Italian validation of the Royal Free Interview for Religious and Spiritual Beliefs

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Summary

Interest in the relevance of religion and spirituality to medicine is growing and concerns the possible association between religiousness, spirituality and well-being. In the rehabilitation field these factors may affect outcome. We translated the “Royal Free Interview for Religious and Spiritual Beliefs” into Italian and validated the Italian language version.

The translation of the Royal Free Interview was accomplished in several steps. Certain adaptations were necessary in order to take into account certain peculiarities of the Italian language and of the Italian-speaking world. The Italian translation presented in this study shows internal consistency: Cronbach’s alpha coefficient 0.82 (spiritual scale) and 0.80 (philosophical scale) in the 53 healthy volunteers; alpha coefficient 0.79 (spiritual scale) and 0.64 (philosophical scale) in the stroke patients. Test-retest reliability, evaluated by means of the intraclass correlation coefficient, was 0.83 (spiritual scale) and 0.99 (philosophical scale).

There are two main reasons why an Italian translation of a religious coping scale was deemed necessary: i) there is a growing awareness of the possible impact of faith on stress and on the outcome of many disabling diseases; ii) Italy has a large and aging population and thus a high prevalence of disabled patients.

KEYWORDS: rehabilitation, religiousness, spirituality, stroke.

Introduction

Interest in the relevance of religion and spirituality to medicine has grown as a result of several studies on the association between religiousness, spirituality and well-being (1-3). Underwood-Gordon et al. (4) reported that these factors affect outcome even in the field of medical rehabilitation.

Religion and spirituality are two overlapping concepts: the first refers to the spiritual experiences and practices of people within a well organized system of beliefs; the second is a broader concept embracing values, the quest for meaning, and differing degrees of participation in religious activities (3,5).

Some researchers (6-8) suggest that religious involvement may influence the impact of stress on physical and mental health. Studies on the religious activities of inpatients revealed that in more than 40% of subjects, their faith helped them to cope with their problems (9). Religious activity and coping ability also seemed to be related to less depressive symptoms. Other authors (10) studied the relationship between physical and psychological health and religious attitude in a sample of 245 inpatients: the majority reported using religion to cope with their problems. Some authors (11), showing how religious inclinations are awakened in stressful life situations, define this concept as religious coping. Longitudinal and cross-sectional studies (8,12,13) showed that religious coping seems to be associated with a less depressed mood during illness and to reduce the negative impact of illness on functional status (14,15).

It is useful, for various reasons, to study religious coping from a medical perspective. Patients feel that their spiritual and physical well-being are equally important; spirituality and religion are sources of hope and encouragement during illness that can help to improve a patient’s quality of life. Many patients feel that exploration of spiritual needs and feelings may enrich the patient-physician relationship (16-18). Physicians should consider patients’ spirituality and religiousness in the same way as they consider other psychosocial factors.

There exist different measures to evaluate people’s religiousness and spirituality. The following are a selection of these.

The “Attribution of Responsibility to God Scale” (19), using four vignettes or stories, assesses the extent to which people attribute the outcomes of certain life events to God. The “Belief in Divine Intervention Scale” (20) is a six-item general measure of belief in divine intervention, designed for heterogeneous populations and situations. The “Religious Coping Activities Scale” (21) investigates the extent to which people turn to religion when faced with stressful situations. It monitors six aspects of religious coping (spiritually-based coping, good deeds, religious discontent, interpersonal religious support, pleading with a higher power, and religious avoidance). The “Religious Problem Solving Scale” (22) investigates the role played by religion in the problem-solving process, measuring different religious problem-solving styles. The “Religious Attitude Inventory” (23) measures the strength or extremeness of a subject’s religious attitude. The “God Image Inventory” (24) investigates various ways in which people perceive God: influence, providence, presence, chal-
lengen, acceptance, benevolence. The "Religious Locus of Control Scale" (25,26) measures the extent to which people believe that they have control over their own lives (internal) or, conversely, that outcomes are beyond their control (external). The "Measures of Religiousness" (22) assess the correlation between religiousness, attributitional style and optimism, also investigating religious influence in daily life, religious involvement and religious hope. The "Intrinsic Religious Motivation Scale" (27) measures motivation for and ways of being religious. The "Religion Scale" (28) investigates three dimensions of people’s attitudes to religious beliefs and practices: ideas about divinity, the relationship between divinity and humanity, behaviours that respect God’s expectations.

Finally, the "Royal Free Interview for Religious and Spiritual Beliefs" (29) aims to establish whether, by measuring spiritual, religious or philosophical beliefs in patients admitted to hospital with acute physical illnesses, it is possible to verify the influence of these beliefs on outcomes. The instrument uses the term religion to indicate religious beliefs, practices, rituals and values. The term spirituality is taken to mean people’s belief in a supreme entity beyond themselves. Instead, the term philosophical beliefs indicates their search for a meaning to life that is independent of both religion and spirituality. The interview consists of three sections: demographic data, clinical assessment of patients' conditions, and items on spiritual, religious and philosophical understanding. Each section is explained to the patient.

In this study the "Royal Free Interview for Religious and Spiritual Beliefs" (30) was selected because it applies to inpatients and the purpose of our study was to validate the original English version; (29) was used instead of sentire as this is a more accurate linguistic rendition.

Materials and methods

Translation

The process of translating the Royal Free Interview into Italian and adapting it to the reality of the Italian-speaking world was one of several stages:

1. Four people with a good knowledge of both English and Italian individually translated the Royal Free Interview from English into Italian;
2. A panel of experts compared the four translations and created a single draft;
3. A preliminary Italian version of the Royal Free Interview was developed from this draft;
4. Five people, different from those involved in step 1, were asked to translate the preliminary Italian version back into English (back translation) in order to test its validity and reliability;
5. A panel of experts compared the back translation with the original English version;
6. The Italian version of the Royal Free Interview was finalized.

When finalizing the Italian version of the Royal Free Interview, socio-cultural peculiarities of the Italian-speaking world were taken into account. Some adaptations were necessary where purely literal translations would have meant a loss of correspondence with the terms widely used in Italian measures.

The following are some examples of such adaptations in the Italian version:

– Hospital Record Number was translated as: Cartella Clinica Numero;
– Employed/Unemployed was translated as: Lavora/Non lavora;
– Section “Concezione Religiosa”.
– Question 5: Orthodox or Liberal was translated as: Osservanza stretta o liberale;
– Question 7: Literature was translated as Letteratura because this is the term (having the same meaning) that is commonly used in our language;
– Section “Concezione Filosofica”.

Understanding was not translated because there exists no equivalent term in our language.

Question 18: pensare was used instead of sentire as this is a more accurate linguistic rendition.

Validation

To test the psychometric properties and the applicability of the Italian version of the Royal Free Interview we enrolled three reference populations (reflecting the procedure followed to validate the original English version) (29): 1. Staff workers at our rehabilitation centre who agreed to participate in the study; A random sample of them was asked to perform a re-test after a two-week interval. 2. A consecutive series of post-stroke inpatients admitted to our rehabilitation centre. Exclusion criteria were: Mini Mental State Examination (MMSE) ≤ 21 (32), inability to complete the questionnaire due to sensory or motor limitations, aphasia, unwillingness to participate in the study (written informed consent was required). 3. A convenience sample of members of religious orders to test the construct validity of the spiritual section of the interview. It was assumed that members of religious orders would score higher than the other two groups on the spiritual section of the scale, the part supposed to measure the level of faith of the responders. All three groups included only fluent speakers of Italian.

Statistical analysis

Group comparisons were made using the Mann-Whitney U test for continuous variables and Pearson's chi-squared test for categorical variables. Internal consistency was measured by means of the Cronbach's alpha coefficient. Test-retest reliability was evaluated by means of the intraclass correlation coefficient (ICC) using the absolute agreement definition. All analyses were performed using the statistical package SPSS version 12.0 (32).

Results

Population

1. Fifty-three staff members participated in the study and 26/53 were re-tested after 2 weeks.
2. One hundred and fifty post-stroke patients were consecutively admitted to our centre in the period 2003-
Religious and spiritual beliefs

2004. Of these, 59 met the exclusion criteria. The remaining 91 inpatients were enrolled in the study. 3. Twenty-seven representatives of religious orders of the Roman Catholic Church agreed to participate in the study.

The characteristics of the three groups are presented in Table I. The members of staff and of the religious orders did not significantly differ in age, but both these groups were younger than the inpatients (staff/inpatients: U=35,000, p<0.0001; religious/inpatients: U=32,500, p<0.0001). With regard to gender, staff members did not significantly differ from inpatients but both groups significantly differed from the members of religious orders, who were more likely (70%) to be men (staff/religious: Pearson chi-squared=10.999, p<0.001; inpatients/religious: Pearson chi-squared=4.463, p<0.05). Level of education was found to be higher among the members of religious orders versus both staff members and inpatients (religious/staff: U=292,000, p<0.0001; religious/inpatients: U=125,500, p<0.0001). However, when compared to inpatients, the staff members showed a higher level of education (staff/inpatients: U=620,000, p<0.0001). Across all three groups the prevalent ethnic origin was white Caucasian. The large majority of the staff members and inpatients had an Italian language background, whereas a substantial proportion (25%) of the members of religious orders spoke languages other than Italian as their mother tongue (religious/staff: Pearson chi-squared=25.789, p<0.0001; religious/inpatients: Pearson chi-squared=41.013, p<0.0001).

Religious beliefs

Thirty-two (60%) staff members and 89 (98%) inpatients reported that they had a religious faith. Gender did not affect the probability of having a religious faith. Among staff members, all those reporting a religious faith were Roman Catholic Christians. Of the inpatients, 87 (96%) were Roman Catholic, 1 (1%) was Orthodox Catholic and 1 (1%) was Jewish. Table II shows the frequency of religious practice among the staff members and inpatients who declared that they had a religious faith. As the table shows, members of both groups were more likely to practise their faith on a daily basis and no significant difference emerged between the two groups as regards the frequency with which they practised their faith. Gender did not affect the frequency of the staff members’ practising of their faith, whereas among the inpatients, women were found to practise their religious faith significantly more often than men (Pearson chi-squared=18.5, p<0.0001). Age was not related to the strength of belief among either staff members or inpatients. A weak inverse relationship was found between education and strength of spiritual belief among staff members (r=-0.33, p<0.05) but not among inpatients.

Reliability

In the 53 staff members the value of the alpha coefficient for internal reliability was 0.82 for the spiritual scale and 0.80 for the philosophical scale. In the inpatients the alpha coefficient was 0.79 for the spiritual scale and 0.64 for the philosophical scale. The ICC for test-retest reliability, evaluated in the staff members, was 0.83 for the spiritual scale and 0.99 for the philosophical scale.

Construct validity

All the members of religious orders declared that they practised their religious faith daily and this rate was significantly higher than that found in both the staff members and the inpatients (religious/staff: Pearson chi-squared=16.971, p<0.001; religious/inpatients: Pearson chi-squared=16.482, p<0.001). The members of the religious orders gave significantly higher spiritual scale

<table>
<thead>
<tr>
<th>Staff (n = 53)</th>
<th>Inpatients (n = 91)</th>
<th>Religious (n = 27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years (mean; SD)</td>
<td>31.0; 7.5</td>
<td>71.6; 10.4</td>
</tr>
<tr>
<td>Gender: Female (n.; %)</td>
<td>36; 68</td>
<td>48; 53</td>
</tr>
<tr>
<td>Education in years (mean; SD)</td>
<td>14.0; 1.9</td>
<td>7.9; 4.3</td>
</tr>
<tr>
<td>Ethnic origin: white Caucasian (n.; %)</td>
<td>53; 100</td>
<td>91; 100</td>
</tr>
<tr>
<td>Native language: Italian (n.; %)</td>
<td>50; 94</td>
<td>90; 99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency of religious practice</th>
<th>Staff (n = 32) n. (%)</th>
<th>Inpatients (n = 89) n. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>17 (53)</td>
<td>52 (58)</td>
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<tr>
<td>Weekly</td>
<td>7 (22)</td>
<td>18 (20)</td>
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<tr>
<td>Monthly</td>
<td>5 (16)</td>
<td>10 (11)</td>
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<tr>
<td>Annual or less</td>
<td>3 (9)</td>
<td>9 (10)</td>
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</table>
scores than the other two groups (religious/staff: \(U=85.500, p<0.0001\); religious/inpatients: \(U=282.000, p<0.0001\)).

Discussion

A recent literature review (33) concludes that spirituality is important to many rehabilitation patients and appears to have an impact on their satisfaction with and quality of life. However, further research is warranted in this area. It is estimated that there are around 250 new cases of stroke every day in Italy. Many studies have investigated the overall outcome of stroke (34.35), but spirituality has never been one of the variables considered. The main reason for this omission is probably the lack of a validated scale. For this reason, we applied the Italian translation to a large group of patients suffering from their first ever stroke.

According to a survey by the “Roma Europea” Foundation, the Italian capital has 3.5 million inhabitants: 77% are Catholics, 12.3% atheists, 8.3% people who have a faith but no specific religion, 2.4% people of other specific religions, such as Protestantism, Judaism, the Orthodox Church, Islam, Buddhism. This latter percentage has risen in the past five years, as a result of an increase in the numbers of both legal and illegal immigrants in Italy. Generally speaking, the city of Rome views a multi-ethnic society as a source of enrichment. Sixty-four percent of all the interviewees (vs 71.4% of the Catholics interviewed) believe that things would be worse without religion. Of the interviewees, 53% support their church financially, a percentage that rises to 74% when considering the Catholic sample. Sixty-eight percent of Roman Catholics believe that Heaven exists (versus 55% of non Catholics). Conversely, 13.1% do not believe in Heaven (as opposed to 25.4% of non Catholics). Finally, 3.9% of Catholics claim not to be interested in things beyond human life (vs 5.4% of non Catholics), whereas 14.9% of Catholics and 14.3% of non Catholics did not answer this question.

A striking finding of the “Roma Europea” Foundation survey was the high percentage of patients reporting a religious faith (88%). In our study, on the other hand, 60% of staff members reported having a religious faith, a figure below that of the Catholic percentage in Rome. It seems that faith is enhanced by disease. However, an adjustment of these data for age is expected in a further analysis. Indeed, further studies on the incidence of anxiety and stroke among inpatients and the buffer effect of faith are in progress at our rehabilitation centre. By contrast, members of religious orders, as expected, gave significantly higher scores on the spiritual scale than the other two groups.

There are two main reasons why an Italian translation of a scale measuring religious coping and problem solving was deemed necessary: i) there is growing awareness of the possible impact of faith on stress and on the outcome of many disabling diseases, and thus of the need to study this; ii) Italy has a large and aging population and thus a high prevalence of disabled patients. The Royal Free Interview was applied to British inpatients. The Italian translation we here present (Appendix) demonstrates internal consistency. The Cronbach’s alpha coefficient was high, for both the spiritual and the philosophical scale, and for both staff members and inpatients. Test-retest reliability and ICC for test-retest reliability were also high. With reference to the construct validity, the members of religious orders declared that they practised their religious faith daily and this rate was significantly higher than that found in both of the other groups.

On the basis of these findings, we think that it would be useful to investigate the religiosity of the Italian population using this validated scale, which has been demonstrated to be an adequate translation from the original version. Further research in this area is warranted. Our future investigations will consider: i) the possible damping effect of religiousness on anxiety and depression; ii) the overall outcome in stroke rehabilitation inpatients declaring a faith compared to other inpatients who do not have a faith.

Acknowledgments

Thanks are due to Mrs Astrid van Rijn for her English revision.

References

APPENDIX

Questionario
“Royal Free Interview”

The Royal Free Interview for Religious and Spiritual Beliefs
(King, Speck & Thomas, 1995) Reviewed by Kevin S. Seybold

Traduzione e adattamento italiani a cura di Daniela Perrone, Annalisa Alesii, Cristiana Spirdigliozzi, Barbara Caracciolo, Salvatore Giaquinto

INTERVISTA AL PAZIENTE

Sezione A

Dati demografici

Indirizzo: ............................................................................................................................................................................ Cartella clinica n.: ...............

Nome: .................................................................................................................. Cognome: ..............................................................

Età: ............... Sesso: ............... Telefono: .............................................. Stato civile: ..............................................................

Lavora/Non lavora: ............................................................ Lavoro: ........................................................................................................

Descrizione del lavoro: ..........................................................................................................................................................

Lavoro del coniuge: ........................................................................................................................................................................

Origine etnica: .......................................................................................................................... Paese di nascita: ..............................................................

Chi convive con Lei al momento? ............................................................................................................................................................

(registrazione i dettagli di altri conviventi/membri della famiglia)

Functional Neurology 2005; 20(2): 77-84
Sezione B
Valutazione clinica delle condizioni del paziente al momento dell’ammissione

Non acuta [ ]
Moderata [ ]
Grave [ ] (ossia, che potrebbe mettere a repentaglio la vita del paziente)
Molto grave [ ] (ossia, che mette a repentaglio la vita del paziente)

Sezione C
Introduzione dell’intervistatore:
Grazie per aver accettato questa intervista. Noi stiamo cercando di capire se le credenze di una persona influenzano quanto gli capita. Sto per farle alcune domande sulle sue credenze. Quando usiamo la parola “religione”, ci riferiamo alla pratica attuale di una fede, per esempio, andare in chiesa o in sinagoga. Alcune persone non seguono una religione specifica ma hanno una loro spiritualità (per esempio, essi credono che esista un’altra potenza o un’altra forza al di fuori di loro che potrebbe influenzare la loro vita). Alcune persone danno un senso a ciò che accade loro nella vita senza credere in Dio o in un’altra potenza esterna. Ciò potrebbe essere chiamata la loro filosofia di vita.

(L’intervistatore potrebbe aver bisogno di ampliare questa frase per assicurarsi che il paziente abbia compreso).

1) Nel modo in cui l’ho appena descritta, direbbe di avere una concezione religiosa, spirituale o filosofica della sua vita?
   SI / NO.
   Se NO, andare alla Domanda 3.

2) Se SI, può spiegare brevemente che forma ha assunto questa concezione?

3) Rispetto a credere o non credere dove lei si porrebbe, adesso, su questa scala?
   (L’intervistatore mostra la scala)

   Intervistatore:
   Se il soggetto esprime (alla domanda numero 2) una concezione religiosa, continuare con la Domanda 4.
   Se il soggetto esprime una concezione spirituale senza una osservanza religiosa, andare alla Domanda 9.
   Se il soggetto esprime una concezione filosofica in assenza di qualsiasi concezione religiosa o spirituale, continuare con la Domanda 14.
   Se il soggetto esprime di non credere affatto, andare alla Domanda 19.

Concezione religiosa

4) Quale religione osserva?

5) Se Cristiana, di che orientamento?
   Se di altro tipo, è un’osservanza stretta o libera?

6) Quanto è importante per lei l’attuale pratica della sua fede?
   (L’intervistatore mostra la scala)

7) Quale forma questa prende?
   – Preghiera privata [ ]
   – Partecipazione ad assemblea religiosa [ ]
   – Letture sulla mia fede [ ]
   – Condivisione con altri [ ]
   – Rapporto uno ad uno con autorità religiosa [ ]
   – Osservanza di rituali religiosi (ad esempio la dieta) [ ]
   – Altra (specificare) [ ]

8) Quanto spesso pratica la sua fede, in qualsiasi forma?
   Almeno una volta al giorno / Una volta al mese / Una volta l’anno o meno

Ora continuare con la Domanda 9

Concezioni spirituali

9) Lei ha detto di credere in una potenza o in una forza al di fuori di se stesso. Quanto questo influenza quello che capita nella sua vita? (ossia, essa può influenzare la sua vita quotidiana, ad esempio con incontri casuali, incidenti, malattia, opportunità inaspettate).
   (L’intervistatore mostra la scala)

10) Quanto questa potenza può influenzare come risponde alle cose che le accadono? (ossia, quanto ciò la aiuta ad affrontare gli eventi che comportano dei cambiamenti nella sua vita o altri eventi?)
   (L’intervistatore deve accertarsi che i pazienti capiscano che il focus è sulla natura personale degli eventi della vita).
   (L’intervistatore mostra la scala)
Religious and spiritual beliefs

11) Quanto questa potenza la aiuta a capire perché le cose accadono nel mondo, al di là delle sue attività quotidiane?  
(Ad esempio eventi politici, guerre o incidenti).  
(L’intervistatore mostra la scala)

12) Quanto spiega i disastri naturali, come i terremoti, gli allagamenti?  
(L’intervistatore mostra la scala)

13) Comunica in qualche modo con questa potenza?  
Sì / NO / Non ne sono sicuro  
Se Sì, descriva la forma di comunicazione (per esempio, preghiera, contatto tramite un medium).  
Ora passare alla Domanda 18

Concezione filosofica

14) Può parlarci del suo approccio filosofico alla vita? Ha un nome specifico?  
(L’intervistatore può aggiungere: esistenzialismo – l’uomo è libero e responsabile delle sue azioni; ateismo – credere che non esistano altri dei; umanesimo – credere nella forza dell’uomo piuttosto che nella religione; libero pensiero – scettico che forma le proprie opinioni).

15) Quanto questa filosofia influenza il suo modo di reagire agli eventi quotidiani? (ossia, quanto la aiuta ad affrontare le cose che le accadono?)  
(L’intervistatore deve accertarsi che i pazienti capiscano che il focus è sulla natura personale degli eventi della vita).  
(L’intervistatore mostra la scala)

16) Quanto questa filosofia la aiuta a capire perché le cose accadono nel mondo, al di là delle sue attività quotidiane? (Ad esempio eventi politici, guerre o incidenti).  
(L’intervistatore mostra la scala)

17) Quanto questa spiega i disastri naturali, come i terremoti, gli allagamenti?  
(L’intervistatore mostra la scala)

18) Quanto le sue credenze l’hanno aiutata durante questa malattia?  
(L’intervistatore mostra la scala)

TUTTI I SOGGETTI DEVONO RISPONDERE ALLE DOMANDE MANENTI.

19) Ora mi piacerebbe chiederle che cosa pensa dei punti di vista che la gente esprime a volte sulla malattia.  
a. Pensa che la malattia sia una punizione per aver agito male?  
(L’intervistatore mostra la scala)  
b. Pensa che la malattia sia predeterminata/dovuta al destino?  
(L’intervistatore mostra la scala)  
c. Pensa che la malattia ci sia mandata per metterci alla prova?  
(L’intervistatore mostra la scala)  
d. Pensa che la malattia sia una conseguenza dello stile di vita? (per esempio: fumo, alcool, sesso).  
(L’intervistatore mostra la scala)

20) Con questi pensieri in mente, direbbe che esista un qualche legame/associazione tra la sua malattia e il suo approccio religioso/spirituale/filosofico alla vita?  
(L’intervistatore mostra la scala)

Questa sezione è dedicata all’intervistato

PER CIASCUNA DOMANDA FACCIAMUNO CERCHIO ATTORNO AL NUMERO SULLA SCALA CHE PIÙ SI AVVICINA AL SUO PUNTO DI VISTA.

<table>
<thead>
<tr>
<th>Domanda n. 3</th>
<th>Non credo affatto</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Credo mollassimo</th>
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<tr>
<td>Domanda n. 6</td>
<td>Non necessaria</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>Essenziale</td>
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<td>Domanda n. 9</td>
<td>Nessuna influenza</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>Fortissima influenza</td>
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<tr>
<td>Domanda n. 11</td>
<td>Non mi aiuta affatto a capire</td>
<td>Mi aiuta molto</td>
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<td>Domanda n. 12</td>
<td>Non mi aiuta affatto a capire</td>
<td>Mi aiuta molto</td>
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<tr>
<td>Domanda n. 15</td>
<td>Nessuna influenza</td>
<td>Fortissima influenza</td>
<td></td>
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<tr>
<td>Domanda n. 16</td>
<td>Non mi aiuta affatto a capire</td>
<td>Mi aiuta molto</td>
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<td>Non mi aiuta affatto a capire</td>
<td>Mi aiuta molto</td>
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<tr>
<td>Domanda n. 18</td>
<td>Non mi aiuta affatto</td>
<td>Mi aiuta molto</td>
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<tr>
<td>Domanda n. 19a</td>
<td>Fortemente in disaccordo</td>
<td>Fortemente d'accordo</td>
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<td>Domanda n. 19b</td>
<td>Fortemente in disaccordo</td>
<td>Fortemente d'accordo</td>
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<td>Domanda n. 19c</td>
<td>Fortemente in disaccordo</td>
<td>Fortemente d'accordo</td>
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<td>Domanda n. 19d</td>
<td>Fortemente in disaccordo</td>
<td>Fortemente d'accordo</td>
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<tr>
<td>Domanda n. 20</td>
<td>Sono convinto che non ci sia alcun legame</td>
<td>Sono convinto che ci sia un legame</td>
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