IDENTIFYING THE SPIRITUAL NEEDS OF THE ONCOLOGY PATIENT

by

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Jan R. Atwood — 12-17-79

JAN R. ATWOOD — Date

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But whoever has the world's goods, and beholds his brother in need and closes his heart against him, how does the love of God abide in him?

I John 4:17 (NAS)

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ABSTRACT

A correlational descriptive study was designed to operationalize the term "spiritual needs", and to test the relationships of selected demographic variables to spiritual needs. In the process, a questionnaire was developed to identify the nature and importance of spiritual needs to patients.

Data were obtained from a convenience sample of 13 adult oncology patients from one southwestern hospital. Eighty four percent of the sample identified one or more spiritual needs, the most frequent of which were hope and prayer. The importance of spiritual needs to the sample was significant at ($p = .0001$). The need for "God's: love and meaning in life were rated the most important. Age, the only significant demographic variable, correlated positively to both the nature and importance aspect. The Nature Subscale had a stable coefficient alpha of 0.87 demonstrating a high level of internal consistency and initial construct validity. The alpha for the Importance Subscale was 0.74.

Implications for clinical nursing care include the value of spiritual needs assessment when planning care for the "whole" person.

CHAPTER 1

INTRODUCTION

A commonly utilized theoretical framework in nursing is the General Systems Theory. Von Bertalanffy (1972, p. 30) described General Systems as "the scientific exploration of 'whole' and 'wholeness.'" It is from this concept of "wholeness" that nursing theorists have attempted to operationalize their view of man and his health needs. Rogers (1970, p. 41) defined man as "the merging of physical, biological, physiological, social, cultural, and spiritual attributes into an individual whole--a whole in which the parts are not distinguishable."

Although nursing stresses this "wholistic" approach in caring for patients, very little information or evidence can be found in the nursing literature referring to the spiritual dimension of nursing care. In fact, according to Stallwood (1975) most nursing literature concentrates on the biopsychosocial dimension and neglects the spiritual to a larger degree.

Therefore, it is the contention of this researcher that if nursing does indeed define man as a biopsychosocial, cultural, and spiritual being, yet neglects the spiritual dimension of the individual, the profession not only denies man's totality but is seriously affecting his well-being in the process. Thus, in order to consider

man in his entirety, all his needs must be accurately defined and assessed, including his spiritual needs.

Statement of the Problem

Dickinson (1975) stated that spiritual care includes attention given to the affective part of man, which is his spirit. The spirit, she defined, as being the animating but intangible principle that gives liveliness to man. From a theological point of view, Stallwood (1975, p. 1087) defined the spirit as that which provides a person with the capacity for God-consciousness; the definition of "God" being left up to the individual. However, it is important to note that the terms "religion" and "spiritual" have been used synonymously in much of the literature, but they are not the same. Kiening (1978, p. 49) stated that if the two terms are used interchangeably as a basis for assessment, "some of the patient's deepest needs may be glossed over or entirely overlooked." Murray and Zentner (1979, p. 439) defined spiritual as "a quality that goes beyond religious affiliation, that strives for inspiration, reverence, and awe, and even in those who do not believe in any god." Religion, on the other hand, refers to a belief in a divine or superhuman power expressed in conduct and ritual (Henderson and Nite, 1978). Murray and Zentner (1979, p. 438) described religion as a "system of beliefs, a comprehensive code of ethics or philosophy, the conscious pursuit of any object that the individual holds supreme." Therefore, by including both the religious and spiritual concerns of patients, specific criteria for assessment of these needs effecting man's spiritual dimension would be established.

According to Hirano (1978) cancer is a disease that causes emotional stress and physical illness and generally ends in death. Cancer is a disease that affects people. Because cancer patients are people, they are assumed to be spiritual beings. It also follows naturally that because cancer patients are spiritual beings, they have spiritual concerns and spiritual needs that will surface in a time of stress and illness. Hirano also explained that spiritual concerns may be expressed by cancer patients in the form of such questions as "Why did God do this to me?" or "What shall I do with what is left of my life?" Because of the life-threatening characteristics of cancer and the trauma of its treatment, cancer patients are more apt to express needs for such spiritual support in the areas of immortality, eternal life, hope, and meaning and purpose in life.

At this point one may ask the question, "Who is responsible for helping these patients meet their spiritual needs?" It almost goes without saying that the clergy are members of the health team trained in dealing with spiritual matters; but as expressed by Hirano (1978) it is not the clergyman's duty alone. The nurse plays a key role in helping patients find available resources for their spiritual needs. But, according to Piepgras (1968), nurses unfortunately feel either ill-prepared or inadequate to assess, let alone deal with, a patient's spiritual problems, thereby missing an opportunity to help patients cope or adapt in illness and crisis situations. Furthermore, it is this researcher's opinion that the inadequacy or inability of nurses to provide spiritual care is due in part to the vagueness of the definition of spiritual needs and lack of documentation of its

significance to patient care. Therefore, it is the endeavor of this study to raise concern and awareness in that spiritual care and the assessment of spiritual needs is not only appropriate but necessary in order for nurses to more effectively care for the needs of the whole person.

Statement of the Purpose

The purposes of this study are as follows: to operationally define the term "spiritual needs" and to develop a tool to identify both the nature of spiritual needs and their importance to the oncology patient; to determine if there is a relationship between the nature and importance of spiritual needs to the oncology patient; and also to determine if there is a relationship between the nature and importance of spiritual needs to the selected demographic variables--sex, age, marital status, ethnic origin, type of cancer, religion, length of present illness, length of present hospitalization, and number of hospitalizations in the past five years.

Significance of the Problem

The nursing literature refers to the spiritual needs of patients but gives nurses very little information specifically defining the nature and importance of these spiritual needs to the individual patient. This information is vital if nurses are to assess, make appropriate interventions, and plan care accordingly to meet these needs. Because there was a lack of an assessment tool and specific guidelines which will identify and measure spiritual needs, the value and significance of this study would be in the development of a tool

that would accurately identify and measure the importance of spiritual needs expressed by patients. A tool of this type will not only provide a foundation for further study in the area of spiritual care, but will be available for nurses to use in the clinical area.

In view of patient outcomes, documenting spiritual needs of the oncology patient would provide additional information and data that could be used in planning care for the "whole" person. And because the literature expresses the fact that life-threatening diseases, such as cancer, may create a "spiritual crisis" or cause spiritual needs to surface, it is necessary that these needs be identified so that they can be dealt with and met in order to enhance optimal well-being of the oncology patient.

Research Questions

The specific research questions identified for this study are:

1. What spiritual needs are identified by oncology patients?
2. How important are spiritual needs to the oncology patient?
3. Is there a relationship between the demographic variables of sex, age, marital status, ethnic origin, religion, type of cancer, length of present illness, length of present hospitalizations in the past five years to the importance of spiritual needs to the oncology patient?
4. Is there a relationship between the demographic variables of sex, age, marital status, ethnic origin, religion, type of cancer, length of present illness, length of present

hospitalization, and number of hospitalizations in the past five years to the identified spiritual needs of the oncology patient?

Conceptual Hypotheses

1. Oncology patients will identify the nature of the spiritual needs which they have experienced.
2. Oncology patients will rate spiritual needs as important.
3. There will be an identifiable relationship between the demographic variables of sex, age, ethnic origin, religion, marital status, type of cancer, length of present illness, length of present hospitalization, and number of hospitalizations in the past five years with the identified nature of spiritual needs of the oncology patient.
4. There will be an identifiable relationship between the demographic variables of sex, age, ethnic origin, religion, marital status, type of cancer, length of present illness, length of present hospitalization, and number of hospitalizations in the past five years with the identified importance of spiritual needs of the oncology patient.

Operational Definitions

For specific use in this study, the following terms are defined:

1. Oncology patients: Persons diagnosed with a condition in which abnormal cells develop, multiply, and invade normal tissues, interfering with normal functions.

2. Spiritual need: Any factor that influences the religious concerns from a structured system of beliefs and rituals, that influences the internal condition of the individual in his perception of the unseen and eternal, or that influences the relationship to a supreme being as defined by the individual.

Assumptions

The assumptions underlying this study are:

1. Man has a spiritual dimension.
2. Man's spiritual dimension consists of more than presence or absence of religious orientation.
3. Man can verbally identify his spiritual needs.
4. Spiritual needs of oncology patients are an appropriate and relevant area of nursing and nursing research.

Theoretical Framework

The theoretical framework of this study is based on: General Systems Theory, Stallwood's Nature of Man, and Maslow's Hierarchy of Needs.

General Systems Theory

Boulding (1972, p. 1) defined General Systems are a "skeleton of science, a body of theoretical constructs which will serve to express general relationships of the empirical world." It is a theoretical framework by which we treat systems as wholes composed of parts which are continually interacting with one another (Ashby, 1972). The parts of a system are independent units but cannot be separated or operate

one without the other. According to Murray and Zentner (1979) any changes in one part affects the functioning and integrity of the entire unit. Putt (1978) stated that the main function of systems is to freely exchange energy and information with the surrounding environment and other systems. Therefore, the ultimate goal of a system would be to maintain the system in a steady state based upon the system's organization and exchange of information (Murray and Zentner, 1979).

Several nursing theorists have defined man within the context of the General Systems Theory. Rogers (1970, p. 41) described man as "the merging of physical, biological, physiological, social, cultural, and spiritual attributes into an individual whole." According to Murray and Zentner (1979, p. 6) "a person is a part of all that is within and around him, whether it be a cell, organ system, family or society. He is more than the sum of all his parts." They go on to explain that the person is a whole system made up of physical, emotional, mental, spiritual, and social parts of which none can operate without the other. And because a person is a system of interdependent parts striving to maintain balance by means of discharging and conserving energy, it becomes one of nursing's primary goals to assist man in this endeavor of balance and adaptation. To accomplish this, further understanding of the nature of man and his specific needs must be considered.

Stallwood's Nature of Man

Stallwood's (1975) model of the nature of man gives a conceptual basis for understanding man's nature, particularly his spiritual dimension. The model consists of three components that are all

dynamically interacting with each other and the environment. It consists primarily of the five senses. The psychosocial component, which is also termed the soul, provides "self-consciousness" through the intellect, emotions, will, and moral sense. The psychosocial component gives man his self-identity and defines his personality. More specifically defined, intellect relates to wisdom, knowledge, and reasoning; emotion is the expression of feelings such as love, hate, joy, anger, sadness, happiness, etc.; the will is defined as that which has control over the decision-making processes; and moral sense distinguishes right from wrong (Stallwood, 1975).

The spiritual component consists of man's spirit. According to Stallwood (1975), the spirit is indefinable scientifically but should be considered as a part of science and "not an opposing realm." The spirit is the God-consciousness with a relatedness to diety, as defined by the individual.

The spirit intereacts with both the psychosocial and biological components. The spirit responds to the intellect via statements of affirmation or doubt about God. The emotions elicited by the spirit are joy, peace, fear, loneliness, anxiety, etc. The spirit are joy, peace, fear, loneliness, anxiety, etc. The spirit responds to the will with either decisiveness or instability and elicits either integrity or guilt through the moral sense of the individual. The spirit's interaction with the biological component is via energetic, productive activity versus illness usually related to stress (Stallwood, 1975).

Stallwood's model identifies man as an individual whole, who is more than just mind and body, but contains a spirit as well. The model

conceptualizes the interrelationship of these three dimensions of man. The model also emphasizes just as a person's biological need is for growth, so it is for the psychosocial and spiritual areas as well. Man will cry out in any area where there is a lack or a need. It becomes important that these needs be met in order for the total person to be fulfilled (Stallwood, 1975).

Maslow's Hierarchy of Needs

Maslow (1970) emphasized that the fundamental characteristic of man is the striving and motivation to obtain goals and meet needs. The needs are vital for motivation, and motivation is necessary in maintaining constancy and balance in the individual. Therefore, needs must be gratified if there is to be a healthy existence.

Maslow's theory consists of five major categories of needs: physiological, safety, belongingness, self-esteem, and self-actualization. He categorizes them according to their priority with the highest need being assigned to those needs most important to maintaining life--the physiological and safety needs.

The physiological needs refer to the body's automatic efforts to maintain a constant state of homeostasis. It is Maslow's argument that if the physiological needs are not met, all the other needs are pushed into the background. At the second level of priority are the safety needs. The safety needs include such concepts as security, stability, dependency, protection, and freedom from fear and anxiety. Belongingness relates to those needs for love and affection. The fourth category, self-esteem, encompasses the need for prestige,

status, attention, recognition, mastery, and self-confidence. The highest need is self-actualization, which refers to man's desire and need for self-fulfillment: the tendency to become what he is potentially.

Maslow (1970) stated that as a human being undergoes intense stress such as an illness the homeostasis of that individual is threatened, creating a wide variety of needs. When these basic human needs are not met, the person will be in a state of disequilibrium. Therefore, in order to maintain a steady state, a person receives signals from his body in the form of motivational drives that strive to resolve unmet needs. When human needs are gratified, homeostasis is regained, and the person once again becomes an integrated whole.

In terms of this study, if homeostasis and need gratification are necessary for optimal balance, it is then necessary that needs of any nature must be recognized and resolved in order to ensure optimal and quality care to every individual.

In summary, the major variable considered in this study and as defined by the conceptual framework is "spiritual need." The "nature of spiritual needs" was derived primarily from Stallwood's Nature of Man, which includes man as having a spiritual nature with corresponding needs. General Systems Theory and Maslow's Hierarchy of Needs form the basis of "importance of spiritual needs" because it is the assumption of these theories that needs must be met in order to fulfill balance and a state of homeostasis in the individual and his interdependent parts.

The demographic variables are sex, age, marital status, ethnic origin, religion, type of cancer, length of present illnessm length of present hospitalization, and number of previous hospitalizations. The variables of sex, marital status, age, religion, length of present illness, length of present hospitalization, and number of previous hospitalizations were derived from Martin, Burrow, and Pomilo (1978), who suggested possible relationships to spiritual needs and proposed further study in this area. Because the religious aspects constitute a part of spiritual needs and also a way of living and thinking, the subject's ethnic origin might indicate a cultural relationship with spiritual needs. Different types of cancer involve different types of treatment and invasion sites of the disease process which results in possible differences in coping mechanisms, perceptions of threat, and body image changes. These differences may possibly influence or have a direct influence on the nature and importance of spiritual needs.

Conceptual Framework

Figure 1 illustrates in model form the conceptual framework of the study. It includes the definition of the constructs: General Systems Theory, Man, Maslow's Hierarchy of Needs, and Stallwood's Nature of Man, and the related axioms.

General Systems Theory is the backbone of the framework. It defines the next level construct, which is Man. Man is defined as a system of interdependent parts and functions, striving for balance and homeostasis. On the right hand side of the model, Stallwood specifically defines man's nature. This leads to the conceptual level which

Figure 1. Model of Conceptual Framework

General Systems Theory

"The scientific exploration of 'whole' and 'wholeness' (Von Bertalanffy, 1972, p. 30)

1. From the concept "wholeness," nursing theorists have attempted to operationalize their view of man. (Putt, 1978, p. 25)

Man

Rogers (1970, p. 41) defines man as "the merging of physical, biological, physiological, social, cultural, and spiritual attributes into an individual whole - a whole in which the parts are not distinguishable."

2. Behavioral scients and theologians have long recognized that man is not a mechanistic collection of separate entities, but an indivisible whole. The Stallwood model illustrates the composite of the whole man (Stallwood, 1975, p. 1086).

3. The fundamental characteristic of man is the striving and motivation to obtain goals and meet needs (Maslow, 1970, p. 59).

Maslow's Hierachy Theory

Man has basic human needs that must be gratified if there is to be an healthy existence. They are categorized according to priority with the highest priority being assigned to those needs most important to maintaining life (Maslow, 1970, pp. 35-35).

Stallwood's Nature of Man

A model illustrating one view of the nature of man, including the components of body, mind and the spirit.

4. Nursing reflects awareness that man is not simply a biological organism, but also has a psychosocial and spiritual dimension (Stallwood, 1975, p. 1086).

5. "Upon examining these expressions of the spirit, a definition of spiritual need emerges" (Stallwood, 1975, p. 1088).

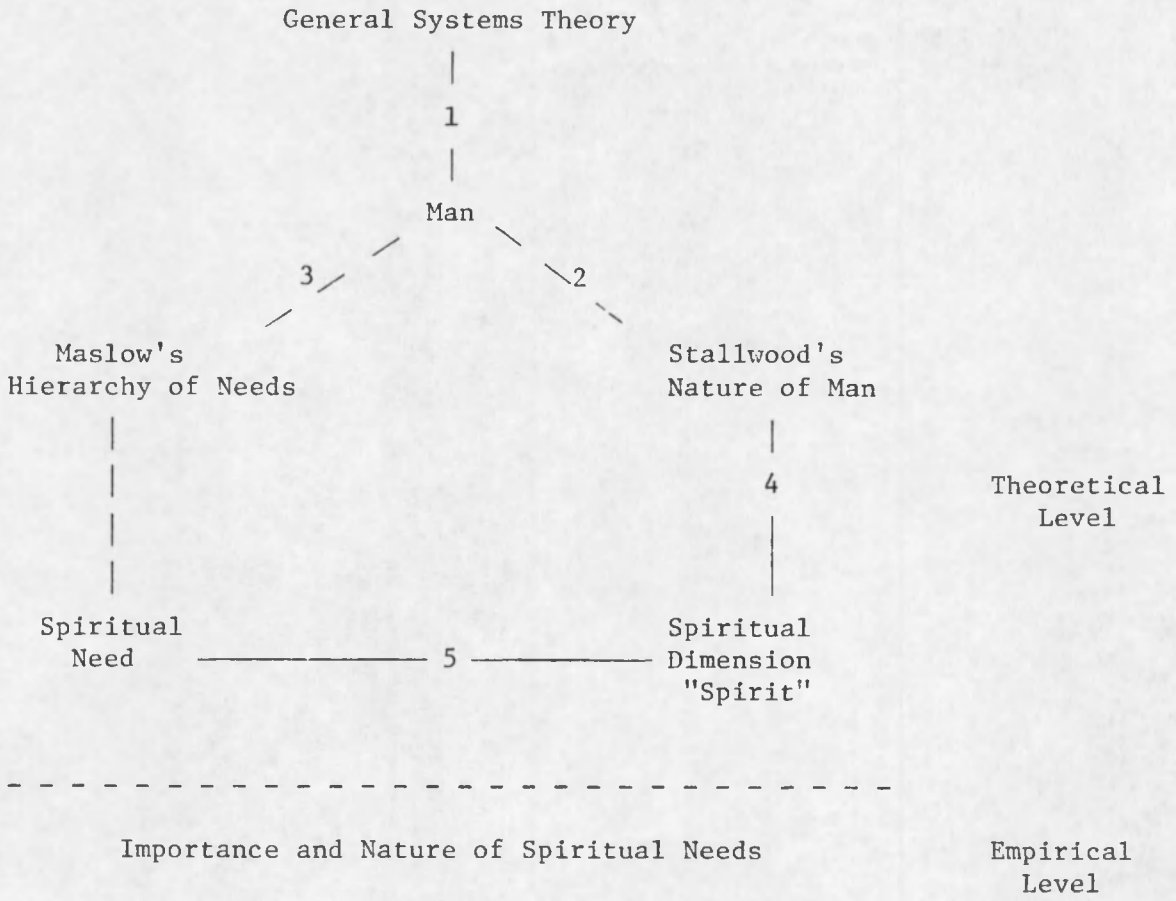

Figure 1. Model of Conceptual Framework

identifies that a part of man's nature is his spiritual dimension or spirit. On the other side of the model is the construct, Maslow's Need Theory. Maslow (1970) defined man in terms of meeting needs in a hierarchical priority. There is an assumed link between Maslow's theory and the concept "spiritual need." The assumption is that spiritual needs are apart of man's need for self-actualization and self-fulfillment, which is consistent with the study's definition of spiritual need. It is therefore the concept "spiritual need" that this study has attempted to define and test at the empirical level through statistical and observational manipulations of the nature and importance aspects.

CHAPTER 2

REVIEW OF LITERATURE

This chapter will include review of the literature on the following three categories: religion and medicine, spiritual needs and nursing, and emotional responses to cancer.

Religion and Medicine

Lipkin (1974, p. 230) stated that "religion has played a very important role in the treatment of countless people throughout history. Faith having brought more comfort to more people than physicians in any age." Hirano (1978) described the relationship of medicine and religion as being prehistoric. In the early history of medicine the healer was the religious person, who cured people of disease through non-physical means directed toward the mind and spirit rather than just the body. Walker (1971, p. 37B) reiterates that the theme years ago was "why religion needs medicine." He adds that the Indian medicine man and the African witch doctor used their skilled knowledge in the use of herbs to which they added "psycho-suggestion" and their appeal to the great spirit to treat an individual. They definitely recognized the wholeness of man in terms of the body, mind, and spirit.

Even though medicine and religion come from the same roots, Hirano (1978) cited the differences in that religion arises from the emotions and instincts and medicine comes from magic and superstition and that it is this gap that causes such a drastic difference in their

relationship. Walker (1971, p. 37B) defined three relationships between medicine and religion that are present in contemporary thinking. The first relationship is the insistance that medicine and religion are two different things and should therefore have nothing to do with each other. Secondly, while religion and medicine are two different things they may have some relationship provided the emphasis is on medicine and religion remains the "junior partner." The last relationship is that medicine and religion should and can be collaborated as equals in dealing with the ills of mankind. Mills (1977, p. 202) also contended that medical staff see the clergy as those who represent the religious aspects and are "anti-scientific." He believed that they see the clergy representing dealings with the "spiritual" as opposed to the "real" world. The clergy represent the hereafter, whereas the scientist or physician is concerned with the practical here and now, and this may cause some friction in their relationships and patient care treatments.

Attempts to close this gap between medicine and religion are ensuing. Clinical pastoral education, which was begun in the 1930s, started to teach and train clergy within the hospital setting, exposing them to the medical discipline and treatment, as well as allowing them to express patient needs from a theological point of view (Hirano, (1978). Many documentations throughout the literature discuss the clergy as being a very important member of the health-care team. DuGas (1972) expressed the feeling that chaplains can contribute much in the care of patients by helping people clarify their anxieties and accept illness. Rines and Montag (1976, p. 105) stated that the clergy may help the nurse and other health workers by "interpreting to

the patient the necessity of treatment, helping to gain his cooperation, and influencing his attitude toward his illness and toward those who care for him." Dealing with such spiritual and religious questions regarding the meaning of life and death, nature of the universe, the ultimate, and life after death is very much a part of the clergy's intervention with seeking patients (Hirano, 1978). According to Fish and Shelley (1978) there is also a need that the nurse and clergy function together. There must be a common goal of caring for the whole person and an open channel of communication between the two professionals. Therefore, Belgum (1967, p. 19) summed up the complementary nature of religion and medical science: "Since there is no human certainty--either scientific or religious--man must proceed in part on the basis of insights and beliefs as well as upon scientific facts, theories, philosophies, assumptions, and common experience."

Psychiatry and psychology have been particularly interested in the dynamics of religion and its effects on the personality. Freud (1957) construed religion as an attempt to resolve the "father-child" conflict, a means of lessening the terrors of nature and fate. He presumed religion to be an outgrowth of insecurity and a defense mechanism invented to protect man from the ultimate threat of death. However, several studies (Martin and Wrightsman, 1965; Templer, 1972; and Osarchuk and Totz, 1973) which compared levels of religiosity and the fear of death found that those who scored high in their needs and attitudes toward religion had literally a lower death anxiety. Williams and Cole (1968) focused their study on the relationship between religion and emotional adjustment. The study failed to support

the Freudian relationship between religion and neurotic inclinations. In fact, on all dimensions of anxiety, active religious subjects manifested the highest level of adjustment. In 1947 the Group for the Advancement of Psychiatry (cited by Appel, 1959, p. 1779) made a statement emphasizing the importance of spiritual beliefs in improving physical, moral, and emotional health. They also documented several psychotherapeutic methods that very closely approximated spiritual values.

In addition, several references have been cited in the literature regarding the role of religion in times of illness and crisis. Lazarus (1974) found a significant number of parents of children with end-stage leukemia reporting a need to rely on their religion or turn to a religion for comfort. One study on severely-burned patients (Andreason and Norris, 1972) focused primarily on the emotional problems encountered in these patients and the prominent adaptive mechanisms used to deal with almost overwhelming physical and emotional stress. The study further affirmed that religiosity provided a sense of identity and a means of support in times of crisis. Paterson (1975) studied parents who had children with cerebral palsy and found that religion played a part in the parents' adaptation to the stress of having a handicapped child.

Therefore, from this review of the literature the relationship between medicine and religion has been discussed. It can be concluded that religion may be a central and positive force in both times of stress and illness, and medical treatment.

Spiritual Needs and Nursing

Many nursing agencies and professional organizations are including spiritual needs and the spiritual dimension of man in their policies and standards. Within the Skilled Nursing Facilities Regulations of the Department of Health of the State of California (1975) there is explicit reference to the spiritual needs of patients and specific instructions to include the assessment of spiritual needs weekly in the progress notes. The White House Conference on Aging (1971) referred to the spiritual needs as the "deepest requirement of the self which, if met, makes it possible for the person to function with a meaningful identity and purpose so that in all stages of life the person may relate to reality with hope." The nursing diagnosis of spiritual needs was accepted by the Third National Conference on Classification of Nursing Diagnosis in 1978. The diagnoses listed consisted of spiritual concern, spiritual distresses, and spiritual despair.

Several nursing theorists have attempted to define the concept of "spiritual" for nursing purposes. Fleeger and Van Heukelem (1977, p. 1) defined spirituality as "the life principle that pervades a person's entire being, his volitional, emotional, moral-ethical, intellectual and physical dimensions." Murray and Zentner (1979) defined spiritual as something that goes beyond religious affiliation. The spiritual is made up of such ingredients as awe, inspiration, seeking harmony with the universe, and reverence as the inner being of a person strives for answers about the infinite. Vaillot (1970, p. 30)

also defined the term spiritual as "the quality of those forces which activate us, or the essential principle influencing us."

Mullane (1958) described the central core of nursing as giving spiritual care and stated that this spiritual support will ease much of the emotional effects and impact of very cold and harsh scientific treatments. Spiritual nursing care has been defined as the availability of the nurse in a human relationship to care for a patient and help him to cope with his pain and suffering (Dickinson, 1975). Dickinson also defined spiritual care as helping the patient to find meaning in suffering which will enable him to endure his illness and also to use it as a source of strnegth in other life experiences. Westburg (1955) listed several types of people who might fall into a "high-risk" category for spiritual needs and therefore require spiritual care. The patient who is lonely and has no visitors, the patient who expresses fear and anxiety, the patient who is preoccupied about the relationship of his religion and his health, and the patient who is dying are examples of Westburg's "spiritual needs" group.

Many nurses have referred to the nursing process as a way of dealing with spiritual needs (Kiening, 1978; Stallwood, 1975; and Fish and Shelley, 1978). Fish and Shelley (1978) explained that spiritual needs must be discerned through the interpretation of observations and the testing of hypotheses. Stallwood (1975) listed a series of related spiritual needs such as love, forgiveness, hope, and the expression of diety. She also offered means of assessment and intervention should these needs arise. Kiening (1978) stated that the

quality of the nurse-patient relationship is a crucial factor in assisting this patient toward spiritual health.

The nursing studies on spiritual needs are very limited. One study was a pilot project conducted at a state psychiatric institution (Carson and Huss, 1979). Two groups of ten subjects diagnosed with chronic undifferentiated schizophrenia were divided randomly into an experimental and control group. For ten weeks, the experimental group was treated daily with a group session that opened and closed in prayer and Bible reading. The prayers and readings were the focus of God's love and concern for each individual. Prior to the treatment both groups received a pretest from a psychological tool indicating various levels of adjustments. After ten weeks both groups were given a post-test with the same psychological tool. The subjects with the intervention showed an increased ability to express their feelings, a more positive outlook about possible changes in their lives, and a decrease in somatic complaints over the responses of the control group. There were no statistical data given; and it was suggested that stronger control of the variables, as well as modification of the data collection tools, was needed with further replication of the study.

Hess (1978) conducted a pilot project to determine patients' perceptions of their spiritual needs. Twelve nurses interviewed a convenience sample of 109 patients in hospitals and extended-care facilities in various parts of the United States. No statistical data were given. The most frequent responses were prayer, need for an awareness of God's presence; fear of death; need to find meaning and purpose in life, death, and suffering; feelings of guilt; loss of

faith; and the need to express faith by visible and tangible means. Martin, Burrow, and Pomilo (1978) performed an empirical descriptive study on identifying spiritual needs of noncritical patients from two general hospitals in the East. It was a convenience sample of 90 subjects. Two instruments, a questionnaire and an interview guide, were designed to elicit from the subjects their perception of their spiritual needs. One part of the questionnaire asked patients to rank in order the seven most frequently cited needs as identified in the Hess study (1978). The highest ranked needs were: relief from the fear of death, knowledge of God's presence, expression of caring and support from another person, and receiving the sacraments. Other findings identified a clergyman as the person with whom the patient preferred to speak about spiritual needs, and the nurse's role was to be kind and to listen. There were some relationships (positive) between certain demographic variables and identified spiritual needs. Female subjects verbalized more needs than males. Those subjects hospitalized five or more times in the past 5 years indicated more spiritual needs than those hospitalized only once. The results of this study did indicate the need for further research in the area of spiritual care, especially in regard to degree of illness, age, sex, and degree of religiosity of patients and their spiritual needs.

Emotional Responses to Cancer

Being diagnosed as having cancer is usually viewed by the individual as an extremely stressful and taumatic event (Peck, 1972). It is also generally agreed that "cancer" is unique among diseases in

the degree of anxiety and emotional responses it evokes because, according to Bouchard and Owen (1972), its meaning is synonymous with death. Schneider (1978) described the diagnosis of cancer as a potential threat of disability, disfigurement, and recurrence. It is a stressful condition, which usually disrupts an individual's pattern and quality of life, as well as generating intense emotional and psychological responses.

The kinds of emotional stresses a cancer patient faces are many, varied, and individualistic. Rosillo, Welty, and Graham (1973) grouped the potential stresses facing cancer patients. The first stressful group is induced by the disease itself, which causes a loss of health, feelings of shame, punishment or retribution, loss of control and an impending fear of death. The second group is related to hospitalization, which may create impairments with family relationships, fear of unusual surroundings, loss of employment, pleasures, and identity. Hinton (1973) presented a similar list of emotional responses that cancer patients bear, including fear of disfigurement, fear of treatment, loss of work role, dependency, alienation, and concern over the future. Learning one has cancer can evoke the emotional responses of anxiety, depression, anger, and guilt (Miller, Denner, and Richardson, 1976). As the cancer patient develops an awareness of his disease and situation, anger becomes the predominant emotion. The vulnerability of becoming dependent due to the diagnosis and medical treatment usually elicitc an intense anger to strike out as emphasized by Donovan and Pierce (1976).

Lipowski (1972) stated that in coping with such psychological and painful emotional reactions to the stress brought on by cancer, patients frequently employ a number of well-defined coping mechanisms. For example, Rosillo, Welty, and Graham (1973) reported that denial, withdrawal, rationalization, intellectualization, suppression, compensation, and regression are common defenses of cancer patients. They also emphasized that each patient would resort to the type of defense that had been characteristic of his past and present life style. Denial appears to be the most frequently used defense mechanism reported in the literature (Hinton, 1973; Peck, 1972; Lynch and Krush, 1968). Mastrovito (1972) described the denial of cancer patients as a coping mechanism that keeps out of the consious the significance of the disease and resulting symptoms.

The manner in which a person may react to a diagnosis of cancer depends on his ability to adapt to a situation of threat. This adaptation to threat depends on one's chronological age, emotional maturity, general patterns of behavior, normal reactions to stress, family relationships, economic situation, and the extent of his knowledge about cancer and the disease process (Bouchard, 1972). Hinton (1973) stated that cancer patients gained a considerable amount of support when able to see examples of others who also had cancer and were bearing it well. Rosillo et al. (1973) emphasized that acknowledging one's own feelings about himself and his disease enhances his sense of being understood, while recognition of his assets and strengths by others will instill a greater sense of security, trust, and optimism. However, few empirical investigations and studies have been done in order

to examine the coping mechanisms employed presently by cancer patients; therefore, little is known of what mechanisms or variables increase effective coping ability to stress induced by cancer and to those which do not decrease stress. One study conducted by Miller and Nygren (1978) attempted to obtain descriptive data in order to evaluate the effectiveness of an educational program designed to assist chronically ill cancer patients in adapting to living with their disease. Ten subjects were selected and the data was derived from the selected subject's response on a standardized test and during two pre- and posteducational program interviews. The results demonstrated that cancer patients required additional coping behaviors to those of the norm which could be made available through educational classes for patients and families. The additional assistance of the educational classes helped reveal a greater appreciation for life to the subjects and assisted the subjects and their families in their adjustment to living with cancer. This was an exploratory study and no statistics were used.

Schneider (1978) presented a study designed to describe the personal concerns and problems identified by cancer outpatients in a clinic setting. The sample consisted of 26 subjects from the medical and radiation oncology clinics in a university hospital. An interview was constructed consisting of a series of open-ended questions related to activities and feelings that people experience on a day-to-day basis. The areas considered were lifestyle, functional status, finances, general status, mood and attitude, major difficulty, concerns and troubles, critical incidents, sources of help, and goals. When asked what problems or concerns they had, 19 (73 percent) of the

subjects answered that they had none. Six subjects (27 percent) answered affirmatively and indicated such concerns as finances, family needs, pain, and a sense of meaninglessness in life. When asked what their sources of strength or help were, the subject's family was the most frequently recognized. The attitude of the doctors and nurses and their honesty ranked second as a primary source of help. Neighbors, friends, and visitors ranked third; and faith in God, prayer, and the Bible ranked fourth. However, the major finding of this study was that cancer patients were willing to talk on an initial contact basis and to share their feelings, needs, and concerns.

In conclusion, a search through the literature revealed very little information concerning approaches for aiding cancer patients in dealing effectively and successfully with the emotional reactions and stress of cancer. Peck (1972) suggested that more research should be done in understanding how the cancer patient integrates his knowledge of his disease and also in identifying the coping mechanisms the cancer patient has already established over a lifetime of experiences in order to more effectively assist these patients in coping with their stress and disease process.

CHAPTER 3

METHODOLOGY

This chapter includes the design of the study, the sample, limitations of the study, development of the tool, the pilot study, the method of data collection, operational hypotheses, and the method of data analysis.

The Design of the Study

This correlational descriptive study was designed to do initial development of an instrument, to identify the nature of spiritual needs, to measure the importance of these needs to the oncology patient, and to assess relationships among selected demographic variables to the nature and importance of spiritual needs.

The Sample

The sample consisted of 13 adult oncology inpatients from a medical unit in one southwestern university hospital. Each subject selected met the following criteria: diagnosis of cancer, hospitalized, English-speaking, 16 years of age or older, mentally alert and oriented, and physically and emotionally capable of completing the questionnaire form. Whether a subject met the criteria was determined by the researcher. However, the availability and ability of the subject to participate in the study was discussed with the nurse responsible for the subject's care.

Limitations of the Study

The limitations of the study were as follows:

1. The Spiritual Needs Tool was developed primarily for this study and therefore has had limited validity and reliability testing.
2. The Spiritual Needs Tool was in English, which eliminated other potential subjects who could not read or speak English.
3. Many variables in the hospital environment, in the individual's cultural framework, and the family's influence were not controlled.
4. The extent of instrument development and the power of the tests of the hypotheses were limited due to time and cost.
5. Due to small sample size, statistical manipulation and resulting conclusions are limited.
6. Generalizability of results will be limited by the convenience sample of adult oncology patients in one unit in one hospital in the Southwest.
7. The female sex of the researcher might inhibit the response of a subject of the opposite sex because of societal expectations.
8. The researcher recognizes her own bias in her belief in the therapeutic aspects of Christianity.

Development of the Tool

The tool entitled "Spiritual Needs Tool" was drafted by the researcher after an extensive review of the literature revaled no appropriate tool designed to identify and measure spiritual needs.

The tool was constructed in the form of a questionnaire consisting of three sections. Section I represented demographic data. It included the demographic variables and factual information about the patient and his present hospitalization. The second section, or the Nature Sucscale, indexed spiritual needs. The purpose of this section was to identify the nature of the spiritual needs of the sample. It consists of 12 items randomly arranged and worth 1 point each. The instructions for Section II included placing an X beside the items personally experienced during the subject's present hospitalization. The sum of all the items checked was the individual's score. These 12 needs were documented in the nursing, psychological, and theological literature as representing spiritual needs of patients. For example, Hess (1978) found the following needs from her study: prayer, meaning and purpose in life and suffering, feelings of guilt, needs to express faith in tangible means such as Bible reading, sacraments and communion, and assistance from clergy. (For complete documentation of each specific need in the questionnaire refer to Appendix A.)

Section III, or the Importance Subscale, was a summated rating scale consisting of a set of items to which the subject was asked to react. The purpose of the Importance Subscale was to measure the significance and importance of the total spiritual needs identified by the sample. The Importance Subscale consists of 14 statements specifically related to the 12 spiritual needs listed in the Nature Subscale. "The need for prayer" and "the need for reading the Bible or other religious material" were thought to be double items and thus were divided into two parts to express praying and reading both by onself

and by someone else. The statements in Section III were designed by the researcher with the exception of statements 1, 4, 5, and 13, which were taken from a scale developed by Schomus (1979). The statements are arranged on a 5-point Likert-type scale. The Likert scale was chosen because the reliability of the scale increases as the number of possible alternative responses increases, permitting several degrees of agreement-agreement-disagreement (Selltiz, Wrightsman, and Cook, 1976). Points of 1 to 5 were assinged accordingly to the discriminators "Not Important" through "Extremely Important." The instructions for this section included circling the degree of importance the subject felt that day about each of the statements listed.

The Pilot Study

A group of five female graduate nursing students were selected to evaluate the tool for content validity. They were also asked to judge the tool for clarity, wording, and relevancy. Each graduate nurse was given the definition of "spiritual needs" and then asked to evaluate the 12 items in the Nature Subscale to determine whether in her opinion and experience the items represented were indeed spiritual needs.

Tool reliability was not ascertained in this pilot study because it was the unanimous consensus of the five graduate nurses that they could not justifiably fill out the questionnaire because none had been hospitalized and therefore could not respond appropriately to the questionnaire form.

The researcher interviewed each graduate nurse to assess her feelings, criticisms, and comments about the format and relevancy of the tool. The following information obtained was used to revise the questionnaire: Section II, "the need for immortality" was changed to "the need for life after death" so it would more closely relate to statement 10 of Section III; the other revision consisted of changing statements 2, 3, 5, 6, 7, 9, 10, 12, and 13 of Section III by adding the phrase "for me" to personalize each statement. (See Appendix B for questionnaire.)

The Method of Data Collection

The seelcted subjects were personally contacted by the researcher at a time designated as convenient by each subject. The researcher introduced herself and explained that she was conducting a study on hospitalized oncology patients in order to understand more about their needs so that nurses may be more effective in helping them meet these needs. The researcher emphasized that she was primarily concerned with the subject's spiritiual and religious needs. The subjects were informed that regardless of their religious affiliation or non-religious affiliation their opinions were desired. The researcher explained that the subject's participation was entirely voluntary and that they would be giving their consent by virtue of filling out the questionnaire. The researcher also explained that there were no known physical or emotional risks and that they could feel free to drop out of the study at any time without affecting the care they were presently receiving. Questions were encouraged and all

subjects were assured that all information would be held strictly confidential. If a subject agreed to participate, the questionnaire was left for the subject to complete. The researcher also informed the subject that she would personally return within 30-45 minutes to pick up the completed questionnaire and to answer any questions.

Operational Hypotheses

The operational hypotheses in this study were:

1. Oncology patients will identify the number of their spiritual needs by checking all applicable needs in the Nature Subscale of the Spiritual Needs Tool.
2. The importance of spiritiual needs to the oncology patient as indexed by the Importance Subscale of the Spiritual Needs Tool will be significantly >1.
3. There will be no relationship between the number of spiritual needs identified by oncology patients and:
   a. age
   b. sex
   c. ethnic origin
   d. religion
   e. marital status
   f. type of cancer
   g. length of present illness
   h. length of present hospitalizations
   i. number of hospitalizations in past 5 years

4. There will be no relationship between the importance of spiritual needs identified by the oncology patient and:
   a. age
   b. sex
   c. ethnic origin
   d. religion
   e. marital status
   f. type of cancer
   g. length of present illness
   h. length of present hospitalizations
   i. number of hospitalizations in past 5 years

The Method of Data Analysis

The data were coded and submitted for computer analysis. Three aspects of the data were analyzed: characteristics of the sample, data related to the hypotheses, and data related to the measurement tool.

To accomplish the above analysis, frequencies, percentage, means, standard deviations, t test, Pearson's correlation coefficients, point biserial correlation coefficients, and analysis of variance were utilized.

CHAPTER 4

PRESENTATION OF THE DATA

In this chapter are described the characteristics of the sample, data analysis related to the hypotheses, and data analysis related to the measurement tool.

Characteristics of the Sample

The characteristics of the sample are represented by frequency distribution and percentages by age, sex, marital status, ethnic origin, religion, type of cancer, length of present illness, length of present hospitalization, and number of hospitalizations in the past 5 years.

The convenience sample consisted of 13 adult oncology inpatients located on one medical unit of a university hospital in the Southwest. As indicated in Table 1, the mean age of the sample was 48 with a range of 16 to 69 years. Four of the subjects were male and 9 were female. The only ethnic group represented was Caucasian. Sixty-one percent of the sample were married, 15.4 percent were either single or widowed, and 7.7 percent were divorced. The two religious groups were Protestant (46.2 percent) and Catholic (30.8 percent). The rmeainder of the sample (23.1 percent) had no religious preference.

The characteristics of each subject's hospitalization and disease process are illustrated in Table 2. The most predominant type of cancer in the sample was leukemia (46.2 percent). The length of present illness ranged from 3 months to 5 years with a mean of

Table 1. Demographic Characteristics of the Sample

Characteristic		Number	Percent
Age			
Range	16–69 years		
Mean	48 years		
Mode	45 years		
Medium	46 years		
Sex			
Male		4	30.8
Female		9	69.8
Total		13	
Marital Status			
Married		8	61.5
Single		2	15.4
Widowed		2	15.4
Divorced		1	7.7
Total		13	
Ethnic Origin			
Caucasian		13	100.0
Religion			
Protestant		6	46.2
Catholic		4	30.8
No preference		3	23.1
Total		13	

Table 2. Disease and Hospital Characteristics of the Sample

Characteristics	Range	Mean	Number	Percent
Type of Cancer				
Leukemia			6	46.2
Cervix			3	23.1
Lung			2	15.4
Multiple Myeloma			1	7.7
Breast			1	7.7
			13	
Length of Present Illness	3 months-5 years	1.5 years		
Length of Present Hospitalization	2-60 days	17.3 days		
Number of Hospitalization in past 5 years	1-30	7.1		

1.6 years. The number of days of present hospitalization ranged from 2 to 60 days with a mean of 17.3, and the number of past hospitalizations in the past 5 years averaged 7.1 times with a range of 1 to 40.

Data Analysis Related to the Hypotheses

The first hypothesis stated that oncology patients would identify the nature of their spiritual needs by selecting the corresponding number of needs on the Spiritual Needs Tool. Hypothesis 1 was assessed by the percentage of the total number of needs from the Nature Subscale (Table 3). Each individual need was calculated by percentage and frequency. The mean, standard deviation, and range indicate the average number of needs selected, the extent of variation of the needs and the range of needs from the total sample.

Table 3. Number of Spiritual Needs Reported by Subjects in Response to the Nature of Spiritual Needs Subscale.

Subject	Number of Needs	Percent (n=12)
1	0	0
2	9	75
3	4	33
4	3	25
5	4	33
6	1	8
7	2	16
8	9	75
9	7	58
10	12	100
11	7	58
12	7	58
13	0	0

Range, 0-12; mean, 5; standard deviation, 2.80

The range of needs selected was from 0 to 12 with a mean of 5. The most frequent number of needs selected was 7. Two subjects indicated no needs and one subject indicated all 12. A total of 84.7 percent of the subjects identified 1 or more needs from the Nature Subscale, therefore, hypothesis 1 was not rejected. In addition, Table 4 describes the frequency and percentage for each need from the Nature Subscale. Hope was selected by 69.2 percent of the subjects and represented the most frequent need, followed by prayer (61.5 percent), meaning and purpose in life (53.8 percent), and the need for God's love (46.2 percent). The least indicated need reported was for rituals of communion and sacraments (23.1 percent).

Table 4. Frequency of Selection of Individual Needs in Nature of Spiritual Needs Subscale

Need	Frequency	Percent (n=13)
Hope	9	69.2
Prayer	8	61.5
Purpose in life	7	53.8
Love	6	46.2
Clergy visit	5	38.5
Bible	5	38.5
Suffering	5	38.5
Belief in God	5	38.5
Life after (death)	4	30.8
Forgiveness	4	30.8
Guilt	4	30.9
Rituals	3	23.1
	65	

The second hypothesis stated that the total score for importance of spiritiual needs on the Spiritual Needs Tool would be significantly greater than 1, i.e., "Not Important" on the subscale. The expectation was that if needs are important to patients, they will indicate the magnitude of importance by a response of 2, 3, 4, or 5. A one-tailed t test was employed to determine if the mean of each subject's overall importance score differed from 1. The significance level accepted was determined prior to analysis as p = .05. The resulting t value (Table 5) was significant at the 0.0001 level, which indicated that the importance of spiritual needs was significant beyond the criterion level. Therefore, hypothesis 2 was not rejected.

Table 5. Student's t Test Analysis of Total Importance of Spiritual Needs (N=13)

Number of Statements	Mean	Standard Deviation	t Value	Level of Significance
14	2.80	1.23	5.62	0.0001

In addition to testing total needs for statistical significance, each need was of interest for the importance it had to patients. Table 6 describes the level of importance of each statement of the sample by frequencies and percentages. The statement that was the most "extremely important" was "For me to know that God loves me" (61.5 percent). The needs "things to work out" (53.8 percent) and

Table 6. Descriptive Analysis of Responses to Importance of Spiritual Needs Subscale

Item	Frequency (Percent, n=13)					
	1	2	3	4	5	6
!	0	2 (15.4)	0	7 (53.8)	4 (30.8)	0
2	1 (7.7)	0	0	5 (38.5)	5 (39.5)	2 (15.4)
3	0	1 (7.7)	2 (15.4)	7 (53.8)	3 (23.1)	0
4	4 (30.8)	1 (7.7)	1 (7.7)	2 (15.4)	2 (15.4)	3 (12.1)
5	8 (61.5)	1 (7.7)	2 (15.4)	2 (15.4)	0	0
6	0	2 (15.4)	1 (7.7)	3 (23.1)	7 (53.8)	0
7	6 (46.2)	1 (7.7)	1 (7.7)	1 (7.7)	0	4 (30.8)
8	0	1 (7.7)	3 (23.1)	5 (38.5)	4 (30.8)	0
9	6 (46.2)	2 (15.4)	3 (23.1)	0	2 (15.4)	0
10	4 (30.8)	1 (7.7)	1 (7.7)	4 (30.8)	3 (23.1)	0
11	5 (38.5)	3 (23.1)	2 (15.4)	3 (23.1)	0	0
12	3 (30.8)	2 (15.4)	0	4 (30.8)	3 (23.1)	0
13	3 (23.1)	1 (7.7)	5 (38.5)	3 (23.1)	1 (7.7)	0
14	1 (7.7)	1 (7.7)	0	3 (23.1)	8 (61.5)	0

1 = not important; 2 = slightly important; 3 = moderately important; 4 = very important; 5 = extremely important; 6 = no response.

"thinking about my meaning and purpose in life" (38.5 percent) were also indicated as extremely important by the sample population. The statement of elast importance was "having the Bible or religious materials read to me" (23.1 percent). Sixty-one percent indicated that the need to receive communion or sacraments was "not important," followed by 46.2 percent indicating that both the statement to be relieved from guilt and a visit from clergy were not important. Three statements had no response from a sizeable percentage of the population. Thirty percent did not respond to "for me to be relieved of any guilt is:," 23.1 percent indicated no response to "Believing my suffering will be worthwhile is:," and 15.4 percent did not respond to "For me establishing a belief in 'God' is:."

Hypotheses 3 and 4 were null hypotheses designed to assess the relationship of each demographic variable with both aspects of spiritual needs: nature, which was the number of needs, and importance, which was the total mean score of the needs. Both hypotheses stated that there would be no relationship between the importance and nature of spiritual needs with the demographic variables. The relationship with age, number of past hospitalization in the past 5 years, length of present hospitalization, and length of present illness were tested by suing Pearson's correlation coefficients. The relationship with sex was tested by point biserial correlation coefficient because the number of needs and importance are each a continuum and sex is a true dichotomy (Table 7), and the relationships with type of cancer, religion, and ethnic origin were tested by analysis of variance (Table 8).

Table 7. Correlations between Demographic Variables and Nature and Importance of Spiritual Needs

Demographic Variable		Nature		Importance	
		r	s	r	s
Age	13	.67	.01	.56	.05
Sex	13	.28	.35	.25	.40
Length of present illness	13	-.34	.24	.02	.94
Length of present hospitalization	13	-.32	.28	-.04	.88
Number of hospitalizations in past 5 years	12	.18	.57	.20	.52

Table 8. Analysis of Variance for Religion and Type of Cancer and Nature and Importance of Spiritual Needs

	Residual	Explained	df	Mean Squares	Significance of F	R^2
Nature						
Cancer	104.500	48.269	4	12.067	.496	.316
Religion	150.833	1.936	2	.968	.938	.013
Importance						
Cancer	478.000	189.231	4	47.308	.562	.284
Religion	600.083	67.147	2	33.574	.588	.101

Ethnic origin was omitted from statistical analysis because only one race (Caucasian) was represented in the sample. The only statistically significant findings with the demographic variables were between age and nature ($p = .012$) and importance ($p = .049$) of spiritual needs. Therefore, hypotheses 3 and 4 were rejected in terms of age only. To minimize a Type I Error, the data were analyzed from a substantive perspective. The selected criterion magnitude of correlation coefficients was 0.4. However, the data revealed no findings that met the substantive criterion.

Data Analysis Related to the Measurement Tool

Both the Nature and Importance Subscales were tested for internal consistency using coefficient alpha. As indicated in Table 9

Table 9. Alpha Correlations of the Nature and Importance of Spiritual Needs Subscales for Internal Consistency

	N	Nature	Importance
Number of items	13	12	14
Range of inter-item correlations	13	-.18–.84	-.58–.81
Average inter-item correlations	13	.36	.24
Unstandardized coefficient alpha	13	.87	.74
Standardized coefficient alpha	13	.87	.78

both subscales fared well. The Nature Subscale has a stable coefficient alpha of 0.87, indicating a high level of internal consistency reliability. Since the items were generated from a theoretical framework of spiritual needs, the coefficient alpha also indicates initial construct validity. The Importance Subscale had an unstandardized alpha of 0.74, indicating a satisfactory level of internal consistency for a new scale and concomitant initial construct validity. Deletion of items 5 and 10, which are the needs related to communion and a life and death, respectively, would significantly improve inter-item correlations and the alpha. Before these items are completely removed from the tool, further review, evaluation and revison would be necessary regarding the appropriateness of these two items in the tool.

Before the Nature Subscale was analyzed for reliability, items 2, 4, and 7 (the need to establish a belief in God, a need for suffering, and the need to be relieved from guilt, respectively) were deleted because they had large amounts of missing data. Therefore, testing these items for reliability would be required.

CHAPTER 5

FINDINGS, SUMMARY, AND RECOMMENDATIONS

This chapter contains discussion of the findings of the study as they relate to the hypotheses, theoretical framework, and the review of the literature. This chapter also contains the summary and recommendations for tool revision, for future study, and for nursing practice.

Findings Related to the Hypotheses

Conceptual hypothesis 1 was supported in this study because 84.1 percent of the sample were able to identify one or more spiritual needs on the Nature Subscale of the Spiritual Needs Tool. Provision was made at the bottom of the Nature Subscale for subjects to add any additional or missing spiritual needs. However, none of the subjects chose to respond. Several conclusions may be made herein: the indexed list of spiritual needs was inclusive, subjects were not willing to commit themselves, or not enough time was given for them to fully assess their feelings and needs in the area covered by the Spiritual Needs Tool.

One of the most interesting findings was that the most frequent needs indicated by the sample were hope, prayer, meaning and purpose in life, and the assurance of "God's" love. These needs deal more with the internal condition of man and his relationship to a supreme being rather than to the concerns from a structured system of beliefs

and rituals, which define religion. This was further supported by the finding that the religious concerns or needs such as communion, sacraments, Bible reading, and clergy visits were the least frequent needs cited in the study by the sample.

Hypothesis 2 indicated that the spiritual needs of the oncology patient were significant and quite important to them. The statement cited as the most "extremely important" was to know God's love. This could explain the oncology patient's need for acceptance and love in light of his disease, which often carries a social stigma, possible disfigurement, and isolation. The statements of "establishing a felief in God" and "being able to pray" were "very important" (53.8 percent) to the sample. This could explain possible methods of coping with a situation or a disease such as cancer which man (physicians, nurses, researcher, etc.) are unable to overcome.

Another very interesting finding that deserves attention was the statement, "to be relieved of guilt" which on the Importance Subscale, was left blank by 30.8 percent of the sample. Possible interpretations could be that either this is not a spiritual need or not an area to which subjects were consciously willing to respond. However, regardless of the reason, the fact that the statement concerning guilt was left blank indicates the need to follow up on this phenomenon to find out more conclusively and thoroughly the reason for the lack of response.

In terms of hypothesis 3 and 4 there was a significant relationship between age and both the nature and importance of spiritual needs. A possible conclusion from this finding is that as one grows

older his developmental tasks consist of more references made to spiritual needs, therefore, he will identify more such needs and they will be more important to him. Also, the fact that the religious influences were greater and standards were stricter years ago than now and that individuals in their 60s and 70s were brought up in a more religious dominant society in contrast to the younger individual, might influence the "age cohort" finding of the older subject identifying more needs and placing more importance on their fulfillment.

Findings Related to the Theoretical Framework

Because man is a whole system composed of interdependent parts constantly interacting with each other and because these parts cannot operate independently each change or stress in any part will affect the balance and integrity of the entire system. This theory is the backbone of the study's theoretical framework. However, without violating the concept of "wholeness," it becomes imperative imperative that nurses who are concerned with understanding human behavior and assessing needs examine the dimensions of "whole" man and the situations that might upset or affect his balance and integrity. Specifically, the study dealt with man's spiritiual component or dimension. The findings of the study indicated that patients were able to define the nature and number of spiritiual needs they were experiencing as well as how important or unimportant those needs were. It was expected that by identifying the nature and importance of patient's spiritual needs a more concrete definition of man's spiritual dimension in terms of nursing care could be defined.

The theoretical framework also included Stallwood's (1975) model of the Nature of Man. It was Stallwood's contention that man's nature included three dimensions: body, mind, and spirit. She proposed that the spiritual dimension of man consisted of his spirit, which has a need for "God-consciousness," and a relatedness to diety as defined by each individual. The findings of the study supported the "God-consicousness" aspect in that 77.1 percent of the sample indicated that to establish a belief in "God" was either "very" or "extremely" important, and 84.6 percent indicated that to know that "God" loves them was also very important.

Stallwood (1975, p. 1089) also stated that "man will cry out in any area where there is a lack or need," and the fact that subjects were able to complete the Spiritual Needs Tool and indicate specific areas of need supports this important assumption.

Maslow's (1970) theory, which is the third element of the theoretical framework, emphasizes that the fundamental characteristic of man is motivation, which is needed to obtain goals and maintain a state of constancy and balance. In terms of this study the degree of importance an individual places on meeting specific needs could be assumed to indicate his ability to identify prioritieis as an early, nessary element for motivation in order to restore harmony and balance in his life. Subjects reported that 57 percent of the 14 statements on the Importance Subscale were "very" or "extremely" important to them. This would seemingly indicate that spiritual needs have a high index of importance, particularly to the convenience sample of oncology patients. This finding relates to Maslow's (1970) assumption that as a

human being undergoes intense stress such as illness the homeostasis of that individual is threatened, creating a wide variety of needs.

Findings Related to the Review of Literature

The review of the literature revealed nursing's efforts to define, understand, and intervene appropriately in man's spiritual needs. However, substantial research and uniform concepts were lacking in the literature. It was therefore the intent of the study to define spiritual needs and thereby contribute to nursing's body of knowledge using a scientific approach. Fish and Shelley (1978) explained that spiritual needs must be discerned through the interpretation of observations and the testing of hypotheses. Four major hypotheses regarding the nature and importance of spiritual needs were tested in the study.

In an attempt to define spiritual needs, the report of the White House Conference on Aging (1971) described fulfillment of the spiritual needs as living all stages of life in hope. The findings in the study also related very highly to this need for hope in that 84.1 percent of the sample indicated "the need for hope" and 53.8 percent indicated it was "extremely important" to them.

Murray and Zentner (1979, p.439) defined spiritual as "something that goes beyond religious affilitation" and that it consists of ingredients affecting man's inner being. The findings also alluded to this difference between "religious" and "spiritual" aspects. For example, needs equated with a religious orientation such as communion or sacraments, visit from clergy, and reading the Bible or

other religious materials ranked very low totally on the Nature and Importance Subscales. The sample indicated that "the need for communion and rituals" (61.0 percent) and "the need for a visit from clergy" (46.2 percent) were "not important."

Mullane (1958) described the central core of nursing as giving spiritual care which will ease the emotional and physical impact of disease and treatment. The findings of the study did indicate some nursing interventions to be recommended. Seventy-six percent of the sample indicated that being able to pray was "very" or "extremely" important. Therefore, nurses need to be aware of this need in their patients and should include in their planning of care quiet time to be used by the patient as he so desires. Sixty-nine percent of the sample also felt that the need to have someone pray for them was very important. This finding allows the nurse to offer her assistance in praying with or for the patient, or if she prefers, for whatever reason, to seek out an appropriate resource person to pray with the patient. Because the need for a visit from clergy or the participation in rituals was ranked so low, it would be recommended always to ask the patient if a clergy's visit would be appropriate or helpful rather than to arbitrarily refer a patient to the chaplaincy. Finally, because the need for hope (84.1 percent) and meaning and purpose in life (53.8 percent) were the most frequent needs identified, nurses must continue to be creative and successful in assisting patients in these areas.

Dickinson (1975) defined spiritual care as halping the patient to find meaning in his suffering which would help him endure his illness. However, in this study the evidence showed that only 30.8 percent

indicated it was "not important," and 23.1 percent did not respond to the importance of this need at all. Possible conclusions considered are that either culturally, the American heritage (all subjects were Anglo-American) emphasized the need to be stoical and placed little emphasis on suffering (Murray and Zentner, 1979), or cancer patients who frequently used the defense mechanisms of denial will actually deny or cover their suffering.

Relating the findings to other studies found in the literature, Hess (1978), who conducted a pilot study to determine patients' perceptions of their spiritual needs, indicated the most frequent responses as being prayer, need for an aswareness of God's presence, fear of death, need to find meaning in life, death and suffering, and feelings of guilt. This researcher's findings in this study corroborated those of Hess in that the need for hope, prayer, meaning and purpose in life, and the need for God's love were the most frequently cited.

Martin, Burrow, and Pomilo (1978) performed an empirical descriptive study on identifying spiritual needs of patients. The highest ranked spiritual needs were as follows: relief from the fear of death, knowledge of God's presence, expression of caring and support from another person, and receiving the sacramanets. The findings of this study contrasted particularly in the area of sacraments, which has a low-importance and low-selected need as compared to the findings of Martin et al. (1978). Martin et al. also demonstrated that an increased number of needs was related to an increased numer of previous hopsitalizations within a 5-year period. This was not supported by

the current study, which revealed no significant relationship to previous hospitalizations.

Summary

The purpose of the study was to operationally define the term "spiritual needs" and develop a tool to identify the nature and importance of spiritual needs of oncology patients. The purpose was also to determine if there was a relationship between the nature and importance of spiritual needs to the selected demographic variables: age, sex, marital status, religion, ethnic origin, type of cancer, length of present illness, length of present hospitalization, and number of hospitalizations in the past 5 years.

The framework for the study was the theory that man is a "whole" system made up of interdependent parts, which must all be functioning together in order to maintain balance and homeostasis. One of these parts is the spiritual dimension; when man is stressed, ill, or compromised, spiritual needs will arise.

The significance of this research was based on the review of the literature, which revealed that spiritual nursing care was important but that there was a lack of a uniform definition of spiritual needs and a lack of research in the area of spiritual nursing care. Therefore, the researcher chose to explore patients' perceptions regarding the nature and importance of their spiritual needs so that this information could provide nurses with a better understanding and background of spiritual needs that may arise when a patient is

hospitalized. Also this study may provide criteria for nursing assessments and interventions needed in spiritual care.

The review of the literature consisted of discussion and studies related to religion and medicine, nursing and spiritual needs, and the emotional responses to cancer.

In order to obtain the purpose of the study a tool was developed and a correlational descriptive study was designed. The measurement tool, entitled Spiritual Needs Tool, was a three-part questionnaire. The first section consisted of demographic data, the second section consisted of an index of 12 spiritual needs and the third section consisted of an interval scale rating the importance of the indexed spiritual needs.

The total convenience sample consisted of 13 adult oncology inpatients on a medical unit in one southwestern university hospital. The researcher administered the questionnaire to each subject, collected the data, coded, and submitted it for computer analysis. The statistical computations consisted of percentages, frequencies, means, ranges, standard deviations, t test, Pearson's correlations, point biserial correlations, and analysis of variance.

The data supported the first hypothesis in that 84.1 percent of the subjects identified one or more spiritual needs on the Spiritual Needs Tool. The need for hope and the need to pray were the most frequent needs cited.

The data also supported the second hypothesis, which stated that the total importance score of spiritual needs identifed by the sample would be significantly greater than one. The level of

significance reported from the t-test analysis was 0.0001, which was significant beyond the predetermined accepted level of p = .05. The findings also revealed that 84.6 percent of the sample felt that to "know God loves them and to have meaning and purpose in life" was both very and extremely important.

The third and fourth hypotheses were null hypotheses. These hypotheses stated that there was no relationship between the nature and importance of spiritual needs to the demographic variables listed in the study. The only variable that correlated significantly with both the nature and importance of spiritual needs was age. Therefore, the third and fourth hypotheses were partially rejected in terms of the age variable only.

The findings related to the tool indicated that the Nature Subscale had a stable coefficient alpha of 0.87 which determined a high level of internal consistency provided support for construct validity. The Importance Subscale did not fare as well. However, deletion of the needs related to communion and life after death would significantly improve the inter-item correlation of the scale and therefore improve internal consistency of the tool.

In conclusion, the term "spiritual needs" was operationally defined and a tool was developed to identify the nature and importance of spiritual needs to oncology patients. The hypotheses of the study were at least partially supported from the data collected. The statistical analysis is not powerful at this time primarily due to the sample size. The tool needs further validity and reliability testing. However, on the basis of this researcher's clinical experience, the

literature, and the content of this study, spiritual needs can be identified, they are important to patients, and they should be recommended in nursing care and assessment.

Recommendations for Tool Revision

The following recommendations for tool revision are suggested:

1. Have tool translated into other languages in order to include a larger sample size.
2. Change the Nature Subscale by eliminating the phrase "the need" after each indexed item.
3. Test the Spiritual Needs Tool using an inductive method for validity.
4. Include with the tool an interview to identify specifically each subject's own definition of spiritual needs, and aim for relatively culture-free items.

Recommendations for Further Study

The following recommendations for further study are suggested:

1. After incorporating instrument and other revisions, replicate the study with a larger random sample.
2. Replicate the study comparing outpatient oncology patients with inpatient oncology patients.
3. Replicate the study comparing patients in a religious-oriented hospital with patients in a community hospital.
4. Design a study to identify what nurses perceive as spiritual needs of patients.

5. Design a study to explore what patients perceive the nurse's role is in caring for their spiritual needs.

Recommendations for Nursing Practice

The following recommendations for nursing practice are suggested:

1. Nurses must be aware that patients do have important spiritual needs while hospitalized and are willing to share them with nursing personnel.
2. A spiritual assessment of every patient should be included in the nursing care plan.
3. Clinical nursing research in defining spiritual needs of patients and appropriate nursing interventions should be continued.

APPENDIX A

SPIRITUAL NEEDS LITERATURE DOCUMENTATION

Meaning and Purpose

To redefine spiritual care we do not need a watered-down version of past religious practices but a broader grasp of man's present search for meaning and practical way of integrating spiritual care into everyday nursing (Dickinson, 1975, p. 1789).

The will-to-meaning is the most human phenomenon of all. An appeal to continue life, to survive the most unfavorable conditions can be made only when such survival appears to have a meaning (Frankl, 1963, p. 154).

Suffering

Helping the patient to find meaning in suffering is the final aspect of spiritual nursing care. Suffering and illness are grim but they have a purpose: the cherishing of life itself (Dickinson 1975, p. 1793).

Hope

The spiritual aspects of nursing then are linked to a hope for survival . . . (Dickinson, 1975, p. 1791).

Belief in God

A belief in a supernatural or divine force that has power over the universe and commands worship and obedience (Murray and Zentner, 1979, p. 438)

Prayer

Prayer is a recognition of our human need for God. It is openness to God's will as well as the statement of our requests, thoughts, and feeling to God (Fish and Shelley, 1978, p. 97).

Sacraments

Sacraments which constitute a source of strength, are a means of spiritual help (DuGas, 1972, p. 249)

Clergy

Patients need the presence of someone to help clarify who they are and what their illness means in terms of the future plans (Gruendemann, 1973, p. 46)

Guilt

Anxiety over failures, neglects, omissions, slights, and wrongs done to others is part of all our life stories. At times, usually depending somewhat on one's religious tradition, (patients) can deal with this sense of wrong-doing in general terms or by means of the sacraments (Mills, 1977, p. 206)

Forgiveness

Symptoms of a spiritual need are reflected in comments by the patient that indicate a desire for love, forgiveness, and acceptance by god (Paige and Looney, 1977, p. 1815).

To read the Bible

The Scriptures are God's personal communication to us. They are the truth of God expressed in words, applicable to people in crisis (Fish and Shelley, 1978, p. 109).

Love:

Thus those in the throes of illness and death need consolation; they need someone to stand with them so as to make misery more bearable and to reassure them that death does not negate love and hope (Mills, 1977, p. 101)

Immortality

Religion denies the finality of death and affirms the continuation of the human personality either in its psychophysical totality or as a soul (Aguilera and Mesch, 1978, p. 73).

There is within almost every human being the quest for immortality, eternal life, or a life after death. Most religions have within their belief system some provision for life after death (Hirano, 1978, pp. 311-312)

APPENDIX B

IDENTIFYING THE SPIRITUAL NEEDS
OF THE ONCOLOGY PATIENT

Dear Patient:

You are being asked to voluntarily give your opinion on the statements in this questionnaire. The questionnaire is a tool designed to help nurses learn more about the religious and spiritual concerns of oncology patients who are in the hospital. The benefit of this questionnaire is to provide nurses with more information in order to improve the quality of patient care and meet the needs of the "whole" person. By responding to the questionnaire you will be giving your consent to participate in the study. There will be no known physical or psychological risks and there will be no cost to you other than approximately 15 minutes of your time. You may choose to drop out of the study at any time without affecting the care you are receiving in any way. Your name is not on the questionnaire, and all information will be confidential. You are free to ask any questions about the questionnaire and study at any time. If you so desire, results of the study may be obtained from the researcher by request.

Patient Questionnaire

Section I

INSTRUCTIONS: Please provide the following information listed below:

Age_____Sex_____Ethnic_____Religion_____

Marital Status
(Single, Divorced, Married or Widowed)_____

Number of Days of Present Hospitalization_____

Reason for Present Hospitalization_____

Length of Present Illness_____

Number of Hospitalizations in Past 5 Years_____

Section II

INSTRUCTIONS: Please place an X beside all the items listed below that you have personally experienced since being in the hospital this time. (Check all that apply)

_____ the need for hope

_____ the need to establish a belief in "God"

_____ the need for life after death

_____ the need for purpose in life

_____ the need for a reason for suffering

_____ the need to read the Bible or other religious material

_____ the need for forgiveness

_____ the need for a visit from clergy

_____ the need to pray or meditate

_____ the need for relief from guilt

_____ the need for "God's" love

_____ the need to participate in sacraments, communion, or other religious rituals

_____ other (Please specify below other needs you may have)

_____

_____

Section III

INSTRUCTIONS: For each statment, circle the phrase that best describes your opinion today.

1. THINKING ABOUT MY MEANING AND PURPOSE IN LIFE IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

2. FOR ME ESTABLISHING A BELIEF IN "GOD" IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

3. FOR ME BEING ABLE TO PRAY IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

4. BELIEVING THAT MY SUFFERING WILL BE WORTHWHILE:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

5. FOR ME TO RECEIVE COMMUNION OR SACRAMENTS IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

6. FOR ME TO THINK THAT THINGS WILL WORK OUT IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

7. FOR ME TO BE RELIEVED OF ANY GUILT IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

8. HAVING SOMEONE PRAY FOR ME IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

9. FOR ME TO RECEIVE A VISIT FROM CLERGY IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

10. FOR ME TO BELIEVE THERE IS A LIFE AFTER DEATH IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

11. HAVING THE BIBLE OR RELIGIOUS MATERIALS READ TO ME IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

12: FOR ME TO HAVE THE ASSURANCE OF FORGIVENESS IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

13. FOR ME READING THE BIBLE OR OTHER RELIGIOUS MATERIALS IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

14. TO KNOW THAT "GOD" LOVES ME IS:

Not Important	Slightly Important	Moderately Important	Very Important	Extremely Important

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