

Explaining the meaning of the WHOQOL-SRPB

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Abstract

Background: WHOQOL-SRPB is an instrument developed to evaluate how spirituality, religiosity and personal beliefs (SRPB) are related to quality of life in health and health care. Recently, Moreira-Alves and Koenig (2006) questioned several aspects concerning WHOQOL-SRPB including the definition of the construct used in the instrument and the fact that its facets are too broad to be considered spirituality and religiosity. The present study is an answer to these questions, based on the clarification of some concepts behind the development of the WHOQOL-SRPB. **Objectives:** To clarify the concepts behind the development of the WHOQOL-SRPB. **Methods:** The questions raised by Moreira-Alves and Koenig (2006) were discussed based on the objectives and conceptual framework of the WHOQOL-SRPB and also on the pertinent literature. **Results:** 1) WHOQOL-SRPB is not an instrument developed to evaluate SRPB but Quality of Life construct; 2) personal beliefs may function as a strategy to cope with life problems, since they give meaning to human behavior and hypothetically influence quality of life; 3) SRPB is a coherent construct and may be considered an independent construct specially concerning psychological well-being; 4) the concepts included in the WHOQOL project were considered genuine cross-cultural concepts through international consensus and this is one of its major strengths. **Conclusions:** WHOQOL-SRPB should be seen as an important contribution to the study of the relationship between quality of life and spirituality, religiosity and personal beliefs.

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Recently *Social Science and Medicine* published a paper called "A cross cultural study of spirituality, religion and personal beliefs as components of quality of life" written by the WHOQOL-SRPB Group (World Health Organization Quality of Life Group-Spirituality, Religion and Personal Beliefs Group [2006]). Since then, Moreira-Almeida and Koenig have been discussing this paper (2006). As members of the WHOQOL-SRPB Group, we address some of the issues raised by them, and simultaneously aim to clarify the goals and limitations of the WHOQOL-SRPB instrument. This is a personal view of the authors who are members of the WHOQOL-SRPB group, not an official view from the World Health Organization.

Work on the WHOQOL-SRPB concerns a cross-cultural study to construct a measure that would assess how spirituality, religion and personal beliefs (SRPB) relate to quality of life (QOL) in health and health care. A Spirituality domain was included in the original quality

of life concept for the WHOQOL instruments following recommendations for its inclusion by focus groups of lay people, convened simultaneously in 18 countries world-wide. Then, the Pilot Field Testing confirmed that the concept of spirituality, religion and personal beliefs was a broad ranging and highly important component of health-related quality of life internationally. The WHOQOL-SRPB is a generic profile that extends the construct derived for the WHOQOL-100 and WHOQOL-Bref instruments where initially, Spirituality was represented minimally. The field test and subsequent studies with the WHOQOL-100 confirmed that the Spirituality domain was insufficient for conceptual and empirical reasons. Consequently, in the mid-1990s, the Division of Mental Health at the World Health Organization initiated a new project to elaborate Spirituality within the WHOQOL, with the aim of making a comprehensive concept that would be useful for work in diverse cultures, and for groups with different spiritual, religious and

personal beliefs. Concurring with the WHOQOL design, this took the form of a module of items covering SRPB related to quality of life and health, which is known as the WHOQOL-SRPB. In the paper recently published by the WHOQOL-SRPB Group, initial quantitative survey data was presented.

The first point to be clarified is that WHOQOL-SRPB is not an instrument to evaluate SRPB, but primarily to evaluate quality of life. SRPB was included because it was seen to be relevant to patients, health professionals and well people from community who told us that SRPB was one of the core aspects of their QOL. Furthermore, the items included were elicited and recommended by focus groups as being concerned with aspects of SRPB that are integrated with their QOL. We agree that some of the facets included in the instrument e.g. Meaning of life, Awe, Wholeness & integration, Hope and optimism, "have been associated with religious involvement, but they are not themselves religiousness and spirituality". In fact, this was exactly the intention as they are QOL facets associated with SRPB according to focus groups impressions from the 18 centers worldwide. Although at first sight it may appear as though some of these concepts do not have spiritual components, the facet working definitions supplied to guide focus groups of users who proposed the wording and concepts of items show differently. For example, the facet on Inner peace, serenity and harmony is defined as: "The extent to which people are at peace with themselves. The source of this peace comes from within the person and can be connected to a relationship the person will have with God, or it may be derived from their belief in a moral code or set of beliefs. The feeling is of serenity and calmness. Whenever things go wrong this inner peace helps you to cope. It is viewed as a highly desirable condition." While item wording in the published measure may not explicitly show evidence of spirituality within them, the guiding definitions did include components of spirituality and so this meaning is embedded.

A philosophy underpinning the WHOQOL-SRPB development is that from a QOL perspective, having a profound belief – religious or not – could give transcendental meaning to life and to daily activities, working as a coping strategy to deal with human suffering and existential dilemmas. We agree with the authors that "the acceptance of the Marxism historical materialism can give someone a strong sense of meaning in life and optimism (believing in the future development of society towards a communist society) so much so that many people have given their lives voluntary to this ideology. However, they would probably take offense at being called spiritual or religious." This is exactly the perspective of the WHOQOL-SRPB: many personal beliefs (e.g. spiritual, religion, Marxism, psychoanalysis) can function as a coping strategy, giving meaning to human behavior, and hypothetically influence QOL. That is why WHOQOL-SRPB is called WHOQOL-SRPB,

not WHOQOL-SR or WHOQOL-R. We could argue and test empirically whether some beliefs are more prone to be successful than others in this complex task.

Secondly, Moreira-Almeida and Koenig state that some WHOQOL-SRPB facets are too broad to be considered as spirituality and religiousness. They assert that "these instruments (including WHOQOL-SRPB) include questions that tap psychological well-being, mental health, meaning and purpose in life and altruistic values that confound any findings where mental health is the outcome". We reply to this argument conceptually and empirically. From a conceptual viewpoint, it is often a challenge to adequately define complex and highly subjective concepts like spirituality, happiness, quality of life, beauty, because of their elusive properties that do not lend themselves readily to measurement. Those concepts are considered by some authors (Gladis *et al.*, 1999) to be "emergent concepts" and are evaluated by characteristics or indicators that could not receive the status of "definition". For those concepts, we have three options: give up the idea of measuring them; measure them through a single generic item (e.g., "How religious are you?") or try to use some measurable items that are characteristics of the concept, but in lower conceptual hierarchy (Lamberts e Shanks, 1997). When items are used to evaluate some characteristics of a construct it can often be argued that others are measured also. For example, items to evaluate sleep in a Depression scale could be interpreted as not measuring depression but problems with sleep. Also, it is expected that the SRPB, psychological and physical dimensions of human beings would be correlated since all represent different aspects of the same concept, namely QOL. Nevertheless, being correlated does not mean that they represent the same dimension or can be used interchangeably. From the previous literature, we expected SRPB to be more closely associated with the Psychological domain than any other, and this was confirmed as the largest association with any domain, including Social. However, the correlation size was only moderate ($r = .46$), indicating that SRPB cannot be adequately substituted by the Psychological dimension without substantial loss of information. Of course, SRPB does need to be correlated with the domains in the WHOQOL in order to justify the case for its psychometric retention within the scale.

We depart from Moreira-Almeida and Koenig's position that "it is not surprising that psychological health is correlated with psychological health". Exploratory factor analysis conducted on all WHOQOL and SRPB facets resulted in a 6-factor solution explaining a substantial 70.2% of the variance. Furthermore, all the SRPB items loaded together onto a second factor, while the other factors included facets from physical, psychological, social and environmental domains (WHOQOL-SRPB Group, 2006). This provides sound but preliminary evidence that SRPB is coherent and stands as an independent construct.

Moreira-Almeida and Koenig have identified a further definitional problem that seems to be more a conundrum of their own work than of ours. They draw on Koenig *et al.* (2001) paper where it is argued that spirituality is “the personal quest for understanding answers to ultimate questions about the life, about meaning and about the relationship with the sacred or the transcendent which may (or may not) lead to or arise from the development of religious rituals and the formation of the community”. Embedded within their own definition of spirituality, we see that spirituality is viewed as an extension of religion. In contrast, the WHOQOL-SRPB Group does not tie spirituality to religion in QOL research observing that those with agnostic or atheist views may also have a rich spiritual life. Such beliefs are widely documented by social anthropologists and can now be generally assessed. Qualitative data from 18 countries affirmed that agnostics and atheists experience and can report spirituality relating to their QOL that helps them to cope with adversity (O’Connell and Skevington, 2004). Agnostics believe that something higher and more powerful exists beyond the material world while acknowledging doubt about its exact nature. They are clear that, for them, this does not involve religion but could for example, be the healing power of Nature. Atheists, on the other hand, do not believe in a higher or religious entity but hold strong personal beliefs which may take the form of a scientific theory like Darwinism or psychoanalysis. Alternatively, they may have a personal philosophy or hold a moral/ethical code like feminism, environmentalism, Marxism, or a particular way of life. In conceptualizing this area much more broadly, we are better able to understand individual differences in this challenging field. This flexibility also enables us to understand how people move from one spiritual position to another during their lifetime. For example, QOL may change at 19 for a person who rejects Christianity when learning about psychoanalysis, could be infused by feminism at 27, and environmentalism at 38, and adjusted further with the discovery of Buddhism at 58. If we apply a definition that ties a spiritual QOL solely to religion, we miss the rich scientific opportunities to investigate the many areas of that person’s spiritual experience across the lifespan.

Finally, the concepts included in the WHOQOL project were genuinely cross-cultural by consensus and this has been one of the considerable strengths. This enabled emic and etic components of QOL to be disaggregated, so that only those with international consensus were distilled and included in the final international instrument. This methodology was adopted for the WHOQOL-SRPB in the same way that it had been for the WHOQOL-100 and WHOQOL-Bref core instruments. Consequently, through many iterations, issues that were particularly important in one culture e.g. Brazil, may have been excluded when found not to obtain a high level of global consensus. For instance,

Detachment and Attachment were important to several Buddhist cultures in the early stages of the WHOQOL-SRPB project, but were not confirmed to be a reliable and valid concept when tested cross-nationally. Through rigorous psychometric testing, these issues were later removed from the international version although they might have been included as local or national items where centers found that the loss of this concept detracted from a holistic view of QOL in that population. So, to say that issues important to participants in Brazilian focus groups (Fleck *et al.*, 2003) were excluded from the final version is correct and this was true for other themes identified by all centers as this procedure is in line with the internationally agreed protocol. Similarly, potential facets like Death and Dying, and Forgiveness and Blame, that were important to English focus groups, were excluded in the final version for the same reason (O’Connell and Skevington, 2005). This misunderstanding appears to have arisen from a lack of appreciation of the truly collaborative nature of the methods used by the WHOQOL Group to undertake its entire program of research, and the unique methodology that distinguishes its development from the development of instruments like the SWBS and FACIT-Sp cited by Moreira-Almeida and Koenig. The latter rely entirely on the adequacy of the translation processes for their international occurrence, as the way in which they were developed lacked a procedure for including internationally agreed concepts to enhance meaning.

As a pioneering work, WHOQOL-SRPB is in the middle of two expanding and very important fields in health measurement: SRPB and QOL. How are these two constructs inter-related? Empirical work will certainly help to answer this question. The WHOQOL-SRPB is not end of this story; it is only the beginning.

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