. Palliat Med 1995; 9:145–152.

13.8% were single. Finally, 87.4% of the sample said they were accompanied by a primary caregiver or received family visits; 12.6% preferred solitude or lacked social support. The sample was recruited from 15 participating health care services throughout Spain: 47.5% from palliative care units, 36.4% from home care palliative services, 16.5% from palliative units in acute care hospitals, and 9.9% from nursing homes.

Measures

The survey included collection of sociodemographic data and several scales to measure medical and psychological indicators.

GES Questionnaire. The tool comprises six open questions to facilitate the patient's trusting revelation of his/her biography and inner world, followed by eight items assessing spirituality as a general factor and the three spirituality dimensions: intrapersonal, interpersonal, and transpersonal. The open questions were designed to create and share a space of intimate communication with the patient and establish a climate of trust. The attitude of the clinician should be one of attentive deep listening, respect, and acceptance. The other eight items were answered on a five-point Likert-type scale, with responses ranging from 0 (not at all) to 4 (a lot) (Appendix I).

Spiritual Well-Being Subscale of FACIT-Sp-12.[9,30] This 12-item instrument has three subscales: meaning, peace, and faith. The response scale ranges from 0 (not at all) to 4 (very much). Internal consistency was 0.76 for meaning, 0.64 for peace, and 0.82 for faith.

Hospital Anxiety and Depression Scale.[31] The Hospital Anxiety and Depression Scale was designed to measure anxiety (seven items) and depression (seven items) in patients with comorbid physical illness. Responses range from 0 (never) to 3 (almost all day). The scale has been found to have appropriate psychometric characteristics in Spanish samples.[32] Alphas were 0.78 for the anxiety subscale and 0.75 for the depression subscale.

Brief Resilient Coping Scale.[33] This four-item scale was back translated and validated in Spain.[34] Each item is rated on a five-point scale, from 1 (totally agree) to 5 (totally disagree), with higher scores reflecting greater resilience. Internal consistency was 0.79.

Additionally, the acceptability of the protocol was assessed with three questions answered by the interviewer, including "degree of acceptance," "degree of comprehension," and "perception of estimated benefits for the patient." Answers were scored on a six-point Likert scale, ranging from 0 to 5, with higher scores indicating better interviewer perception. Cronbach's alpha was 0.62.

Statistical Analysis

The statistical analyses of the GES questionnaire included computation of item means, standard deviations, inter-item correlations, and homogeneity (corrected item-total correlations). Cronbach's coefficient alpha is the most widely used estimator of a scale's reliability. However, it has been criticized as being only completely appropriate with essentially *tau-equivalent* items (and tests) as a lower bound for the true reliability.[35] More explicitly, a tau-equivalent test assumes that all items measure the same latent variable, on the same scale, with the same degree of precision, with all true scores being equal.[36] When tau-equivalence does not hold, alpha will frequently underestimate the population value. Popular alternatives to alpha coefficients are the *glb* (greatest lower bound) and *rho* indexes. Therefore, two estimates of item reliabilities were calculated: 1) using the factor loadings of the confirmatory factor analysis (CFA) and 2) by correlating each item with the overall factor to which it is theoretically and empirically related. Thus, reliability of the scale was estimated using Cronbach's alpha, *glb*, and *rho* coefficients.

Factorial validity of the scale was estimated using EQS 6.1[37] (Multivariate Software, Inc., Encino, CA). CFA was used to study the factorial validity of the questionnaire. The a priori model of the questionnaire structure was based on both theoretical reasons and an exploratory factor analysis. Given the approach of the current study, one key issue is the model's ability to represent data properly. Most authors advocate for a set of indexes in assessing fit.[38,39] These are the Chi-square test, which, if not statistically significant, should be interpreted as indicative of data-model fit and the Goodness-of-Fit Index (GFI),[40] which ranges from 0 to

1, with models considered suitable when GFI exceeds 0.9. GFI is the absolute best performance index;[41,42] the Comparative Fit Index, one of the relative rates of greater use and better performance,[39] also ranges from 0 to 1, with a value of 0.9 considered the minimum required to defend the model,[43] and finally, the Root Mean Square Error of Approximation (RMSEA), a measure of error per degree of freedom model, which gives an idea of model parsimony.[44] Values less than 0.08 indicate a reasonable model, whereas 0.05 indicate a good fit.[45] The 90% confidence interval for RMSEA also was included, with intervals including 0.05 as rationale for a good fit.[46]

Construct validity also was studied, using correlations with the corresponding dimensions of FACIT-Sp-12. Criterion-related validity was established by correlating several constructs related to spirituality in the palliative care literature: anxiety, depression, and symptom intensity. Finally, clinical utility of the questionnaire was assessed.

Results

Confirmatory Factor Analyses Regarding Construct Validity

To establish the factorial validity of the GES Questionnaire, a CFA was specified, estimated, and evaluated with an a priori second-order structure. Overall fit indexes supported the scale structure (Table 2). RMSEA probably over-penalized the model because of the small number of indicators forming the first-order factors.

An examination of the factor loadings provides an idea of the analytical fit of the model, complementing fit-index information. Every indicator loaded significantly ($P < 0.05$) and high on the three hypothesized first-order factors, giving support to the overall spirituality approach. The standardized factor loadings were within a minimum of 0.46 (Item 3, "I find meaning in my life") in the intrapersonal spirituality factor and a maximum of 0.98 (Item 5, "I feel connected to a supreme reality [Supreme Being, Nature, God]") in the transpersonal spirituality factor (Fig. 1). The three first-order factors also loaded significantly ($P < 0.05$) and high in second-order hypothesized factor, with a minimum of 0.41 for the transpersonal spirituality first-order factor, and a maximum of 0.88 for the interpersonal spirituality first-order factor. All factor loadings were well above the values considered indicative of adequate consistency with the a priori structure.

Table 2
Model Overall Fit

χ^2	*d.f.*	*P*	GFI	CFI	RMSEA	90% CI RMSEA
29.117	17	<0.05	0.942	0.926	0.083	0.000–0.103

d.f. = degrees of freedom; GFI = Goodness-of-Fit Index; CFI = Comparative Fit Index; RMSEA = root mean square error of approximation.

Internal Consistency

Cronbach's alpha was 0.72; rho also was estimated and was 0.783; glb was 0.835. Therefore, several indices support the internal consistency of the scale. Descriptive statistics, floor and ceiling proportions, item homogeneity, alpha if-item-deleted, and inter-item correlations are presented in Table 3. Means were between 2.92 and 3.58, about the mid-point of the item scale. Only Item 4 shown a considerable proportion of ceiling effect (it had a 0.68 proportion). Item homogeneity could be considered adequate, although Item 8 had a minimum correlation of 0.26. Inter-item correlations were adequate for items of the same factor, but they were not always statistically significant when items of different factors were correlated. The internal consistency of the scale and items may be considered adequate according to the prevailing psychometrics mainstream, emphasizing the usefulness principle.[47] Following this principle, Items 4 and 8, despite their ceiling effect and lower consistence, should be retained. All the items in the scale are outstanding in terms of the definition of the construct of spirituality, as evidence for their validity is good.

Validity

Criterion-related validity was established through concurrent measures by correlating several constructs linked to spirituality in multiple palliative care studies.[6,48] Spirituality was hypothesized to relate to depression, anxiety, resilience, and other measures of spiritual well-being, as detailed in the previous section. Spirituality correlated with depression: −0.448

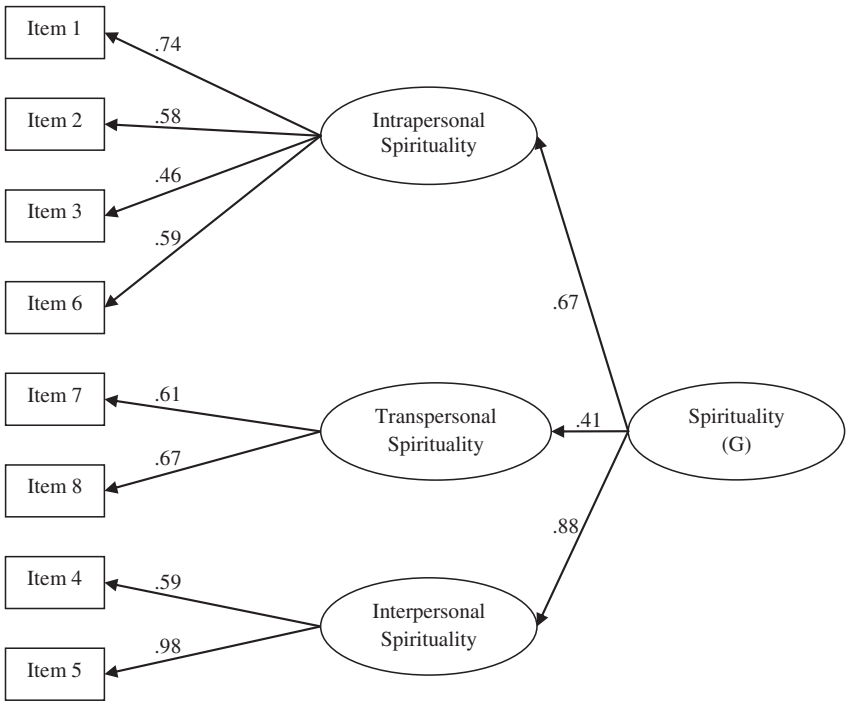

Fig. 1. Standardized factor loadings for the GES second-order model. For the sake of clarity, errors are not shown. GES = Grupo de Espiritualidad de la SECPAL.

($P < 0.001$); with anxiety: −0.263 ($P = 0.006$); and with resilience: 0.332 ($P < 0.001$). Correlations among the different factors of spirituality and these variables are shown in Table 4. Positive and high correlations with FACIT-Sp-12 subscales were found: 0.639 ($P < 0.001$) with meaning; 0.322 ($P = 0.001$) with peace; and 0.323 ($P = 0.001$) with faith.

Clinical Assessment of the Questionnaire

Interviewers' perceptions of the acceptance of the survey items by the participant, comprehension, and benefit deserve special attention. As informed by interviewers, the mean ± SD for acceptance was 4.40 ± 0.82; for comprehension, 4.27 ± 0.88; and for the perception of benefit for the patient, 3.77 ± 1.2.

Discussion

Currently, there is an emerging need for consensus regarding the definition and measure of spirituality in the palliative care context.[5] Some instruments have been developed specifically for palliative care patients but only a few of them seem clinically applicable and useful. Recent literature reviews found evidence for the scarcity of robust measures relating to spirituality in end-of-life care.[49] More recently, analyzing 35 research studies, Cobb et al.[50] pointed out the additional difficulties of research with advanced and end-stage conditions, primarily because of ethical and methodological challenges. These authors also proposed a challenging question for empirical studies of spirituality: "To what extent do they enlarge our understanding and increase access to the subject?" because some of the questionnaires are focused on religious issues, are lengthy, or have not been sufficiently validated in the cross-cultural palliative care setting.[15,16,51]

Our intent was to develop a questionnaire that was useful as guidance for clinicians, providing a short and easy application, to stimulate dialogue with end-stage patients about fundamental aspects of their spiritual dimension and care. The questionnaire also had to fulfill psychometric requirements. This article presents the psychometric properties of a new eight-item questionnaire, based on theoretical background and experience, with satisfactory clinician perception,[21] and which takes into account Spanish culture and the important

Table 3

Means, SDs, Item Homogeneity, Alpha If Item Deleted, and Interitem Correlations for the Eight Items of the GES Questionnaire

							Interitem Correlations						
Item Wording	Mean	SD	Floor Proportions	Ceiling Proportion	Item Homogeneity	Alpha If Item Deleted	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7
Item 1	2.98	0.96	0.19	0.31	0.44	0.68	—						
Item 2	3.10	0.88	0.09	0.36	0.34	0.69	0.46[a]	—					
Item 3	2.92	1.03	0.28	0.33	0.46	0.67	0.33[a]	0.28[a]	—				
Item 4	3.58	0.74	0.00	0.68	0.39	0.69	19	0.22[b]	0.31[a]	—			
Item 5	3.33	0.86	0.19	0.49	0.57	0.66	0.43[a]	0.31[a]	0.29[a]	0.58[a]	—		
Item 6	3.00	0.91	0.28	0.29	0.51	0.67	0.44[a]	0.31[a]	0.26[a]	0.28[a]	0.37[a]	—	
Item 7	3.10	1.05	0.28	0.44	0.37	0.69	0.10	0.06	0.33[a]	0.06	0.20[a]	0.28[a]	—
Item 8	2.94	1.32	0.93	0.46	0.26	0.73	0.03	−0.06	0.16	0.11	0.25[a]	0.20[b]	0.41[a]

GES = Grupo de Espiritualidad de la SECPAL.
There were only three missing values, corresponding to Items 4, 5, and 6, and each of them were from different people.
[a] $P < 0.01$.
[b] $P < 0.05$.

Table 4

Correlations Among the Three Factors From GES, FACIT-Sp-12 Factors (Meaning, Peace, Faith), Depression, Anxiety, and Resilience

Variables	Intrapersonal Spirituality	Transpersonal Spirituality	Interpersonal Spirituality	Meaning	Peace	Faith	Depression	Anxiety
Intrapersonal spirituality	—							
Transpersonal spirituality	0.229[a]	—						
Interpersonal spirituality	0.476[b]	0.270[b]	—					
Meaning	0.541[b]	0.550[b]	0.248[b]	—				
Peace	0.298[b]	0.177	0.221[a]	0.245[a]	—			
Faith	0.061	0.615[b]	0.036	0.260[b]	0.093	—		
Depression	−0.292[b]	−0.412[b]	−0.301[b]	−0.547[b]	−0.260[b]	−0.171	—	
Anxiety	−0.277[b]	−0.16	−0.298[b]	−0.240[a]	−0.279[b]	0.122	0.413[b]	—
Resilience	0.208[a]	0.305[b]	0.231[a]	0.387[b]	0.313[b]	0.228[a]	−0.468[b]	−0.318[b]

GES = Grupo de Espiritualidad de la SECPAL; FACIT-sp = Functional Assessment of Chronic Illness Therapy-Spiritual Well Being.
[a] $P < 0.05$.
[b] $P < 0.01$.

role that the interpersonal dimension plays in it. Hence, it features three dimensions of spirituality: intrapersonal, interpersonal, and transpersonal. Although these are universal dimensions of spirituality, the way they are represented in this questionnaire is distinctive: Interpersonal spirituality is construed as a dimension of its own and represented with the same number of items as the transpersonal dimension, which is difficult to find in other spirituality measures designed for the context of palliative care.[19] Our questionnaire has been developed under the assumption of human beings' spiritual nature, the approach to the dying process as an opportunity for growth, and the conviction that adequate spiritual care can provide an opportunity for healing.

To test for the scale's factorial validity, a second-order factor CFA was estimated. This factor structure was based on the spirituality models proposed by GES. Therefore, it is a completely a priori model. Fit indexes, taken together, showed adequate fit to the data, confirming both the three first-order factors and a general spirituality second-order factor. Factor loadings for first-order factors ranged from 0.46 to 0.98, and from 0.41 to 0.88 for the second-order measurement model. Thus, according to this evidence, the data fit the proposed model appropriately and no problems of estimation were found. Results seem to provide evidence that the interpersonal dimension is a key part of spirituality in the Spanish palliative care context, as this dimension is the dimension with the higher factor loading in the model.

Regarding internal consistency, the results provide clear evidence of a reliable and internally consistent scale, both at the scale and item levels. Criterion-related validity was tested with other spirituality measures, depression, anxiety, and resilience. The correlations were statistically significant and positive, and, thus, they are consistent with previous literature.[52,53] Overall criterion-related correlations indicated adequate criterion validity of the scale.

Clinical assessment of the questionnaire showed good rates of acceptance, comprehension, and perception of the benefits for patients, highlighting clinicians' acceptance of the questionnaire. In relation to the concerns of Cobb et al.,[50] results arising from professionals' assessment of the tool gave support to the usability of the questionnaire, fulfilling the purpose of being a guideline for caregivers, whose sensitivity, experience, presence, and compassion cannot be replaced by any tool. It must be remembered that in the field of spiritual care, questionnaires such as the one proposed, focused on guiding spiritual resources and needs assessment, must be used carefully by professionals, who must be aware of crossing into sacred territory that deserves the utmost respect and sensitivity. At the same time, the instrument should be a guide to facilitate care rather than a measurement instrument. In spiritual care, which is the ultimate goal of all this work, the spiritual maturity of the practitioner applying the questionnaire is probably more important than the questions themselves.

This study features both strengths and limitations. Its main strength may be the synergy between its bedside-experience approach and its psychometric soundness. Other strengths are the wide scope of professionals and patients included, the grounding in humanistic, integrative, and trans-denominational models of spirituality, the attention to suffering and spiritual care, which is consistent with pluralistic contemporary Western culture, and the special attention to truly interpersonal issues. Another contribution is the empirical evidence through CFA analysis of a second-order structure or holistic spirituality construct.

Unfortunately, a direct evaluation of the therapeutic impact of the questionnaire has not been conducted, nor has a formal assessment of patients' perceptions about the clinical benefit of the assessment. As well, interviewer selection, based on their knowledge of GES spirituality model, to some extent limits this study's external validity.

Further research with patients and their families is needed to assess the potential impact of this instrument on the trajectory of each patient's suffering and the quality of their end-of-life experiences.

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Appendix I

English and Spanish Versions of the GES Questionnaire

Open Questions/Preguntas Abiertas
Right now, in your current situation:/*En su situación actual*:

- What worries you most?/*¿Qué es lo que más le preocupa?*
- What bothers you most?/*¿Qué es lo que más le molesta?*
- What helps you most?/*¿Qué es lo que más le ayuda?*
- What or who supports you in crisis situations?/*¿En qué o en quien se apoya en situaciones de crisis?*
- What makes you feel secure, safe?/*¿Qué le hace sentir seguro, a salvo?*
- What do people value about you?/*¿Qué es lo que la gente valora más de Ud.?*

GES Questionnaire/*Cuestionario GES*

Item No.	Dimension	Item Content
1	Intrapersonal	Looking back on my life, I feel satisfied with what I have lived and with myself. *Revisando mi vida me siento satisfecho con lo que he vivido y conmigo mismo.*
2	Intrapersonal	I've done (accomplished) in my life what I felt I had to do. *He hecho en mi vida lo que sentía que tenía que hacer.*
3	Intrapersonal	I find meaning in my life. *Encuentro sentido a mi vida.*
4	Interpersonal	I feel loved by people who are important to me. *Me siento querido por las personas que me importan.*
5	Interpersonal	I feel in peace and reconciled with other people. *Me siento en paz y reconciliado con los demás.*
6	Intrapersonal	I believe that I have been able to bring something valuable to life or to others. *Creo que he podido aportar algo valioso a la vida o a los demás.*
7	Transpersonal	Despite my illness, I still hope that positive things will happen. *A pesar de mi enfermedad mantengo la esperanza de que sucedan cosas positivas.*
8	Transpersonal	I feel connected to a supreme reality (o supreme Being, nature, God, …) *Me siento conectado con una realidad superior (la naturaleza, Dios, …).*

Spanish translations are printed in *italics*.

Appendix II

Participating Palliative Care Teams and Percentage of Patients From Each Team

Palliative Care Team	Percentage of Patients
Hospital Santa Creu i Sant Pau (Barcelona)	13.8
Equipo PADES (Granollers, Barcelona)	13.0
Fundación Santa Susanna (Caldes de Montbui, Barcelona)	4.6
Hospital Puerto Real (Cádiz)	7.4
Hospital de la Magdalena (Castellón)	1.9
Hospital Dr Negrín (Las Palmas de Gran Canaria)	2.8
Fundación Hospital San José (Madrid)	9.2
Centro de Cuidados Laguna (Madrid)	5.5
Hospital 12 de Octubre (Madrid)	1.9
Centro de Cuidados de Cáncer CUDECA (Málaga)	11.1
Hospital Juan March (Mallorca)	1.9
Hospital General (Mallorca)	3.7
SAR Santa Justa (Sevilla)	11.1
Hospital Dr. Moliner (Valencia)	1.9
Hospital Pare Jofré (Valencia)	10.2