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Research Article

Validation of the Japanese Version of the Spiritual Care Competence Questionnaire

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Abstract

Background: The Government of Japan has implemented a strategic problem-solving policy for cancer diseases since 2007 based on the requests of cancer patients [1]. In this plan, the Japanese government proposed the need for palliative care and human resource development in order to alleviate the mental distress of cancer patients. In 2012 (MoHLW of Japan, 2012) [2] they further introduced that cancer patients have spiritual pain and should be addressed in palliative care. In spite of this consensus, the education in Spiritual Care approaches for medical professionals is not systematically provided in Japan. Therefore, there is a need for the development of Spiritual Care competencies of medical professionals in Japan. Therefore, the purpose of this study was to validate the Japanese version of the Spiritual Care Competence Questionnaire (SCCQ) and measure these competences of health care professionals. **Materials and Methods:** Cross-sectional survey among 262 health care professions (71% nurses, 8% medical doctors, 21% others). As for the analysis method, the Japanese version of the SCCQ was prepared by examining the content validity: Survey data were analyzed using factor extraction following the weightless least-squares method with rotation of the Promax method with Kaiser normalization. For the extraction of the Japanese version model, we performed confirmatory factor analysis and examined the degree of fitting index. In addition, the relationship between the basic attributes of the eight items and the factors was examined using correlation coefficients. **Results:** A 16-item model for the Japanese version was extracted from the 26 items for the German version. Goodness of fit TKI was 0.888 and CFI was 0.918. Factors are the 7th Proactive empowerment competence (Japanese version 1st), 3rd Documentation competences (Japanese version 2nd), 2nd Team spirit (Japanese version 3rd), 6th Interviewing competences (Japanese version 4th), 1st Perceptual competences (Japanese version 5th) factor from the German version. However, the 5th factor showed a negative loading and was significantly negatively associated with prayer habits, meditation habits, working hours per week, and job satisfaction. **Conclusion:** Because of the Japanese version of the SCCQ we found that Japanese health care professionals have an attitude of respect for others, respecting the patient's religiousness, spirituality, and beliefs, and a characteristic of exchanging opinions in a team-spiritual manner. On the other hand, there was also a characteristic that they did not recognize the perception of spiritual needs, but this was thought to be due to the lack of knowledge of the concept of spiritual needs, that is, the lack of education in spiritual needs. There are many people who have faith, and in order for Japanese medical workers to provide mental care, it is necessary to educate them about mental care suitable for Japanese people. Moreover, a comparison using the Japanese version of the SCCQ can explain what somewhat internationally accepted spiritual characteristics and issues the Japanese have, and can be said to be effective for international comparison.

Keyword: Spiritual care competence; Japanese; Questionnaire; Health care professionals

Background

Cancer has been the leading cause of death in Japan since 1981. Therefore, a "Basic Plan for Promotion of Cancer Control" was developed in June 2012 underlining that cancer patients not only have physical pain but also psychological pain such as anxiety and depression, employment and financial burden, etc. [1]. Further, it was stated that "prompt and appropriate palliative care for various pains of patients and their families, such as social distress, has not yet been sufficiently provided in cancer treatment." The Basic Act on Cancer Control revised in December 2016 states that palliative care includes "physical or mental distress or anxiety in social life related to persons suffering from cancer or other specific illnesses". It is defined as "treatment, nursing and other actions whose main purpose is to maintain and improve the quality of medical treatment by palliative medicine" (Article 15). In other words, there was a social demand for nursing to relieve the pain of patients with cancer. Furthermore, the World Health Organization (WHO) has already proposed the need for Spiritual Care for cancer patients [3], and spiritual issues were evaluated and cared for quite early on. However, these "spiritual issues" were so far not an issue of relevance in Japan.

While in Western societies it is more or less accepted that everyone has a "spiritual" dimension, leaving it open what exactly this "spiritual" is, it is accepted that it is either different from institutional religiosity, but nevertheless may include this religious dimension. One definition of spirituality is that it "refers to an attitude of search for meaning in life. The searching individual is aware of its divine origin [4], and feels a connection with others, nature and the Divine etc. Because of this awareness one strives towards the realization (either formal or informal) of the respective teachings, experiences or insight, which has a direct impact on conduct of life and ethical commitments." [5]. According to this definition, it involves 1) specific experiences, 2) attitudes and convictions, and 3) practices and rituals. These may differ with respect to culture and religious orientation. Whatever a person regards as Sacred, the respective "Divine" refers to either a transcendent and or an immanent source, e.g. God, Allah, JHWH, Tao, Brahman, Prajna, and All-One etc.

The Japanese religious background has historically different characteristics from other countries. It is said that the Japanese had a devotion to worship nature, which is called primitive Shinto, for about 1,500 years. After that, the nation and Shinto were connected and spread throughout the country. In the old days, many citizens did not have a deep Shinto doctrine. With the introduction of Buddhism about 1300 years ago, beliefs with doctrine became known, and the inner side peculiar to the Japanese was formed, with the belief that Shinto and Buddhism coexist. Therefore, many Japanese worship the god of Shinto on New Year's Day, and the rituals that accompany their growth are devoted to Shinto. However, the death ritual relies on Buddhism. There is no particular opportunity to study comparative religion at school, and the distinction between religion and devotion are generally not a concern. In this way, clear forms of belief and doctrine like Christianity have not spread to the Japanese.

According to a 2015 survey published in the World Face book of the US Central Intelligence Agency (CIA), 70% of Japanese said they believed in Buddhism and Shintoism. A 2021 survey of religious groups by the Japanese Agency for Cultural Affairs found Shintoism at 48.5%, Buddhism at 46.5% and Christianity at 1%. In this way, the statistics belonging to the Japanese religion are various. The emperor, the symbol of the Japanese people, is the supreme Shinto priest of Shinto, and while many Japanese participate in Shinto-style ceremonies during the New Year, very few consider Shinto as their religion.

Modern Japanese Buddhists often participate in Buddhist ceremonies during the apocalyptic rites. In Japan, the Edo shogunate, which banned Christianity for 260 years from 1612 AD, required that all citizens belong to Buddhist temples. It is called the Terauke system. This system was a system of mutual surveillance to exclude Christianity.

About 150 years have passed since this system was abolished, but it can be said that there are still local communities in which many people become temple parishioners. Japanese people have a history of Christianity being slaughtered in the Edo period, so there is a possibility that they do not express their faith clearly.

Today, many Japanese have a Shinto religion (resulting to nature worship) and they are inspired by a strong sense of ancestry. However, most Japanese do not follow exclusive religious doctrines. The broader and more general term 'spirituality' is not well established in Japan resulting in misconceptions when it is interpreted as a matter of religious faith. Given that many Japanese do not want to be affiliated with any particular religious institution or denomination, the term "spirituality" may be suitable for determining their search for connectedness, meaning, and transcendence. Being "non-religious" (mushūkyō) does not mean one is an "atheist", while it may mean one is "spiritual" without a specific religious affiliation [6].

In fact, in Japan there is little scientific education about the impact of a person´s spirituality as a resource and how healthcare professionals could support this resource. Kagawa University's nurse course set up the Spiritual Care class as free subject for the first time at a national university in 2012 in the 4th grade of the School of Nursing, Faculty of Medicine.

Apart from addressing spiritual struggles in palliative care, another approach is addressing patients´ spiritual needs, which assumes that a person´s spirituality can be a resource and thus supported by health care professionals [7]. These needs can be categorized as specific Religious needs, Existential needs, Inner Peace needs and Giving / Generativity needs [7]. While Religious needs are of course relevant for people who follow theistic religions, the non-religious needs are also relevant for non-religious people. However, also in Western societies, these needs often remain unmet [8], and thus there is a strong demand that health care professionals require courage and competences to address such needs. When patients were diagnosed with they may become aware of their spiritual needs as they may ask for meaning of life [9], and which resources they have that provides meaning, hope and orientation [7]. It is unclear whether all unmet needs result in spiritual pain, and whether all spiritual pain is a matter of anguish [10]. Healthy people may often be unaware of their spiritual needs as these needs are often triggered by stressful life situations or burden. Spiritual pain is first a matter of the perception and interpretation, and thus emanate from the mind and soul. Spiritual pain is about human life, death, love and compassion / hate, indifference, marital love, divorce / respect, and society, the world, and the universe [11,12]. As the underlying triggers and dimensions are complex, Spiritual Care is a multidisciplinary approach in health care and involves, nurses, physicians, psychologists, social workers, chaplains etc. [13].

Thus, apart from professional competences, health care professionals also require the courage and competence to address the existential and spiritual dimensions of their patients, even when they may not share their beliefs and convictions. If nurses, physicians and other health care providers develop and improve their spiritual care competences and implement structures that allow documentation of patients´ spiritual needs on the one hand and adequate reactions on the other hand (in terms of supporting interventions), patients may feel valued and better cared for. In the best case, this additional support and attention will decrease their spiritual pain and struggles. However, if the medical staff does not pay attention to the spiritual pain and spiritual needs, the patient will continue to suffer and may question his life at all. Therefore, medical professionals need to take this topic serious and should try to improve their competences to address it and support their patients accordingly. Some of these competences are 'innate' (i.e., compassion) and others need to be developed and trained (i.e., documentation, empowerment, team spirit). To monitor such competences, the 26-item SCCQ was developed [14]. It was so far applied and validated in different samples, i.e., in Germany [14], Norway [15], Spanish speaking America [16], Pakistan [17], Italy (Zorzella et al., in preparation), and should be validated in Japan. The instrument was developed to be applied in different health care professions, and applicable to religious and non-religious people. In its best-validated (Spanish language) version, it differentiates six main factors: 1) Empowerment competences, 2) Conversation competences, 3) Perception of spiritual needs, 4) Spiritual self-awareness competences, 5) Team spirit, 6) Documentation competences, and as a separate dimension (which is not a competence), the Hindrances [16]. The primary German language version showed a similar factorial structure but differentiated the slightly different "Knowledge about other Religions", which is relevant in a multicultural society (Frick et al., 2019): 1) Perception competences, 2) Team Spirit, 3) Documentation competences, 4) Self-Awareness competences, 5) Knowledge about other Religions, 6) Conversation competences, and 7) Empowerment competences.

Purpose

The purpose of this study is to validate the Japanese version of the Spiritual Care Competence Questionnaire and measure these competences in health care professionals in Japan. Thus it is of conceptual relevance, as most Japanese would not regard themselves as religious [6], while they nevertheless may nominally refer to Shintoism or Buddhism as a worldview. It is so far unclear how this may influence Spiritual Care competences defined in Western societies.

Method

Development of the Japanese version of the SCCQ

First, the 26 items of the SCCQ in its German version were translated into Japanese by a German interpreter who stayed in Germany for over 30 years. Two Japanese people who have experience in developing psychological scales adjusted this first translation to Japanese culture. In this process, the content validity and superficial validity were confirmed. Problematic terms were those related to the concept off "spirituality".

Next, a Japanese fluent in German language, who lives in Germany, translated it back into German. The two original developers examined the validity of this back translation. After confirming that there were no problems with the primary intention and semantic content of items, the Japanese version was confirmed.

Study Participants

The Health Care Professionals (HCP) from university hospitals, rural hospitals, nursing stations and geriatric health facilities etc. were collected predominantly by network sampling and some via web survey between October 2020 to September 2021.

The study was conducted according to the guidelines laid down in the Declaration of Helsinki and all procedures involving human subjects were approved by the ethics committee of Kagawa

University, Faculty of medicine; No. 2020-116. All the respondents to the survey fully understood the research content and obtained their consent.

The online survey was conducted on 140 people using the google form, and 125 people were conducted by the questionnaire method for 265 people. Six of them were excluded from the analysis due to a lack of data.

Analytical Methods

Based on the data from the Japanese questionnaire, a confirmatory factor analysis of the 7-factor structure as found in the German sample was performed to confirm the fit of the model. In case the German model did not fit well, principal component analysis was performed from the 26-item data by Promax rotation with Kaiser normalization. Such an adjusted version was then again confirmed by confirmatory factor analysis, and the validity of the construct was examined. In addition, multiple regression analysis was performed to investigate the factors that influence the understanding of Japanese spirituality. For all analyses, SPSS-Amos16 (IBM, co., Ltd.) was used for the analysis.

Result

Description of the Sample

For data analysis, we had 259 valid cases. Most were women (86.6%), while men were in the minority (13.4%). Their mean age is 43.2 ± 11.9 [21 to 78 years] there are three omissions. Among them, 76 HCP were from national university hospitals, 62 from agricultural cooperative hospitals, 59 from home-visit nursing stations and geriatric health facilities, 44 from the Catholic hospital in Shikoku Island, and 21 from the Nursing Junior College in Osaka City, Japan.

They were medical doctors (7.6%), nurses (71.4%), Physical therapists/ Occupational therapists / Speech therapist and co-medical therapists (4.6%), and others (clerk etc.) (15.3%). The fields of medical profession are internal medicine (17.6%), surgery (13.0%), palliative medicine (5.7%), obstetrics and gynecology (2.3%), pediatrics (2.7%), clinical psychology (7.3%), others (30.9%); here a total of 233 respondents answered with 29 omissions.

Participants´ average number of years of experience was 18.2 ± 11.6 years with 7 omissions. The average working hours per week was 36 ± 17.0 hours with 10 omissions. 35% of collaborators were 40 hours full-time of standard working hours in Japan (Table 1). Work satisfaction averaged 3.3 ± 0.8 on a 5-point scale with 2 omissions. The family composition was 164 (62.6%) for married people, 70 (26.7%) for unmarried people, and 28 (10.7%) for single people after their marriage. 168 (64.1%) had experience as a parent and 94 (35.9%) did not have.

The Participants' faith was predominantly Buddhism (75.6%), while a minority followed Shinto (3.4%) or were Roman Catholic 9 (3.4%), and other Christianity and other religions 40 (15.3%). Nevertheless, most would not regard themselves as active in their faith / religion (46.2%) or not that much (38.9%), while only 14.5% regarded themselves as a religiously faithful person.

N=262

Sex	n	Male	35	Female	227														
	%		13.4		86.6														
Age	mean	43,18±11.86（21-78）																	
Family	n	Unmarried	70	Single	28	Married	164												
	%		26.7		10.7		62.5												
Chile-rearing experience	n	Yes	168	None	94														
	%		64.1		35.9														
Prayer habits	n	Yes	38	None	121	Neither	102												
	%		14.5		46.1		39.1												
Prayer and meditation habits	n	Yes	32	None	136	Neither	93												
	%		12.2		51.9		35.6												
Religion	n	Buddhism	198	Shinto	9	Evangelist	3	Catholic	9	Other chlistianity and other	40								
	%		75.5		3.5		1.2		3.5		15.4								
Proffetion	n	Doctor	20	Nurse	187	Co-medical	12	Others	40										
	%		7.6		71.3		4.5		15.2										
Medical specialty	n	Internal medicine	46	Surgery	34	Palliative care	15	Obstetrics and Gynecology	25	Geriatrics	6	Pediatrics	7	Psychiatry	19	Others	81		
	%		19.7		14.6		6.4		10.7		2.6		3.0		8.2		34.8		
Weekly working hours	mean (h)	36.0±16.9																	
Years of work experience	mean (year)	18.2±11.0																	
Job satisfaction (1-5)	mean	3.3±0.8																	

Table 1: Basic Attribute Result N=262.

Construct validity of the SCCQ

While the primary German version had the following model fit indicators (CFI= 0.96, TLI= 0.95, RMSEA= 0.04, SRMR= 0.05), the 7-factor structure model was less satisfying in the Japanese sample (χ^2 = 1825.46 (p <0.0001), CFI = 0.834, and TLI = 0.790, RMSEA=0.066). In the original German version, all the inter factor correlations showed positive and significant correlations, while the Japanese data showed negative values of the first factor 'Perception competences' with the other six SCCQ factors. Therefore, the scale becomes inconsistent and the Japanese answers did not fit the German version model. The following two items derived from the 5-item German version factor showed negative results: 'GQ7; I can perceive existential/spiritual needs, even if the patients have little relation to religion', (Ich kann existentielle / spirituelle Bedürfnisse wahrnehmen, auch wenn die Patienten zur Religion wenig Bezug haben, Japanese is 'JQ6宗教に関心がない患者のスピリチュアルなニーズを感覚的に認識できる') and 'GQ8. I can also talk to non-religious patients about their existential / spiritual needs' (Ich kann auch mit religionsfernen Patienten über ihre existentiellen / spirituellen Bedürfnisse reden, Japanese is 'JQ7; 無宗教の患者とスピリチュアルニーズを語る').

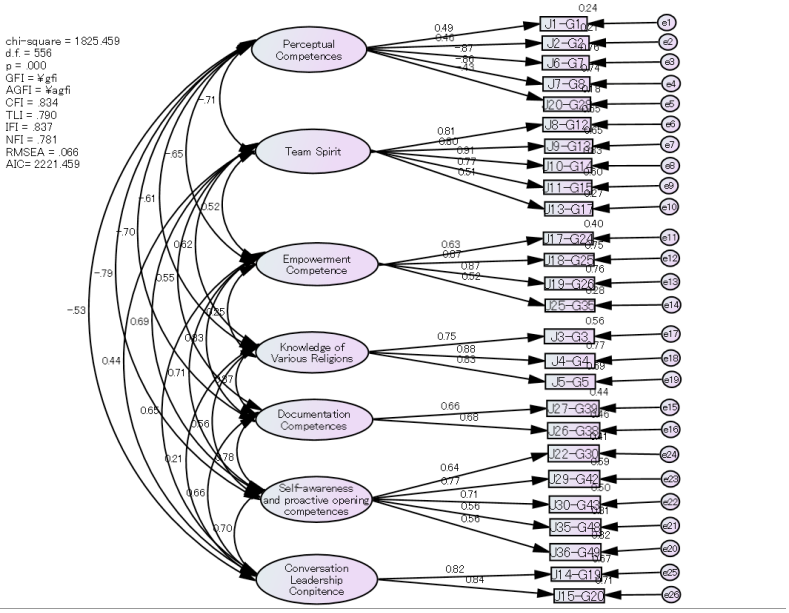

Figure 1: 26 items of the 7-factor model from the German model with Japanese data.

Therefore, a 5-factor 16-item model was extracted from the 26 items, after a cut-off point of 0.5 factor loadings, by performing factor extraction using the weightless least-squares method with rotation of the Promax method with Kaiser normalization. 63.67% of variance was explained by these 5 factors. The commonality after factor extraction was 0.336-0.923 (Figure1).

As shown in Table 2, the order of the factors has changed in the Japanese version compared to the German version. The Japanese version of factor 1 (Proactive empowerment competence) consisted of three items German version of factor 7 (Conversation readership competence) and one item of factor 5 (Documentation competences). The Japanese version of Factor 2 (Documentation competences) consisted of three items of German version of Factor 3 (Empowerment competence) and one item of Factor 4 (Knowledge of various religions). The Japanese version of Factor 3 (Team spirit) was same items of German version of Factor 2 (Team spirit). The Japanese version of factor 4 (Interviewing competences)) is two items of German version of factor 6 (self-awareness and positive initiation ability), and the fifth factor (Perceptual Competence) is two items of first factor (Perceptual competence) (Table 2).

Table 2 shows the average score and standard deviation of the Japanese version. The average score of the 26 items was 2.17 in the Japanese version, with a standard deviation of 0.66-0.92.

The right side of Table 2 shows the mean and standard deviation of the original German version. In order to strictly compare the Japanese results with the SCCQ, it is necessary to compare the average values. Therefore, because of both surveys were four-way, we compared the SCCQ average of 3 points and the Japanese version of 4 points by aligning the score ranks.The average item score for the German version was 2.90 with a standard deviation of 0.66-1.06.

In the Japanese version, the item with the highest average score was Q18 (m=3.00, SD=0.75)-Q19 (m=3.05, SD=0.75) for respecting the patient's beliefs and attitude toward Spiritual Care. The item with the lowest average score was Q36 Regular participation in a mental training event (m = 1.37, SD = 0.68). In the German-language version of the survey, items with high scores were #19 (m=3.34, SD=0.75)-#20 (m=3.34, SD=0.72), and were speaking freely about existential and religious topics. The lowest item was #4, knowledge of identifying spiritual needs.

The characteristics of the items that make up the factors were as follows. #25-#26 items of the 7th factor of the SCCQ included in the 1st factor of the Japanese version has higher average scores (Q18=3.00, Q19=3.05) than the results of the German version (#25=1.79, #26=2.62). This was about having an attitude that considers the patient's beliefs and spiritual attitudes. However, the Japanese version (Q17=2.31) has lower average values for # 24(3.09) SCCQ items included here. This was a consideration for the patient's religious practice.

Similarly, the Japanese version (Q22=2.44) of SCCQ #30(3.00), which was deleted from the Japanese version as factor 1, had a lower score. This is because the Japanese score poorly on how health care providers characterize their own spirituality and their relationship with their patients.

There is no significant difference in scores between the Japanese version of factor 3 and the German version of factor 2 for team spirit.

Both the Japanese version of the 4th factor (Q14=2.61, Q13=2.61) and the 5th factor score (Q2=1.97, Q1=1.93) high in the German version (#19=3.34, #20=3.34; #2=2.88, #1=3.04). Q20 (2.79), which was deleted from the Japanese version as the fourth factor, has a large difference from the German version (#28=3.38). This was an item to endure the pain of the patient and family together.

N=262

Japanese version factors	Japanese Quetionnaie	mean (1-4)	SD	1	2	3	4	5	SCCQ Factors	Gearman Questio>naie	SCCQ mean(From 3-point law to 4-point law)	SCCQ SD
1st Proactive empowerment competence	QI9患者の信念やスピリチュアルな姿勢を尊重、援助する	3.05	0.75	0.982					7th	26. Ich unterstütze meine Patienten dabei, ihre spirituelle Überzeugungen und Haltungen zu reflektieren.	2.62	0.98
	QI8治療上の決定で患者のスピリチュアルや態度/信念に配慮	3.00	0.75	0.848					7th	25.Bei therapeutischen Entscheidungen achte ich auf religiöse / spirituelle Einstellungen, Haltungen und Überzeugungen des konkreten Patienten.	1.79	0.94
	Q27患者の私と異なる宗教的特性を十分配慮する	2.96	0.93	0.677					5th	39.Ich achte darauf, dass die religiösen Besonderheiten von Patienten aus anderen Religionsgemeinschaften angemessen berücksichtigt werden.	2.84	0.81
	QI7患者が宗教的行為に参加できるよう配慮する	2.31	0.90	0.662					7th	24.Ich ermögliche meinen Patienten die Teilnahme an religiösen Handlungen / Feiern.	3.09	1.01
Deletion in Japanese version	Q26私と異なる宗教の患者の宗教的特性をよく理解している	2.13	0.71	0.446					5th	38.Ich weiß gut Bescheid darüber, welche religiösen Besonderheiten von Patienten aus anderen Religionsgemeinschaften berücksichtigt werden müssen.	2.29	0.81
	Q30患者のスピリチュアルな懸念を表現できる場を提供する	2.26	0.86	0.434					4th	43.Ich eröffne verbal, aber auch non-verbal einen „Raum", in dem der Patient ggf. spirituelle Anliegen einbringen kann, aber nicht gezwungen wird.	2.30	1.03
	Q25スピリチュアルな会話では適切な枠組みを留意する	2.26	0.78	0.338					7th	35.Ich achte auf den geeigneten Rahmen für spirituelle Gespräche.	2.73	0.97
	Q22自らのスピリチュアリティ—患者との関わりを特徴づける	2.44	0.75	0.253					4th	30.Meine eigene Spiritualität prägt meinen Umgang mit anderen/kranken Menschen.	3.00	1.00
2nd Documentation competences	QI4スピリチュアルの必要性を確認する知識	1.54	0.73		0.886				3rd	4.Ich kenne Instrumente / Fragebögen zur strukturierten Erfassung spiritueller Bedürfnisse.	1.51	0.81
	Q5患者のスピリチュアル体験を理解する方法の知識	1.53	0.72		0.765				3rd	5.Ich weiß, wie ich die spirituelle Anamnese meiner Patienten gut und nachvollziehbar dokumentieren kann.	1.89	0.92
	Q3スピリチュアルな病歴収集用具の知識	1.75	0.81		0.762				3rd	3.Ich kenne Instrumentarien (z.B. Themenliste) zur Erhebung einer spirituellen Kurz-Anamnese.	1.63	0.86
	Q36精神的なトピックのトレーニングイベントに定期的に参加	1.37	0.68		0.581				4th	49.Ich besuche regelmäßig Fortbildungsveranstaltungen zu spirituellen Themen.	1.89	1.06
Deletion in Japanese version	Q35定期的にスピリチュアリティーを深めるよう留意している	1.85	0.92		0.469				4th	48.Ich kümmere mich regelmäßig um die Vertiefung meiner eigenen Spiritualität (z.B. Besinnungstage, Meditation, Gottesdienstbesuch etc.).	2.62	1.13
	Q7無宗教の患者とスピリチュアルニーズを語る	2.03	0.89		0.467				1st	8.Ich kann auch mit religionsfernen Patienten über ihre existentiellen / spirituellen Bedürfnisse reden.	2.95	0.90
	Q6宗教に関心がない患者のスピリチュアルなニーズを感覚的に認識できる	2.17	0.86		0.439				1st	7.Ich kann existentielle / spirituelle Bedürfnisse wahrnehmen, auch wenn die Patienten zur Religion wenig Bezug haben.	2.73	0.90
	Q29患者のスピリチュアルニーズに対応するため定期的に患者にかかわる	1.79	0.83		0.352				4th	42.Ich gehe regelmäßig auf Patienten zu, um deren spirituelle Bedürfnisse anzusprechen.	1.84	0.86
3rd Team spirit	QI0患者のスピリチュアルケアをチームで意見交換	1.92	0.83			0.905			2nd	14.Im Team tauschen wir uns regelmäßig über das Thema Spiritualität in der Patientenbegleitung aus.	1.92	0.89
	Q8施設ではスピリチュアルな話題を随時対応	2.21	0.87			0.789			2nd	13.In unserer Einrichtung (Praxis, Klinik usw.) besteht eine große Offenheit für das Themenfeld Spiritualität.	2.84	0.97
	Q9患者のスピリチュアルなニーズをチームで語る	1.92	0.89			0.780			2nd	12.Wir sprechen regelmäßig im Team über die spirituellen Bedürfnisse der Patienten.	1.87	0.91
	QI1定期的にチーム自らのスピリチュアリティーを語り合う	1.72	0.74			0.601			2nd	15.Im Team tauschen wir uns regelmäßig über unsere eigene Spiritualität aus.	1.67	0.74
4th Interviewing compitences	QI4実存的な話題をこだわりなく話す	2.61	0.78				0.907		6th	19.Ich bin in der Lage, ein offenes Gespräch über existenzielle Themen zu führen.	3.34	0.75
	QI5宗教的な話題をこだわりなく話す	2.61	0.86				0.648		6th	20.Ich bin in der Lage, ein offenes Gespräch über religiöse Themen zu führen.	3.34	0.72
Deletion in Japanese version	QI3チームでは問題状況に対応する方略をもつ	2.19	0.90				0.380		2nd	17.Im Team haben wir Rituale (z.B. Abschieds- und Unterbrechungsrituale), um gemeinsam mit problematischen Situationen umzugehen.	1.99	0.98
	Q20患者家族の痛みや苦痛を共に耐える	2.79	0.66				0.346		1st	28.Ich bin in der Lage, Schmerzen / Leid von Patienten und ihren Angehörigen auszuhalten.	3.38	0.66
5th Perceptual competences	Q2患者家族のスピリチュアルなニーズを認める	1.97	0.68					-0.962	1st	2.Ich traue mir zu, spirituelle Bedürfnisse von Angehörigen wahrzunehmen.	2.88	0.81
	QI患者のスピリチュアルニーズを認める	1.93	0.71					-0.790	1st	1.Ich traue mir zu, spirituelle Bedürfnisse von Patienten wahrzunehmen.	3.04	0.76

Table 2: Principal component analysis Varimax rotation factor analysis.

After performing a confirmatory factor analysis with this five-factor structure, Figure 2 was adopted. The goodness of fit of the model was 0.880 for GFI, 0.814 for AGFI, 0.569 for PGFI, 0.918 for CFI, 0.888 for TLI, 0.919 for IFI, and 0.91 for RMSEA. χ^2 was 277.81 (88), p <0.0001, and it was an acceptable model, although the goodness of fit of the model was not as good as that of the German version with its 7 factors. The path coefficient from Spiritual Care showed an acceptable value of 0.53, 0.67, 0.92, 0.49, -0.18 from factor 1 to factor 5. The load between each factor and the item was also acceptable (Figure 2). The goodness of fit of the Japanese version of the model was compared with that of the German version. Almost similar goodness of fit was obtained (Table 3).

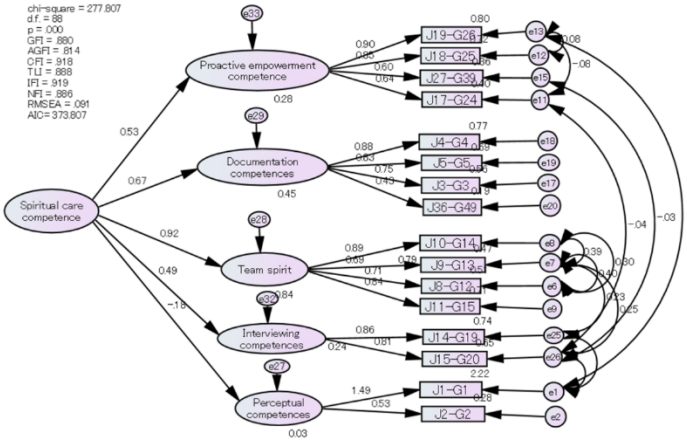

Figure 2: SCCQ Japanese 5-factor structural model.

	χ^2	*p*	AGFI	PGFI	TLI	CFI	RMSEA
7-factor German structural model in 26 German items	1031.492	0.000	0.692	0.619	0.789	0.811	0.099
5-factor Japanese structural model in 26 German items	277.807	0.000	0.814	0.569	0.888	0.918	0.091

Table 3: Fix index of SCCQ Japanese 5-factor structural model.

Reliability

The reliability of the 16 items in the Japanese version was 0.823 for α coefficient, and 0.818, 0.805, 0.890, 0.816, 0.893 for α coefficient from the first factor to the fifth factor. This indicates good internal consistency of these 5 factors.

Relationship between 5 factors and basic attributes

In the cross-correlation of the five factors of the 16 items in the Japanese version, the fifth factor showed a negative association unlike the other factors (Table 4).

The relationship with the basic attributes were in most cases not significant or marginal to weak only. Best associations were found for Praying / Meditation and Perception competences (r = -.23) and Interviewing competences (r = .20), and for work satisfaction with Perception competences (r = -.24) and Team Spirit (r = .20). Worktime was only marginally or not at all related.

N=262

	Factor1	Factor2	Factor3	Factor4	Factor5
	Conversation Readership Competence	Empowerment Competences	Team Spirit	Self-awareness and Proactive Opening Competences	Perceptual Competences
Factor2	.243**				
Factor3	.441**	.537**			
Factor4	.563**	.221**	.381**		
Factor5	-.413**	-.163**	-.336**	-.366**	
Sex	.133*	*n.s.*	*n.s.*	*n.s.*	*n.s.*
Age	.137*	*n.s.*	*n.s.*	*n.s.*	*n.s.*
Chile-rearing experience	-.136*	*n.s.*	-.131*	*n.s.*	*n.s.*
Prayer habits	*n.s.*	.161**	*n.s.*	*n.s.*	-.128*
Prayer and meditation habits	.191**	.166**	*n.s.*	.200**	-.227**
Years of work experience	*n.s.*	*n.s.*	*n.s.*	*n.s.*	*n.s.*
Weekly working hours	.159*	*n.s.*	*n.s.*	*n.s.*	-.125*
Job satisfaction	.162**	.128*	.201**	.169**	-.235**
*:p<0.05, **:p<0.01					

Table 4: In the cross-correlation and relationship for basic attributes between 5 factors.

Discussion

The data of the participants in this survey were not distorted in age, medical field, and years of experience, employment form, and job satisfaction. Most of the religions were Buddhism (75.5%), and 3.5% were Shinto. However, the centrality of this religious affiliation is unclear. There are also Japanese Buddhists who meditate according to Zen teachings, but this is not common. Nor do they attend worship every Sunday as Christians do. They do not attach importance to daily prayer like Muslims do. Therefore, many Japanese cannot be said to have religious customs in their daily lives. Therefore, from an early age, little is learned about the inner depths of the person and the meaning of the spiritual dimension. When people die and are buried, they need Buddhist rituals. In this way, the relationship between Japanese people and religion is not conscious of the existence of a god that transcends human beings on a daily basis, but it can be said that they are conscious of the existence of a gradual transcendent existence at each turning point in their lives. In other words, it can be said that they have faith rather than religious spirit.

From the comparison of the item average values in this survey, it can be said that the Spiritual Care ability expressed by all 26 items is lower in the Japanese than in the German version of

the survey. From the characteristics of the average score of items, the items with high Spiritual Care ability of the Japanese were the attitude of respecting the patient's beliefs and spiritual attitudes. This is considered to be a manifestation of the characteristic of treating others politely (Japanese is 'Omotenashi'), which is one of the characteristics of Japanese people. Compared to the linguistic ability of talking about existential and religious topics without particularity, which is the item with the highest ability in the German version of the survey, it may be said that the Japanese provide care not with language but with attitude.

On the other hand, items with low Japanese ability were characterized by the lack of regular mental training. This may be due to a lack of understanding or a lack of opportunities for specialist training in the Spiritual Care of patients. However, the training of qualifications for cancer nursing specialist nurses (JNA, 2022) [18] and Japan spiritual care societies has begun in Japan (JSSC, 2020 ;) [19], and these results are expected.

The order of the Japanese SCCQ version factors is different compared to that of participants from countries with a theistic background. The main factor of the Japanese version is Proactive empowerment competence (3rd in the primary version), (Japanese version 2nd) Documentation competences, 2nd (Japanese version 3rd) Interviewing competences, 6th (Japanese version 4th) Team spirit, 1st (Japanese version 5th) factor from the German version. However, the Japanese version of the 5th factor (Perceptual competences) showed a negative loading. This factor 5 was significantly negatively associated with prayer habits, meditation habits, working hours per week, and job satisfaction.

All four factors inherited from the German version respect the patient's religious characteristics and spiritual attitudes, understand their spiritual needs, discuss the patient's spiritual care in teams, and discuss existential and religious topics. I was asked to select the items that I would like to talk about without any prejudice. It turns out that Japanese medical practitioners have spiritual relationships that are no different from those in other countries. However, it was found that there was no common understanding of the concept of spiritual pain, which is the patient's internal anguish.

ii ; **Reasons for Items Excluded in the Japanese SCCQ from German version**

There were 10 items that did not transfer from the German version of the SCCQ to the Japanese version.

Items #6 which is Q6 in the Japanese version ((‘Shuukyou ni kanshinnganaikannja no spiritual needs wo kankakuteki ni ninshikidekiru') showed negative values. In other words, even if there is a patient's spiritual needs, if the medical staff does not know the spiritual needs, they may not admit that they exist. Further, item #7 which is Q8 in the Japanese version (‘mushuukyou no kanja to spiritual needs wo kataru') was not adopted in the Japanese version, too. As many Japanese medical professionals cannot recognize spiritual needs as concepts, it is difficult to talk about them.

28th item (Ich bin in der Lage, Schmerzen / Leid von Patienten und ihren Angehörigen auszuhalten, Japanese version 20th is ‘kanja Kazoku no itami ya kutu wo tomoni taeru') in the German version of factor 1 were not accepted in the Japanese version. It can be said that this is because Japanese medical practitioners do not clarify spiritual needs, which is the concept of suffering.

17th item (Im Team haben wir Rituale (z.B. Abschieds- und Unterbrechungsrituale), um gemeinsam mit problematischen Situationen umzugehen, Japanese version 13th is ‘team dewa monndaijoukyou ni taiousuru houryaku womotu') in the German version of factor 2 were not accepted in the Japanese version. Because of, teams of members from different occupations may not share how to solve problems.

35th item (Ich achte auf den geeigneten Rahmen für spirituelle Gespräche, Japanese version 25th is 'spiritual na kaiwa deha tekisetuna wakugumiwo ryuuisuru') in the German version of factor 3 were not accepted in the Japanese version. The proper framework is theory, and spiritual conversation cannot be based on theory. It is thought that because the study of spirituality is insufficient.

38th item (Ich weiß gut Bescheid darüber, welche religiösen Besonderheiten von Patienten aus anderen Religionsgemeinschaften berücksichtigt werden müssen, Japanese version 26th is ‘watashi to kotonaru shuukyounokannja noshuukyouteki tokusei wo yoku rikaishiteiru') in the German version of factor 5 were not accepted in the Japanese version. Many Japanese medical professionals say they are Buddhists; it is only natural that the medical staff themselves are poor in their own religious understanding, so they cannot understand the patient's religious beliefs.

30th item (Meine eigene Spiritualität prägt meinen Umgang mit anderen/kranken Menschen, Japanese version 22th is 'mizukara no spirituality- kannja tono kakawari wo tokuchoudukeru') in the German version of factor 6 were not accepted in the Japanese version. Some studies have shown that medical practitioners themselves can understand spirituality through accumulated clinical experience, but this cannot be said to be applicable to all medical practitioners. This is probably because many Japanese medical practitioners do not have a common understanding of the concept of spirituality.

42th item (Ich gehe regelmäßig auf Patienten zu, um deren spirituelle Bedürfnisse anzusprechen, Japanese version 29th is ‘kanja no spiritual needs ni taiousurutame ni teikiteki ni kannja ni

kakawaru') in the German version of factor 5 were not accepted in the Japanese version. Many Japanese medical professionals do not recognize the patient's spiritual needs and will not understand the need to engage with the patient on a regular basis.

43th item (Ich eröffne verbal, aber auch non-verbal einen „Raum", in dem der Patient ggf. spirituelle Anliegen einbringen kann, aber nicht gezwungen wird, Japanese version 30th is 'kanja no spiritual na kenen wo hyougendekiru ba wo teikyousuru') in the German version of factor 5 were not accepted in the Japanese version. Many Japanese medical professionals do not recognize the spiritual needs of patients and will not be able to provide a place to express their concerns.

48th item (Ich kümmere mich regelmäßig um die Vertiefung meiner eigenen Spiritualität (z.B. Besinnungstage, Meditation, Gottesdienstbesuch etc.), Japanese version 35th is 'teikiteki ni spirituality wo fukameruyou ryuuishiteiru') in the German version of factor 5 were not accepted in the Japanese version. Any Japanese medical professionals have few opportunities for regular spiritual learning. However, the clinical experience of death increases the awareness of the spirituality of the medical practitioner, and it will be necessary to understand this systematically.

From the above, Japanese medical practitioners do not have a common understanding of the concept of spiritual needs, so they cannot share the concept and discuss care. In addition, since spirituality can be acquired through experience, if there is an opportunity to learn, it will be possible to explain the connection between the inside of the patient and the inside of the medical staff.

iii; Characteristics of care of Japanese medical staff

Results from all respondents showed that the Japanese version of Factor 5 non-perceived spirituality (having no concepts to explain a patient's inner spirituality) was negatively associated with prayer and meditation habits.

Based on the relationship between the Japanese version of factor 5 and basic attributes, it is possible that Japanese people, who have plenty of time for prayer and meditation and are highly satisfied with their work, are providing spiritual care. In other words, it can be said that Japanese medical workers are educated to respect the inner feelings of patients in the medical worker-training course, not to understand the spirituality of patients by learning spiritual care. This may be a cultural adaptation of Japanese religion and care.

From the above two results, it can be said that even in Japan, medical professionals who have prayer and meditation habits perceive spirituality. With the inclusion of Catholic hospitals in this survey, it is possible that Spiritual Care is being implemented in hospitals with a religious (Baptism or another religions) background and Healthcare professionals preparing internally for patient care in Japan.

Clinical research on cancer nursing in Japan. A survey of 295 mid-career nurses on the relationship between spirituality and spiritual care revealed that clinical experience enhanced nurses' inner spirituality, which contributed to the provision of spiritual care. However, there is a possibility that the inner aspects of nurses are perceived as meaningfulness and sense of values rather than spirituality=. Therefore, in order to clarify the spiritual care of Japanese nurses, it is necessary to learn and share the concept of spiritual needs and spiritual care internationally.

As foreigners increasingly receive medical services in Japan, it is hoped that the internationally accepted concept of spiritual needs will be understood. A new kind of care for the Japanese may be created by combining the inner processes and spiritual needs unique to the Japanese.

iv; Complementary Theories to Support Spiritual Care

However, prayer behavior was also recognized by medical professionals who did not necessarily belong to the religious background. In other words, there was a change due to the introduction of the concept of caring in Japan 2000. In other words, the involvement of caring methods such as "being by", "recognizing the value of existence", "promoting redefinition", and "sharing distress" is similar to the spiritual care approach [20]. The theory of caring had great significance in supporting palliative care in Japan since the 1980s and training of cancer specialist nurses since 1994 [21-25].

Conclusion

Because of the Japanese version of the survey, we found that Japanese medical practitioners have an attitude of respect for others, respecting the patient's religiousness, spirituality, and beliefs, and we found that there were few opportunities for professional training in spiritual care on a regular basis [26]. On the other hand, there was also a characteristic that they did not recognize the perception of spiritual needs, but this was thought to be due to the lack of knowledge of the concept of spiritual needs [27], that is, the lack of education in spiritual needs. There are many people who have faith, and in order for Japanese medical workers to provide mental care, it is necessary to educate them about mental care suitable for Japanese people [28]. Moreover, a comparison using the Japanese version of the SCCQ can explain what somewhat internationally accepted spiritual characteristics and issues the Japanese have [29], and can be said to be effective for international comparison.

Research Limits

The limit of the survey Japanese people was that it was not possible to obtain a large number of survey collaborators because

the understanding of the concept of spirituality was not widespread.

In addition, because this study was a cross-sectional study, we did not longitudinally evaluate the impact of the care of Japanese professionals trained in spiritual care. Therefore, it is necessary to clarify the learning outcomes of Japanese people's spiritual care ability longitudinally.

In addition, Japanese people believe in Buddhism and Shintoism at the same time, but they have a different way of thinking about religion than some monotheistic people.

Especially in the survey of the Japanese, there was a characteristic that they used attitudes rather than verbal explanations. Therefore, it may be necessary to examine the relationship between care attitudes and spiritual needs in future research on care in Japan.

Finally, a German study suggests that verbal communication with patients is associated with higher pain relief scores. In Japan as well, it is necessary to devise education so that medical personnel can speak frankly about such patients and the source of their pain.

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