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Translation and Validation of the Dutch Version of the Spiritual Care Competence Questionnaire (SCCQ-NL)

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Abstract: The importance of spirituality in the treatment of mental illness is increasingly acknowledged, but mental healthcare professionals often feel they lack specific competence. An instrument is missing to quantify the spiritual care competence of mental healthcare professionals in the Netherlands. The aim of this study was thus to translate the Spiritual Care Competence Questionnaire (SCCQ) into Dutch and validate it for use in mental healthcare. After translation, the SCCQ-NL was distributed in a cross-sectional design among 3497 healthcare professionals in two mental healthcare institutions (MHIs) in the Netherlands. In the sample of 730 completed questionnaires, exploratory factor analysis revealed seven factors: perception of spiritual needs competencies, team spirit, spiritual self-awareness, documentation competencies, empowerment and proactive opening competencies, knowledge about other religions, and conversation competencies. One item was deleted during the process. Internal consistency for the 25-item SCCQ-NL subscales is sufficient with Cronbach's alpha ranging from 0.64 to 0.81. Conversation competencies and perception of spiritual needs scored highest in the sample, next to knowledge about other religions and empowerment competencies, while spiritual self-awareness, team spirit and documentation competencies scored the lowest. Small but significant differences in several subscale scores were found for profession, identifying oneself as a believer, practicing prayer and/or meditation, age and working years. The SCCQ-NL can be used for the assessment of spiritual care competencies and for the planning and evaluation of training and improvement strategies.

Keywords: spiritual care; competence; validation; questionnaire; mental healthcare; professionals; translation; Dutch

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1. Introduction

Spirituality is linked to longevity (Alimujiang et al. 2019) and psychological well-being (Greenfield et al. 2009), and there is a striking increase in scientific studies of the positive effects of religiosity and spirituality on physical and mental health (De Diego-Cordero et al. 2023; Hoenders and Braam 2020; Villas Boas et al. 2023). Additionally, it is recognized that spirituality and religion can play an important role in how patients cope with physical and mental illness (Koenig 2012; Brewer-Smyth and Koenig 2014; Koenig et al. 2020). Positive as well as negative religious/spiritual (R/S) coping is said to be related to several health

outcomes such as severity of symptoms in, for example, depression (Koenig 2012), bipolar disorder (Stroppa et al. 2018), and PTSD (Trevino et al. 2016; Chen and VanderWeele 2018; as cited in Koenig et al. 2020). Also, R/S struggles can lead to serious distress and affect mental health and well-being (Stauner et al. 2016). In the Netherlands, the importance of spirituality in the recovery from mental illness is increasingly recognized by professionals and policymakers. This translates for example into the emergence of positive health, in which spirituality is seen as one of the important contributing factors in physical and mental health (Huber and Garssen 2016), and into the recent publication of a clinical standard for spiritual care in mental healthcare in the Netherlands (AKWA GGZ 2023). This is in accordance with the position paper of the World Psychiatric Association that states that spirituality should be an integrated part of mental healthcare (Moreira-Almeida et al. 2016), even though much is still unclear on how to apply spirituality in psychiatry (Hoenders and Braam 2020).

Spirituality can be defined in many ways and is recognized as a multifactorial construct and complex phenomenon, and definitions may vary across cultures (De Brito Sena et al. 2021). Here, we will use the definition commonly used in the Western research literature in the last 15 years: "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al. 2009). A recent study shows that policymakers, patients, and mental healthcare professionals in the Netherlands equally value meaning (as a spiritual–existential dimension) as an important factor in mental health, and more than in general healthcare (Van de Loo et al. 2022). This adds to a growing body of research that shows that a large number of patients have a strong interest in discussing spirituality in medical consultation with their physician (Best et al. 2015; Büssing et al. 2009). The majority of patients in mental healthcare think spirituality-integrated care is important and hope to address spiritual issues in their therapies (Currier et al. 2020; Oxhandler et al. 2018). And while research shows that religious and spiritual patients benefit more from an R/S-focused therapy, compared to non-R/S-focused therapy (Bouwhuis-van Keulen et al. 2023), the need to talk about spiritual concerns is not restricted to religious patients who seek treatment in religiously affiliated institutions. Many religiously unaffiliated patients are interested in R/S-integrated therapies too (Rosmarin et al. 2015) but their needs are most likely more implicit in secular settings (Van Nieuw Amerongen-Meeuwse et al. 2019), which requires different competencies from healthcare professionals. Research in the Netherlands has shown that a substantial number of patients in a secular setting also want their R/S concerns to be addressed by their therapist but many times find their needs are not being met (Van Nieuw Amerongen-Meeuwse et al. 2020). This is consistent with international research in which patients report that they receive less spiritual care than preferred in medical care (Fuchs et al. 2021).

Even though professionals working in mental healthcare value spirituality in mental health, they seem reluctant to apply it in clinical practice. One of the reasons may be that practitioners feel that they are not the appropriate person to talk about these topics and think patients should be referred to healthcare chaplains. However, patients' needs to address R/S concerns are not limited to pastoral care professionals; patients suffering from mental health problems also want to discuss R/S concerns, more in depth than just having their spiritual history being assessed, with their psychologists, psychiatrists, and nurses (Mohr and Huguelet 2014; Van Nieuw Amerongen-Meeuwse et al. 2020). When R/S concerns are integrated in treatment, it is called spiritual care, which could be defined as "a type of care that addresses and seeks to meet existential and spiritual needs and challenges in connection with illness and crisis" (Hvidt et al. 2020; 2, as cited in Pastrana et al. 2021). However, spiritual care can be seen as a complex and interactive process that is grounded in the therapeutic context (Tavares et al. 2022).

Research suggests that the main reason for (mental) healthcare professionals not to provide spiritual care is a lack of competence and proper training (Green et al. 2020;

Magaldi-Dopman et al. 2011; Villas Boas et al. 2023). For example, Dutch nurses working in mental health care stated that they need more competence and practical guidelines for practicing spiritual care in clinical work (Schep-Akkerman and Van Leeuwen 2009). Also, many psychotherapists, psychologists, and psychiatrists experience personal R/S or existential identity struggles themselves, which may (unknowingly) interfere with their attitude towards the R/S struggles of their patients or with feeling competent in their professional role (Magaldi-Dopman et al. 2011; Glas 2014). In the way the professional performs their role in general, there is always something (indirectly) communicated about how the professional relates to their role performance (Glas 2017). When it comes to R/S needs, by not talking about it in a clinical setting, for example, it is communicated that "we do not talk about those subjects here" (Glas 2020). Patients, in turn, make subtle evaluations by observing their psychotherapists to determine whether the sharing of spiritual or religious content is welcomed (Bartoli 2007). Also, they may be hesitant to mention spiritual R/S needs or struggles for fear of being misunderstood by their therapist (Magaldi-Dopman et al. 2011; Worthington 1989). This dynamic, in which both patients and healthcare professionals feel hesitant to address R/S and existential needs in treatment, even though both see the importance of it, may create a vicious circle, which leads to avoidance of the subject and thus to the absence of potential health benefits. Moreover, unmet spiritual concerns or needs can lead to distress and to unnecessary physical and emotional suffering (Edwards et al. 2010; as cited in Pastrana et al. 2021).

Professional competence is needed to span the distance between clients' existential and spiritual struggles and needs and therapists' personal and professional attitudes (Van Nieuw Amerongen-Meeuwse et al. 2018). Spiritual care competence is defined as "the ability to assess for and provide interventions to care for a patients' spiritual needs (Green et al. 2020), while strengthening the resilience of health care professionals (Frick and Schiessl 2015) and improving the connection and collaboration between professional care takers and their patients" (Paal et al. 2015; as cited in Mandelkow et al. 2022). It is a shared responsibility of physicians, nurses, psychotherapists, healthcare chaplains, and other healthcare professionals (Frick 2017) and is defined by specific knowledge, skills, and attitudes (Van Leeuwen et al. 2009; Green et al. 2020), competencies in which mental healthcare professionals in the Netherlands—apart from healthcare chaplains—are usually not (sufficiently) trained.

Addressing meaning and religious, spiritual, and existential topics in therapy can be challenging in a Western healthcare system which, over the last few decades, has become illness-centered, even though it is steadily making a shift towards more person-centered care (Bouwhuis-van Keulen et al. 2023). In many Western societies, the religious and spiritual landscape is transforming because of secularization, individualization, globalization, and pluralization (Woodhead et al. 2016; as cited in Liefbroer et al. 2017). This leads to more individualized spirituality than traditional religiosity and to a diversity of spiritual, religious, and cultural needs among patients, which requires professionals to deal with these diverse needs (Liefbroer et al. 2017). This is especially relevant for the Netherlands where, in 2022, only 43% were religiously affiliated, a number declining every year (Schmeets and Houben 2023). Compared to 84% being religiously affiliated in the World population (Pew Research Center 2012), the Netherlands is highly secularized. Because of secularization in the Netherlands, religious affiliations have been partly abandoned, and people are searching for new ways to find meaning. It may be that the need for meaning is now finding its way into the domain of mental healthcare (Hoenders and Braam 2020). Also, even though religious affiliation is declining, there is a large group that still call themselves spiritual, and those who are not affiliated may have experiences or a worldview that can be conceptualized as spiritual (Matise et al. 2017). Accordingly, patients seeking clinical care have experiences or beliefs related to spirituality or religion that may help or hinder their health, next to the fact that (mental) suffering irrevocably leads to existential questions and concerns (Hoenders and Braam 2020). Therefore, clinicians should be equipped to address these issues within the psychotherapeutic context (Gladding and Crockett 2019).

In studying this and thinking about what clinicians in the Netherlands would need to apply spiritual care, we noticed that a validated Dutch questionnaire to assess spiritual care competencies, which can also be used in research, is currently missing. The Spiritual Care Competence Scale (Van Leeuwen et al. 2009) is an instrument to assess nursing competencies in spiritual care and was validated among nursing students, but it is not designed to apply to multiple healthcare professions. The aim of this study was to translate and validate in Dutch another questionnaire, the Spiritual Care Competence Questionnaire (SCCQ, Frick et al. 2019), that can be used for different professions and working fields in healthcare and was thus validated in a sample of different healthcare professionals. The SCCQ was developed to assess the multi-professional, self-perceived, spiritual care competencies of healthcare professionals and care teams in a clinical context, and to be used in the planning and evaluation of spiritual care competence training. An advantage of the SCCQ is its ability to address the complexity of spirituality and religiosity in contemporary secular societies (Frick et al. 2019), so the instrument seems ideal for the Dutch situation. We will explore whether the underlying factor structure is the same in the Dutch sample as in the initial German sample. The SCCQ has already been validated in German (Frick et al. 2019), French (Neves Oliviera 2019), Norwegian (Mandelkow et al. 2022), Spanish (Pastrana et al. 2021) and Japanese (Shimizu et al. 2023). An additional objective is to explore which areas of spiritual care mental healthcare professionals feel they lack competence in and what hindrances they experience in providing spiritual care themselves.

2. Materials and Methods

2.1. Study Design

A cross-sectional study was performed among healthcare professionals in two mental healthcare institutions (MHIs): Lentis (in 2022) in the north and Altrecht (in 2023) in the middle of the Netherlands. The Medical Ethics Review Board (METc) of the University Medical Center Groningen (UMCG) concluded that the protocol did not fall within the scope of the Medical Research Involving Human Subjects Act (WMO) and registered it under research number 202100533.

2.2. Participants' Selection

Participants were recruited using a convenience sampling method. In both MHIs, the email addresses of all the professionals (N = 3497) who work directly with patients in a therapeutic context (i.e., psychiatrists, psychotherapists, nurses, residential supervisors, psychomotor therapists, etc.) were provided to the first author by the human resources department after gaining permission from the board of directors. Participants worked at both inpatient and outpatient clinical settings for the treatment of mild-to-severe mental health problems. They received an invitation email to participate in the study with a link to the informed consent form and online survey. In the following four weeks, they received two reminder emails if they had not yet started or completed the questionnaire. For the online survey, Medoq by RoQua was used. RoQua, part of the UMCG, developed a system for routine outcome measurement among patients (see: www.roqua.nl, accessed on 1 September 2020), but also offers Medoq, an online research tool for data collection in non-UMCG-related populations. Data were pseudonymized during data collection.

2.3. Measures

2.3.1. Spiritual Care Competence Questionnaire

The primarily 26-item Spiritual Care Competence Questionnaire (SCCQ) is scored with a 4-point Likert scale (0—strongly disagree, 1—disagree, 2—agree, 3—strongly agree). In the original German version, the SCCQ identifies seven factors: (1) perception of spiritual needs [5 items; Cronbach's alpha = 0.82]; (2) team spirit [5 items; Cronbach's alpha = 0.81]; (3) documentation competencies [3 items; Cronbach's alpha = 0.84]; (4) spiritual self-awareness competencies [5 items; Cronbach's alpha = 0.83]; (5) knowledge about other religions [2 items; Cronbach's alpha = 0.73]; (6) interviewing competencies [2 items; Cron-

bach's alpha = 0.86]; and (7) empowerment competencies [4 items; Cronbach's alpha = 0.79] (Frick et al. 2019).

The SCCQ also has additional items that can be used as explanatory variables, of which four items address barriers to spiritual care (44. My knowledge about religion/spirituality is too poor for me to get involved in a competent manner; 46. I do not have time for religious/spiritual topics; 47. No suitable room is available for talking privately about religious/spiritual topics; and 45. I do not perceive myself as an appropriate person for religious/spiritual topics). These are originally grouped into an additional scale (hindrances, Cronbach's alpha = 0.72) in the initial SCCQ, but do not represent competencies and were therefore not included in the factor analysis (Frick et al. 2019).

2.3.2. Additional Variables

Additional items were used for correlational analyses and comparisons between groups for the purpose of gaining more insight into the distribution of SCCQ-NL scores in the sample. In addition to generic sociodemographic data (gender, age, marital status), items about participants' professions and areas of work, years of employment, working hours per week, and their professional satisfaction were assessed (5-point Likert scale: 4—very satisfied, 3—satisfied, 2—more or less satisfied, 1—not satisfied, 0—very unsatisfied). Two other items addressed religious affiliation (Christianity, Judaism, Islam, Hinduism, Buddhism, other) and whether participants regard themselves as an (actively) believing person (3—yes, indeed, 2—yes, somehow, 1—rather not, 0— not at all). Finally, respondents were asked if, and how often, they meditated or prayed (3—yes, on a regular basis; 2—occasionally, 1—rather rarely, 0—not at all).

2.3.3. Translation

The original German-language questionnaire was translated into Dutch by the first and second authors (forward translation), with the second author being experienced in translating German research instruments into Dutch. Next, the questionnaire was translated back into German (backward translation) by a native speaker with a master's degree in German literature who has been living in the Netherlands for 21 years and is therefore bilingual. To ensure accuracy, the translation was reviewed by the two SCCQ developers and the principal investigator, and any inconsistencies were discussed and adjusted by the Dutch researchers. In a pilot study, the translated version was proofread and filled in by 10 healthcare psychologists who were in training to become licensed clinical psychologists. This led to some final adjustments which were reviewed by all researchers for the last time.

2.3.4. Extra Care for Meaning Competence Items

In MHI 2, we added six items apart from the SCCQ-NL. Three items were derived from the Spiritual Care Competence Scale (SCCS) (Van Leeuwen et al. 2009), and three other items were derived from the Spiritual and Religious Competencies in Clinical Practice (Vieten and Scammell 2015) and translated into Dutch by De Bruijn (2020). The SCCS was originally developed to measure six core domains of spiritual care-related nursing and was validated among nursing students, with Cronbach's alpha ranging from 0.56 to 0.82 (Van Leeuwen et al. 2009). The Spiritual and Religious Competencies in Clinical Practice are research-based guidelines to help mental healthcare professionals to ethically and effectively address R/S issues in a clinical setting (Vieten and Scammell 2015). These six items were used in an unpublished preliminary study by Van den Bent et al. (2022). In their study, the six selected items were translated, adjusted, and (partly) used to measure spiritual care competence among a diverse group of mental healthcare professionals (psychiatrists, psychologists, nurses, and others). The main adjustment they made to the items was replacing "spirituality" with "search for meaning", a concept that is supposed to overlap with spirituality (Hoenders and Braam 2020). This resulted in the following items: 1. I am aware how my own background and beliefs can influence my professional attitude, perception and assumptions when dealing with patients about meaning; 2. I can

recognize questions about meaning and address them accordingly; 3. When confronted with questions about meaning, I adopt an unbiased attitude, without instantly trying to find answers; 4. I know there is a wide variety in meaning, with both positive and negative properties; 5. I recognize my personal limitations when discussing questions of meaning; 6. I can effectively assign care for meaning to another caretaker (i.e., healthcare chaplain, social worker). In the initial study by Van den Bent et al., the six items were considered as one scale, demonstrating good internal consistency (Cronbach's alpha = 0.81). For the current study, these provisional items will be referred to as the Care for Meaning Competence construct, which will be compared to the SCCQ factors to see if it can contribute to the construct validity of the SCCQ-NL.

2.4. Statistical Analyses

Analyses were conducted with IBM SPSS Statistics for Windows, version 28.0.1. Analyses consisted of descriptive statistics and internal consistency analyses (Cronbach's alpha). For exploratory factor analysis and confirmatory factor analysis, the sample was randomly split into two subsamples. Principal component analysis (PCA) with oblimin rotation and Kaiser's normalization was used on the first subsample (N = 368), with 0.4 as a cut-off for factor loadings (Stevens 1992). Monte Carlo PCA for parallel analysis was used as an additional step to exploratory factor analysis (Watkins 2005). For the identification of possible factor structures in the data, we chose to run a PCA because this method captures the variance in the data without assuming any underlying structure, which was our initial goal, in contrast to factor analysis (FA), which aims to uncover latent factors that explain the covariance structure among variables. Furthermore, we decided to rotate the analysis using oblimin rotation, since this technique enables a simple and more interpretable structure as it also allows the derived components to be correlated with each other, which can better reflect the underlying structure of the data.

Confirmatory factor analysis was performed on the second subsample (N = 362) with R version 4.3.1 and the Lavaan package (Rosseel 2012) to confirm the best model fit, based on the following fit statistics: root mean square error of approximation (RMSEA), standardized root mean square residual (SRMR), comparative fit index (CFI) and Tucker–Lewis index (TLI). The thresholds for a good fit were CFI and TLI > 0.95, SRMR < 0.07, and RMSEA < 0.05.

First-order correlations were calculated using Spearman's rho. Correlations with $r > 0.5$ were considered strong, those with r between 0.3 and 0.5 were considered moderate correlations, those with r between 0.1 and 0.3 were considered weak correlations, and those with $r < 0.1$ were considered negligible or to have no correlation (Cohen 1988). With independent-samples t-tests and one-way ANOVA, comparisons between groups were made for SCCQ-NL scores. In some cases, differences between groups were analyzed with a Welch test following ANOVA, after Levene's test showed a violation of the assumption of equal variances for ANOVA. The significance level was set at $p < 0.05$ (two-tailed). For effect sizes, we used Cohen's d and eta-squared. Cohen's $d = 0.2$ was regarded as a small effect, Cohen's $d = 0.5$ a medium effect, and Cohen's $d = 0.8$ a large effect. For eta-squared, we used 0.01 = small effect, 0.06 = moderate effect, and 0.14 = large effect (Cohen 1988). Two of the independent variables were dichotomized to facilitate group comparisons. The item "I am an (actively) believing person" was dichotomized in believers (3—yes, indeed, and 2—yes, somehow) and non-believers (1—rather not and 0—not at all). The item "I pray or meditate" was dichotomized in practicing prayer/meditation (3—yes, on a regular basis; 2—occasionally) and not practicing prayer/meditation (1—rather rarely, 0—not at all). Also, three age groups were formed based on visual binning, with each group containing 33.3% of the sample, ascending in age.

3. Results

3.1. Demographics

Of the 833 healthcare professionals who gave their consent and started the questionnaire (response rate = 23.8%), 730 fully completed the survey (completer rate = 87.6%). In Table 1 is shown that 72.6% of the respondents were female (N = 530), 27% male (N = 197), and 0.4% mentioned "other" or did not want to provide an answer for gender (N = 3). The mean age was 44.6 years (SD = 12.3) ranging from 21 to 78 years. Most respondents worked in the field of psychiatry (95.5%) and were nurses (39.2%); psychologists, including psychotherapists (26.9%); physicians, including psychiatrists (10.5%); (creative/psychomotor) therapists (4.5%); or "other" (18.9%). Participants worked on average 30.1 h per week (SD 5.5) and worked 17.3 years in this profession/field (SD 12.0). Job satisfaction was high with a mean score of 4.2 (SD 0.6) on a five-point scale. The participants' religious affiliation was predominantly Christian (23.3%), followed by an affiliation described as other (12.1%) than the five world religions Judaism, Islam, Hinduism, and Buddhism, which were reported, respectively, by 0.1%, 0.4%, 1.0%, and 1.1% of respondents. Answers in the group "other" were very diverse. Respondents added, for example, the following: humanistic, pagan, Jehova's witness, "I believe in love", "I believe in the source", etc. The largest group, (62.1%), however, reported having no religious affiliation. Only 25.8% answered that they were a believing person (yes, somewhat; yes, indeed), while 47.7% of respondents prayed or meditated (yes, sometimes, and yes, regularly). There were no significant differences in demographic variables between the two MHIs, except for profession (X^2 (4, n = 730) = 34.30, $p \leq 0.001$).

Table 1. Demographic variables and characteristics of participants.

	Lentis (N = 338)	**Altrecht (N = 392)**	**Total (N = 730)**
Variable	%/mean ± SD	%/mean ± SD	%/mean ± SD
Gender (%) [1]			
Women	76.0	69.6	72.6
Men	23.4	30.1	27.0
Other	0.3	0.3	0.3
Prefer not to answer	0.3	-	0.1
Mean age (years)	44.6 ± 12.2	44.6 ± 12.4	44.6 ± 12.3
Marital status (%)			
Married	45.0	45.4	45.2
Unmarried, living together	29.0	29.3	29.2
Divorced	7.4	5.6	6.4
Single	13.3	15.8	14.7
Widowed	0.6	-	0.3
Other	4.7	3.8	4.2
Work experience (years)	18.0 ± 11.9	16.8 ± 12.0	17.3 ± 12.0
Weekly working time (hours)	30.3 ± 5.4	31.0 ± 5.5	30.1 ± 5.5
Profession (%)			
Physician	5.0	15.3	10.5
Nurse	47.6	32.1	39.3
Psychologist	23.4	29.8	26.8
Therapist (i.e., creative or psychomotor)	3.6	5.4	4.5
Other	20.4	17.4	18.9

Table 1. *Cont.*

	Lentis (N = 338)	Altrecht (N = 392)	Total (N = 730)
Discipline (%)			
Internal medicine	0.3	-	0.1
Geriatrics	1.8	0.3	1.0
Psychiatry/psychotherapy	94.7	96.2	95.5
Other	3.3	3.6	3.4
Job satisfaction (1–5)	4.1 ± 0.6	4.2 ± 0.6	4.2 ± 0.6
Religious affiliation (%)			
Christianity	21.9	24.7	23.4
Judaism	0	0.3	0.1
Islam	0.6	1.3	1.0
Hinduism	0.3	0.5	0.4
Buddhism	0.6	1.5	1.1
Other	12.7	11.2	12.1
None	63.9	60.5	62.1
Believing person (%)			
Not at all/rather not	73.4	75.0	74.2
Yes, somewhat/yes, indeed	26.6	25.0	25.8
Praying and/or meditating (%)			
No, not at all/rarely	50.9	53.6	52.3
Sometimes/yes, regularly	49.1	46.4	47.7

[1] Sub headings are presented in italics.

3.2. Factor Analysis

3.2.1. Exploratory Factor Analysis

The internal consistency of the 26 items was good (Cronbach's alpha = 0.88). With principal components analysis (PCA) with oblimin rotation and Kaiser normalization on the first subsample, a Kaiser–Meyer–Olkin value of 0.85 was found, exceeding the required value of 0.6 (Kaiser 1970, 1974 as cited in Pallant 2020, p. 208). Also, Bartlett's (1954) test of sphericity was significant ($p < 0.000$). Both parameters indicated that the item set was suitable for factor analysis.

A PCA was performed two times. The first PCA revealed seven factors with eigenvalues > 1.0, which were almost identical to the factors in the initial German sample and explained 61.3% of the variance. Items 42 ("I regularly approach patients to talk with them about their spiritual needs) and 43 ("I open verbally, but also nonverbally, a "space" in which the patient may bring spiritual concerns—but is not forced to do so") loaded on the factor of empowerment competence, instead of their original factor of spiritual self-awareness, and were redistributed accordingly, thus creating the factor empowerment and proactive opening competencies. Item 28 ("I am able to tolerate the pain/suffering of patients and their relatives") was deleted because, even though the factor loading of the item was good (0.59), the item did not load on its original factor but on conversation competencies. Also, item 28 seemed to measure a different construct to the other items in this factor (corrected item–total correlation < 0.3). Finally, the internal consistency of the factor increased substantially after deleting the item: Cronbach's alpha = 0.74 if the item was deleted, compared to 0.64 when the item was kept. The internal consistency of the seven factors was moderate (Cronbach's alpha = 0.64 for documentation competencies) to good (Cronbach's alpha = 0.81 for perception of spiritual needs) (Table 2).

However, the scree plot was inconclusive about the optimal number of factors. Additional parallel analysis revealed five factors with initial eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size (26 variables × 368 respondents), thus indicating that a five-factor model would best fit the data.

Table 2. Factorial structure of the 25 items of the SCCQ-NL.

	Mean [0–3]	Corrected Item-Scale Correlation	Cronbach's α if Item Deleted	Factor Loading						
				1	2	3	4	5	6	7
Factor 1. Perception of spiritual needs (eigenvalue 6.7, Cronbach's alpha = 0.810) [1]										
1. I am confident I can perceive the spiritual needs of patients	2.02 ± 0.60	0.636	0.764	0.697						
2. I am confident I can perceive the spiritual needs of patients' relatives	1.96 ± 0.66	0.589	0.780	0.664						
7. I am able to perceive existential/spiritual needs even if patients have little relation to religion	1.69 ± 0.77	0.665	0.744	0.594						
8. I can also talk with nonreligious patients about their existential/spiritual needs	1.88 ± 0.80	0.643	0.757	0.536						
Factor 2. Team spirit (eigenvalue 2.2, Cronbach's alpha = 0.753)										
14. In the team, we exchange regularly about spirituality in patient support	0.93 ± 0.71	0.687	0.654		0.806					
12. In our team, we speak regularly about patient's spiritual needs	0.90 ± 0.74	0.630	0.671		0.733					
13. In our institution there is a great openness to the topic of spirituality	1.40 ± 0.73	0.531	0.706		0.733					
15. In the team, we regularly exchange about our own spirituality	0.92 ± 0.75	0.515	0.711		0.655					
17. In the team, we have rituals (for example farewell and interruption rituals) to deal with problematic situations	1.10 ± 0.97	0.324	0.801		0.500					
Factor 3. Spiritual self-awareness (eigenvalue 1.9, Cronbach's alpha = 0.756)										
48. I regularly take care of deepening my own spirituality	1.23 ± 1.12	0.685	0.552			−0.862				
49. I regularly attend professional development sessions on spiritual topics	0.53 ± 0.88	0.570	0.700			−0.786				
30. My own spirituality shapes my dealings with others/sick people	1.50 ± 1.01	0.527	0.740			−0.711				
Factor 4. Documentation competencies (eigenvalue 1.5, Cronbach's alpha = 0.644)										
3. I am familiar with instruments (e.g., FICA, HOPE, ELMO) for creating a short spiritual history	0.14 ± 0.43	0.563	0.485				0.855			
4. I am familiar with instruments/questionnaires for structurally assessing spiritual needs	0.17 ± 0.47	0.559	0.463				0.842			
5. I know how to document the spiritual history of my patients in a comprehensible way	0.75 ± 0.83	0.407	0.797				0.597			
Factor 5. Empowerment and proactive opening competencies (eigenvalue 1.5, Cronbach's alpha = 0.731)										
25. In the case of therapeutic decisions, I pay attention to religious/spiritual attitudes and convictions of the individual patient	1.99 ± 0.77	0.518	0.681					0.713		
35. I pay attention to the appropriate framework for spiritual conversations	1.21 ± 0.87	0.536	0.673					0.635		
26. I encourage my patients to reflect their spiritual beliefs and attitudes	1.74 ± 0.80	0.531	0.676					0.597		
24. I enable my patients to participate in religious activities/celebrations	1.85 ± 1.08	0.322	0.751					0.518		
42. I regularly approach patients to talk with them about their spiritual needs	1.09 ± 0.77	0.478	0.692					0.429		
43. I open verbally, but also nonverbally, a "space" in which the patient may bring spiritual concerns—but is not forced to do so	1.73 ± 0.84	0.478	0.690					0.406		
Factor 6. Knowledge about other religions (eigenvalue 1.1, Cronbach's alpha = 0.744)										
38. I am well aware of the religious characteristics of patients from other religious communities	1.73 ± 0.66	0.592	NA						0.850	
39. I take care that the religious characteristics of patients from other religious communities are adequately considered	1.88 ± 0.66	0.592	NA						0.840	
Factor 7. Conversation competencies (eigenvalue 1.0, Cronbach's alpha = 0.735)										
19. I am able to conduct an open discussion on existential issues	2.46 ± 0.60	0.572	0.361							0.826
20. I am able to conduct an open discussion on religious issues	2.43 ± 0.59	0.513	0.455							0.796
Deleted item										
28. I am able to tolerate the pain/suffering of patients and their relatives	2.55 ± 0.53	0.292	0.735							

[1] Factor labels are presented in bold.

In a second PCA with oblimin rotation for the primary 26 items, factor analysis was repeated on the first subsample with a fixed number of five extractable factors. Item 28 was again removed due to it not fitting the other items in the assigned factor (corrected item–total correlation < 0.3). Item 43 ("I open verbally, but also nonverbally, a "space" in which the patient may bring spiritual concerns—but is not forced to do so") was deleted as a result of a low factor loading. The remaining 24-item model revealed five factors, explaining 53.0% of the variance. In the first factor, the items of the primary German SCCQ factors perception of spiritual needs and conversation competencies were combined in one factor. Items in factors 2, 3, and 4 corresponded with the initial SCCQ factors team spirit, spiritual self-awareness and proactive opening competencies, and documentation competencies, respectively. As in the first factor, the fifth factor also combined items of two initial factors, namely empowerment competencies and knowledge about other religions. Internal consistency scores were moderate to good, with Cronbach's alpha ranging from 0.64 to 0.76.

Additionally, in the seven-factor as well as five-factor model, the reliability score for documentation competencies exceeded the critical value of 0.6 for Cronbach's alpha, but a value higher than 0.7 is preferred. Deleting item 5 would substantially increase the reliability score of documentation competencies (Cronbach's alpha if item deleted = 0.796), but the item loading was good (>0.5), and inter-item correlations were above the required value of 0.3 (El Hajjar 2018). Inspection of the content of the items in documentation competencies showed that item 5 measures knowledge about documenting the spiritual history, while items 3 and 4 measure knowledge about assessment tools for spiritual history taking. Both are important aspects of documentation competencies, so item 5 was kept for content reasons.

For the factorial structure of the seven-factor model, see Table 2. The factorial structure of the five-factor model can be requested from the researchers.

3.2.2. Confirmatory Factor Analysis

Since exploratory factor analysis yielded two models, which both showed a substantial overlap with the original German seven-factor SCCQ, confirmatory factor analysis (CFA) was performed on the second subsample (N = 362) to confirm the best model fit, after the adequacy of the second subsample for CFA was statistically confirmed (Bartlett's test $p < 0.001$, KMO-value = 0.85).

The CFA showed a superior fit for the seven-factor model (CFI = 0.988, TLI = 0.986, RMSEA = 0.047, and SRMR = 0.067) compared to the five-factor model (CFI = 0.959, TLI = 0.953, RMSEA = 0.086, and SRMR = 0.087); see Figure 1. The seven-factor model was therefore used in further analyses.

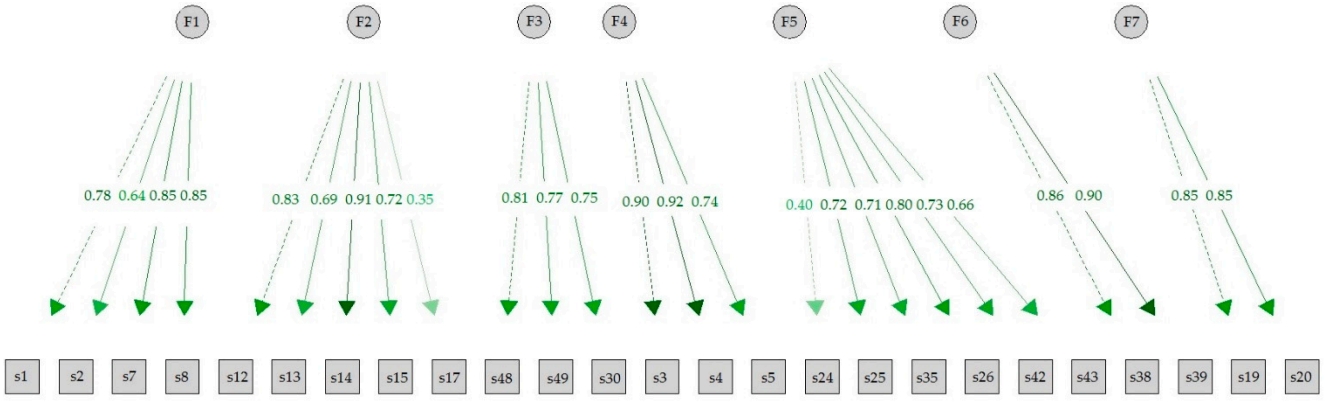

Figure 1. Outcome of confirmatory factor analysis on the second subsample (N = 362). Factor loadings are displayed with one-directional arrows from factors to variables.

Strong correlations (i.e., $r \geq 0.5$) were found within the subsample for factor 1 with factor 3 ($r_{F1,F3)} = 0.51$), factor 5 ($r_{F1,F5} = 0.73$), and factor 7 ($r_{F1,F7} = 0.65$). Factor 2 correlated strongly with factor 4 ($r_{F2,F4} = 0.50$) and factor 5 ($r_{F2,F5} = 0.58$). Factor 3 showed a strong correlation with factor 5 ($r_{F3,F5} = 0.57$). Finally, factor 5 correlated strongly with factor 6 ($r_{F5,F6} = 0.68$) and factor 7 ($r_{F5,F7} = 0.56$).

3.3. Distribution of the SCCQ-NL Scores in the Sample

The highest-scoring item was item 19 ("I am able to conduct an open discussion on existential issues"), followed by item 20 ("I am able to conduct an open discussion on religious issues"), which are the conversation competencies items. The lowest-scoring items belonged to the documentation competencies factor, with the lowest being item 3 ("I am familiar with instruments (e.g., FICA, HOPE, ELMO) for creating a short spiritual history"). The factors that scored highest were conversation competencies and perception competencies, followed by knowledge about other religions, empowerment competencies, spiritual self-awareness, and finally team spirit and documentation competencies (see Table 3).

Respondents in MHI 2 scored significantly higher than those in MHI 1 on both team spirit and knowledge about other religions, but with small effect sizes (Cohen's $d = -0.20$ and -0.33, respectively).

ANOVA showed no gender-related differences in SCCQ-NL scores. However, ANOVA was significant for age for all SCCQ-NL factors, except for conversation competencies. Post hoc comparisons showed that perception competencies and spiritual self-awareness were higher in the older participants compared to the younger ones. Also, the youngest respondents (i.e., $\leq$37 years) scored significantly lower on team spirit and empowerment competencies compared to older respondents (38 years and older). Respondents under age 53 scored significantly lower on knowledge about other religions. The effect sizes were significant but small for team spirit, knowledge about other religions, and empowerment competencies ($Eta^2 = 0.02$, 0.02, and 0.03, respectively), and medium for spiritual self-awareness and perception of spiritual needs ($Eta^2 = 0.05$ and 0.07, respectively).

There were also significant differences between professions in most of the SCCQ-NL factors, but effect sizes were small, with the eta-squared ranging from 0.01 to 0.04. Psychologists scored significantly lower on perception competencies compared to physicians (including psychiatrists), nurses, and the "other" group, and significantly lower on team spirit than physicians/psychiatrists. Also, psychologists scored significantly lower than nurses, creative/psychomotor therapists, and the "other" group on spiritual self-awareness. Furthermore, psychologists scored significantly lower on empowerment and proactive opening competencies compared to nurses, and lower on knowledge about other religions compared to nurses and the "other" group. For documentation competencies, the mean score for creative/psychomotor therapists was significantly lower than for physicians/psychiatrists, and for nurses.

Finally, respondents who identified themselves as believers scored significantly higher on perception of spiritual needs, spiritual self-awareness, empowerment competencies, knowledge about other religions, and conversation competencies. The effect sizes were small for empowerment competencies, knowledge, and conversation competencies (Cohen's $d = 0.3$, 0.3, and 0.4, respectively), medium for perception competencies (Cohen's $d = 0.5$), and substantially large for spiritual self-awareness (Cohen's $d = 1.3$). Respondents who practiced prayer/meditation also scored higher on these competencies than those who did not, except for knowledge about other religions, with small effect sizes for empowerment competencies and conversation competencies (Cohen's $d = 0.3$ for both) and a very large effect size for spiritual self-awareness (Cohen's $d = 1.7$) (Table 3).

Table 3. SCCQ-NL and hindrance item scores and differences for MHI, age, profession, believers/non-believers, practicing/not practicing prayer/meditation.

		Perception	Team Spirit	Spiritual Self-Awareness	Documentation	Empowerment	Knowledge Religions	Conversation	Hindrance Items			
									44. Knowledge	45. Responsible	46. Time	47. Space
All (N = 730)	Mean	2.07	1.03	1.14	0.34	1.61	1.80	2.42	1.40	1.06	0.92	0.62
	SD	0.49	0.56	0.80	0.45	0.57	0.63	0.55	0.89	0.85	0.82	0.81
Institution												
MHI 1 (N = 338)	Mean	1.87	0.97	1.17	0.31	1.57	1.69	2.44	1.46	0.99	0.86	0.65
	SD	0.56	0.57	0.83	0.43	0.61	0.64	0.53	0.88	0.83	0.81	0.86
MHI 2 (N= 392)	Mean	1.92	1.08	1.12	0.36	1.65	1.898	2.51	1.35	1.11	0.97	0.59
	SD	0.58	0.54	0.79	0.46	0.54	0.60	0.59	0.90	0.86	0.83	0.78
F value		0.01	**3.89**	0.84	0.89	5.89	**7.61**	1.59	0.52	4.599	0.41	3.39
p-value		n.s.	**0.007**	n.s.	n.s.	n.s.	**<0.001**	n.s.	n.s.	n.s.	n.s.	n.s.
Age												
21–37 (N = 249)	Mean	1.71	0.91	0.92	0.28	1.48	1.69	2.43	1.55	1.20	0.99	0.59
	SD	0.55	0.49	0.73	0.36	0.53	0.61	0.53	0.87	0.84	0.83	0.799
38–52 (N = 248)	Mean	1.89	1.07	1.17	0.36	1.66	1.82	2.39	1.36	0.97	0.87	0.58
	SD	0.56	0.57	0.78	0.47	0.58	0.59	0.55	0.89	0.799	0.82	0.79
>53 (N = 233)	Mean	2.09	1.10	1.36	0.37	1.699	1.91	2.46	1.27	1.00	0.89	0.69
	SD	0.54	0.595	0.84	0.498	0.58	0.67	0.56	0.89	0.89	0.82	0.85
F value		**28.7**	**8.6**	**19.3**	**3.61** [a]	**10.98**	**7.4**	0.77	**10.25**	**7.598**	2.16	1.77
p-value		**<0.001**	**<0.001**	**<0.001**	**0.03**	**<0.001**	**<0.001**	n.s.	**0.001**	**0.005**	n.s.	n.s.
Profession												
Physician/psychiatrist (N = 77)	Mean	1.94	1.14	1.14	0.394	1.60	1.79	2.42	1.16	1.09	1.14	0.43
	SD	0.51	0.54	0.76	0.52	0.51	0.65	0.51	0.92	0.85	0.87	0.72
Nurse (N = 287)	Mean	1.94	1.05	1.17	0.36	1.68	1.85	2.38	1.40	0.89	0.86	0.77
	SD	0.55	0.54	0.79	0.49	0.55	0.60	0.57	0.91	0.81	0.82	0.85
Psychologist (N = 196)	Mean	1.72	0.91	0.94	0.31	1.53	1.69	2.45	1.55	1.22	0.98	0.47
	SD	0.595	0.53	0.71	0.36	0.57	0.59	0.50	0.82	0.83	0.79	0.79
Therapist (creative/psychomotor) (N = 33)	Mean	2.00	1.10	1.495	0.13	1.59	1.68	2.47	1.39	1.27	0.79	0.52
	SD	0.55	0.52	0.71	0.24	0.42	0.54	0.499	0.86	0.91	0.78	0.71
Other (N = 137)	Mean	2.01	1.06	1.299	0.35	1.61	1.90	2.49	1.30	1.09	0.85	0.66
	SD	0.57	0.64	0.93	0.43	0.66	0.72	0.59	0.90	0.88	0.83	0.79
F value		**6.79**	**3.36** [a]	**7.00** [a]	**6.16** [a]	2.05 [a]	**3.36**	1.16	**3.35**	**5.26**	**2.51**	**5.43**
p-value		**<0.001**	**0.01**	**<0.001**	**<0.001**	n.s.	**0.01**	n.s.	**0.01**	**<0.001**	**0.04**	**<0.001**

Table 3. *Cont.*

		Perception	Team Spirit	Spiritual Self-Awareness	Documentation	Empowerment	Knowledge Religions	Conversation	Hindrance Items			
									44. Knowledge	45. Responsible	46. Time	47. Space
"I am an (active) believing person"												
Believers (N = 188)	Mean	2.11	1.08	1.82	0.37	1.72	1.93	2.56	0.96	0.77	0.83	0.69
	SD	0.54	0.58	0.69	0.49	0.59	0.64	0.52	0.83	0.82	0.81	0.82
Non-believers (N = 542)	Mean	1.82	1.01	0.91	0.33	1.57	1.76	2.38	1.55	1.15	0.95	0.59
	SD	0.56	0.55	0.71	0.43	0.56	0.62	0.55	0.86	0.84	0.83	0.81
F value		**0.07**	0.68	**0.77**	3.196	**0.36**	**0.02**	**0.59**	**4.86**	**0.43**	0.84	0.03
p-value		**<0.001**	n.s.	**<0.001**	n.s.	**0.002**	**0.002**	**<0.001**	**<0.001**	**<0.001**	n.s.	n.s.
"I pray or meditate"												
Practicing prayer/meditation (N = 348)	Mean	2.02	1.05	1.67	0.37	1.696	1.85	2.51	1.20	0.93	0.91	0.68
	SD	0.55	0.58	0.69	0.48	0.58	0.61	0.54	0.86	0.84	0.84	0.83
Not practicing prayer/meditation (N = 382)	Mean	1.79	1.00	0.67	0.31	1.53	1.76	2.35	1.58	1.18	0.92	0.57
	SD	0.57	0.54	0.58	0.41	0.55	0.64	0.55	0.88	0.84	0.80	0.79
F value		**1.05**	2.52	**5.896**	3.32	**0.02**	1.07	**1.46**	**0.58**	**0.41**	4.56	1.57
p-value		**<0.001**	n.s.	**<0.001**	n.s.	**<0.001**	n.s.	**<0.001**	**<0.001**	**<0.001**	n.s.	n.s.

[a] based on Welch test for profession, because Levene's test showed violation of the assumption of equal variances for ANOVA. Significant differences are highlighted (bold). n.s.—not significant.

3.4. Hindrances

Internal consistency for the non-competence hindrances scale was not sufficient in this Dutch sample (Cronbach's alpha = 0.51), which did not improve if any of the four items were deleted. Instead of using it as a scale, the items were used separately to assess four aspects of hindrances that respondents can experience in providing spiritual care. Table 3 also shows item scores and comparisons between groups for the hindrance items. The item that scored the highest (i.e., areas in which respondents experience being hindered the most) was 44 ("My knowledge about religion/spirituality is too poor to get involved in a competent manner"), followed by 45 ("I do not perceive myself as an appropriate person for religious/spiritual subjects"). Items 46 ("I do not have time for religious/spiritual topics") and 47 ("No suitable room is available for talking privately about religious/spiritual subjects") scored the lowest.

There were no significant differences in the hindrance item scores between MHI 1 and MHI 2. Women (M = 1.46, SD = 0.88) experienced a lack of knowledge about religion/spirituality more than men (M = 1.22, SD = 0.89; $t(725) = 3.27$, $p = 0.001$), but the effect size was small (eta-squared: 0.01). ANOVA showed that younger respondents ($\leq$37) scored significantly higher for lack of knowledge and not feeling responsible/the appropriate person for spiritual care than the 38–52 and 53-years-and-older age groups, but the effect sizes were small ($Eta^2 = 0.10$ and 0.02, respectively). There were also significant but small (Eta^2 ranging from 0.01 to 0.03) differences between professions for all four items. Psychologists experienced, more than physicians (and psychiatrists), the feeling that they lacked knowledge about spirituality and religion to contribute competently Also, psychologists felt significantly less responsible than nurses to talk about spiritual and religious topics. Finally, nurses experienced significantly more than physicians and psychologists that they lacked an appropriate room to talk about religious/spiritual topics.

An independent-sample *t*-test was also performed for respondents who identified as believers versus non-believers and respondents practicing prayer/meditation versus not practicing prayer/meditation. Non-believers scored significantly higher on lacking knowledge to competently attribute (item 44) than believers. The same was found for not feeling responsible and not being the appropriate person to talk about religious/spiritual topics (item 45). Non-believers scored significantly higher on this hindrance item than believers, with both items having medium effect sizes (Cohen's $d = -0.5$ and -0.7, respectively). This difference was also found for those who did not practice prayer/meditation, who scored significantly higher on the lack of knowledge item (44) than respondents who practiced prayer/meditation. Also, those who did not practice prayer/meditation scored significantly higher on not feeling responsible and not being the appropriate person to talk about religious/spiritual topics (item 45), but the effect sizes were small (Cohen's $d = -0.4$ and -0.3, respectively).

Self-perceived competence on the SCCQ-NL was negatively and significantly correlated with hindrance items 44, 45, and 46, measuring lack of knowledge, not feeling responsible or the appropriate person for religious/spiritual topics, and not having time to talk about religious/spiritual topics, respectively. Item 47 ("no suitable room is available to talk about spiritual/religious topics") correlated with spiritual self-awareness and conversation competencies (Table 4).

Table 4. Correlation analysis for SCCQ-NL factors and hindrance items.

	44. My Knowledge [. . .]	**45. I Do Not Perceive Myself as [. . .]**	**46. I Do Not Have Time [. . .]**	**47. No Suitable Room [. . .]**
44. My knowledge about religion/spirituality is too poor to get involved in a competent manner	1.000			
45. I do not perceive myself as an appropriate person for religious/spiritual topics	0.288 **	1.000		
46. I do not have time for religious/spiritual topics	0.226 **	0.277 **	1.000	
47. No suitable room is available for talking privately about religious/spiritual topics	0.096 **	0.070	**0.311 ** **	1.000
Perception competencies	**−0.488 ** **	−0.268 **	−0.195 **	−0.012
Team spirit	−0.205 **	−0.146 **	−0.121 **	−0.023
Spiritual self-awareness	**−0.358 ** **	**−0.312 ** **	−0.103 **	0.094
Documentation competencies	−0.208 **	−0.149 **	−0.114 **	−0.037
Empowerment and proactive opening competencies	**−0.390 ** **	**−0.302 ** **	−0.163 **	−0.010
Knowledge about other religions	**−0.340 ** **	−0.178 **	−0.129 **	−0.033
Conversation competencies	**−0.346 ** **	−0.165 **	−0.202 **	−0.107 **

** Spearman's rho is significant at the $p = 0.01$ level; moderate correlations are highlighted (bold).

3.5. Correlation of the SCCQ-NL Factors with Other Variables

3.5.1. Extra Care for Meaning Competence Items

The six Care for Meaning Competence (CMC) items were only presented to the MHI 2 sample. Of 392 SCCQ-NL completers in MHI 2, 381 (97%) also filled in the CMC items. As in the unpublished Dutch study by Van den Bent et al. (2022), the items had sufficient internal consistency to pass for one scale (Cronbach's alpha = 0.72). The item scores ranged from 2 to 5; the mean score for the CMC scale for the MHI 2 sample was 4.01 with a standard deviation of 0.55. All seven SCCQ-NL factors correlated positively and significantly with the CMC scale, as with the other SCCQ-NL scales, with weak-to-strong correlations (Table 5).

Table 5. Correlation analysis of SCCQ-NL subscales with CMC items and work variables.

	Perception	**Team Spirit**	**Self-Awareness**	**Documentation**	**Empowerment**	**Knowledge Religions**	**Conversation**
Perception competencies	1.000						
Team spirit	**0.332 *****	1.000					
Spiritual self-awareness	**0.383 *****	0.184 ***	1.000				
Documentation competencies	0.292 ***	0.298 ***	0.126 ***	1.000			
Empowerment competencies	**0.524 *****	**0.423 *****	**0.335 *****	**0.344 *****	1.000		
Knowledge about other religions	**0.357 *****	0.233 ***	0.167 ***	0.157 ***	**0.461 *****	1.000	
Conversation competencies	**0.471 *****	0.155 ***	0.218 ***	0.159 ***	**0.370 *****	0.277 ***	1.000
Care for Meaning Competence (CMC) [a]	**0.527 *****	0.221 ***	0.179 ***	0.218 ***	**0.472 *****	**0.473 *****	**0.458 *****
Working hours	0.014	0.019	−0.123 ***	0.090	0.006	0.077	0.085
Job satisfaction	0.033	0.070	−0.036	0.042	0.051	0.058	0.128 ***
Working years	0.193 ***	0.115 **	0.149 ***	0.028	0.114 **	0.133 ***	−0.020

*** correlation is significant at the 0.001 level; ** correlation is significant at the 0.01 level; moderate and strong correlations are highlighted (bold); [a]. N = 381 for correlations with CMC construct (only MHI 2 respondents were presented the CMC items).

3.5.2. Work-Related Variables

Finally, we calculated the correlations between three work-related variables, i.e., weekly working hours, job satisfaction, and years working in this profession (Table 5). Weekly working hours were negatively correlated with spiritual self-awareness. Job satisfaction was positively correlated with conversation competencies. The number of years professionals were working in this profession showed significant positive correlations with the SCCQ-NL factors, except for documentation and conversation competencies.

4. Discussion

A validated instrument to self-assess spiritual care competence among healthcare professionals is missing in the Netherlands. Therefore, we translated and validated the Spiritual Care Competence Questionnaire (SCCQ) (Frick et al. 2019) in Dutch.

In a sample of 730 mental healthcare professionals working in two large mental healthcare institutions (MHIs) in the Netherlands, we found a seven-factor structure with a similar distribution of items compared to the original German SCCQ. After the deletion of one item based on statistical considerations, the seven factors we found for the 25-item SCCQ-NL were as follows: perception of spiritual needs competencies, team spirit, spiritual self-awareness, documentation competencies, empowerment and proactive opening competencies, knowledge about other religions, and conversation competencies. The resemblance of the SCCQ-NL item distribution across factors, with the item distribution in the initial SCCQ factors, indicates good content validity.

There are indications for sufficient construct validity since all seven SCCQ-NL factors significantly correlated with the Care for Meaning Competence (CMC) scale in the MHI 2 sample. Even though the CMC items were only used once before in an unpublished study, the CMC items were partly obtained and adapted from the Spiritual Care Competencies Scale (Van Leeuwen et al. 2009), which was one of the questionnaires that were consulted when developing the SCCQ (Frick et al. 2019). Therefore, the CMC scale and SCCQ factors should theoretically be related. When tested, they indeed were, which is an indication of good convergent validity (Trochim 2006; as cited in El Hajjar 2018). The same applies to the hindrances items, which should theoretically be (negatively) related to the SCCQ-NL factors, which they were for three of four hindrance items. Discriminant validity was implied by the absence of correlations between job satisfaction and working hours and the SCCQ-NL factors (except for very small correlations between job satisfaction and conversation competencies, and between working hours and spiritual self-awareness). This is in concordance with Frick et al., who, when developing the SCCQ, tested the discriminant validity by correlating it with a theoretically unrelated variable (Frick et al. 2019; El Hajjar 2018). Consequently, with acceptable-to-good reliability, the SCCQ-NL measures spiritual care competence on seven subscales.

The respondents in our sample were not familiar with instruments to structurally assess patients' spiritual needs and hardly knew how to document their findings (documentation competencies). This shows that the documentation of spiritual needs requires specific skills and is a complex issue. The literature shows that this is related to patient privacy, differences in training, and unclear responsibilities in the spiritual care of various disciplines (Ross and McSherry 2020), and thus requires further research. Relatively low scores on team spirit and spiritual self-awareness were remarkable, since they do not assess individual and professional competencies per se but are related to knowing oneself and one's personal religious/spiritual identity and being aware of one's attitude toward spirituality and spiritual care. A lack of awareness of one's R/S identity can lead to countertransference or the avoidance of patients' spiritual needs and R/S topics (Magaldi-Dopman et al. 2011; Hengeveld-Sloëtjes et al. 2020; Magaldi and Trub 2018), thus potentially undermining the therapeutic process.

Conversation competencies, perception competencies, knowledge about other religions, and empowerment competencies scored the highest in the sample, indicating self-perceived competence in these areas. However, since general perception, conversation,

and empowerment competencies are competencies that mental healthcare professionals are typically trained in, and the SCCQ assesses self-perceived competencies, these may be classified as extra high in terms of social desirability (Frick et al. 2019), while in the meantime, respondents may be unaware of the vocabulary that is specific to R/S treatments, which is not used in regular psychotherapy (Bouwhuis-van Keulen et al. 2023). Also, relatively low scores on spiritual self-awareness and team spirit in relation to high scores on conversation, perception, and empowerment competencies may indicate professionals' tendency towards an expert position in the therapeutic relationship. This leans more towards the medical model, while spiritual care is person-centered care that "prioritizes the needs, preferences, and life goals of the individuals and families receiving health services" (Doherty et al. 2020, p. 1). This asks for an open, non-judgmental attitude towards religion and spirituality, with an awareness of the professionals' own (non)religious history, norms, values, and biases (Verhagen 2012; Magaldi and Trub 2018). Education in spiritual care can facilitate this attitude and increase competence and spiritual self-awareness (Magaldi-Dopman et al. 2011).

Integration of spiritual care training into the education of mental healthcare professionals in the Netherlands is lacking. Notably, according to this study, psychologists seem to stand out within the professional landscape, displaying lower scores on various SCCQ-NL scales compared to psychiatrists and nurses, and especially reporting lower self-assessed spiritual self-awareness compared to doctors/psychiatrists, nurses, and creative and psychomotor therapists. Also, psychologists report more barriers, such as lacking knowledge to competently attribute R/S needs and not considering themselves the appropriate person for providing spiritual care. This may stem from a lack of specific education on this topic. Furthermore, education can discourage spiritual care competence among psychologists. For example, even though psychologists are open to spiritual topics, they feel hesitant to address them (Mandelkow et al. 2022), and it has been reported by psychologists that their academic programs neglect spiritual and religious training and are in fact hostile to the discussion and exploration of students' religious or spiritual identity, implying that it is taboo (Magaldi-Dopman et al. 2011). We hypothesize that in the Netherlands, psychologists experiencing relatively more barriers and less competence compared to other professional groups may similarly be a consequence of the lack of education and a discouraging academic environment.

Even though other professions also do not receive much spiritual care competence training, there may be a more open atmosphere toward R/S topics. For example, recently, an education module on philosophy, ethics, and worldview, including spirituality and religion, was added to the curriculum of psychiatry residents in the Netherlands (Braam as cited in Lansink 2020), and psychiatrists—more than other physicians—are inclined to address R/S struggles and needs with their patients, especially in cases of anxiety or depression (Verhagen 2012). Nurses, too, typically receive training in spiritual care, especially with regard to palliative care. Finally, art therapy is traditionally open to spirituality. It "entails a therapeutic relationship that allows the expression and exploration of mental and spiritual needs through art" (Bell 2011; in Laranjeira and Querido 2023, p. 1). However, overall, little is known about how education relates to spiritual care competencies for the different professions in mental healthcare professions in the Netherlands. There is a need for further research on the role of education and spiritual care competence. Because the effect sizes for differences between groups were small, we suggest a broad research scope to further study differences in spiritual care competence, education, and the role of R/S identity and spiritual self-awareness for Dutch mental healthcare professionals. Interestingly, age and working years showed a positive correlation with SCCQ-NL scores, indicating that seniority is associated with increased spiritual competence. Beyond education, there is a seemingly natural process at play: with age comes wisdom.

Aside from the profession or the maturation process of the professional associated with age and working years, being a self-identified believer or practicing prayer and/or meditation comes with higher self-assessed spiritual self-awareness and perception, conver-

sation, and empowerment competencies than one's counterparts. With strong effect sizes, these differences are meaningful. This indicates that professionals who have a personal interest and/or find R/S important in their lives feel more comfortable and competent to provide spiritual care, even though we can assume they have had the same education as non-believers. The items of the spiritual self-awareness scale, however, especially items 48 ("I regularly take care of deepening my own spirituality") and 49 ("I regularly attend professional development sessions on spiritual topics"), may lead to bias, since agnostics or atheists will be more likely to reject these statements. Atheists and agnostics may be aware of their norms, values, points of view, or (non)religious/spiritual history and identity and how they influence their professional role, but they may be faced with different challenges in providing spiritual care (Magaldi-Dopman et al. 2011) in comparison with their believing and practicing-prayer and/or -meditation peers. However, research shows that the personal spirituality of the health professional is critical for providing spiritual care, and this calls for further research (Mächler et al. 2022). One study for example showed that, also across cultures, identifying oneself as not—or slightly—spiritual was predictive of not providing spiritual care (Bar-Sela et al. 2019). In our sample, 52.3% of respondents did not practice prayer and/or meditation, and 74.2% identified as non-believers. These percentages may be even higher in the entire professional mental healthcare population due to the potential selection bias in our study (i.e., participants in the study may have already been interested in the topic and/or had a positive view of it).

The abovementioned percentages show that identifying oneself as an (actively) believing person is not the same as praying or meditating. The bracketing of "active" in the item may, in hindsight, have created unclarity. More research on the definition and operationalization of terms like believer, spiritual, and religious, and how they relate to spiritual care competence, is needed.

The distribution of scores on the SCCQ-NL scales was similar to that of the German sample in terms of high- to low-scoring competencies, even though the proactive opening competencies items (i.e., 42 and 43) were redistributed to the subscale of empowerment competencies in the Dutch sample. In the Dutch as well as German samples, conversation competencies scored the highest, followed by the perception of spiritual needs. Knowledge about other religions scored third highest in the Dutch sample, followed by empowerment competencies. In the German sample, these positions were reversed. Spiritual self-awareness, team spirit and documentation competencies scored fifth, sixth, and seventh highest, respectively, in both samples. These similarities were to be expected, because even though there are cultural differences between both countries (Blom 2019), German and Dutch societies are at least partly similar, being neighboring Western European countries with a partially shared history, originally Christian identity, and undergoing Western, modern-day cultural changes such as secularization and multi-culturalization. Still, the Netherlands is more secularized than Germany, with 43% versus 58.2% of the population being religiously affiliated, respectively. In secularized societies, traditional religion makes way for more individual spirituality, for example in the search for meaning and purpose. This may make concepts like meaning, purpose, and spirituality more relatable for professionals and patients in the Netherlands than the concept of religion. However, there is a debate about how to define spirituality, religion, faith, and meaning (Paul Victor and Treschuk 2020; Hoenders and Braam 2020). Spirituality may be associated with vagueness, and religion for many people in the Netherlands can be associated with repressive institutions. The use of these concepts without a clear theoretical definition may potentially create countertransference, which poses conceptual and practical challenges for the training of spiritual care competencies and implementing spiritual care in Dutch mental healthcare. As unclear definitions of the concept of spirituality and confounding similarities with other concepts may create a barrier to implementing spiritual care (Tavares et al. 2022), a clarification of these concepts might facilitate practice and research (Clark and Emerson 2021; Tavares et al. 2022; Paul Victor and Treschuk 2020; Villas Boas et al. 2023) and, thus, should be part of spiritual care competency training.

4.1. Strengths and Limitations

A strength of this study lies in its large sample size, encompassing two large MHIs from different regions, with minimal variations in SCCQ-NL scores, thereby enhancing the generalizability and applicability of the findings across the Netherlands. Another strength of this study stems from the inclusion of professionals from various disciplines, providing valuable insight into spiritual care competence within the context of multi-professional mental healthcare. The findings not only contribute to the understanding of spiritual care competence but also have implications for the development and evaluation of spiritual care competencies training, for which the SCCQ-NL can be used.

One limitation of this study is the reliance on self-assessed competencies, which can potentially lead to the over-reporting of actual competencies. Addressing this issue, Frick et al. (2019) suggest the need for objectification through observational research or consulting treated patients. A second limitation is that both MHIs involved in this study are secular institutions. Previous research conducted in the Netherlands indicates that patients attending a religiously (i.e., Christian) affiliated mental health clinic tend to report higher spiritual needs, which were more frequently addressed by mental healthcare professionals compared to patients attending a secular institution (Van Nieuw Amerongen-Meeuwse et al. 2020). Conducting our study solely in secular institutions may jeopardize the generalizability to other settings. A third limitation is that the CMC scale was only used in a previous unpublished study, and in our sample, it was only applied in MHI 2. More research comparing the SCCQ-NL items with other instruments that aim to assess spiritual care competence among multiple healthcare professions is recommended to replicate construct validity research. However, to our knowledge, there are no such instruments available in the Netherlands at present. A final limitation is the lack of diversity in our sample, with, for example, only 0.5% of respondents reporting being Muslim, compared to 5% of the population in the Netherlands (CBS 2020). Also, for gender, only 0.4% in our sample identified as "other", while percentages in the population vary between 1.8% and 5% (the latter for people under 34 years of age) (Van Kleef et al. 2023). This may imply that what is known as the "religiosity gap", referring to the differences between the degree of religiousness of professionals and that of the patients they are treating, may also be applicable in our sample, not only for religiosity but also for gender.

4.2. Recommendations for Further Research

Qualitative research is recommended on mental healthcare professionals' religious/spiritual identities and attitudes and how these influence their spiritual care competencies. This can contribute to understanding the interplay between personal beliefs and professional practices and can provide valuable insights for enhancing spiritual care in diverse healthcare settings in the Netherlands.

Also, qualitative research is recommended that is aimed at specifying the hindrances encountered by mental healthcare professionals in applying spiritual care. An exploration of the knowledge gaps that hinder competent attribution and identifying factors that leave professionals feeling less inclined and qualified to address spiritual concerns can be used for tailoring custom-made training.

Finally, further research should be focused on testing the validity and reliability of the SCCQ-NL in diverse healthcare settings, as it was intended to do. Assessing the instrument's reliability and validity (including confirmatory factor analysis) across different (multi-religious) contexts will enhance its applicability within the multi-cultural, secularizing Netherlands and contribute to standardized evaluations of spiritual care competence.

5. Conclusions

The SCCQ-NL is a valid and reliable instrument to assess spiritual care competencies for multi-professional mental healthcare teams in the Netherlands. It can be used in training, evaluation, and implementation strategies for spiritual care in Dutch mental healthcare. By assessing and enhancing spiritual care competence, mental healthcare professionals can

be more equipped to identify and address the R/S struggles and needs of their patients, as well as to empower patients to come to terms with R/S struggles that contribute to psychological distress or learn to utilize their R/S as resources for coping. This may include referring patients to the right healthcare professional like a healthcare chaplain.

Based on this study, spiritual care training should encompass professionals' own (non-)R/S identity and its impact on the professional role, while enhancing spiritual self-awareness and addressing countertransference and the avoidance of R/S topics. Simultaneously, it should enhance openness and collaboration within care teams in providing spiritual care. Furthermore, training should augment knowledge on how to assess and document spiritual history and patients' spiritual struggles and needs. Attention should be paid to the vocabulary, attitude, and (knowledge about) topics typical for spiritual care. Ideally, spiritual care competence training should be part of the basic training and education of (mental) healthcare professionals.

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