others», the divergence of value orientations of the individual and society. The basic set of adaptive mechanisms is determined empirically. The basic directions of psychological support of families of injured servicemen are determined.

**Key words:** family of servicemen, social and psychological adaptation, adaptive potential, psychophysiological condition of women.

RELIGIOSITY IN NURSING: THE TRANSLATION, VALIDATION AND CULTURAL ADOPTION OF THE CENTRALITY OF RELIGIOSITY SCALE – 10 IN GREEK LANGUAGE

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Religion has an important role in today’s society. Understanding religious perception and aspects of a person is a very complex process and could reflect one’s moral values, cultural background and tradition. Many nurses around the world are religious and some religious motivations often prompt becoming a nurse. Aim of the study was the translation of the centrality of religiosity scale (CRS-10) in Greek language and the validation of the scale for the Greek population. The CRS-10 questionnaire is an anonymous self-administered questionnaire that contains ten, five point Likert scale, closed questions (ranging 1–5). The questionnaire was translated into Greek language and then back translated in the English in order to be checked for any inconsistencies. The sample of the study was 318 nurses and nurse assistants. Exploratory factor analysis, with principal components analysis was performed for checking the construct validity of the questionnaire. The test-retest reliability and the internal consistency were also examined. Statistical analysis performed by the use of SPSS 21.0. Statistical significance level was set at P = 0.05. The final Greek version of the questionnaire includes all of the ten questions. The mean age of the participants was (43.01 ± 7.60) years. One factor exported from the statistical analysis. The Cronbach-a coefficient was 0.919 for the total questionnaire.

**Key words:** validity, reliability, religiosity, nursing.

Introduction. The trained nurse has become one of the great blessings of humanity, taking a place beside the physician and the priest.... – William Osler

Religion has an important role in today’s society. Understanding religious perception and aspects of a person is a very complex process and could reflect one’s moral values, cultural background and tradition. It is a fact that there is not a widely agreed definition for religion and the meaning of it can be described by three words faith, worship and ethics. Many religion worldwide are composed by a set of symbols that are respectful and awe-inspiring and connected to rituals in which a set of believers takes part. Regardless of whether a religion is associated with a belief in deities or not, there are always beings or objects that cause awe or admiration [12]. According to O’Neill & Kenny [22], religion refers to the outward expression of faith, these are internal beliefs and values concerning God or any higher Being [22]. It is an organized belief system that affirmed and supported by a human institution, an ethnicity or culture, which is characterized by ritualistic procedures and specific practices, It can affects a person’s way of coping in various situations such as addictions by forming a norms [13].

Allport and Ross [1] distinguished religiosity in Intrinsic and Extrinsic religiosity. Extrinsic concerns aspects of social integration, acceptance or criticism provided by others and from dogma and ritual. Intrinsic, on the other hand, is related to the frame
of the meaning allowing personal interpretations for life. The intrinsic religiosity, as a concept, it is closer to spirituality than the extrinsic [1]. Huber and Huber [13] from a more sociologic perspective and by combining psychology of religion stated that there is more aspect of religiosity than those mentioned. According to them personal religious construct-system can be described by five domains. Intellectual domain refers to the knowledge and that one person has on religion and religiosity. Ideology refers to the beliefs that people have regarding their existence. Public practice regards to the commitment to religious communities and activities. Private practices are concerning individualized activities and rituals in private space. Finally, the domain of religious experience refers to a kind of direct contact to an ultimate reality [13].

According to World Health Organization (WHO), religiosity along with spirituality, can play an important role in health behaviors and in coping with terminal, life threatening and chronic diseases and it is has been recognized as important aspect of human health. Thus, an increasingly worldwide research interest on this domain has been observed in the past decades. Despite the fact that religiosity is gaining ground on health research for the possible benefits that patients may have by integrating it in their care, the link that has with health is documented since antiquity. For centuries health care facilities and religious places where either close by to each other and in many cases where in the same place. Originally, religious leaders were the primary healers of those who were in need. They are still the primary contact for health care for many people in some societies today. Then, too, religious beliefs are often intertwined with health practices, influencing the acceptance of illness, treatment and nursing care [3, 9–11]. For centuries health care were provided within monasteries and those were used to take care of the sick, pilgrims, and travellers [19]. It has been document and widely agreed that Byzantium was a landmark in hospital care. In addition almost of the hospitals, were annexed to monasteries and they were called Xenones, linking that bond between religion and health care. The nursing staff was either volunteers or paid personnel [16]. The relation between nursing and religion goes back to Byzantium era where professional nursing personnel were used for the first time in Byzantium hospitals; they were female and belonged to the Church. Their main duties were physical and Psychological support of patients [14].

Upon until today many nurses around the world are religious and some religious motivations often prompt becoming a nurse. Moreover, nurses now are taught and expected to assess and support spiritual well-being, identify spiritual distress and in many cases to provide religious and spiritual care [28, 30]. Over the years it is argued that nurses spiritual and religious beliefs affect nursing care and nurses who are more religious works to make sure the patient’s religious beliefs are upheld, fact that can play an important role in patients satisfaction with care, especially in contexts like palliative care [6]. Furthermore, nurses religiosity can have a protective function and provide structures which help nurses cope with patients’ suffering and everyday stressors within the clinical practice. Religious coping dominated by basic trust where prayer is used as a coping strategy may support the nurses [8, 28, 29].

As an emerging topic, religiosity has gain the attention of researchers worldwide and many valid tools that asses’ various aspects of religiosity has been developed. Yet few studies have ever been applied in Greek nurses examine their religiosity. In addition, there is a lack of a brief and valid instrument in Greek language that assess religiosity and especially an instrument that is addressed general population. The purpose of the present study was the translation of The Centrality of Religiosity Scale (CRS-10), in Greek language and the validation of the scale for the Greek population.

**Material and methods.** *The Centrality of Religiosity Scale* (CRS). The Centrality of Religiosity Scale (CRS) is a measure of the centrality, importance or salience of religious meanings in personality. It is asses five aspects of religiosity intellectual domain, ideology, private and Public practice and finally the domain of religious experience. It has been developed by Huber and has yet been applied in many studies in sociology and psychology of religion and many health related studies. The basic scale is provided in three lengths with 15 (CRS-15), with 10 (CRS-10) and with 5 items
The Centrality of Religiosity Scale (CRS) Questionnaire. In the distribution of nurses’ answers (n = 318) in the Centrality of Religiosity Scale (CRS-10) is presented.

Construct Validity of the Greek version of CRS-10. Factor Analysis was applied to explore construct validity of the questionnaire. In particular, exploratory factor anal-
ysis was applied that shows if the correlation between items can be explained by a smaller number of factors. For extracting the factors principal components analysis method was applied. High value of KMO index (KMO = 0.924) and the statistical significance of Bartlett’s Test of Sphericity ($\chi^2(45) = 1859.717; P < 0.001$), suggesting that there is a sampling adequacy and by applying factor analysis will give satisfactory results. The factor analysis resulted to one factor, with Eigenvalue 5.83 (Kaiser criterion) that interpreted 58.39 % of the total variance. All items loadings in the factor had values > 0.4 which is the marginal acceptance point, more specific loadings range from 0.668–0.825.

**Scale reliability.** The Reliability of CRS-10 questionnaire was tested for the characteristics of stability and internal consistency.

For testing the reliability of the CRS-10 the test-retest method was used. From the total of 318 nurses, 40 of them they completed the questionnaire for a second time (retest) after a four weeks period. A period of time sufficient that there is no remembrance of previous answers. For the statistical control the repeatability of measurements between test and retest, the Pearson’s correlation coefficient was estimated and paired $t$-test for the difference between the two administrations of the questionnaire. Results of the test – retest reliability. Correlations between the two administrations of the questionnaire, in scale total score ($r = 0.987; P < 0.001$) and in the level of individual questions had a value $r$ ranging from 0.842 to 0.96 which is suggesting that a strong correlation between the two administrations exist. Moreover, $t$-values in the Paired $t$-test between the two administrations, in scale total score ($t = -0.934; P > 0.05$), as well as in the level of individual questions was not statistical significance. Thus, we can say there were not any differences between the two administrations and the questionnaire has high test – retest Reliability meets the characteristic of Stability.

**Internal consistency.** For testing the internal consistency of the CRS-10 Cronbach’s Alpha coefficient was used. Internal reliability coefficient for the total score of the CRS-10 questionnaire was 0.919 which showed that the scale has very good internal consistency. Moreover, values of Cronbach’s in case that one item was deleted from the scale, were checked. The audit showed that not any substantial increasing of the Cronbach’s a will happened if an item was deleted from the scale. Thus, we can say that all the questions were important internal coherence with the other.

**Discussion.** The aim of our study was to assess the validity and reliability of the Greek version of Centrality of Religiosity (CRS-10). Judging from the results obtained the Greek version of the Centrality of Religiosity (CRS-10) proved to have satisfactory psychometric properties for a Greek population. The scale displayed good reliability, with sound internal consistency as assessed by coefficient $\alpha$, and a degree of test-retest reliability. The excellent Pearson correlation coefficient for the test-retest of the scale suggests that any repetition of the test would be likely to render the same results. The tool therefore proved to be reliable and it can be used to assess religiosity in Greek population.

Despite the fact that Huber and Huber [14], developed the Centrality of Religiosity scale as a multidimensional scale measuring five dimensions of religiosity, the current version resulted to one factor. This could be attributed to the fact that we used a shorter version of CRS and not the full length of 15 items. In fact, this five dimensional structure is being supported in other studies to [33], not only in German population, but in Poland to [13, 34]. On the other hand, it is not unusual for measures resulting in different factor structure during the validation procedure, especially measures that are applied for this blurry and personal issue. Darviry et al. [7] validate the Intrinsic/Extrinsic Religious Orientation Scale in Greek population and resulted in three factors instead of two. In contrast to these other studies in Greek population measuring religiosity came to the conclusion that religiosity in Greek population can be interpreted as one domain, suggesting a continuum of religious behavior and the perception of religiosity as one [7, 19].

Our participants were primarily Christian Orthodox, and they are rated as religious according to Huber and Huber classification based on the score of CRS-10. It has been
reported in previous studies in Greek population regarding religiosity that religion and religious practices have an important role in their lives [2, 24, 25]. Furthermore, many researches have documented that personal devotion, participation in religious activities, and religious salience are positively associated with psychological well-being in Greek orthodox populations [17]. Those positive effects of religiosity can determent a crucial role in coping with clinical practice stressors but sometimes also in the clinical decision taking [27]. A common feature among mentally resilient individuals is the existence of an internal system of moral values and a code of conduct that appear to be protective against traumatic events and the risk of depression and anxiety disorders. In addition, religiosity is considered to be a valuable resource in shaping mental resilience against life difficulties and traumatic events. It is worth noting that according to a study in the United States, following the events of September 11, 2001, religion for 90 % of respondents was the second most prevalent stress strategy [26]. According to L. S. Meltzer et al. [19], nurses who viewed religion highly important experienced less emotional exhaustion than those to whom religion was less important. Thus, a direct link between religion and work related stress is highlighted in their study and revealing the positive effects that religiosity can have. Moreover, nurses that report themselves as religious can cope better in caring for dying patients, task that can be stressful [4].

According to our study there were some differences observed, regarding religiosity and demographic factors such as gender, profession and educational level. Women found to be more religious fact that is supported by other studies in Greece [31, 32], that were concluded to this. Religiosity and the centrality of religion in women are prevailed over time and religious practices are more important for women. The other differences that our study yield was those regarding profession and educational status, there two variables can be examined together cause in Greece nurses consider to be those who had a university degree and nurse assistants are usually high school or vocational schools graduates. According to a study in Ireland in 2011, less educated have a greater level of religiosity than those who are more educated (“Census 2011 Profile 7 Religion, Ethnicity and Irish Travellers – Ethnic and cultural background in Ireland – CSO – Central Statistics Office”, 2017). While according to Sacerdote and Glaeser in 2001, church attendance is increasing with education. In fact, they observed education is the most statistically important factor explaining church attendance, after eliminating other factors in regression analysis on their sample [23]. Thus, it can be clearly support on the exact effect that education can have in religiosity.

One limitation of the present study can be that data collection took place only in two hospitals of Attica. It would be interesting to assess religiosity in nurses that are residence in rural areas and check if there are any differences, thus people in rural areas consider being more cohering and with tighter family bonds, factors that can influence religiosity.

Practice implications. It is a fact that most the existing nursing literature focuses on the importance of being aware of and understanding the patient’s spiritual or religious beliefs and needs, and less about nurses perception and importance of religiosity [4]. According to Musgrave and McFarlane [21], religiosity, spiritual well-being and education can influence and help to shape positive attitudes toward spiritual care of Israeli oncology nurses. Furthermore spiritual and religious nurses are more willing to let patients take control of conversations about end-of-life care and make sure the patient’s religious beliefs are upheld [6, 18]. Nurses must be able to provide spiritual care and to addressing spiritual and religious concerns of their patients. In order to be able they must first have an understanding of their own religious and spiritual beliefs.

Conclusions. In today’s societies that are characterized by the constant stressors that people experience religiosity and spirituality have proven to be protective resources. Religiosity can provide relief and comfort and contribute to mental balance. Moreover, can provide an explanation of the world system and give meaning and purpose to existence that is why it should not ignore the importance of the life of people. Religious nurses can provide spiritual and religious care on those who are in need.
References


INTEGRATED CARE PLATFORMS TO SUPPORT MENTAL HEALTH PATIENTS

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Integrated Care improve outcomes for both patients and their caregivers; creating access to better integrated socio-sanitary care e-Services (integration of health care, social care, long-term and self-care in any kind of health/living conditions) outside of hospitals; reducing unnecessary hospital admissions and enabling effective working of professionals. They can be considered as organizers of care around the needs of people with the aim of improving the health services through better coordination across different levels of socio-sanitary care and from different providers within each level. The introduction of integrated care programmes could undeniably improve the quality of life of both patient suffering from mental health but also for their home care-givers. As a result, the Croatian Health Insurance Fund and the Rijeka City Department of Health and Social Welfare in collaboration with the Psychiatric Hospital “Lopača” (founded by the City of Rijeka), participated in the CIP-ICT-PSP Project “INclusive INtroduction of INtegrated CAre (INCA)” trials to evaluate how the use of such platform would affect the health and quality of life of the people suffering from mental health problems or other mental health disorders, their caregivers, their doctors and social services.

Key words: Integrated Care, e-health, mental health, social care, self-care, monitoring health, Chronic tele-health, inclusive, remote patient monitoring, socio-sanitary care integration, integrated care monitoring, accountable care, patient care repository, patient-centric communication, proactive care.

Introduction. Despite wide acknowledgment of the potential benefit of integrated care [1], the use of telehealth – the provision of care at a distance – a key component in future integrated care remains limited and with wide disparities across and within European countries. Different factors contribute to this. These include: lack of solid data and of legal clarity; technical issues and market fragmentation; ethical issues and, last but not least, poor awareness of the benefits of integrated care from health authorities, patients and health professionals [2]. Integrated healthcare delivery links multiple levels of care management, coordinates services and encourages professional collaboration across a range of care delivery [3,4,5]. Integrated healthcare is not about structures or common ownership, but rather about networks and connections – often between separate organizations – that focus the continuum of healthcare delivery around patients and populations. It is clinical and financial accountability to a defined set of patients or a population that ties together delivery organizations.

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