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Oncology patients' and professional nurses' identification of patient spiritual coping strategies

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ONCOLOGY PATIENTS' AND PROFESSIONAL NURSES' IDENTIFICATION OF PATIENT SPIRITUAL COPING STRATEGIES

by

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THESIS

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... thanks to the Lord for He is good;
His lovingkindness and faithfulness is
everlasting ... Psalms 100:4,5

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ABSTRACT

Patients experiencing cancer utilize a variety of coping strategies. However, little attention has been given toward the patient's religious faith as a coping strategy. Nursing literature referring to man's spiritual dimension affirms the idea that man is seen as a spiritual as well as biological, psychological, and social being (Fish & Shelley, 1978; Highfield & Cason, 1983). Recognition of man as a bio-psychosocial-spiritual being necessitates an understanding and assessment of the patient's spiritual coping strategies.

A descriptive survey is utilized to identify the spiritual strategies important to 25 hospitalized cancer patients. Twenty five nurses were conveniently selected to examine their awareness of the spiritual coping strategies utilized by one of their patients. One of each nurse's patients was randomly selected for study. A semi-structured one-time interview was adapted from McCorkle & Benoliel (1981). The 30 interview items with content validity describe the patient's spiritual concerns and use of resource persons with spiritual activities as part of their coping strategy in living with cancer.

The findings of the study reveal that patients utilized family (92%), clergy (76%), friends (68%), physicians and nurses (48%) as resource persons with whom to share their spiritual concerns. The most common spiritual activity utilized by patients was prayer (84%), followed by religious objects and/or music (64%), and reading the Bible (56%). Not quite half of the nurses (44%) could identify the patient's religion. Nurses were able to identify some (48-60%) of the spiritual resource persons utilized by their patients, but few (16-60%) of their spiritual activities. The data may provide guidelines for nursing assessment and promotion of the spiritual coping strategies utilized by cancer patients. Once identified, the nurse can assist the patient as needed with the spiritual strategies important to him thereby enhancing his ability to cope with cancer.

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CHAPTER ONE

INTRODUCTION

Cancer is more than just another chronic disease. It is perceived by many as a dreaded, potentially fatal illness. This elicits the deepest fears of mankind, disrupts families, and challenges the very values that make life worth living. Patients confronted with this kind of stress have special coping problems shared with no other group (Weisman, 1979).

Nurse author, Jean Stallwood (1975) states that a person's spiritual values are confronted perhaps for the first time during illness. Religious faith is an important issue to consider in coping with cancer (Friedman, 1980), but is seldom recognized as a strategy for assessment and enhancement of the patient's ability to cope.

Coping plays an important role in sustaining an individual's overall functioning in illness. The health care personnel who takes the responsibility for assessing and promoting the patient's effective coping skills can lessen the negative impact of the illness (Thornbury, 1982). Nurses, then, who are working with patients and available to them 24 hours a day, are in a unique position to assess and enhance the cancer patient's own coping strategies.

Various strategies utilized by patients coping with cancer are well documented in the literature for nursing assessment and intervention (Friedman, 1980). However, little attention is given toward the spiritual strategy

in particular. Darocy (1979) notes that even when the nurse is aware that spiritual care is an important aspect of nursing, it is often overlooked in the actual delivery of care.

Man has been commonly described as a bio-psycho-social-spiritual being, holistic, and unique (Yaira & Torres, 1975). For effective health care of the whole patient, assessment of the patient's coping strategies within the spiritual dimension, along with that of the other dimensions, should be incorporated into the scope of nursing practice. The nurse's assessment of patients coping strategies should include more than identification of the patient's religious faith. The specific spiritual activities and resource persons the patient utilizes as part of his strategy in coping with cancer should also be assessed.

Nurses should also be aware that the patient's use of spiritual activities and/or resource persons may indicate the presence of a patient spiritual need. Many patients express some concern relative to spiritual needs; oncology patients in particular. Patients who have been told they have cancer often begin to consider the meaning of their lives which, the researcher believes, also includes an evaluation of their spiritual concerns. The researcher has been requested by oncology patients for assistance in bible reading and prayer, for example, that would indicate a need to relate to God or a higher being.

Problem

Recognition of man as a spiritual being necessitates an understanding of his spiritual coping strategies and the nurse's role in his spiritual care. It has not been established what spiritual strategies hospitalized cancer patients' utilize in coping and if the nurses caring for such patients are aware of the spiritual coping strategies utilized by their patients. The specific problems addressed in this study are (a) what do oncology patients identify as spiritual needs and coping strategies (i.e., their use of spiritual activities and resource persons), and (b) do nurses caring for oncology patients recognize the same patient spiritual needs and strategies as those identified by their patients.

Purpose

Research about patient spiritual needs and coping strategies is necessary for establishment of the nurse's role in spiritual care. The overall purpose of this study is to describe the use of spiritual coping activities and resource persons by hospitalized cancer patients. Specifically, this study will examine the degree of agreement between the spiritual coping strategies identified by the patient and those identified by his nurse.

Assumptions Basic To This Study

1. All human beings have a spiritual dimension which may be utilized as a strategy in coping with cancer.

2. Oncology nurses can identify patient spiritual strategies and needs.

3. Patient responses are reliable and serve as the source from which to compare the nurses' responses.

Scope of the Study

This study focused on the patient's spiritual dimension within the framework of coping to identify patient spiritual coping strategies for nursing assessment and intervention. Therefore, this study encompassed: (a) the literature on man as a spiritual being, and religious faith related to coping; (b) previous spiritual research studies; (c) emperical findings as they relate spiritual care to the role of nursing; and (d) implications and recommendations for nursing practice, education, and research.

CHAPTER TWO

THEORETICAL FRAMEWORK AND REVIEW OF LITERATURE

Literature support for the theory that man is seen as a spiritual being will be reviewed first as this theory is central to the focus of this study. The patient's reliance on religious faith will then be discussed within the context of coping, after which a critical analysis of spiritual research studies is presented.

Man As a Spiritual Being

Psychology, theology, and nursing literature reflect the idea that man is a spiritual being. Paul Tournier, a renowned psychologist and physician, views man's spirit as an integral perspective of his being. He states:

> It (the spirit of man) is concerned with a personal relationship with God and fashions the mind and the body in accordance with that relationship . . . Furthermore, these three realities--body, mind, and spirit--are not just elements by whose juxtaposition a man is constituted. They are three aspects of one and the same unity: man (Tournier, 1965, pp. 61-62).

Theological references to man's spirit describe a personal relationship with God--however "God" may be defined. The Judeo-Christian viewpoint designates the spirit to be an integral aspect of man which equips him to experience this meaningful relationship (Stallwood, 1975).

Most theologians agree upon the concept of a transcendental being (God) and/or transcendental order as a necessary component of the spiritual aspect of man. Pruyser (1974), a clinical psychologist known for his association with ministers, his consultant experiences with seminaries, and his considerable theological insights, identifies that one of the dimensions of spiritual experience is an individual's awareness of the Holy. He also notes that an individual's purpose or sense of vocation validates his existence in relationship to his Creator or higher being. Rudolf Otto (1917/1924), in his classic theological writings, describes man's religious and spiritual experiences as those that lie within a transcendent presence beyond man and yet are also felt within man.

Several nurse authors have also defined the spiritual aspect of man. Vaillot (1970, p. 30) identifies spiritual in a general meaning as the "quality of forces which activate us, or the essential principal influencing us." The concept of spirit, according to Dickinson (1975), is the affective part of man, the spirit or quality of his feelings. Other nurses specifically relate man's spiritual aspect with the concept of God or a higher being (Fish & Shelly, 1978; Highfield & Cason, 1983; Hubert, 1963; Stallwood, 1975).

Man's relationship with God provides him with a meaning and purpose in life. Stallwood (1975) elaborates that out of an individual's relationship with God, a person derives a

meaning and purpose in life, and can experience unconditional love, forgiveness, hope, and trust. Yet some individuals have an intense belief in their own attributes, power, achievements, and perpetual existence without any internalized theological belief system (Kalish, 1981; Leininger, 1978). The humanist relies only on himself in coping with life and the problem of destiny (Huxley, 1961). However, for the focus of this study the spiritual dimension of man refers only to his relationship with God or a higher being which gives him a meaning and purpose in life.

Several authors support the contention that a person's concern about the meaning of life is one reason for spiritual care (Travelbee, 1966; Jourard, 1974; Fish & Shelley, 1978). According to Jourard (1974) the spiritual aspect of man reveals whatever a person regards as the highest value in life, which in turn allows the person to establish and integrate meaning in his life. Travelbee defines nursing as assisting an individual or family with the experience and meaning of his life and illness and explains that an individual's spiritual needs, in addition to his physical and psychosocial needs, are an important part of his life experiences. The nurse is given responsibility for assisting man with his life experiences which includes the incorporation of his spiritual as well as biological and psychosocial aspects of nursing care (Travelbee, 1966).

The importance of including spiritual care within the scope of nursing has been addressed in the literature for over 20 years (Hubert, 1963; Travelbee, 1966; Hirano, 1978; Fish & Shelley, 1978; Highfield & Cason, 1983; Nelson, 1984). Recently, spiritual distress has been noted as a category in the syntax of nursing diagnosis (Gordon, 1982). Watson (1979) not only emphasizes that the nurse has the opportunity, but an obligation to become familiar with the spiritual and religious influences in a patient's life. Stoll (1979) recognizes that a person has physical, emotional, and spiritual needs that should encompass the scope of nursing if nurses are interested in care of the whole person.

Spiritual needs have been defined throughout nursing literature in a variety of ways but with similar basis. According to Stallwood (1975. p. 1088) a spiritual need can be defined as "any factors necessary to establish and maintain a person's dynamic personal relationship with God (as defined by that individual)". Kealey (1974, p. 3) broadens Stallwood's definition to include "a requirement of the spirit or inner core (immaterial nature) of a person which is necessary for harmony of that person with God, self, others and the universe". A spiritual need is defined by Fish & Shelley (1978, p. 39) as "the lack of any factor or factors necessary to establish and/or maintain a dynamic, personal relationship with God." For the purposes of this study, man's spiritual dimension of being is dependent upon

a transcendent presence that gives man a purpose and direction in life. Therefore, a spiritual need is defined as the need to establish or maintain a relationship with God or a higher being that provides man with a purpose and direction in life.

The review of literature strongly supports the theory that man is seen as a spiritual being. Recognition of man as a spiritual being necessitates an understanding of his religious faith as a coping strategy that may be utilized to lessen the negative impact of cancer and sustain his overall functioning in illness. The nurse can promote the spiritual strategies important to the patient and enhance his ability to cope with cancer.

Coping and Religious Faith

Coping in general implies successful adaptation to a stressful situation. However, it is commonly referred to as the specific cognitive and behavioral acts used by individuals to decrease a perceived threat and its associated stress. The transactional model of Lazarus and Cohen explains that coping responses are most influenced by cognitive threat appraisals. The individual evaluates the illness threat and assesses the adequacy of his coping resources (including environmental supports and his own repertoire of coping responses). If the resources are assessed as adequate, the illness is perceived as less threatening; otherwise, the threat is increased (Thornbury, 1982).

Stress is an inevitable aspect of normal living, though some people experience more severe or sustained stressful situations than others. What constitutes the major difference in adaptational outcome is coping. Coping serves two functions--problem solving and regulation of emotional distress. Problem solving encompasses the ability to change the situation for the better, if possible, by either (a) changing one's own offending action (focus on self) or by (b) changing the damaging or threatening environment. However, there are many situations, one of which may be cancer, in which little can be done to eradicate the problem. Under such conditions, it is necessary to manage the subjective components of stress-related emotions themselves to prevent them from getting out of hand, damaging or destroying morale and social functioning. Four coping modes have been identified by Lazarus and Launier serving both problem-solving and emotion-regulating functions. These modes are: information-seeking, intrapsychic processes, direct action, and inhibition of actions (Lazarus, 1980).

Information seeking involves increasing knowledge about the stressful situation in order to make a sound coping decision or to reappraise the damage or threat. This mode not only provides the basis of action (problem-solving function), but also the function of making a person feel better by rationalizing or bolstering past decisions (regulation of emotional distress) (Lazarus, 1980).

The intra-psychic mode is the use of all the cognitive processes to regulate emotion and includes, as it were, those things the person says to himself. It encompasses self-deceptive mechanisms (such as denial, reaction formation, and projection), avoidance, and efforts to obtain detachment or insulation (such as isolation, undoing, intellectualization) from a threat in order to achieve control over the situation. The actions within this mode can be focused on self ("I am not inadequate or evil.") or on the environment ("This situation is not dangerous.") (Lazarus, 1980).

Direct action includes anything one does (except cognitively) to handle stressful encounters. These actions are virtually unlimited, and are as diverse as the environmental demands and personal goals which people have to manage, such as expressing anger, fleeing, taking medicine, or jogging to preserve one's health. Actions in this coping mode may be aimed at the self or the environment since both are potentially capable of being changed, resulting in an alter stressful person-environment relationship for the better. The action may also be directed at overcoming emotional injury as when a grieving person becomes buried in work (Lazarus, 1980).

Inhibition of action is aimed at holding back action impulses that will do harm and proves more effective than taking action that poorly remedies the stressful situation. These actions make it possible for the person to choose the

appropriate coping action for his situation. The individual can choose the appropriate action only if strong impulses, such as anger and fear, are held back in the interest of other values (Lazarus, 1980).

In light of the Lazarus model, reliance on one's religious faith (through bible reading, prayer, taking of sacraments, etc.) could be viewed as a direct action of coping. Bible reading, along with other spiritual activities, may be seen as a behavioral action or activity that a person utilizes to obtain peace, strength, or direction in a stressful situation. The personal goal of a person relying on his religious faith would demand that his coping actions be aimed towards his relationship with God through specific spiritual activities as opposed to coping from a reliance on power from within himself (the humanistic viewpoint). Spiritual activities involve behavioral acts in addition to cognitive processes which are not centered only on those things the person says to himself but are centered on a God or higher being outside of himself. Therefore in keeping within the definition of the spiritual dimension for this study, spiritual activities are viewed as actions within the coping mode of direct action and not that of the intrapsychic.

Several authors feel that religious faith enhances the patient's ability to cope (Highfield & Cason, 1983; Devine, 1980; Martin, Burrows, & Pomilio, 1976; Kealey, 1974; Carson, 1971). Hinton (1975) denies any enhancement.

However, evidence exists which indicates that religious faith is an important concern to the cancer patient. One function of that religious faith is to help the patient cope and reduce stress as he adjusts to living with cancer.

Weisman (1975) identified religion as one of seven areas of concern among cancer patients. He found that church attendance was one of several factors that contributed positively toward a lower emotional distress among cancer patients. The direct relation between church attendance and lower emotional distress may seem to indicate that "God is a good thing" (Weisman, 1979, p. 78). However, this may merely indicate that church is an excellent conduit for human relationships and offers a conventional support system.

The influence of theological concepts on coping may be difficult to assess, but none the less important. Regardless of their previous beliefs--whether theologically minded or not--sick people often contemplate theology in some form or have it suggested to them by visitors of friends (Weisman, 1979). Patients faced with a limited lifespan, such as oncology patients, struggle to find some sense and meaning (Kubler-Ross, 1973). In light of a catastrophic illness, many patients find strength and solace in religion. Patients often turn to pastoral counselors that can help put the fear of death in perspective of a religious philosophy (Blumberg, Ahmed, Flaherty, Lewis, & Shea, 1981).

Reeves (1983) identified the most frequent coping methods utilized by 25 cancer patients as (a) trust in God, (b) the hope of getting better, (c) accepting the fact of cancer, and (d) prayer. Other patients report reading the Bible as a way of coping with cancer (Bean, Cooper, Alpert, & Kipnis, 1980). Several activities of religious faith (such as bible reading, prayer, and calling on clergy) have been noted in the nursing literature (Kealey, 1974; Martin, Burrows, & Pomilio, 1976). Once identified, the nurse can assist the patient, as needed, with the spiritual activities important to him thereby enhancing his ability to cope with cancer.

Spiritual Research Studies

Although seldom described within the framework of coping, several authors have specifically focused their research on the spiritual dimension of patients in general (Stallwood, 1969; Kealey, 1974; Martin, Burrows, & Pomilio, 1978) and others in specific regards to the population of cancer patients (McCorkle & Benoliel, 1981; Highfield & Cason, 1983). Research studies on the patient's spiritual dimension have included: patient's identification of their spiritual needs, activities, and resource persons (Stallwood, 1969; Kealey, 1974; Martin, Burrows, & Pomilio, 1978); nurses' awareness of patients' spiritual needs, activities, and resource persons (Kealey, 1974; Highfield & Cason, 1983); and the development of a tool for identification of patients' spiritual coping strategies

including the use of spiritual activities, resource persons, and expression of spiritual needs (McCorkle & Benoliel, 1981). Table 1 includes a description of these studies except for the McCorkle & Benoliel research which is primarily reviewed for its development of a spiritual interview. The major studies are critically analyzed for their generalizability, instrument validity and reliability, and contribution to nursing knowledge and practice.

The focus of the Stallwood descriptive survey (1969) was to determine patients' awareness of their spiritual needs during hospitalization. A large sample of adult patients, predominately composed of members of the Protestant faith, were interviewed in a variety of health care settings. The interview questions had only face validity and no reported reliability data.

This study has little generalizability beyond the present sample due to its sample selection technique. Patients were conveniently selected for the survey and cannot be representative of any other population other than its own. A self-selection bias exists because only those who want to participate in the study are included. This sample of nurses may be overrepresented or underrepresented by some characteristic relevant to the research study.

Reactive effects may also affect this study's potential for generalization as a threat to the external validity of the design. The Hawthorne effect is always a possibility in that people may respond differently because they know they

Table 1

Description of Nursing Research Studies That Identify Patients' Spiritual Dimension

Research Study and Date	Design/Tool	Sample Subjects Selection Criteria	Setting	Variables And Description of Sample	Validity and Reliability of Instrument
Stallwood 1969	Descriptive Survey	109 patients 18 yrs. or older, not critically ill, hospitalized 3 days or longer.	Acute care settings or extended care facilities in various parts of the U.S. 65% placed in nonsectarian health facility	Women 55% of N Men 45% Protestant 67% Catholic 22% Jewish 6% No affiliation 5% Age 18-90 yrs. (range)	Face Validity Reliability not reported
Kealey 1974	Descriptive Survey/ Interview - Semi-structured (patients)	40 patients, randomly chosen Age: 21-65 Fluent in English lang. Religion: Christian-Judeo Hospitalized in non-critical unit Mentally & physically capable of participation in 30-60 minute interview	Cancer Hospital Veteran's Hospital Community Hospital Medical Center 10 patients/setting: 5 medical pts. 5 surgical pts.	Majority of pts. were: 1) high school graduates 2) white 3) middle aged 4) married 5) Protestant 6) hospitalized at least once previously 7) 1/2 hospitalized under one week 13 hospitalized 1-2 wks 6 hospitalized 2-4 wks 1 hospitalized 4+ wks 2 ready for discharge 8) 23 males, 17 females	Content validity with support by literature review and based on material from Nurses Christian Fellowship. Reliability not clearly reported.
	Questionnaire (nurses)	24 Registered Nurses Working fulltime on medical-surgical units for 3 consecutive days during the week of data collection Giving patient care or team leading during time specified for the study Of Judeo-Christian background	Attempted to include 6 nurses/setting: 3 medical RNs 3 surgical RNs	The nurses were: 1) white - all 23 (one nurse did not reply) 2) diploma graduates - 12 A.D. grads - 2 B.S. grads - 9 3) practicing for 5 yrs. or less - 15 practicing longer than 5 yrs. - 8 4) sectarian schools attended - 8 nurses (Catholic, Lutheran, Baptist, etc.) non-sectarian schools - 15 5) religious faith: Protestant - 11 Catholic - 10 none - 2	Content validity supported by review literature and developed from Kramer's study (1957)[a]. Tested for reliability on 2 surgical nurses not included in the study.

[a]Kramer, P. A survey to determine the attitudes and knowledge of a selected group of professional nurses concerning spiritual care of the patient. Unpublished master's thesis, University of Oregon, 1957.

Table 1 (continued)

Research Study And Date	Design/Tool	Sample Subjects Selection Criteria	Setting	Variables And Description of Sample	Validity and Reliability of Instrument
Martin, Burrows & Pomilio 1976	Interview & Questionnaire (Likert 5 pt. Scale) Descriptive Survey	90 patients for the questionnaire 65 pts. for the interview Criteria: Availability Voluntary participation Rationality Non-critical status	Adult population of 2 general hospitals	Questionnaire: 49 M; 41 F 64% married 48% Catholic 42% Protestant age: 16-87, mean 53.8 yrs. Interview: 34 M; 31 F Hospitalized during past five years: 1 time - 27% 2 times - 23% 3 or > times - 49% no response - 1%	Content validity with support by literature review. Also used Stallwood interview results as basis for questionnaire and interview content validity.
Highfield & Cason 1983	Descriptive Study/ Questionnaire	35 surgical nurses Criteria: worked with cancer pts. consented to participate 35 out of 100 nurses chose to participate	1200 bed southwestern medical center	R.N. - 80% of N L.V.N. - 20% Ave. Age - 32 yrs. Ave. length of practice - 10 yrs. Religion: Protestant - 25 Catholic - 7 Jewish - 1 Unspecified - 1 none - 1 Spiritual care included in basic nursing curriculum - 53%	Content validity by panel of theology and psychology experts. No information about tests for reliability.

are part of a research study. This study is also subject to experimenter bias. Knowing the nature and purpose of the study, the investigator may consciously or unconsciously bias reporting of the results and draw faulty inferences.

Despite the limitations of this study, the survey proves useful to describe that a variety of patients do have spiritual needs upon hospitalization. The patients most frequently expressed the need for prayer (though the number of patients expressing this need was not reported). Eighteen percent of the patients reported a fear of surgery and death, and the need to find meaning and purpose in life, death, and suffering. Patients also expressed a desire for spiritual assistance from a variety of resource persons. They ranked the clergyman (minister, priest, or rabbi) as the first person with whom to discuss their spiritual needs; nurses were second, followed by family members, friends, and other hospital personnel. The researcher concluded that many patients would appreciate help in meeting their spiritual needs from a nurse who was available to listen and intervene or refer the patient to his appropriate spiritual counselor (Stallwood, 1969).

Kealey's unpublished master's thesis (1974) focused on the spiritual needs expressed by hospitalized patients as well as the nurse's role in administering to these needs. Patients were interviewed and the nurses were given a 52-item questionnaire from the same four settings as the patients: a cancer hospital, veteran's hospital, community

hospital, and medical center. Ten patients (5 medical and 5 surgical) and 6 nurses (3 medical and 3 surgical) were selected from each setting.

Twenty three males and 17 females constituted the patient population. The majority of the patients were high school graduates, white, middle-aged Protestants. The patients' disease states were stated only in general terms: 11 with cancer; 6 with cardiovascular disease; 5 with endocrine disease; 12 with gastro-intestinal disease; 3 with respiratory disease; and 3, one each with neurological, urinary, and other disease. All 24 nurses were female. The majority of them were white, diploma graduates, and had practiced nursing for less than five years. Eight of them had attended sectarian schools; 11 professed to be Protestants, 10 Catholics, and 2 held no religious affiliation (Kealey, 1974).

The patient interview was based on literature from the nurses Christian Fellowship organization. Content validity was further substantiated by the researcher's review of literature. However, estimates of reliability were not made clear. The interview was pilot tested with two patients before it was conducted with those in the study.

The content for the nurses's questionnaire was based upon an interview utilized in an earlier thesis (Kramer, 1957). The Kramer interview was derived from a review of the literature establishing its content validity and was not tested for reliability. Content validity of the revised

instrument was addressed by two surgical nurses not included in the study. Reliability of the nurses' questionnaire was not reported.

Kealey's approach to content validity is in accordance with Polit & Hunger's (1978) interpretation as it was judged to represent spiritual issues. However, the use of only 2 patients and 2 nurses to validate the patient interview questions and nurse questionnaires is inadequate. Reliability of both instruments are not clearly established and this weakens the generalizability of the findings beyond the present sample. It is questionable whether the results are applicable to even the sample under study when reliability is not reported.

Several other factors in this study may effect its generalizability. The nurses were conveniently selected and cannot be representative of any other population other than its own due to a self-selection bias. However, the sample of patients was randomly chosen except in one setting where all the surgical patients were needed to meet the criteria for selection. Unfortunately, this exception weakens the generalizability of results obtained from the patient interviews.

The relatively small sample size for patients (N=40) and nurses (N=24) is another cautionary factor for generalizations made beyond the samples under study. In addition, the Hawthorne effect and potential for

experimenter bias during patient interviews are a threat to the external validity of the design.

Though one fourth of the sample was oncology patients, the data were not delineated to oncology patients as a subgroup. Instead, the oncology patient responses were recorded with the rest of the patients as a whole. However, with a small subgroup of only 10 oncology patients separate analysis of these patients' responses would yield less stable statistics, a greater standard error, and therefore little and cautionary generalizability to the oncology patient population.

Despite the possible threats to the study's generalizability, the data obtained from the respondents contribute important knowledge to the dearth of research concerning patient spiritual coping activities and the role of nursing in assistance with these activities. The results were appropriately analyzed with descriptive statistics.

The vast majority of patients (90%) stated a need for God's presence and help, and spiritual support from their faith. Three fourths of the patients interviewed sought help from clergy, prayer, and religious books while 83% were active Bible readers. The use of activities such as prayer, reading the Bible or other religious books, and seeking clergy for spiritual assistance, suggest that some patients regard their spiritual dimension as an integral part of their coping strategies during a crisis such as illness.

The majority of nurses (95%) agreed upon the role of the nurse in patients' spiritual care. Most of the nurses indicated that their own religious faith helped them to console patients needing spiritual comfort. They considered listening to patients' verbalizations of spiritual concerns and feelings, reading religious material, and referring the patients to clergymen as important ways for nurses to help patients fulfill their spiritual needs (Kealey, 1974). In conclusion Kealey recommends that a spiritual/religious evaluation be included in the nurse's patient assessment (1974).

The focus of the Martin, Burrows, & Pomilio study (1976) was to determine the spiritual needs, activities, and use of resource persons of adult hospitalized patients. Ninety patients were given a 26-item questionnaire and 65 of them agreed to be interviewed after completing the questionnaire. The patient demographics in this study were not well described. Disease states of the patients were not included and the patients interviewed were only described by the number of times they had been hospitalized in the past five years. Those who completed the questionnaire were almost equally distributed between Catholic and Protestant religious faiths, and were predominately married and middle-aged.

Content validity, based on the Stallwood interview and a review of literature, was reported for both the questionnaire and interview. Estimates of the instruments'

reliability was not reported thereby weakening the generalizability of the findings beyond the present sample. The generalizability of the study's results are also limited, despite the large sample size, by the convenient sampling technique utilized for the participants. In addition, the Hawthorne effect and possible experimenter bias during the interviews pose a potential threat to the external validity of the design. A problem in instrumentation occurs in this study with several investigators interviewing patients thereby posing a threat to the internal validity of the design. Despite these limitations, important information was obtained which enhances nursing knowledge about the patient's spiritual dimension.

The four most important spiritual needs ranked by the patients in the questionnaire were relief from fear of death, a knowledge of God's presence, expression of caring and support from another person, and receiving the sacraments. Persons with whom most patients preferred to speak about spiritual needs were clergymen--chaplains, ministers, priests or rabbis. Patients also utilized prayer (25%), bible reading (25%), and visits from clergy (57%) during their hospitalizations. Church attendance or worship was found to be important among 13% of the patients (Martin, Burrows, & Pomilio, 1976).

The patients also described their perceptions about the nurse's role in spiritual care. The majority (65%) felt

that nurses were qualified to help patients meet their spiritual needs and most (73%) felt that nurses should ask every patient if he wanted to see a clergyman. The vast majority (97%) believed nurses give spiritual care by being concerned, cheerful, and kind. Most of the patients (77%) also included listening to the patient review his beliefs and feelings as spiritual care. Fifty-nine percent did not feel that a patient's beliefs about God were too personal to discuss with the nurse. An even greater majority (87%) did not feel that nurses who talked about God with their patients were trying to convert them (Martin, Burrows & Pomilio, 1976).

The interview revealed specific spiritual needs expressed by male and female patients. The researchers found that 48% of the subjects (N=65) interviewed expressed a spiritual need during hospitalization. Men, comprising 32% of those verbalizing a spiritual need, expressed the need for support, hope, help, a relationship to God, and freedom from discouragement. Women (the remaining 68%) verbalized a variety of the following needs: relief from nervousness, worry, fear, loneliness; concern for husband and children; fear of tests and diagnosis; knowledge of God's presence and relatedness; need for calmness, comfort, salvation; desire to see a clergyman; communion; and reason for suffering (Martin, Burrows, & Pomilio, 1976).

Based on these findings, the researchers recommend that, on patient admission or as part of their routine

nursing care, nurses should assess if their patients wish to see a clergyman. They also felt nurses need not feel hesitant to give spiritual assistance because the patients strongly supported the nurses' role in spiritual care. The nurses' major responsibility was felt to be that of listening and referral and not that of knowing all the right theological answers.

The focus of the Highfield & Cason study (1983) was identification of the nurses' awareness of oncology patients' spiritual needs. A 49-item questionnaire was distributed to 100 nurses practicing on surgical floors in a 1200-bed private hospital in a large southwestern medical center. Of the 35 nurses who responded, 80% were registered nurses and the remainder were licensed vocational nurses. Their average age was 32 and average length of practice was 10 years. All except one claimed some religious affiliation: 25 Protestant, 7 Catholic, and 1 Jew (Highfield & Cason, 1983).

Content validity for the questionnaire, based on nursing and pastoral literature, was established by a panel of theology and psychological experts. A pilot study was conducted before the questionnaire was distributed. However, the sample size of the pilot study was not reported and it is unclear whether this study was utilized to establish content validity and/or reliability of the questionnaire.

A self-selection bias also exists for this study based on the 35% questionnaire return rate, limiting its

generalizability to the sample under study. The small sample size is another cautionary factor in generalizing the results beyond the present sample. It is assumed that the authors distributed the questionnaires without biasing the nurses' decision to participate. The results were reported appropriately with descriptive statistics.

It is unknown what reactive effect the setting may have on the results. Some nurses may have completed the questionnaire in the work setting with possible influences of work-related distractions; others may have completed theirs in a more relaxed environment whether at home or in a quiet room in another part of the hospital. In addition, it is unclear whether the nurses were instructed to fill out the questionnaire independently to guard against the bias of consultation from peers.

The questionnaire was divided into two sections: the first contained 31 behaviors or conditions indicative of a spiritual problem; the second included 18 behaviors or conditions indicative of spiritual health. Each nurse was asked to rate, on a 1-5 scale, how frequently their patients exhibited these behaviors and conditions. In addition, the nurses were to identify them with either the psychosocial or spiritual dimension of man. The results were appropriately analyzed with descriptive statistics.

Most of the nurses (more than 50%) identified only 5 of 31 problems as spiritual in nature. Four of these items contained a direct reference to God or religion with the

fifth item relating to the meaning of suffering and death. In addition, the only items signifying spiritual health that nurses identified within the spiritual dimension were those containing direct references to God or particular religious beliefs and practices. These findings suggest that nurses support the definition that man's spiritual aspect of being is related to his relationship with God or a higher being and not inclusive of psychosocial or man-centered elements (such as the reliance on self or others for love and support).

No items containing direct references to God or religion were checked as patient problems. The only item within the spiritual dimension to be identified as a problem was the meaning in suffering and death, which was thought by the nurses to occur infrequently among their cancer patients. On the other hand, they identified patient problems in the psychosocial dimension to occur frequently.

The researchers contributed the infrequency of spiritual problems identified by nurses to several factors. Nurses may have a limited ability to recognize spiritual problems because of their own fear and guilt or presuppositions about the nature of man which may lead them to communicate with their patients in ways that inhibit patient expressions of spiritual needs. The infrequency of spiritual problems could also be a true reflection of patient behavior. However, there is no way to verify this since patients themselves were not interviewed.

Since the nurses were more aware of problems they identified as psychosocial than spiritual, the researchers concluded that nurses may not effectively identify and offer interventions for some spiritual problem, particularly those dealing with specific religious practices and beliefs (Highfield & Cason, 1983). Furthermore, nurses should be able to identify the spiritual coping activities used by their patients. Otherwise the patient may not be assisted with those coping activities important to him. Additional research is needed to identify the spiritual needs of cancer patients and the spiritual coping activities used by the patient to help meet these needs.

The descriptive methodological research of McCorkle & Benoliel (1981) was designed to develop an interview tool for identification of coping strategies utilized by cancer patients. Sixty-one newly diagnosed lung cancer patients were interviewed in a pilot study of this tool. Patients first completed the Inventory of Current Concerns (ICC) to identify problem areas of concern to the patient. The McCorkle & Benoliel interview was then utilized to survey coping activities for each of the areas identified by the patient as a concern. The semi-structured interview included items which related to the patient's relationship with God or higher being (such as the use of prayer, bible reading, clergy, and church attendance).

The investigators reported face and content validity of their interview. Content validity of the interview is based

on the ICC developed by Weisman and Worden (McCorkle & Benoliel, 1981). Reliability was not specifically tested for by the investigators. They felt it did not warrant further reliability testing since the content about religious concerns is based on the ICC with known validity and reliability (McCorkle, 1984). The Chronbach's alpha coefficient, used to derive a statistical estimate of internal reliability, was reported to be 0.81 for the ICC section on religion (Weisman, Worden, & Sobel, 1980). However, this form of instrument reliability by adoption weakens the study's generalizability.

Several research assistants interviewed the cancer patients which introduces the possibility of instrumentation problems with different interviewers. This is a threat to the internal validity of the design. It is unknown whether the authors tested for inter-rater reliability, but the assistants were all instructed at the same time, by the same person, on the procedure for data collection.

Again, the Hawthorne effect and experimenter bias are possible reactive effects which pose a threat to the external validity of the design. The small sample size of cancer patients interviewed, in addition to previously mentioned reactive effects, limits the generalizability of the results to the population under study.

A detailed description about the method of sample selection and procedure was not included in the manual of data collection instruments (McCorkle & Benoliel, 1981).

Sixteen (26%) cancer patients identified religious concerns and were subsequently interviewed for the coping activities utilized within the spiritual dimension. The results of the study describing the patients' use of spiritual activities were also not included in the manual of data collection instruments. However, this research proves most valuable for its development of an interview tool used to describe spiritual coping activities. The interview content identifies spiritual activities specifically related to the patient's relationship with God or higher being without any overlay of psychosocial content.

Summary

The results of these studies demonstrate that some patients have perceived spiritual needs evidenced during hospitalization (Stallwood, 1969; Kealey, 1974; Martin, Burrows, & Pomilio, 1976; Highfield & Cason, 1983). In addition, patients have identified their use of specific activities within the spiritual dimension as an integral part of their coping strategy with illness. Fish & Shelley (1978) also note that these spiritual activities may indicate the presence of a spiritual need and thus may be recognized by nurses for assessment of spiritual needs.

These studies did not measure the spiritual needs or use of spiritual activities and resource persons identified by cancer patients as compared with those identified by nurses. One of the studies applicable to cancer patients included psychosocial items as part of the spiritual

assessment tool (Highfield & Cason, 1983). The psychosocial dimension does not adequately address the spiritual dimension as defined by this researcher. Among all the study instruments reviewed, the McCorkle & Benoliel interview proves most promising and adaptable for the purposes of this study. It was specifically designed for use with cancer patients for identification of spiritual strategies specifically related to the patient's relationship with God or higher being.

The review of literature and research studies demonstrate that many patients consider their spiritual dimension an important part of their lives. Patients in general, including cancer patients, have identified the use of a variety of spiritual activities and resource persons in coping with cancer. Despite the references in nursing literature that assert that spiritual care is an important aspect of nursing, little research has been conducted regarding the spiritual dimension of hospitalized cancer patients. Further studies on patients' and nurses' identification of spiritual needs would be valuable in establishing the nurse's role in spiritual care.

Definition of Terms

The following terms are defined by this researcher for use in this study as based upon the theoretical framework.

Spiritual care: is the assessment of patient spiritual needs and coping strategies; the assistance given to support the patient's use of spiritual strategies in meeting his spiritual needs, and in coping with stressful situations such as cancer. This assistance, whether by direct personal intervention or referral, may be given by nurses, clergy, or other individuals.

Spiritual need: is the need to establish or maintain a relationship with God or a higher being that provides man with a meaning and purpose in life as measured by the patient's verbal expression and/or observable behaviors such as prayer, Bible or other religious reading, visits by or telephone calls to spiritual resource persons, or participation in sacraments or church worship.

Meaning: the reason or value given to particular life experiences by the patient (not health care staff) undergoing an experience.

Spiritual strategies: the use of spiritual activities (such as bible reading and prayer) and spiritual resource persons (such as a minister, priest, rabbi, or friend) to cope with a stressful situation.

Oncology patient: an adult person (18 years or older), male or female, with a histological diagnosis of cancer, undergoing treatment for curative or palliative care of their disease.

Professional nurse: any registered nurse who interacts with oncology patients and is identified as the primary care giver of a patient under study.

Primary care giver: is a registered nurse regularly assigned to work, at least two 12-hour shifts/week, with a cancer patient under study.

CHAPTER THREE

METHODOLOGY

Descriptive research is necessary to describe the phenomena of man's spiritual needs and strategies when previous studies in the nursing literature have been plagued with methodological weaknesses. Though no judgments or evaluations can be made, the description of patient and nurse responses to an interview about the patient's spiritual dimension can be the basis for further, more rigorous studies. The descriptive study can also prove useful in theory development of patient spiritual needs and use of spiritual coping strategies (Polit & Hungler, 1978, pp. 23-24).

Survey research is also utilized in this study to examine the distribution of patient and nurse attitudes about the patient's spiritual dimension in a given population. A descriptive survey is appropriate to describe attitudes and intentions of individuals in a sample by asking them to answer a series of questions (Polit & Hungler, 1978, pp. 206-207). The interview technique is chosen for data collection in this study because it is thought to increase the subject's response rate, produce additional data through observation, and obtain better quality data than self-administered questionnaires (Polit & Hungler, 1978, pp. 352-353).

This study also describes the degree of agreement between the spiritual needs and strategies identified by the

patient and those patient spiritual needs and strategies identified by the nurse. The difference between patient and nurse characteristic and demographic variables, and the patient's expression and nurse's identification of patient spiritual needs and strategies are also examined. A descriptive correlational study aims to describe the relationship among factors rather than to infer cause-and-effect relationships (Polit & Hungler, 1978, p. 185). Therefore, a descriptive-correlational survey is the appropriate research design for this study.

Sample

The sampling procedure selected for a research study depends on the availability of study subjects and support of hospital administrations for participation in nursing research. One major medical center in San Francisco was selected for this study due to its support of nursing research and availability of oncology patients and nurses. A hospital with an established protocol for nursing research was chosen for this study to avoid the additional time needed for administration to establish first-time nursing research.

Random sampling of patients and nurses would provide for probability sampling and more conclusive generalization of the research findings than a convenient sampling technique. However, this randomization of patients and nurses could prove arduous. It is difficult to know exactly how many patients are available for random selection during the time

interval needed for data collection, as well as how long that number will remain stable. When hospitalized patients are randomly selected at a given time, a small sample size could result depending on patient census. Random selection of nurses could further limit the sample size since the nurse must also be paired with a patient willing to participate in the study.

Generalizability of the study findings is also influenced by the sample size, increasing in direct proportion to the size of the sample. A larger sample size can be secured with a sample of convenience and is therefore preferred over randomization. Convenient sampling, though a non-probability selection technique, will accept any individual for study if they meet the established criteria. This sampling procedure is also appropriate when replicating a study with new samples (Polit & Hungler, 1978, p. 458). The McCorkle & Benoliel interview tool will be replicated with only slight modifications for this study.

Therefore the nurses were selected according to purposive selection criteria. However, in accordance with Polit & Hungler (1984, p. 461), to gain a greater degree of generalizability, stratified random sampling was utilized to select patients for inclusion in the study. The patients were subdivided or stratified into groups according to the nurses who agreed to participate in the study. Each patient

in the study was then randomly chosen, using a table of random numbers, from among the patients of the participating nurses.

At least 25 nurses were to be match-paired with 25 patients for the degree of agreement between the spiritual strategies and needs identified by the patient and those identified by the nurses. A sample size of 25 pairs may be considered adequate for descriptive research. A lack of resources and time limited the sample to this size.

Nurses were selected for study based on three criteria. As the first criterion, only registered nurses were included in this study. Second, the nurse must be identified as the primary care giver of a patient under study. This was verified verbally by the nurse, in addition to the researcher checking the patient's chart for notations of care by the nurse under study. Primary care giver is defined as a registered nurse regularly assigned to work (at least two 12-hour shifts/week) with a cancer patient under study. Third, the nurse must be willing to participate in the study as evidenced by her signature on the informed consent (see Appendix A).

Patients were selected for study according to four criteria. First, they must be a hospitalized male or female adult (18 years or older), as verified by chart review and patient response. Second, they must be aware of their diagnosis of cancer as verbally verified during the interview. They may be undergoing treatment for curative or

palliative care of their disease. Third, patients must be willing to participate in the study as evidenced by signature on informed consent (see Appendix B). Lastly, those cancer patients diagnosed within 6 weeks of data collection will be excluded from this study.

The recently diagnosed patient is faced with the crisis of having cancer, which is often associated with death and dying (Ehlke, 1978). A patient is faced with a crisis when an insurmountable obstacle prevents the usual methods of coping from resolving the distressing situation. The search for solution and resolution is time-limited for four to six weeks before the individual may move to a healthy adaptation or maladaption (Carter, 1976, p. 8). The diagnosis of cancer, no matter what type, presents an insurmountable obstacle and crisis that elicits spiritual questions about the meaning of life (Hirano, 1978, p. 311). To avoid the effects of crisis on the recently diagnosed cancer patient's identification of spiritual needs, these patients were screened and excluded from the study. Patients were screened for a new diagnosis of cancer by chart review.

Data Collection Instrument

The McCorkle & Benoliel interview tool (1978) is the instrument best applicable to the descriptive purposes of this study. It was designed for use with cancer patients for identification of religious strategies specifically related to the patient's relationship with God or higher being. Furthermore, the language of the interview tool is

germane to the purposes of this study. The semi-structured interview includes items describing the patient's relationship with God or higher being, his use of spiritual activities and resource persons, and his expression of spiritual needs. This tool was used only with lung cancer patients (McCorkle & Benoliel, 1978), but the items are general and should not pose a problem in use with other types of cancer patients. The authors correctly caution the use of this tool as purely descriptive.

Although the tool's content validity and reliability (0.81 Chronbach's alpha coefficient) is based on that of another's (ICC), further research utilizing the McCorkle & Benoliel tool can be initiated to establish validity and reliability of its own. Content validity is further established by the present researcher's review of literature and expert panel who judged it to adequately represent spiritual issues. The expert panel consisted of three experts in oncology nursing and one in theology.

The patient interview was slightly modified (as described later) by the researcher for use in this study. The nurse interview was developed by the researcher to correspond directly with the items on the patient interview. Introductory and demographic sections were added by the researcher previous to the interview schedule for both patients and nurses (See Appendix C and D). The patient interview is semi-structured which allows the patient to contribute items of concern that may not be asked by the

researcher in a structured interview (Polit & Hungler, 1978, pp. 329-330). The nurse interview is more structured, but an open-ended question was added last so items of concern to the nurse that had not been asked could be addressed here.

The beginning introduction of the patient interview guide has been slightly altered and a few questions have been added to elicit information specific to the focus of the interview. An additional question has been utilized to determine if a patient includes a relationship with God or a higher being in his definition of "spiritual". A second question was added to identify if the patient's attitude about spiritual things had changed since the diagnosis of cancer was made (see Appendix C).

Items 25-28 were added to the section entitled "other information" because an individual's expressions of guilt, blaming God, and/or need for forgiveness may also be reflective of spiritual need. Kealey (1974) notes that many people believe that illness is a punishment from God for some sin or failure. Those individuals beset by guilt feelings often search for forgiveness and peace from God (Pruyser, 1974; Hirano, 1978). Item 28 was added since the fear of death and/or suffering may cause a person to be reflective of his relationship with God or higher being. Patients in the Martin, Burrows, Pomilio study (1976) identified relief from these fears as their most important spiritual need.

The items in the "other information" section were designed by the original tool's authors for collection of information in the absence of direct question. However, three of these items (17,18,19) were relocated by the researcher for direct questioning. The researcher did not believe it would bias or cause undue harm to ask the patient (at the appropriate point during the interview) a question about Bible memorization, watching religious television, or listening to religious radio.

Twenty one of the patient interview items were utilized to describe the degree of agreement between the patient spiritual needs identified by the patient and those identified by his nurse. These items have been chosen to correlate patient and nurse responses because they reflect needs and coping strategies within the spiritual dimension as described in the review of literature. The other items are either more descriptive of the same needs and strategies or elicit qualitative responses which, in both cases, will be utilized for the descriptive purposes of this study. For clarity, the items chosen for correlating the agreement among patient and nurse identification of patient spiritual needs and coping strategies have been listed in Table 2.

It was not possible to combine the interview guide with coding scales for the patient interview. Open-ended questions of the interview allowed for information to be volunteered at any time. Therefore, the researcher was familiar with the coding guide so that all information was

Table 2

List of Interview Items Utilized to Measure the Agreement Among Patients and Nurses

The patient has:

i. Stated a religious affiliation (identify which one).

1. spoken to clergyman.

2. spoken to someone in his family.

3. spoken to a friend.

4. spoken to a non-clerical professional (physician, nurse, or other).

5. reviewed his life in reference to his relationship with God.

8. prayed in recent weeks.

13. asked someone to pray with him.

14. asked someone to pray for him.

15. read the Bible recently.

15b. read other books besides the Bible.

16. gone to church recently.

16a. made contributions to church (in personal service or financially).

17. memorized Bible verses.

18. watched religious television or listened to religious radio.

19. surrounded self with religious objects and music.

20. tried to find meaning and purpose in life related to God.

25. made references to guilt feelings related to God.

Table 2 (continued)

26. made references to blame/anger towards God.
27. made references to a need for forgiveness from God.
28. made references to a fear of death and suffering that causes him/her to be reflective of his relationship with God.

Note: The items are numbered according to the same number utilized on the patient and nurse coding scales.

smoothly and methodically recorded on the coding scale throughout the interviews (McCorkle & Benoliel, 1981).

Procedure for Data Collection

Permission of the institution review board was obtained for conducting this study, including the approval of both nurse and patient consent forms (Appendix A and B). Oncology nurses were approached for their consent to participate in the study afterwhich they were randomly match-paired with one of their patients for the correlational purposes of this study. The patient was interviewed first after signing the consent to participate in the study. The nurse was interviewed immediately following the patient interview to avoid any interaction with the patient that could bias the nurse's responses.

A coding system, known only to the researcher, was utilized to maintain subject confidentiality. The author was the only researcher conducting interviews for this study. Careful monitoring of personal reactions to the responses of patients and nurses was necessary to avoid interviewer bias affecting data collection. In addition, interview items were read as they appeared on the interview schedule.

The researcher took great care to be sensitive to patient problems that could have arisen during the course of the interview. Following the approved protocol by the institutional review board, the patients' religious preference was identified by chart review before the

interview was conducted. Patient referral for assistance with spiritual problems could then be made to the patient's appropriate spiritual resource person. The nursing staff was notified for follow-up of problems as needed. If indicated, the patient, nurse, or researcher could discontinue the interview at any point.

CHAPTER FOUR

RESULTS

The specific purpose of this study was to determine the degree of agreement between the spiritual strategies identified by the patient and those strategies identified by his nurse. The spiritual strategies examined include the patients' use of specific spiritual activities and resource persons. Information from patients as to how they view the nurse's role in assisting them with spiritual concerns and strategies was included. In addition, nurses were interviewed for the kind of information that would assist them in assessment of patient spiritual strategies and needs.

Twenty-six nurses were approached for participation in the study. One nurse refused due to her belief that the process of interviewing was an inappropriate way to assess patient spiritual needs. For each of the participating 25 nurses, one of their patients was randomly chosen for inclusion in the study. (Nurses averaged 5 patients for random selection.) When a patient refused to participate in the study, the consenting nurse was match-paired with another of her patients by utilizing a table of random numbers.

One patient refused due to fatigue and another patient was randomly chosen. Another patient did not initially refuse but did so when asked specific questions about prayer and Bible reading. She stated that she had a distinct

belief in God, but the questions were getting too personal so she did not wish to continue. Another patient was randomly chosen to participate. A total of 25 nurses were paired with 25 patients.

Patient Characteristics

The demographics and characteristics of the patients are described in Tables 3 and 4. The majority were Caucasians (64%) with the mean age of 48 years; male (64%), and of the Protestant faith (56%). Nearly half had experienced cancer in their families among parents, grandparents, and siblings.

The patients had a variety of cancer diagnoses, but the majority had leukemia: 9 with Acute Myelogenous Leukemia (AML), and 1 each with Acute Lymphocytic Leukemia (ALL) Chronic Lymphocytic Leukemia (CLL), and Chronic Myelogenous Leukemia (CML). Most of the patients knew their diagnosis for one year or longer.

Over 90% of the patients had an advanced disease or less than an estimated 6 months to live as indicated by physician chart notes and/or nursing reports. The limited diseases included ALL (no relapse since diagnosis 1½ years ago) and Squamous Cell Carcinoma of the anus. Patients were judged to be realistically aware of their prognosis if they correctly knew whether their treatment was for cure or palliation. In addition, they also needed to correctly identify the progression or effectiveness of their

Table 3

Demographics of Patients (N = 25) Included in the Study

Demographics	(N)	%
Age		
18 to 39 years	(8)	32
40 to 59 years	(13)	42
60 to 80 years	(6)	26
Sex		
Male	(16)	64
Female	(9)	36
Race		
Caucasian	(16)	64
Black	(3)	12
Hawaiian	(2)	8
Hispanic	(1)	4
Mexican American	(1)	4
American Indian	(1)	4
American Portuguese	(1)	4
Religion		
Protestant	(14)	56
Catholic	(8)	32
Mormon	(1)	4
Jehovah Witness	(1)	4
None	(1)	4

Table 4

Characteristics of Patients (N=25) Included in the Study

Characteristics	(N)	%
Personal experience with cancer		
Family	(11)	44
Friends	(2)	8
Cancer diagnosis		
Leukemia	(12)	48
Lung	(3)	12
Breast	(2)	8
Gynecologic	(2)	8
Unknown primary	(2)	8
Gastro-intestinal	(1)	4
Lymph	(1)	4
Musculoskeletal	(1)	4
Melanoma	(1)	4
Length of time patient has known diagnosis		
< 1 yr.	(9)	36
1 - 4 yrs.	(10)	48
5 - 10 yrs.	(4)	16
Prognosis		
Limited	(2)	8
Advanced	(23)	92

Table 4 (continued)

Characteristics	(N)	%
Patient's perception of prognosis		
Unaware	(6)	24
Realistically aware	(19)	76

treatment. Patient responses were judged to be correct if in accordance with physician and nurse reports.

More than four fifths of the patients were realistically aware of their prognosis. Of the few that were unaware, three did not understand that their disease was extensive with distant metastases and the others were unaware that their leukemia, in spite of chemotherapy, had progressed to "uniformly fatal" proportions as noted by the physician's progress noted. Each of these cases was reported to the head nurse for follow up.

Patient Interviews

The diagnosis of cancer admittedly influenced the patients' feelings about spiritual things. Seventeen patients (68%) stated an increased awareness and enhancement of their spiritual feelings since diagnosis. The patients were very open and candid in discussing their belief in God, their spiritual concerns, and their strategies of using spiritual resource persons and spiritual activities.

Twenty four patients (96%) stated a religious affiliation and one patient (4%) professed to be a humanist relying only on himself and others. Twenty two (88%) found their meaning and purpose in life through their belief and relationship in God. Two professed a belief in God, but not to the point where they sought a relationship with God for purpose and meaning in their life. However, they did "call on God as needed--in times of trouble" through prayer for peace and strength in physical healing. Twenty two of the

patients felt their spiritual experiences were both emotional and intellectual while two felt they were primarily emotional.

Patients described a variety of perceived spiritual needs and concerns throughout the interview. Sixteen (64%) expressed a need to find strength and hope, both physically and emotionally, in their relationship with God (through prayer), family, and friends. Nine patients (36%) specifically stated they were working on their relationship with God by trying to trust Him more and rely on Him to work things out. Thirteen patients (52%) expressed a fear of death and suffering that caused them to reflect upon their relationship with God and their eternal security in life after death. Two of these patients had near death experiences that prompted their concern for eternity. Eight patients (32%) referred to clergy for communion and the need for forgiveness. Others (20%) specified a need to pray for peace and for getting better or cured. Only two patients (8%) expressed that they "blamed God for what was happening" to them and that they were "angry with God." None of the patients claimed any feelings of guilt related to God, such as they should have prayed or read the Bible more.

Various resource persons were sought by patients to discuss their spiritual concerns (see Table 5). The patients utilized a combination of persons for spiritual support, but confided mostly (92%) in their families. Though utilized the least, just under half the patients

Table 5

Resource People with whom Hospitalized Patients Share their Spiritual Concerns

Resource Person(s)	(N)	%
Family	(23)	92
Clergy	(19)	76
Friend	(17)	68
Professional	(12)	48

sought spiritual help and support from nurses and physicians. All 12 of these patients saught help from nurses and only 6 of them from physicians. They felt nurses were more accessible than the physicians. Just over half of the patients (13) stated they were "not sure nurses and physicians would have time for spiritual concerns," so they relied on family, clergy, and friends.

The specific spiritual activities used by the patients are described in Table 6. Patients (84%) reported the greatest use of personal prayer in addition to asking others to pray for them. However, not as many (20% less) asked others to pray with them.

The next highest category included their use of religious television, radio, music, and objects (such as plaques, rosaries, and wall hangings). Over half read the bible and relatively few memorized Bible verses or read other religious books. The frequency of reading religious books is not to be confused with that of Bible reading since some of the patients utilized both. Seven patients read the Bible at least seven hours per week; five read two to six hours; one read one hour; and one would have read seven hours or more if his eyes had not become affected by metastases. The patient having difficulty reading was referred to his nurse and hospital chaplain for assistance with bible reading. Thirty-two percent of the patients did request the spiritual activity of communion.

Table 6

Spiritual Activities Utilized by Hospital Cancer Patients (N = 25)

Activities	(N)	%
Prayer	(21)	84
Asks other to pray for him	(21)	84
Asks other to pray with him	(16)	64
Religious objects and/or music	(16)	64
Religious TV or radio	(16)	64
Reads Bible	(14)	56
Attends Church	(13)	52
Makes contributions to church	(10)	40
Reads other religious books	(10)	40
Memorizes Bible verses	(9)	36
Requests communion	(8)	32

Over half of the patients attended church at least once a week immediately prior to their hospitalization. A total of six patients reported that their illness caused a decrease in their attendance from several times a week to once a week. Their committment to church is evidenced by their activity of making regular (weekly or monthly) contributions to their church either financially and/or in personal service in 85% of those who attend church. The patient's contributions to church may be made while he is hospitalized and may be viewed as another kind of spiritual activity, in and of itself, that patients use to cope with cancer.

The hospitalized cancer patients utilized a mean of 5.4 spiritual activities (60%) and 3.2 resource persons (80%) for spiritual support and assistance. In addition, they expressed a mean of 2.0 spiritual needs (40%). The majority of patients affirmed a belief in God and revealed a variety of spiritual concerns, namely to find strength and hope amidst their circumstances. Several variables may be considered for their relationship to these findings.

Welsh Aspen T-tests (for unequal variances) were utilized to describe the difference between sex, race, religion, church attendance, experience with cancer, the patients' perception of their prognosis, and the patient's response on four spiritual categories. Pearson's correlation coefficients were utilized to describe the association of age and the length of time the diagnosis was

known by the patient with the patient's response on four spiritual categories. These test results are described in Tables 7, 8 and 9. However, due to the sample size and descriptive nature of this study, inferences drawn from these results are limited to the sample under study and may be the basis of recommendations for further research.

Pearson's correlation coefficients did not yield any significant statistical results for the variables of patient age and length of time the patient knew his cancer diagnosis with the patient's response on the four spiritual categories. T-tests did not yield any significant results for the variables of patient religion, race, experience with cancer, or diagnosis of leukemia.

The two variables which were statistically significant ($p<.05$) were patients' regular church attendance and perception of their prognosis. Those who regularly attended church were found to express more spiritual needs, and use more spiritual resource persons and activities during their hospitalization than those who did not regularly attend church. The patients who were realistically aware of their prognosis also expressed a greater number of spiritual needs and use of spiritual activities as opposed to those who were unaware of their prognosis.

Another interesting note is the results obtained when all the spiritual items in Table 2 are combined together for a total score of spiritual items. Patients with regular church attendance and those who are realistically aware of

Table 7

Statistical Results (T-Values) Describing the Difference between Patient Demographic Variables and the Patient's Response on the Four Categories of Spiritual Needs, Resource Persons, Activities, and Total Spiritual Items

	Spiritual Needs	Spiritual Resource Persons	Spiritual Activities	Total Spiritual Items
Sex (M vs F)	-0.51	-1.82	-1.92	-2.08
Race (Caucasian vs others)	-0.04	-0.14	-1.39	-1.07
Religion (Catholic vs Protestant)	1.03	1.98	1.42	1.89
Church attendance (non-attendance vs regular attendance)	-2.13*	-3.56**	-5.71***	-5.47***

*$p<.05$. **$p=.003$. ***$p<.001$

Table 8

Statistical Results (T-Values) Describing the Difference Between Patient Characteristic Variables and the Patient's Response on the Four Categories of Spiritual Needs, Resource Persons, Activities, and Total Spiritual Items

	Spiritual Needs	Spiritual Resource Persons	Spiritual Activities	Total Spiritual Items
Experience with cancer (none vs family and friends	-0.66	0.03	-0.82	-0.65
Perception of prognosis (unaware vs aware)	-3.60**	-1.53	-2.19*	-2.43*
Diagnosis of Leukemia (Leukemia vs others)	-0.25	-0.03	0.53	0.33

*$p<.05$. **$p=.002$.

Table 9

Correlation (Pearson's r) of Patient Demographic and Characteristic Variables and the Patient's Response on the Four Categories of Spiritual Needs, Spiritual Resource Persons, Spiritual Activities, and Total Spiritual Items

	Spiritual Needs	Spiritual Resource Persons	Spiritual Activities	Total Spiritual Items
Age	-0.16	-0.10	0.6	-0.02
Length of time diagnosis known	-0.05	-0.33	-0.20	-0.27

their prognosis scored higher results when all of the spiritual items were combined. Female scores were nearly statistically significant (p=0.051) for the expression of total spiritual items combined.

Nurse Characteristics

The characteristics of nurses in this study are described in Tables 10 and 11. The majority were Caucasian (84%) in their mid-to-late twenties, with a mean of 26 years. There were no male nurses working on the unit where data collection took place. Most of the nurses worked on the day shift (7a.m.-7p.m.) but two did work on the evening/night shift (7p.m.-7a.m.). During the two and one half months of data collection, it was convenient for both the researcher and only two nurses to conduct the interviews on the evening/night shift. However, since the nurses rotated shifts every other month, most of the nurses on the unit were available for inclusion in the study.

There was a near even representation of Catholics (40%) and Protestants (36%) as well as 5 who did not profess to any religious affiliation. Only 9 of the 20 (45%) who claimed a religious faith attended church at least once a week. Twenty one (88%) nurses defined "spiritual" as relating to God or a higher being in order to find meaning and purpose in life. Four (16%) held humanistic viewpoints of reliance on self and others and not a higher being in order to find meaning in life.

Table 10

Demographics of Nurses (N = 25) Included in the Study

Demographics	(N)	%
Age		
22 - 25	(8)	32
26 - 29	(11)	44
30 - 35	(6)	24
Sex		
Male	(0)	0
Female	(25)	100
Race		
Caucasian	(21)	84
Asian Japanese	(2)	8
Black	(1)	4
Mexican American	(1)	4
Religion		
Catholic	(10)	40
Protestant	(9)	36
Eastern	(1)	4
None	(5)	20

Table 11

Characteristics of Nurses(N=25) Included in the Study

Characteristics	(N)	%
Personal experience with cancer		
Family	(14)	56
Friends	(2)	8
"Scare" with self	(1)	4
Nursing degree		
BSN	(21)	84
AD	(3)	12
Diploma	(1)	4
School of nursing classes attended on spiritual needs		
none	(10)	40
1 - 10 hrs.	(11)	44
15 hrs.	(3)	12
> 15 hrs.	(1)	4
Length of RN practice		
1 - 2 yrs.	(7)	28
3 - 4 yrs.	(9)	36
5 - 10 yrs.	(9)	36

Table 11 (continued)

Characteristics	(N)	%
Time worked with cancer patients		
0.5 - 2 yrs.	(10)	40
3 - 4 yrs.	(10)	40
5 - 10 yrs.	(5)	20
Time worked with terminal patients		
< 1 yr.	(20)	80
1 - 2 yrs.	(3)	12
3 - 7 yrs.	(2)	8
Time scheduled to work with patient in study		
2 12 hr. shifts	(16)	64
3 - 10 12 hr. shifts	(6)	24
> 10 12 hr. shifts	(3)	12
How well RN knows patient (in relation to others she has cared for)		
not as good	(14)	56
same as	(5)	20
better than	(5)	20
unsure	(1)	4

Table 11 (continued)

Characteristics	(N)	%
How well RN assesses spiritual needs (as compared with others RNs)		
not as good	(3)	12
same as	(16)	64
better than	(5)	20
unsure	(1)	4

Twenty two nurses (84%) graduated with a BSN, 3 of which did so from a sectarian school of nursing. Forty percent of the nurses did not have any classes that dealt with patient spiritual needs, while 44% received 1-10 hours of instruction on the nurse's role in spiritual care, usually as a subcategory of psychosocial needs or in death and dying lectures. Three of the nurses (12%) were taught one unit (15 hours) specifically regarding religion and spiritual care of patients. The remaining nurse could not designate a number of hours of spiritual instruction since it was so pervasive through her nursing program as an intrinsic part of their nursing framework.

Most of the nurses had specialized in cancer nursing the majority of the time they have been registered nurses. They averaged over 4 years of nursing practice of which 3.4 years has been in cancer nursing. Most of the nurses (80%) spent less time (under 1 year) working with terminal patients who were not diagnosed with cancer. Most important the majority worked with their patients a total of 24 hours before their interview, and stated they did not know their patient as well as others they have cared for. The nurses felt they assessed patient spiritual needs as well as the other nurses on the floor, but commented that they thought none of the nurses assessed these needs very well. One nurse could not compare her care of the patient under study to others she has cared for, nor could she compare her ability to assess spiritual needs with that of other nurses.

This group of nurses, self admittedly, did not appear to be very well versed on patient spiritual needs or strategies and only a few had sought out continuing education classes on spiritual care.

The nurses differed from their patients who were interviewed in that they were younger females of both the Catholic and Protestant faiths. Not as many nurses attended church on a regular basis, less of them claimed to have a religious affiliation, and fewer claimed a belief in God or higher being for the meaning and purpose in their life.

Nurse Interviews

For the expressed purpose of this study, nurses were asked to identify their patient's religion and beliefs (items i,5,20), use of spiritual/resource persons (items 1-4), and activities (items 8,13,14,15,15b,16,16b,17-19) as described in Table 2. In addition, they were asked if their patient expressed a spiritual need (items 25-28).

The nurses' responses were matched with that of their patient's for correct identification of the patient's religious beliefs, spiritual resources and activities, and needs (see Tables 12-15). The nurse response of "don't know" was scored as an incorrect identification and not in agreement with the patient. Each of the nurses' responses were based upon their verbal interactions with and observations of their patient. No other source of information was identified. The chi-square test of goodness of fit (as described later) was utilized to determine

Table 12

Agreement Among 25 Pairs of Nurses and Patients on the Spiritual Beliefs of Hospitalized Cancer Patients

Spiritual Belief	Agree (Pairs)	%	Chi-square value
Finds meaning and purpose in life related to God	(19)	76	6.76*
Reviews life in relation to God	(17)	68	3.24
Religion	(11)	44	0.36

*$p < .01$.

Table 13

Agreement Among 25 Pairs of Nurses and Patients on the Spiritual needs of Hospitalized Cancer Patients

Spiritual Needs	Agree (Pairs)	%	Chi-squares value
Guilt feelings related to God	(23)	92	17.64**
Blame/anger towards God	(22)	88	14.44**
Fear of death and suffering	(18)	72	4.84*
Need for forgiveness	(15)	60	1.00

*$p<.05$. **$p<.001$.

Table 14

Agreement Among 25 Pairs of Nurses and Patients on the Spiritual Resource Persons Utilized by Hospital Cancer Patients

Resource Person	Agree (Pairs)	%	Chi-square value
Family	(15)	60	1.00
Professional	(15)	60	1.00
Clergy	(13)	52	0.04
Friend	(12)	48	0.04

Table 15

Agreement Among 25 Pairs of Nurses and Patients on the Spiritual Activities Utilized by Hospitalized Cancer Patients

Spiritual Activity	Agree (Pairs)	%	Chi-square value
Religious objects and/or music	(15)	60	1.0
Reads Bible	(12)	48	0.04
Prayer	(10)	40	1.00
Asks other to pray for him	(10)	40	1.00
Asks other to pray with him	(10)	40	1.00
Attends church	(10)	40	1.00
Makes contributions to church	(10)	40	1.00
Reads other religious books	(10)	40	1.00
Religious TV or radio	(7)	28	4.84*
Memorizes Bible verses	(4)	16	11.56**

*$P < .05$. **$P < .001$.

whether the nurses' agreement with patients departed significantly from the 0.50 (50%) level of chance.

It is assumed that the patients were reliable sources from which to compare the nurses' responses with. Potential problems that were not realized in this study were: (a) patients would have a tendency not to mention or share a belief in God or supreme being to a stranger-interviewer due to their lack of rapport with the interviewer and; (b) their sensitivity, and possibly of even embarassment in describing spiritual needs especially among a male sample with a female interviewer. Patients were open, showing no evidence of withholding information and lacked any contradictory statements. At least to this extent the patients have demonstrated their responses as reliable.

As described in Table 12, only 44% of the nurses could identify their patient's religion. There were not any nurses who incorrectly identified their patient's religion; they reportedly did not know. However, 68% identified that their patients' reviewed their life in relation to God during their conversations with family, friends, clergy, and professionals; 7 nurses did not know, and 1 did not identify that a patient did review his life in relation to God during these conversations. Although 76% correctly identified if their patient found meaning and purpose in their life through a relationship with God; 6 nurses did not know. Included in these statistics is the correct identification

of a patient who specifically had no preference for religion in his life as a humanist.

Four spiritual needs were anticipated for comparison of agreement among the nurses and patients (see Table 13). The nurses, in general, scored a high agreement on their patients' spiritual needs. Sixty percent correctly identified the patient's need for forgiveness. Six nurses did not correctly identify their patient's need for forgiveness through their stated need and/or request for communion. Four of them did not know if their patient had this need or not.

Guilt feelings and blame/anger towards God were expressed by a minimal number of patients and correctly identified by the nurses as such, lending a high percentage of agreement for these needs. Only two nurses did not know if their patients had guilt feeling or blame/anger towards God. One nurse did not recognize that her patient was blaming God for her illness. Two nurses stated they did not know whether their patients expressed a fear of death and 5 did not correctly identify that their patients did.

Many of the nurses did not correctly identify their patient's spiritual resource person (see Table 14). Just over half correctly identified their patient's use of clergy with 11 stating they did not know their patient's use of clergy and 1 not identifying that a patient did refer to clergy. Seven nurses did not know the patient's use of family and friends as spiritual resource persons. Two of

the nurses incorrectly identified that patients utilized family and friends for spiritual support when they reportedly did not, which may indicate they assumed their patients did because of their observed interactions with friends. One nurse did not identify that a patient utilized family for spiritual support when they did, and 4 did not recognize the patients' use of friends. Five nurses incorrectly identified their patients' use of professionals for spiritual support. Five nurses reported they did not know about their patients use of professionals as spiritual resource persons.

Neither did the nurses correctly report their patient's use of spiritual activities (see Table 15). Forty percent of the nurses correctly identified the use of the major spiritual activity utilized by patients, that being prayer. The nurses were as unlikely to identify if their patients asked others to pray with or for them. Fifteen nurses did not know if their patients prayed or asked others to pray with them. Two nurses did not identify the patient's use of asking others for prayer, 1 incorrectly thought her patients asked others to pray for him, and 12 did not know.

Nurses (60%) best recognized their patients' use of religious objects or music, while a low 16% identified their use of Bible memorization. It may be assumed that nurses identified more overt activities such as the use of religious objects and music as compared to prayer which may be performed more often in privacy and/or in silence.

However, this rationale does not seem plausible in light of low agreement scores on other activities, such as religious television and radio (28%), Bible (48%), and other religious book (40%) readings, which can be considered just as overt.

Twelve nurses (48%) did not know if their patients read the Bible and 20 (80%) did not know their patients' use of Bible memorization; one did not correctly identify her patient's use of bible reading or of its memorization. Thirteen nurses did not know if their patients read other religious books; two did not identify that their patient's did. Fifteen nurses did not know if their patients watched religious television or listened to religious radio in contrast to only 5 who did not know their patients' use of religious objects or music. However, only three nurses did not identify that their patients utilized religious television or radio as opposed to 5 that did not identify the use of religious objects or music.

The nurses were equally inadequate (40%) in their identification of patients' church attendance and contributions. Twelve nurses did not know if their patients attend church while 3 incorrectly thought they did. Fourteen nurses did not know if their patients contributed towards church (either in personal service or financially) with 1 incorrect identification that the patient did.

The goodness of fit chi-square statistic was utilized to determine whether the proportion of nurse and patient agreement departed significantly from the 0.50 level. The

nurses' agreement of 76% on the patients' belief that he finds meaning and purpose in life was found to be significant above the 0.50 level, thereby suggesting that this was not an agreement by chance (Table 12). Likewise, the proportion of agreement among nurses and patients was significant above the 0.50 level for the patients expression of: guilt feelings towards God, fear of death and suffering, and blame or anger towards God (Table 13). The nurses' proportion of agreement on the patients' use of spiritual resource persons did not significantly depart from the 0.50 level (Table 14). However, the nurses' proportion of agreement was less than 0.50 for the patients' use of religious television or radio, the Bible memorization (Table 15). This was due to the large number of nurses who self-admittedly did not know their patients use of Bible memorization (N=20) and religious television or radio (N=15). The nurses' response of "don't know" was automatically recorded as a disagreement with the patient.

Welsh Aspen T-tests were also applied to various variables for possible differences in the nurses ability to match the expressions of their patients. Statistically significant results were obtained for the variables of race, patient diagnosis, and how well the nurse knew the patient under study (see Tables 16 and 17). Nurses were found to identify a greater number of spiritual activities utilized by patients when the nurses knew their patients the same or better than others they cared for in the past. These nurses

Table 16

Statistical Results (T-Values) Describing the Difference Between Demographic Variables and Nurse and Patient Agreement on the Four Categories of Spiritual Needs, Resource Persons, Activities, and Total Spiritual Items

	Spiritual Needs	Spiritual Resources	Spiritual Activities	Total Spiritual Items
Nurse's Religion (Catholic vs Protestant)	0.64	-1.49	0.59	-0.40
Nurse's Church (non-attendance vs regular attendance)	0.43	-0.59	-0.25	-0.27
Patient's Religion (Catholic vs (Protestant)	-0.21	1.58	0.09	1.27
Patient's Sex (Male vs female)	1.26	-0.31	1.21	1.11
Patient's Race (Caucasian vs (others)	1.26	0.72	2.07*	1.76

* $p \leq 0.05$.

Table 17

Statistical Results (T-Values) Describing the Difference Between Characteristic Variables and the Nurse and Patient Agreement on the Four Categories of Spiritual Needs, Resource Persons, Activities, and Total Spiritual Items

	Spiritual Needs	Spiritual Resources	Spiritual Activities	Total Spiritual Items
Nurse's experience with cancer (none vs family and (Friends)	0.67	-0.05	-0.94	-0.50
How well RN knows patient (not as good vs the same or better than other patients)	-0.33	-1.11	-2.34*	-2.64*
Patients diagnosis (leukemia vs others)	2.58*	0.66	1.58	2.13*

* $p \leq 0.05$.

also matched a greater number of total spiritual items (Table 2) expressed by their patients.

Nurses were better able to describe the spiritual activities of their caucasian patients as opposed to those of other races in this study. In addition, the nurses identified the spiritual needs of leukemia patients better than those of patients with other diagnoses. The nurses identified a greater number of total spiritual items for their leukemia patients as well.

Pearson's correlation coefficients did not yield any statistically significant association of the patient and nurse agreement with the variables of the nurses' age; time worked with cancer patients, terminal patients, and their patient in the study; self-appraisal of their ability to assess spiritual needs; years of nursing practice; and number of classes on spiritual needs (see Table 18). In addition, the T-tests results indicate that the agreement among nurses and their patients about the patient's use of spiritual coping strategies and needs did not differ among any of the variables of the nurse's religion, church attendance, and experience with cancer. In addition, the nurse and patient agreement was not any different for the variables of the patient's sex or religion.

Table 18

Correlation (Pearson's r) of Nurse Demographic and Characteristic Variables and the Nurse and Patient Agreement on the Four Categories of Spiritual Needs, Spiritual Resource Persons, Spiritual Activities, and Total Spiritual Items

	Spiritual Needs	Spiritual Resources	Spiritual Activities	Total Spiritual Items
Age	-.27	.32	.06	.16
Time worked with Cancer patients	.05	-.08	.14	.10
Time worked with terminal patients	-.17	-.07	-.36	-.35
Time scheduled to work with their patient under study	-.02	.26	.08	.15
Rn's ability to assess spiritual needs	.21	.21	.25	.31
Years of nursing practice	-.08	-.14	-.18	-.19
Number of classes on spiritual needs	.03	-.03	-.07	-.10

The Nurse's Role in Spiritual Assessment and Interventions

The nurse's role in assisting patients with their spiritual concerns and strategies was described from the patient's perspective. The patients felt it was important and appropriate for nurses to:

Let the patient share/talk about their feeling about God and be willing to listen	N=19
Respect and acknowledge the patients religious beliefs	N=11
Provide privacy for prayer and assist the patient with praying as requested	N=13
Assist the patient with Bible reading as requested	N=11
Refer patients to clergy for prayer, communion or sacraments	N=14
Comfort patients by being positive, kind, gentle, and giving good physical care	N= 8

One patient commented that a nurse's spiritual assistance is fine, but that he preferred to handle spiritual things on his own. Another thought the nurse should "be sensitive in bringing up spiritual things--i.e., know the patient's religion" and would probably need to have a close relationship with the patient. A different patient said emphatically, "Don't hesitate to bring it up!" and another commented she did not hear talk about God and would like to! Two patients (one male and one female) summed up the majority of the patients' feelings by stating, "People fall back on their religion in times of crisis and have staff recognize this--support the patient's beliefs as a

strength and resource for him, but make it specific to the patient's background."

The nurses' perspective is somewhat different than the patients'. In response to the open-ended question, "What would you like to know about assessing patient spiritual needs," three nurses remarked they would not initiate a conversation about the patient's religion or spiritual things unless the patient brought it up first. One nurse stated that spiritual assessment was important, but felt it was easy to forget as she was too busy in delivering physical patient care.

On the other hand, 13 nurses thought spiritual assessment was important and were interested to learn more about it to enable them to better meet their patient's needs. Four of these nurses incorporated spiritual assessment as a part of their daily nursing care. The remaining eight nurses, although not commenting on the importance of spiritual assessment, did express a desire to learn more about meeting patients' spiritual needs. The nurses responded with the following types of information they would like to know:

What role does the patient's religious affiliation play in their life?

- do patients have a need to talk about spiritual things (1)
- what are their spiritual needs (1)
- what (activities & interventions) is important to them (6) N= 8

A care plan for assessment and intervention of patient spiritual needs (4)

- how to identify conflicts that need a spiritual resolution (2)
- How patients & families feel about their illness and are dealing with it (3)
- how to initiate the subject in a timely manner without offending patients (19)
- how can nurses become more aware of spiritual needs and encorporate them into their daily nursing care (1)
- How to support and assess spiritual needs when patients are in crisis or grieving/specific questions or statements to be of comfort (3) N=32

More about different religions

- practices and rites (7)
- they may view death differently (1) N= 8

Spiritual resources for patients N= 3

CHAPTER FIVE

DISCUSSION

The findings of this study support the review of literature and research studies which demonstrate that many patients consider their spiritual dimension an important part of their lives (Fish & Shelley, 1978; Weisman, 1979; Bean, Cooper, Alpert & Kipnis, 1980; Reeves, 1983; Highfield & Cason, 1983). The vast majority of patients utilized a variety of spiritual activities and resource persons as part of their strategy in coping with cancer. It is not surprising that patients aware of their prognosis expressed a significant number of spiritual needs and use of spiritual activities since the prognosis of 92% of the patients was advanced with a limited life expectancy. This result coupled with the patients reported increase in awareness and enhancement of their spiritual feelings upon diagnosis indicates the important role that the patient's spiritual dimension plays as part of his coping strategy.

The spiritual coping activities found to be utilized most often by the patients are prayer, bible reading, and the use of religious objects, music, television or radio. Oncology nurses should take note of these activities, assess if their patients utilize them as part of their coping repertoire, and assist them with the activities as needed. Nurses also need to know that some patients will desire communion or other sacraments and should be referred to their clergy.

Equally important is the patients' committment and desire to attend church. Over half of the patients attend church and utilize a significant number of spiritual resource persons and activities during their hospitalization. Some patients expressed a concern that their attendance had decreased due to illness. Discharge planning may then include the patient's ability to attend church with an assessment for transportation or church services in the home as an alternative.

The spiritual resource persons utilized most often by the patients were their family and clergy. Oncology nurses should then identify the patient's spiritual resource person for referrals as needed. Just under half the patients utilized nurses as a resource for spiritual needs and for assistance with spiritual activities. However, all the patients expressed a variety of ways that nurses could offer spiritual assistance. They reported that it was appropriate for nurses to listen to the patient talk about God; refer the patient to clergy; provide privacy for prayer and assist the patient with prayer as requested; respect and acknowledge the patient's religious beliefs; and assist the patient with Bible reading as requested. These patient suggestions for the nurse's role in spiritual care are consistent with those found in the review of literature (Kealey, 1974; Fish & Shelley, 1978; Martin, Burrows, & Pomilio, 1978).

It is of interest to note that females tended to score a higher expression of total spiritual items including the expression of religious beliefs, spiritual needs, and use of spiritual activities and resource persons. The Martin, Burrows, Pomilio study (1978) demonstrated that more than two thirds of the subjects verbalizing spiritual needs were females. These researchers interpreted the differences as a reflection of our society that inhibits a man from expressing a need or request for help. However, the men responded quite openly during the interviews in the present study as they verbalized a variety of spiritual needs and coping strategies. Although Tumin (1973, p. 320), professor of Sociology and Anthropology, states that "men and women are constituted differently, look differently, and everywhere behave differently" which may account for the near significant difference in lower numbers of male responses on all spiritual items combined.

It is not surprising to note that the nurses who self-admittedly knew their patients as well or better than other patients they cared for significantly recognized their patients' use of spiritual activities and expression of total spiritual items. This may indicate that nurses view spiritual concerns as a sensitive topic and are more comfortable initiating an assessment of spiritual needs and coping strategies when sufficient time has allowed a rapport to develop between nurse and patient. It is also reflective of a patient's remark that a close relationship (between

patient and nurse) may be necessary in bringing up spiritual matters. However, spiritual concerns were not viewed by the patients in general as a sensitive topic. This reinforces the importance of nurses to incorporate assessment of spiritual coping strategies as part of their daily nursing care. Nurses need not feel hesitant to initiate a discussion of a topic that they may believe is sensitive. The chance that the topic may be a sensitive one to some patients (as in the case of only one in this study) should not preclude its assessment.

Nurses also identified the spiritual needs and expression of total spiritual items of leukemia patients better than those of other patient diagnoses. This may be indicative of this nursing unit's focus and specialization in care of leukemia patients. The nurses under study cared for all the adult leukemia patients (which constituted 30% of the nursing unit's patient census) in the hospital where data were collected. Nurses were also noted to identify spiritual activities of their caucasian patients better than those of other races. The majority of nurses were caucasian which may indicate their ability to better recognize the spiritual activities of patients of like nationality. However, 75% of the leukemia patients were caucasians indicating that diagnosis and race are confounding variables for this sample.

Nurses intent on giving holistic care need to incorporate the spiritual dimension in their assessment of patient coping strategies. The nurses in this study

identified their patients' expression of spiritual needs to a satisfactory degree (72-96%) except for the need for forgiveness (60%). However, it should be noted that the high agreement on the patient's expression of guilt feelings and anger/blame towards God may have been inflated due to the minimal number of patients expressing these needs.

The nurses' relatively high agreement on the patients' fear of death and suffering may be due to a variety of factors. Relief from the fear of death and suffering is a patient need that most oncology nurses in general are aware of due to the threat that cancer may present to their patient's life. Despite its spiritual implications, fear of death and suffering may also be perceived as a psychosocial need that nurses more readily assess. It is also possible that the nurses made their responses considering what most cancer patients would feel concerning spirituality instead of what their match-paired patient may have said.

Of interest, the nurses could not identify the patients' specific religious affiliation, but they could recognize that their patients reviewed their life and found meaning and purpose in relation to God. The nurses' definition of spiritual did not significantly differ from that of the patients. In contrast, the nurses could not adequately describe (beyond 60% of the time) their patients' use of spiritual coping activities and resource person. This is partially due to the fact that only four nurses in

the study (16%) incorporated any kind of patient spiritual assessment in their daily nursing care. However, the nurses in this study are not alone in their lack of assessing patient spiritual coping strategies.

Nurses, in general, are hesitant to incorporate assessment of the patient's spiritual dimension into their practice of care. This reluctance may stem from several factors. Nurses may feel the constraints and lack of time for such assessment as noted by the nurses in the present study. In addition, patient questions may make nurses feel as vulnerable as their patients--especially if nurses are unsure of their own spiritual beliefs. The fear that the nurse won't quite measure up in the spiritual domain may be another reason for reluctance in bringing up spiritual matters (Dettmore, 1984). Just as similarly done with the sensitive topic of death and dying, classes on spirituality can be developed and offered for nurses to identify their own feelings about spiritual issues. Once nurses are aware of their own spirituality, they can better care for others with spiritual concerns.

In addition, nurses needed to be educated about the importance of spiritual coping activities and how the nurse can best assist their patients with these activities, thereby strengthening their patients ability to cope. It is also important to identify that a patient does not utilize spiritual coping strategies in his repertoire of coping (as in the case of one patient in this study). Nursing

education includes content about patient physical and psychosocial needs, but information about spiritual needs (and consequently information about spiritual coping strategies) is often lacking (Highfield & Cason, 1983).

However, nurses who received spiritual content during their nursing education did not assess their patients' spirituality any better than the nurses who did not receive spiritual instruction. Several factors may account for the similar results obtained from the educated and non-educated in patient spiritual needs and coping strategies. One nurse claimed spiritual instruction as an intrinsic part of her conceptual nursing framework. In contrast, the rest of the nurses received a mean of only 2.9 hours of such instruction. It is possible that the allotted time for spiritual instruction was not sufficient to equip nurses for assessment of their patients' spirituality. In addition, the actual content of the nurses' spiritual instruction is unknown.

Ideally, nurses should be educated about patient coping strategies in their school of nursing as part of their conceptual framework for nursing practice. To include the practicing nurse no longer in school, spiritual classes may be offered in their own health setting as part of orientation or through continuing education classes.

Several key elements should be included in the nurse's education on the nurse's role in spiritual care. As requested by nurses in the study, this education should

include instruction about the beliefs and practices important to patients of various religious backgrounds (Pumphrey, 1979) and the resources available to the patient for spiritual support. Suggestions for nursing assessment and intervention are essential elements to this education.

The lack of time to do an assessment of spiritual coping strategies is a legitimate concern. Therefore, a timely assessment needs to be developed for practical use by the staff nurse. Such an assessment may be adapted from the McCorkle & Benoliel interview (1981). Nurse author Stoll (1979) suggests incorporating a few basic questions in the initial assessment of the patient, such as: Is your faith (religion) helpful to you; are there any religious practices (diet, communion, clergy visits) you would like to continue with while in the hospital; and has being sick made any difference in your religious practices that I could help you with in any way.

If the nurse identifies that the patient would like assistance with prayer, bible reading, or has some pervasive spiritual questions about the meaning of life, the patient can be referred to his appropriate spiritual resource person (such as a minister, priest, or friend). The nurse may also choose to personally assistance the patient by attaining the scriptures he needs, reading those scriptures aloud, or praying with the patient as he so desires. If the nurse does not feel comfortable with such personal involvement and the patient's spiritual resource

person is not available, the patient can be referred to a nurse who feels more comfortable in giving spiritual care. Any combination of these interventions are within the scope of nursing practice and assist the patient with spiritual activities he uses to cope with cancer.

A relationship could be established between the hospital's spiritual care-giver (usually a clergyperson) and the oncology nurses to ensure continuity of the patient's spiritual care. The clergyperson could become highly visible and provide in-services as requested and needed. Accessibility of clergy to the nurses may be enchanced with phone numbers readily available on the nursing unit.

The nurse is viewed as an essential partner to the clergyperson in meeting the spiritual needs of cancer patients (Hirano, 1978; Nelson, 1984). When the patient's spiritual need requires more time or ability than the nurse has to give, the appropriate clergy should be called. However, it is imperative that the nurses be alert to the spiritual needs expressed by their cancer patients which may necessitate a referral to clergy. As evidenced by the patients in this study, this would include a variety of spiritual needs such as the need to find strength and hope, to trust in God, to pray for peace, to receive forgiveness from God and eternal security in life after death.

Some initial research in the area of spirituality is found in Richman's study on death anxiety (1982). The purpose of this study was to determine whether or not

religious faith reduced fear of death. Death anxiety was measured as part of a more comprehensive instrument among 150 subjects representing three religious groups (Baha'i, Christian Scientists, and Catholic Charismatics). The findings revealed varying degrees of death anxiety and suggest it is invalid to stereotype patients' death anxiety on the basis of religious affiliation.

Although the present study was not designed to identify the effect of religious affiliation on patient death anxiety, it does reveal that the patient's religious affiliation does not significantly influence the expression of spiritual needs or the use of spiritual activities and resource persons among Catholic and Protestant patients. It may likewise be suggested to avoid stereotyping patient spiritual coping strategies on the basis of religious affiliation. This is not to say that the religious affiliation in and of itself is not important to the patient. Over half of the patients attended church which signifies their committment to their religious faith and affiliation. However, the use of spiritual strategies can not be based upon their specific religious affiliation.

Little research has been done to verify the spiritual needs, resource persons, and activities utilized by cancer patients. The studies are descriptive in nature due to the lack of research on the patient's spiritual dimension. Further studies on the patient's identification of spiritual coping activities most helpful to him and the nurse's

identification of those activities would be valuable in establishing guidelines for nursing practice. A practical, valid, and reliable assessment tool to identify spiritual coping strategies can then be based on the knowledge of spiritual activities most common among cancer patients.

Additional research is needed to further support the findings that cancer patients rely on their religious faith as a coping strategy in their adjustment to living with cancer. It would also be important to identify how nurses can help patients cope who do not prescribe to any spiritual belief system.

The results of this study are limited to oncology nurses and a heterogenous sample of oncology patients with a variety of cancer diagnoses. Due to the sample size, although coupled with stratified random sampling, and the descriptive nature of this study caution is taken in drawing general inferences from the findings of this study. However several implications for nursing practice, education, and research have been suggested for consideration. Based upon the findings of this study, it is recommended that:

1. Nurses incorporate an assessment of the patient's spiritual coping strategy as part of their ongoing patient evaluation, with particular regard for the patient's use of spiritual activities and spiritual resource personnel.

2. Nurses establish a liaison with hospital clergypersons for continuity of patient spiritual care.

3. Discharge planning include an assessment of the patient's ability to attend church (when church attendance is an expressed desire of the patient).

4. More instruction regarding the nurse's role in spiritual care be included in the educational preparation of nurses at the fundamental level and in continuing education classes.

5. Further nursing research is needed to verify the spiritual coping activities and resource persons utilized by cancer patients.

Summary

Nurses working with cancer patients are presented with an array of concerns, one of which is how to enable the patient to cope with the stresses of having cancer. The nurse aims to identify coping strategies that enable the patient to lessen the negative impact of cancer and sustain his overall functioning in illness. Recognition of man as a spiritual being necessitates that nurses assess patient coping strategies within the patient's spiritual dimension. These activities can then be promoted by the nurse for enhancement of the patient's ability to cope with cancer.

Nurses can incorporate assessment and promotion of these spiritual activities within their scope of nursing practice in a variety of ways. The nurse must identify the spiritual coping activities important to the patient before assisting him with minimizing the stress associated with cancer. This can be accomplished with an assessment adapted

from McCorkle & Benoliel (1981) and Stoll (1979). Promotion of the patient's spiritual coping activity may include: providing the patient with privacy for prayer, scripture reading, or other religious practices; assisting him with the spiritual activity as needed; or referring him to his spiritual resource person.

The review of literature and research gives evidence to the importance of assessing the cancer patient's religious faith and spiritual activities for enhancement of his ability to cope. Nurses must be educated about these overlooked coping activities within the spiritual dimension if they aim to help the cancer patient cope with those activities important to him.

Appendix A

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

(NURSE)

Kathy Sodestrom, R.N., B.S.N., is doing a study on the spiritual needs of hospitalized cancer patients. It is hoped that the results of this study will increase nursing knowledge about the needs of cancer patients thereby serving as a basis for future planning of nursing care.

If you agree to participate in this study, it will involve talking with me for about 20 minutes for each time you describe the the spiritual needs of one of your patients. You may be asked to participate in more than one interview so that you can identify the spiritual needs of more than one patient. Your responses will be kept as confidential as possible and all interview notes will be coded. Your name will not be revealed to anyone else or in any written reports of this study.

The only risks or discomforts from taking part in this study are the inconvenience of the extra time you will spend, and the possibility that you may become uncomfortable with some of the questions. If you get tired or anxious about anything, please let me know. You may decline to answer any questions and are free to stop the interview at any time you wish. The interview should not interfere with your hospital routine.

There will probably be no personal benefit to you from participating unless you derive satisfaction from knowing you may have helped to increase nursing knowledge about the needs of patients.

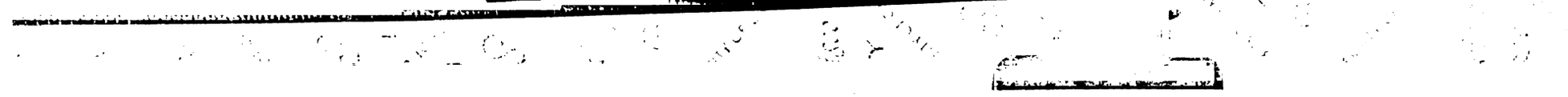
If you have any questions now, please feel free to ask them. If they arise later, please contact me by leaving a message at my advisor's office at UCSF: (415) 666-4558 or (415) 666-4668. In addition, you may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. You may reach the committee office by calling: (415) 666-1814 from 8:00 A.M. to 5:00 P.M., Monday through Friday, or by writing to the Committee on Human Research, University of California, San Francisco, CA 94143.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to refuse or to withdraw at any point in this study without jeopardy to your medical care. If you wish to participate, please sign this form and you will be given a copy.

_____ _____

Date Subject's Signature

CHR Approval Number 944202-01



Appendix B

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

(PATIENT)

Kathy Sodestrom, R.N., B.S.N., is doing a study on the spiritual needs of hospitalized cancer patients. It is hoped that the results of this study will increase nursing knowledge about the needs of cancer patients thereby serving as a basis for future planning of nursing care.

If you agree to participate in this study, it will involve talking with me for about 30 minutes. Your responses will be kept as confidential as possible and all interview notes will be coded. Your name will not be revealed to anyone else or in any written reports of this study.

The only risks or discomforts from taking part in this study are the inconvenience of the extra time you will spend, and the possibility that you may become uncomfortable with some of the questions. If you get tired or anxious about anything, please let me know. You may decline to answer any questions and are free to stop the interview at any time you wish. The interview should not interfere with your hospital routine.

There will probably be no personal benefit to you from participating unless you just feel better having talked to someone or unless you derive satisfaction from knowing you may have helped to increase nursing knowledge about the needs of patients.

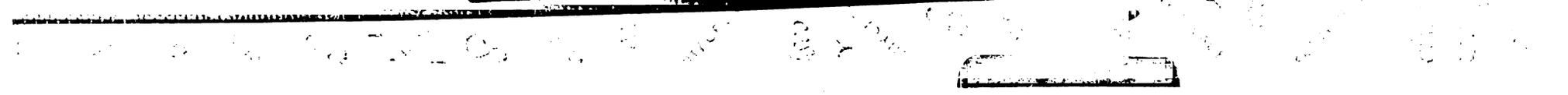
If you have any questions now, please feel free to ask them. If they arise later, please contact me by leaving a message at my advisor's office at UCSF: (415) 666-4558 or (415) 666-4668. In addition, you may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. You may reach the committee office by calling: (415) 666-1814 from 8:00 A.M. to 5:00 P.M., Monday to Friday, or by writing to the Committee on Human Research, University of California, San Francisco, CA 94143.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to refuse or to withdraw at any point in this study without jeopardy to your medical care. If you wish to participate, please sign this form and you will be given a copy.

_____ _____

Date Subject's Signature

CHR Approval Number 944202-01



Appendix C

Patient Interview

Patient Code #

Prior to Interview

(Verification by chart and/or hospital staff)

Cancer diagnosis _____

Other Current medical diagnoses _____

Prognosis _____

Length of time patient has known diagnosis _____

Age _____ Sex _____ Race _____ Religion _____

Demographic Section

Thank you for your participation in this interview about patient spiritual needs. I will be reading the questions. I want to assure you that there are no right or wrong answers.

Why were you admitted to the hospital? _____

_____

Are you undergoing any treatment for your cancer? _____ If yes, what

kind of treatment? _____

What is it for? _____

How effective do you feel your treatments are or have been? _____

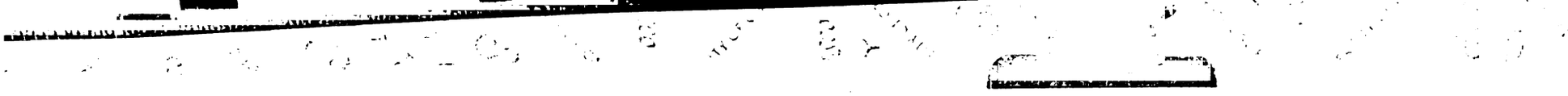
_____

Have you had any personal experience with cancer prior to your diagnosis (family or friends)? _____

What is your religion? _____

What is your church affiliation? _____

Note: The following patient and nurse interview guides and coding scales have been adapted from McCorkle & Benoliol (1981) with permission.



Patient Interview

(14) I. Have you ever spent time by yourself, just thinking about spiritual things?

(14a) i.) Have you done this recently?

(14b,6) ii.) How would you describe these times? (Did you review your life in relation to God? Are these times emotional, intellectual?)

(20) iii.) What does "spiritual" mean to you? (Does it include relating to a higher being or God to find purpose and meaning in life?)

iv.) Who or what is your God?

(7) II. What about other quiet activities, like prayer? (Prayed recently?)

(8,9,10,11) i.) Could you tell me a little about this? (Specific vs. general, favorite prayers vs. different ones.)

(12,13) ii.) Have you ever asked anyone to pray with you? Have you ever asked anyone to pray for you?

Note: The numbers enclosed in parentheses in the left margins of the interview guide are cues to where information should be recorded on the coding scale on page 103.

(15,16b) III. Do you read the Bible? _____ Do you read other spiritual/religious books? _____ If yes, what books?

_____

Is this different since your cancer was diagnosed?

(15) i.) About how much time in the past week would you say you have spent doing this?

(15c,d) ii.) What did this do for you?

(17) iii.) Do you ever memorize Bible verses? When did you? How often?

(18) iv.) Do you ever watch religious TV, or listen to religious radio?

(19) v.) Do you like to have religious objects or music beside or around you?

vi.) Have your feelings about spiritual things changed since your cancer was diagnosed?

(16) IV. Do you attend church? (at least once a week)

i.) Is this different since your cancer was diagnosed?

(16a) ii.) Make contributions to church (in personal service or financially)?

(1,2,3,4) V. Have you spoken about your spiritual thoughts or concerns to someone? To whom did you speak, and how often?

(1b,c,5) i.) What kinds of things did you talk about? (If patient spoke to clergy: Did you ask for readings, specific prayers, specific rites?)

(5) ii.) Did this allow you to get a lot off your chest?

(1d,2a,3a) iii.) Do you plan to do this again, or have you already?

VI. How do you think nurses can assist you with your spiritual needs?

THANK YOU FOR PARTICIPATING IN THIS INTERVIEW AND SHARING YOUR THOUGHTS WITH ME TODAY!

VII. Other Information (to be recorded immediately after interview completed, but not in the presence of the patient).

Check where appropriate and indicate whether information is volunteered (V), based on observation (O), inference (I), or impression (IM).

(21) Does something about his/her spiritual concerns.

(22) Does not think about spiritual concerns; distracts self with busywork.

(23) Can cite specific examples of new-found altruism, kindness, generosity, etc., in trying to live a better life.

(24) Practices meditation, biofeedback, fasting, etc.

Patient made reference to:

(25) guilt feelings related to God

(26) blame/anger towards God

(27) need for forgiveness from God

(28) fear of death and suffering that causes the patient to be reflective of his relationship with God

Patient Code # _____

Coding Scale For Patient Information

The patient:

1. has spoken to a clergyman. 1. Yes No

   a. has met personally in recent weeks, or has made an appointment to meet personally (as opposed to telephone or casual meetings) with the clergyman. a. Yes No

   b. asked specific questions, raised particular issues about his problems. (Were specific worries/crises mentioned?) b. Yes No

   c. asked for additional help, such as readings, specific prayers, special rites, etc. c. Yes No

   d. arranged a definite schedule of future appointments (even one). d. Yes No

2. spoke to someone in his family. 2. Yes No

   a. did this on more than one occasion, or with more than one person. a. Yes No

   b. asked specific help of this person in some way b. Yes No

3. spoke to a friend. 3. Yes No

   a. did this on more than one occasion a. Yes No

   b. asked specific help of this friend in some way b. Yes No

4. spoke to non-clerical professional (physician, nurse, or other). 4. Yes No

5. reviewed, in the above conversations, his life to this point in reference to his relationship with God. 5. Yes No

6. describes his spiritual experiences as primarily

   Emotional
   Unsure
   Intellectual
   Both Intellectual and Emotional

The patient:

7.	has prayed in recent weeks.	7. Yes No
8.	has prayed...(how often)	8. once a day few times weekly weekly
9.	when he prays, does this for about	9. half hour a few min. 5 minutes
10.	describes his prayers as	10. specific unsure general
11.	prefers to use	11. different prayers favorite prayers
12.	has asked someone to pray with him.	12. Yes No
13.	has asked someone to pray for him.	13. Yes No
14.	spends time thinking about spiritual things	14. Yes No
	a. has done this recently	a. Yes No
	b. sometimes reviews his life at these times in reference to his relationship with God.	b. Yes No
15.	has read the Bible recently	15. Yes No
	a. has spent, in the past week, in Bible reading	a. 7 hours 2-6 hours 1 hour
	b. has read religious books other than the Bible (tracts do not count).	b. Yes No
	c. had questions about what he read regarding his relationship with God	c. Yes No
	d. talked with someone about these	d. Yes No

The patient:

16.	has gone to church recently	16. Yes No
	a. makes contributions (in personal service or financially)	a. Yes No
17.	Memorizes Bible verses	17. Yes No
18.	Watches religious television; listens to religious radio	18. Yes No
19.	Surrounds self with religious objects, music	19. Yes No
20.	Tries to find meaning and purpose in life related to God	20. Yes No

Other Information

Volunteered Information	Observation	Inference	Impression
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			

Appendix D

Nurse Interview

Nurse Code #_____
Prior to Interview

(verification by Head Nurse)

Yes _____ No _____ The registered nurse (potential participant is a primary care giver of cancer patients).

Demographic Section

Thank you for your participation in this interview about patient spiritual needs. I will be reading the questions aloud to you so that all of the nurses are asked exactly the same questions. I want to assure you that there are no right or wrong answers.

Are you a registered nurse? _____ For how long? _____

How long have you worked with terminal patients (excluding cancer)?_____

How long have you been working with cancer patients? _____

How long with (patient's name)? _____ Patient Code # _____

How well do you know the patient? _____ Not as good as others
_____ Same as others
_____ Better than most

What is your age? _____ Race? _____ (Observed) Sex: M F

Religion? _____

Church Affiliation? _____

School of Nursing attended? _____

Was this a sectarian (religious) or non-sectarian school? (Circle one)

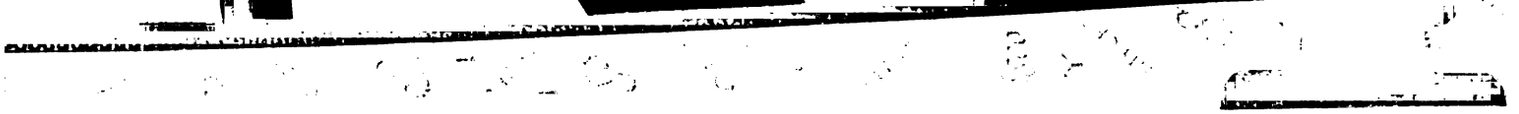
Have you taken any classes on or including spiritual needs of patients? _____

For classes including spiritual needs, estimate # of C.E.U.s for portion of class on spiritual needs: _____

In comparing yourself to other nurses, would you say that you assess patient spiritual needs ... not as well as other nurses? _____
... the same as other nurses? _____
... better than most nurses? _____

Have you had any personal experience with cancer (family, friends, self)?

_____



Nurse Interview and Coding Scale Combined

Do you know if your patient:

		Yes	No	Do Not Know	Source of Information
i.	Do you know your patients religion?	i.			
1.	has spoken to a clergyman?	1.			
2.	spoke to someone in his family about spiritual things?	2.			
3.	spoke to a friend about spiritual things?	3.			
4.	spoke to a non-clergical professional? (physician, nurse, or other)	4.			
5.	reviewed, in the above conversations, his life to this point in relation to God or a higher being?	5.			

6. What does "spiritual" mean to you? Relating to a higher being, or God, to find meaning and purpose in life?

Do you know if your patient:

			Yes	No	Do Not Know	Source of Information
7.	has prayed in recent weeks?	7.				
8.						
9.						
10.						
11.						
12.	has asked someone to pray with him?	12.				
13.	has asked someone to pray for him?	13.				
14.						
15.	has read the Bible?	15.				
	a.					
	b. has read religious/spiritual books other than the Bible (tracts do not count)?	b.				
	c.					
	d.					

Do you know if your patient:

		Yes	No	Do Not Know	Source of Information
16.	has gone to church recently?				
a.	makes contributions to church (in personal service or financially)				
17.	memorizes Bible verses				
18.	watches religious TV or listens to religious radio				
19.	surrounds self with religious objects and music				
20.	tries to find meaning in life in relationship to God				

21.

22.

23.

24.

Does your patient make reference to:

25.	guilt feelings related to God?				
26.	blame/anger toward God?				
27.	need for forgiveness from God?				
28.	fear of death and suffering that causes reflections of his relationship with God?				

29. What would you like to learn/know that would help you assess his spiritual needs?

THANK YOU FOR PARTICIPATING IN THIS INTERVIEW AND SHARING YOUR THOUGHTS WITH ME TODAY!

Bibliography

Bean, G. Cooper, S., Alpett, R. & Kipnis, D. (1980). Coping mechanisms of cancer patients: A Study of 33 patients receiving chemotherapy. CA-A Cancer Journal for Clinicians, 30, 256-259.

Blumberg, B. D., Ahmen, P., Flaherty, M., Lewis, J. & Shea, J. (1981). Living with cancer: An overview. In P. Ahmen (Ed.), Living and dying with cancer, (pp. 3-32). New York: Elsevier.

Carson, J. (1971). Learning from a dying patient. American Journal of Nursing, 71, 233-334.

Darocy, C. (1979). Religious consideration in patient care. Journal of Practical Nursing, 29 (12), 18-21.

Dettmore, D. (1984). Spiritual care: Remembering your patient's forgotten needs. Nursing 84, 14 (10), 46.

Devine, B. (1980). Attitudes of the elderly toward religion. Journal of Gerontological Nursing, 6, (11), 679-687.

Dickinson, C. (1975). The search for spiritual meaning. American Journal of Nursing, 75 (10), 1789-1792.

Fish & Shelley, J. (1978). Spiritual care: The nurse's role. Illinois: Intervarsity Press.

Fox, D. (1982). Fundamentals of research in nursing (4th ed.). Norwalk, CT: Appleton-Century-Crofts.

Friedman, B. D. (1980). Coping with cancer: A guide for health care professionals. Career nursing, 5 (2), 105-110.

Gordon, M. (1982). Nursing diagnosis: Process and application. New York: McGraw-Hill.

Highfield, M. & Cason, C. (1983). Spiritual needs: Are they recognized? Cancer Nursing, 6, 187-192.

Hinton, J. (1975). The influence of previous personality on reactions to having terminal cancer. Omega, 6, 95, 111.

Hirano, D. Y. (1978). Spiritual ministries with cancer patients. In P. Burkhalter & D. Conley (Eds.), Dynamics of oncology nursing, (pp. 309-320). New York: McGraw-Hill.

Hubert, M. (1963). Spiritual care for every patient. The Journal of Nursing Education, 2 (2), 9-12.

Huxley, J. (1961). The humanist frame. London: George Allen & Irwin.

Kalish, R. A. (1981). Coping with death. In P. Ahmed (Ed.), Living and dying with cancer, (pp. 223-239). New York: Elsevier.

Kealey, C. (1974). The patient's perspective on spiritual needs. Unpublished Master's Thesis, University of Missouri-Columbia.

Kramer, P. (1957). A survey to determine the attitudes and knowledge of a selected group of professional nurses concerning spiritual care of the patient. Unpublished Master's Thesis, University of Oregon.

Kubler-Ross, E. (1973). Life and death: Lessons from the dying. In R. H. Williams (Ed.), To live and to die: When, why, and how, (pp. 150-159). New York: Springer-Verlag.

Lazarus, R. S. (1980). The stress and coping paradigm. In L. Bonde & J. C. Rosen (Eds.), Competence and coping during adulthood, (pp. 28-69). Hanover, NH: Unvisity Press of New England.

Leininger, M. (1978). Transcultural nursing: Concepts, theories and practices. New York: John Wiley & Sons.

Martin, C., Burrows, C. & Pomilio, J. (1976). Appendix A: Spiritual needs of patients study. In S. Fish & J. Shelley (Eds.), Spiritual-care: The nurse's role (pp. 150-166). Illinois: Intervarsity Press.

McCorkle, R. (1984, February). Personal communication.

McCorkle, R. & Benoliel, J. Q. (1981). A manual of data collection instruments. Unpublished manual, University of Washington.

Nelson, B. (1984). A nurse-chaplain's view: Nurses and pastors as partners. Journal of Christian Nursing, 1, 20-22.

Otto, R. (1924). The idea of the holy. (J. W. Harvey, trans.). London: Oxford University Press.

Polit, D. & Hungler, B. (1978). Nursing research: principles and methods. Philadelphia: J. B. Lippincott.

Pruyser, P. (1976). The minister as diagnostician. Philadelphia: Westminister Press.

Pumphrey, J. B. (1977). Recognizing your patient's spiritual needs. Nursing 77, 7, (12), 64-70.

Reeves, M. (1983, May). Coping with cancer: Methods used by cancer patients and their significant support persons. Paper presented at the Eighth Annual Congress of the Oncology Nursing Society, San Diego.

Richman, K. (April 1982). Effects of religious affiliation on death anxiety. Abstract published in Proceedings of the Seventh Annual Congress of the Oncology Nursing Society, St. Louis.

Stallwood, J. (1969). Appendix A: Spiritual needs survey. In S. Fish & J. Shelley (Eds.), Spiritual care: The nurse's role (pp. 150-166). Illinois: Intervarsity Press.

Stallwood, J. (1975). Spiritual dimension of nursing practice. In I. Beland & Passas (Eds.), Clinical nursing (3rd. ed.). New York: McMillian.

Stoll, R. (1979). Guidelines for spiritual assessment. American Journal of Nursing, 79 (9), 1574-1577.

Thornbury, K. M. (1982). Coping: Implications for health practitioners. Patient counseling and health education

Tournier, P. (1965). The healing of persons. Translated by Edwin Hudson. New York: Harper & Row.

Travelbee, J. (1966). Interpersonal aspects of nursing (2nd ed.). Philadelphia: F. A. Davis.

Tumin, M. (1973). Equality and inequality: Facts and values. In R. H. Williams (Ed.), To live and to die: When, why, and how, pp. 319-325). New York: Springer-Verlag.

Vaillot, M. (1970). The spiritual factors in nursing. Journal of Practical Nursing, 20 (9), 30-31.

Watson, J. (1979). Nursing--The philosophy and science of caring. Boston: Little, Brown, and Company.

Weisman, A. D. (1979). Coping with cancer. New York: McGraw-Hill.

Weisman, A., Worden, J. & Sobel, H. (1980). Psychosocial screening and intervention with cancer patients: Research report. Boston, MA: project Omega.

Yura, H. & Torres, G. (1975). Faculty curriculum development, Part III: Conceptual framework--Its meaning and function (NLN Publication No. 15-1558). New York: National League of Nursing.

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