RESEARCH

VALIDITY EVIDENCE OF THE SPIRITUAL CARE COMPETENCE SCALE FOR BRAZILIAN UNDERGRADUATE NURSING STUDENTS

EVIDÊNCIAS DE VALIDADE DA SPIRITUAL CARE COMPETENCE SCALE PARA ESTUDANTES DE GRADUAÇÃO EM ENFERMAGEM BRASILEIROS

EVIDENCIAS DE VALIDEZ DE LA ESCALA DE EVALUACIÓN DE ESPIRITUALIDAD PARA ESTUDIANTES DE GRADO BRASILEÑOSEN ENFERMERÍA

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ABSTRACT

Objective: to translate and culturally adapt the Spiritual Care Competence Scale to be used among undergraduate Nursing students and verify the validity evidence of the scale's adapted version. ***Method:*** a methodological study carried out with 266 Nursing students in a Brazilian public university of the state of São Paulo. The scale was submitted to a translation and cultural adaptation process and analysis of its psychometric properties (construct validity and reliability). ***Results:*** linguistic and conceptual equivalences were obtained; the scale was well accepted among the students; six subscales were obtained by the exploratory factorial analysis with factorial loads of the items higher than 0.46; some items were relocated differently from the original scale. The internal consistency assessed by the Cronbach's alpha of the subscales, based on the distribution obtained by the exploratory factorial analysis, ranged from 0.54 to 0.87. The AC1 Gwet indicator evidenced correlation between the test and retest moments for all the items ($p<0.01$). ***Conclusion:*** the Spiritual Care Competence Scale version adapted for Brazilian Nursing students presented good validity evidence based on its internal structure and reliability. It can be used in future research studies.

Keywords: Spirituality; Nursing; Validation Study; Teaching; Psychometrics.

RESUMO

Objetivo: *realizar a tradução e adaptação cultural da Spiritual Care Competence Scale para uso entre estudantes de graduação em Enfermagem e verificar evidências de validade da versão adaptada dessa escala.* ***Método:*** *estudo metodológico conduzido com 266 estudantes de Enfermagem, em uma universidade pública brasileira do estado de São Paulo. A escala foi submetida a um processo de tradução e adaptação cultural e análise das propriedades psicométricas (validade de construto e fidedignidade).* ***Resultados:*** *as equivalências linguística e conceitual foram obtidas; a escala mostrou boa aceitação entre os estudantes; seis subescalas foram obtidas pela análise fatorial exploratória, com cargas fatoriais dos itens superiores a 0,46; alguns itens foram realocados diferentemente da escala original. A consistência interna avaliada pelo alfa de Cronbach das subescalas, a partir da distribuição obtida pela análise fatorial exploratória, variou de 0.54 a 0.87. O indicador AC1 Gwet evidenciou correlação entre os momentos teste e reteste para todos os itens ($p<0.01$).* ***Conclusão:*** *a versão da Spiritual Care Competence Scale adaptada para estudantes de Enfermagem brasileiros apresentou boas evidências de validade baseada na estrutura interna e confiabilidade. Ela pode ser usada em estudos futuros.*

Palavras-chave: *Espiritualidade; Enfermagem; Estudo de Validação; Ensino; Psicometria.*

RESUMEN

Objetivo: *realizar la traducción y adaptación cultural de la Spiritual Care Competence Scale para estudiantes de grado en enfermería y comprobar evidencias de validez de la versión adaptada de dicha escala.* ***Método:*** *estudio metodológico llevado a cabo con 266 estudiantes de enfermería en una*

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universidad pública brasileña del estado de San Pablo. La escala atravesó un proceso de traducción y adaptación cultural y de análisis de propiedades psicométricas (validez de constructo y confiablidad). ***Resultados:*** *se obtuvo equivalencia linguística y conceptual; la escala demostró buena aceptación entre los estudiantes; del análisis factorial exploratorio se obtuvieron seis subescalas, con carga factorial de elementos superior a 0,46; algunos elementos se reubicaron de manera diferentea la escala original. La consistencia interna de las subescalas evaluada por el alfa de Cronbach, a partir de la distribución obtenida por el análisis factorial exploratorio, varió entre 0.54 y 0.87. El indicador AC1 Gwet comprobó correlación entre los momentos pruebay reevaluación de todos los elementos (p<0.01).* ***Conclusión:*** *la versión de la Spiritual Care Competence Scale adaptada para estudiantes de enfermería brasileños presentó evidencias de validez basada en la estructura interna y confiabilidad. Puede usarseen futuros estudios.*
Palabras clave: *Espiritualidad; Enfermería; Estudio de Validación; Enseñanza; Psicometría.*

INTRODUCTION

Spiritual care refers to the systematic care provided by nurses to meet the patients' spiritual needs.[1,2] It includes specific attributes and competencies (abilities or skills) to efficiently provide spiritual care.

It is expected that the nurses meet the spiritual needs. The lack of this care results in inattention to vitally important aspects and can be related to the nurses' fear or discomfort when dealing with spiritual issues, for not feeling prepared to implement spiritual care.[2-4]

A recent literature review identified 14available instruments on spiritual care directed to nurses and Nursing students. Among the dimensions contemplated by these instruments, the spiritual care competence was not verified.[2] This spiritual care aspect can reflect on the care provided, as the lack of professional training to meet these patients' demands is a key element to the non-provision of this care.

It is known that attitudes directed to spirituality and spiritual care are correlated with competencies for providing spiritual care.[5,6] In addition, positive attitudes towards spirituality and spiritual care among nurses who provide critical care were predictors for better performance in work involving spiritual care.[7,8]

Occasionally, the students report not having the necessary competencies for assessing spiritual needs and providing spiritual care involving interpersonal relationship, communication skills, conditions for the development of a trust relationship, sensitivity, self-knowledge, patient-centered approach, apart from knowledge on spirituality and the caring process steps.[1] Assessing the undergraduate Nursing students' competences for spiritual care can favor the implementation of spirituality and spiritual care topics in Nursing curricula, which are absent or little developed in Nursing teaching, whether in the national or in the international context.[1,6,8-10] Thus, it is important that programs directed to the strengthening of the theoretical and practical dimensions on spiritual competences are developed during the students' training.[8,11]

The Spiritual Care Competence Scale(SCCS) is recommended to assess students and nurses' competences.[1,5,8,12] This scale was recently made available in Brazil, validated for a sample of health professionals.[13] No study conducted in Brazil using this scale with Nursing students was found.

The objective of this study was to translate and culturally adapt the SCCS for its use among undergraduate Nursing students and verify the validity evidence of the scale's adapted version.

METHOD

This is methodological study developed in two phases: a) translation and cultural adaptation; and b) analysis of the measurement properties of the Spiritual Care Competence Scale(SCCS)[12] for the Brazilian context among undergraduate Nursing students.

This scale, created by Van Leeuwen[12], firstly published in English, is composed of 27 items distributed into six subscales: a) assessment and implementation of spiritual care (six items); b) professionalization for improving the quality of spiritual care(six items); c)personal support and patient counseling(six items); d) referral to professionals(three items); e)attitudes towards the patient's spirituality(four items); f)communication (two items). A Likert scale analyzes each item with five possible answers from "I strongly disagree" to "I strongly agree"; the score is obtained by the sum of the items, ranging from 27 to135. A cutoff point was not identified; the highest the score, the greater the spiritual care skills. Initially, the scale was validated by a sample of Norwegian Nursing students and presented adequate reliability, with a Cronbach's alpha coefficient of subscales from 0.56to0.82.

The translation and adaptation processes of the SCCS considered literature recommendations[14,15] and employed the following stages: translation, conciliation of the translations, back-translation, evaluation by a committee of experts, and test among the target population; this last stage was carried out by means of a semantic evaluation with students, described below.[15]

Initially, two bilingual translators translated the instrument from English into Portuguese, independently. Subsequently, the translations were compared and analyzed regarding similarities and differences by the two authors of this study, conciliating them. The synthesized version was back-translated by another two individuals, independently. Subsequently, a committee of five researchers on spirituality with experience in studies of instrument validation analyzed the items translated considering their usability, understanding, pertinence to the theme, and equivalences between the instruments in both languages, defining a translated version. Then, this version was sent to the author of the SCCS with its corresponding back-translation into European English, which was approved.

Subsequently, this version of the SCCS was subjected to a semantic evaluation by undergraduate Nursing students to investigate the scale understanding by future users and solutions of possible misunderstandings, using the DISABKIDS® group method.[15] For this phase, the following instruments were used: sociodemographic characterization(age, gender, marital status, course time) and the instruments for semantic evaluation.[15] One of these instruments was a general evaluation of the scale, aiming at verifying global impressions(what they think of the instrument; whether the items were understandable; difficulties in using the answer categories, and relevance of the items to what is proposed; whether they would like to add, change, or not to answer an item or make any considerations about the instrument). The other instrument was a specific evaluation of the items (relevance and difficulty in understanding each item and suggestions for their reformulation).

After these procedures, the adapted version of the SCCS for the use of Brazilian Nursing students was obtained, which was subsequently submitted for the analysis of its measurement properties.

The study population consisted of Nursing students in different academic years of a Brazilian public university in the state of *São Paulo*. The students participated in this study at a pre-scheduled time, outside academic activities, and provided their formal consent.

For the semantic evaluation phase, they were recruited through snowball sampling; 18 students in different academic periods. All answered the instrument for sociodemographic characterization and overall semantic evaluation. These students were grouped into three groups of six students; each group answered the instrument of specific semantic evaluation for the items of the two subscales. This phase took place in June 2016.

For the analysis of the psychometric properties phase, all the students of the institution (n=489) were invited, except those who had participated in the previous phase. A sample of at least 270 participants was estimated at this phase, considering the expectation of 10 interviewees per item of the instrument under analysis. A total of 266students expressed interest, and 72of them participated in the retest stage. All the students individually answered the instrument of sociodemographic characterization and the SCCS – version adapted for Brazilian Nursing students.

Data collection to verify the psychometric properties by construct validity (by means of exploratory factorial analysis[16]) and reliability (assessed by internal consistency[17] and reproducibility, using test and retest[18]) of the adapted version took place from August to November 2016.

For statistical analyses, version 22.0 of the Statistical Package Social Science(SPSS) for Windows was used. The qualitative variables (nominal and categorical) were presented as simple frequencies; the quantitative variables (continuous) as mean, standard deviation, and minimum and maximum values.

The exploratory factorial analysis was conducted to identify the dimensionality of the SCCS – version adapted for Brazilian Nursing students. In order to identify the sample size adequacy, the conduction of the factorial analysis, and the null hypothesis test, the Kaiser-Meyer-Olkin(KMO) index and Bartlett's sphericity test were used. Values higher than0.50 in the KMO test and p-values below 0.05 in the Bartlett'ssphericity test were considered adequate.[16] The principal components analysis was considered based on the eingenvalues, which represent the total explained variance of the factors. The extraction of the principal components was made upon Varimax orthogonal rotation with Kaiser normalization.

Reliability was assessed by internal consistency and reproducibility. Internal consistency was assessed according to Cronbach's alpha and the values considered adequate were ≥ 0.70.[17] Reproducibility (test-retest) was assessed by the AClG*wet*[18] indicator, 15 days after the first answer, the period considered adequate for this type of research.[17]

The study was approved by the institution's Ethics Committee of Research in Human Beings (CAAE 49216615.4.0000.5393; Opinion No. 173/2015). All the participants signed the Free and Informed Consent Form. The author of the original version authorized the use of the scale for this study.

RESULTS

The translation from English to Brazilian Portuguese and the back-translation were made to obtain equivalence between the two languages. Divergences between both translators were predominantly regarding the pronoun that characterizes the subject of the action (as in the following example: Translator one – "*Posso relatar....*"; Translator two – "*Eu posso relatar...*").

A committee of five researchers, three PhD professors with more than 10 years of experience in teaching and research and two PhD students, all with research studies on spirituality, analyzed all the versions produced in the translation and back-translation process, considering the idiomatic, semantic, experiential and conceptual equivalences, and approved a version that obtained acquiescence from the author of the original instrument.

In the overall semantic evaluation of the SCCS-version adapted for Brazilian Nursing students with future users (n=18), 94.5% considered it very good; 72.5% considered it comprehensible; 83.5% indicated no difficulties; 83.5% considered it very relevant for the professional practice; and 78% of the students answered that they would not change or add any content in the scale.

In the specific evaluation, when considering each item separately, the students commented that the most difficult items were 21 (72%) and six (60.5%). All the items were considered

relevant, except item 21, and most of them were well understood by the students; they also considered that it was not necessary to change the text of any item of the scale.

For the analysis of the measurement properties, 266 students in different academic periods participated, with a mean age of 21.5 years old (standard deviation of 3.1; minimum of 18 years old; and maximum of 49 years old), 232 women and 34 men; 36 married, 229 single, and a widower.

Reliability, analyzed by internal consistency using Cronbach's alpha coefficient, presented values adequate for the domains with the items originally established and for the total scale (≥0.70),[17] except for the referral to professionals domain (alpha=0.65) (Table 1).

Prior to the exploratory factorial analysis, the specific tests based on the data matrix obtained were conducted for investigating the pertinence of the principal components analysis. Bartlett's sphericity test rejected the null hypothesis that the data correlation matrix was an identity matrix (p<0.01), and the KMO index was 0.85; therefore, these results show that the data matrix can be factorized.

The commonalities, proportion of variance for each variable included in the principal components analysis, in this study varied from 0.76 to 0.47 and were over 0.5 for most of the items. The value considered adequate[16] was not obtained for items 6, 9, and 17, which were 0.47, 0.49, and 0.49, respectively.

Table 2 presents results of the exploratory factorial analysis, considering the number of factors identified, with the corresponding factorial loads.

The principal components analysis resulted in six factors or domains, explaining 61.2% of the total variance estimated; each factor received eigenvalues higher than 1, which justified the six factors and, respectively, explained 27.8, 11.3, 8.4, 5.8, 4.1, and 3.9% of the scale variance.

According to the exploratory factorial analysis, some items were relocated differently from the original version (Table 3).

The adapted version of the SCCS for Brazilian Nursing students grouped the items differently from the English version in the six domains. Among the differences, it is important to note the relocation of items 2 and 3 from the "assessment and implementation of spiritual care" domain to "professionalization for improving the quality of spiritual care"; the relocation of item 20 from the "referral" domain to "personal support and patient counseling"; the fusion of the "communication" domain with "attitudes toward the patient's spirituality", resulting in the domain called "attitude and communication towards the patient's spirituality". Additionally, items 13 and 14 originated a new domain: "competence assumed for the provision of spiritual care", previously constituting the "personal support and patient counseling" domain.

The variation of the Cronbach's alpha of the subscales, based on the distribution obtained from the exploratory factorial analysis, varied from 0.54 to 0.87, with the lowest alpha values being in the "assessment and implementation of spiritual care" (alpha=0.69) and "referral to professionals" (alpha=0.54) subscales (Table 2).

The reproducibility analysis was employed considering the test-retest analyzed by the *Gwet* indicator,[18] which evidenced a statistically significant correlation between the data answered by the students (n=72) at the two measurement moments of the adapted scale, for all the items (*p*<0.01).

DISCUSSION

The SCCS was translated, culturally adapted, and validated for Brazilian undergraduate Nursing students. The methodological steps were similar to those of other studies regarding translation or transcultural adaptation[15,19] and enabled to avail an instrument that is clear, easy to answer, and suitable to be used in different educational contexts.

All the items were considered pertinent (factorial loads >0.3), which evidences the items' relationship with the construct[16] and their permanence in the adapted version of the SCCS for Brazilian

Table 1 - Distribution of the means of the total scores in each domain of the adapted version of the SCCS for Brazilian Nursing students and values referring to internal consistency (n=266). *RibeirãoPreto*, SP – Brazil, 2016

SCCS – Adapted version	Mean of the scores	Standard Deviation	Internal Consistency*
Assessment and implementation of spiritual care	22.08	3.69	0.76
Professionalization and improving the quality of spiritual care	21.56	4.08	0.84
Personal support and patient counseling	22.30	3.68	0.77
Referral to professionals	9.84	2.17	0.65
Attitude towards the patient's spirituality	17.95	2.24	0.79
Communication	9.18	1.04	0.86
Total	**102.91**	**12.00**	**0.89**

* Internal consistency using Cronbach's alpha verified based on the original conformation of the items.

Tabela 2 - Análise das cargas fatoriais exploratórias, dos autovalores e consistência interna para cada fator da SCCS versão adaptada para estudantes de Enfermagem brasileiros (n = 266). *Ribeirão Preto*, SP - Brazil, 2016

Items / Domains	Factorial loads						
	1	2	3	4	5	6	I C*
Item 8 Na enfermaria eu posso contribuir para o desenvolvimento profissional na área do cuidado espiritual	0.760						0.69
Item 12 Eu posso implementar um projeto para melhoria do cuidado espiritual na enfermaria	0.718						
Item 10 Eu posso treinar outros profissionais de saúde a prestar cuidado espiritual aos pacientes	0.693						
Item 7 Na enfermaria eu posso contribuir para a garantia de qualidade do cuidado espiritual prestado	0.665						
Item 11 Eu posso fazer recomendações políticas sobre o cuidado espiritual para a gerente de Enfermagem	0.649						
Item 2 Eu posso adequar o cuidado do paciente às suas necessidades espirituais durante sua consulta	0.648						
Item 3 Eu posso adaptar o cuidado de um paciente às suas necessidades espirituais, a partir da consulta multidisciplinar	0.645						
Item 9 Na enfermaria eu posso identificar problemas relacionados ao cuidado espiritual durante as discussões entre os profissionais de saúde	0.577						
Item 26 Eu posso escutar ativamente a história de vida de um paciente em relação à sua doença/incapacidade		0.801					0.87
Item 22 Eu demonstro respeito, sem preconceitos, pelas crenças espirituais e religiosas de um paciente, independentemente de sua tradição espiritual ou religiosa		0.799					
Item 27 Eu tenho uma postura receptiva na interação com um paciente (interessada, simpática, que inspira confiança, empática, genuína, sincera e próxima)		0.783					
Item 23 Eu estou aberto às crenças espirituais/religiosas dos pacientes, mesmo se elas diferirem das minhas		0.760					
Item 24 Eu tento não impor minhas próprias crenças espirituais/religiosas ao paciente		0.699					
Item 25 Eu tenho consciência das minhas próprias limitações ao lidar com crenças espirituais/religiosas de um paciente		0.697					
Item 16 Eu posso ajudar um paciente a manter a sua prática espiritual diária (incluindo oportunidades para praticar rituais, rezar, meditar, ler a Bíblia/Alcorão e escutar música)			0.799				0.77
Item 18 Eu posso encaminhar os familiares de um paciente a um conselheiro espiritual/pastor, etc. se eles me solicitarem e/ou se expressarem necessidades espirituais			0.679				
Item 15 Eu posso dar informação a um paciente sobre locais na instituição para expressão de sua espiritualidade (incluindo cuidado espiritual, centro de meditação, serviços religiosos)			0.654				
Item 20 A pedido de um paciente com necessidades espirituais, eu posso encaminhá-lo de forma oportuna e efetiva a outro profissional de saúde (ex. capelão/ padre/ sacerdote muçulmano)			0.647				
Item 17 Eu posso atender às necessidades espirituais de um paciente durante o cuidado diário (por exemplo, durante o cuidado físico)			0.461				
Item 5 Eu posso informar por escrito as necessidades espirituais de um paciente				0.767			0.54
Item 1 Eu posso relatar verbalmente e/ou por escrito as necessidades espirituais dos pacientes				0.687			
Item 4 Eu posso registrar o componente do cuidado espiritual do paciente no plano de cuidados de Enfermagem				0.659			
Item 6 Eu posso informar verbalmente sobre como o paciente se comporta espiritualmente				0.525			
Item 14 Eu posso avaliar o cuidado espiritual que eu prestei em consulta a um paciente e o cuidado realizado por intermédio da equipe disciplinar /multidisciplinar					0.777		0.86
Item 13 Eu posso prestar cuidado espiritual a um paciente					0.763		
Item 21 Eu sei quando devo consultar um conselheiro espiritual para discutir sobre o cuidado espiritual de um paciente						0.677	0.80
Item 19 Eu posso efetivamente encaminhar a outro cuidador/ trabalhador da área da saúde / de outra área o atendimento às necessidades espirituais de um paciente						0.605	
Self-values	**7.503**	**3.046**	**2.271**	**1.565**	**1.107**	**1.049**	

* Internal consistency using Cronbach's alpha verified based on the original conformation of the items.

Table 3 - Grouping of the items in the six domains of the SCCS original version and of the version with Brazilian nursing students

Domains of the SCCS original version	Items	SCCS domains – Brazilian version	Items
Assessment and implementation of spiritual care	1, 2, 3, 4, 5, 6	Avaliação e implementação do cuidado espiritual	1, 4, 5, 6
Professionalization and improving the quality of spiritual care	7, 8, 9, 10, 11, 12	Capacitação profissional para melhor qualidade do cuidado espiritual	2, 3, 7, 8, 9, 10, 11, 12
Personal support and patient counseling	13, 14, 15, 16, 17, 18	Apoio individual e aconselhamento ao paciente	15, 16, 17, 18, 20
Referral to professionals	19, 20, 21	Encaminhamento	19, 21
Attitude towards the patient's spirituality	22, 23, 24, 25	Atitude e comunicação em relação à espiritualidade do paciente	22, 23, 24, 25, 26, 27
Communication	26, 27	Competência assumida para execução do cuidado espiritual	13, 14

students. However, the analysis resulted in a distribution of items different from the original proposal.

The exploratory factorial analysis of the SCCS Portuguese version also evidenced a grouping of items different from the original proposal, into four factors, with adaptation regarding the titles of the Domains.[20] In this study, all the items presented factorial loads justifying their maintenance in the scale, as in a previous validation Study.[20] The factorial analysis of the SCCS Chinese and Turkish versions also extracted a number of factors different from the original version; in both studies, three factors were extracted.[21,22] In a Brazilian study whose sample was composed of health care team professionals, the authors found seven factors but decided to maintain the same ones of the original English version.[13] The advantage of our study was the redistribution of the among the factors.

The commonalities values for items 6, 9, and 17 were discreetly below 0.5; this can be an indication that the variables represented by these items are not linearly correlated.[16] The choice of maintaining these items like in the original scale[12] was based on the fact that the commonalities were discreetly below the reference value and on the necessary precaution in dealing with changes of an instrument in its initial phases of validation for Brazilian Nursing students and because it has already been validated or used in other cultures.[20-23] The authors of the national study that validated the SCCS with health professionals had the same precaution.[13]

With the Brazilian undergraduate Nursing students, when carrying out the EFA, five of the domains originally presented maintained most of their items. The communication subscale had its items grouped among the other subscales and two items were not allocated in the original subscale (personal support and patient counseling), resulting in the subscale called "competence assumed for the provision of spiritual care". It is important to remember that there is a consistent relationship between communicative skills (active hearing, empathy, and interest, among others) and the other domains proposed in the instrument's theoretical scope.[24] In addition, such characteristics and skills are behaviors whose roots are related to the attitudes of the professional. In our study, the items related to these communicative behaviors are within subscale five (attitudes towards the patient's spirituality).

The differences regarding the conformation of factors between SCCS original and Brazilian versions must not be interpreted as final, neither as subjected to the exclusion of items, as this study describes the initial results of the scale validation to Brazilian Portuguese in this population. This can be related to construct understanding and not to the sample Characteristics.[25]

When considering the students' performance according to the SCCS version of this study, the results (mean=102.91; SD=12) were similar to those obtained by the nurses who participated in the validation of the Turkish version (mean=103.40; SD=17.32).[22]

The scale's global internal consistency in our study proved to be adequate (Cronbach's alpha=0.89) and similar to the findings of other researchers in different countries, ranging from 0.77 to 0.93.[13,20-23] Regarding the alpha values below 0.70 for items from two of the domains originated upon factorial analysis, the literature has revealed that there is no consensus about the reliability interpretation of an instrument based on the value of the coefficient obtained; in addition, the acceptance of values above 0.50 when measuring attitudes or behaviors has been identified.[26]

In the reliability analysis,the results obtained with items 19 and 21 of the "referral to professionals" dimension presented a lower correlation with the total score of the subscale to which they belong, namely "I can effectively assign care for a patient's spiritual needs to another care provider/care worker/care discipline" and "I know when I should consult a spiritual advisor concerning a patient's spiritual care". It is important to note that these items, in the semantic evaluation, were considered little understandable by a student, relating the report to the similarity among the items, which reinforces the idea that limited familiarity with the theme may have contributed to the results obtained.

The measurement stability of the Nursing students' competences for spiritual care was adequate for the time interval stipulated in this study (approximately 15 days).[17] This positively reinforces the instrument's measurement quality obtained at different moments.

The study limitations focus on the selection of participants from a single, secular and public institution, whose curriculum partially contemplates spirituality issues, as well as on the non-identification in the sample of other possible intervening variables in the expression of the competence for spiritual care.

Analyses of psychometric properties, particularly the confirmatory factorial analysis, are recommended in samples of students from different educational contexts.

Valid instruments are necessary for the development of research studies, mainly for assessing the effectiveness of educational interventions. The essential contribution of the study for the profession is providing a valid instrument to identify the perceptions on the competencies for spiritual care, especially because the spiritual dimension is often neglected by the health professional due to lack of training and preparation, shortage of time, cultural aspects, related to a perception of inability to provide such care.[2,4,9,11] However, the perceptions of the health care teams about the competence for spiritual care may be different from those of the Nursing students, and a version of the scale using this specific population seems important for Nursing teaching.

CONCLUSION

The Spiritual Care Competence Scale- version adapted for undergraduate Nursing students in Brazil proved to be reliable, presenting adequate internal consistency and stability in the measurements at different times. It can be also used in further studies, particularly in Nursing education, helping the students to evaluate their own spiritual competences and the spiritual competences when providing care.

Further studies are necessary using the same population to evaluate subscales based on the confirmatory factorial analysis. In addition, the lack of similar valid instruments for Nursing requires new studies on this theme.

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