Nurses Caring for the Spirit: Patients With Cancer and Family Caregiver Expectations

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Purpose/Objectives: To determine what patients with cancer and primary family caregivers expect from nurses with regard to having their spiritual needs addressed.

Research Approach: Descriptive, cross-sectional, qualitative study using Miles and Huberman's approach to data reduction.

Setting: Outpatient and inpatient settings in a county hospital and a comprehensive cancer center, both located in a large, southwestern, metropolitan area.

Participants: 28 African American and Euro-American adult patients with cancer and primary family caregivers were purposively selected to provide variation of experiences (e.g., religious backgrounds).

Methodologic Approach: In-depth, semistructured, tape-recorded interviews conducted by the investigator. Analysis of transcribed interviews concurrently with data collection followed a process of data concentration, data display, and conclusion drawing.

Main Research Variables: Spiritual needs, spiritual care.

Findings: Informants identified nursing approaches for spiritual needs, including kindness and respect; talking and listening; prayer; connecting with symmetry, authenticity, and physical presence; quality temporal nursing care; and mobilizing religious or spiritual resources. To provide spiritual care, nurses must possess requisites of a personal, relational, or professional nature.

Conclusions: Although some patients or caregivers do not want overt forms of spiritual care, others are eager for them. Many recognize nonreligious actions or attitudes that nurses can practice to care for spiritual needs.

Interpretation: Nurses must consider how they can address patient preconceptions and requisites for spiritual caregiving. Nurses may need to educate the public regarding their role as holistic and spiritual healthcare providers.

Key Points . . .

- When patients with cancer and their family members were asked initially whether they wanted nurses to provide spiritual care, a continuum of responses from yes to maybe to no resulted.
- Findings support the adage that spiritual care is more about being, rather than doing.
- Mandates exist for nurses to provide spiritual care.

Nurses and other healthcare professionals are becoming much more aware of the unique spiritual challenges of living with cancer (Flannelly, Flannelly, & Weaver, 2002). They also are more appreciative of the spiritual resources that patients with cancer and their families use to cope with cancer's challenges. Since the 1980s, a movement to include spiritual care in nursing care has grown steadily (Barnum, 1996; Taylor, 2002). This reflects the very religious history of nursing as well as a growing overt interest in spirituality in today's society. This renewed interest in how spirituality intersects with health has generated hundreds of empirical studies that generally provide support for the notion of spiritual care (Koenig, 2001; Levin, 1994).

This empirical support, combined with society's yearnings for spirituality, presumably is what has influenced professional organizations recently to mandate what is, in effect, spiritual care. Most notably, the Joint Commission on Accreditation of Healthcare Organizations (2000) now requires a spiritual assessment be completed for every admission and spiritual support be provided for any patient who requests it. The American Association of Colleges of Nursing (AACN) document, *The Essentials of Baccalaureate Education for Professional Nursing Practice*, now includes "spiritual" in the list of dimensions for which students must learn to provide care (AACN, 1998). The new International Council of Nurses (2000) ethics code states that nurses should provide an environment where the spiritual beliefs of patients are respected.

Purpose

Considering the context of nurses striving to care for the spirit, nurses must assess what patients and their caregivers want and expect. Thus, the purpose of the current study was to determine what patients with cancer and their primary family caregivers expected of nurses with regard to having spiritual needs addressed. More specifically, this study sought to describe patient perceptions of spiritual care and nurses' role in it by creating a categorized list of types of spiritual care appropriate for nurses to provide. This study is part of the initial, qualitative phase of a larger project investigating spiritual needs of patients with cancer and family caregivers.

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Literature Review and Conceptual Influences

Although several nurse researchers have investigated the spiritual caregiving practices of nurses (Kuuppelomaki, 2002; Narayanasamy & Owens, 2001; Sellers & Haag, 1998; Taylor, Amenta, & Highfield, 1995; Tuck, Pullen, & Lynn, 1997), a paucity of information exists about patients' views of nurses caring for the spirit. Also, some large studies (e.g., King & Bushwick, 1994; Oyama & Koenig, 1998) have explored patients' perceptions of physicians providing spiritual care. Evidence to guide nursing practice, however, is scanty. This meager body of evidence also is from research that often is methodologically weak.

In general, these studies indicate that serious illness or hospitalization can help people become more receptive to spiritual care from nurses. Conco (1995) observed that patients value spiritual caregivers, regardless of their profession, who helped to (a) enable transcendence to find greater meaning and purpose (e.g., by sharing personal experiences of making meaning when suffering), (b) enable hope (e.g., by sharing experiences of surmounting challenges), and (c) establish connectedness (e.g., by being present, touching, accepting and understanding, self-disclosure, sharing spiritual beliefs). However, the transferability of these study findings is limited because the sample was comprised only of Christians.

A few studies have documented some specific expectations or perceptions that patients without cancer have about nurses addressing spiritual needs (Bauer & Barron, 1995; Emblen & Halstead, 1993; Martin, Burrows, & Pomilio, 1978; Reed, 1991). When 19 surgical patients were asked, "How do you think a nurse might provide for spiritual as opposed to physical comfort?," their responses included providing prayer, scripture, compassion, and presence; talking, touching, or smiling with patients; offering referrals; providing physical care; assessing needs; and being accommodating to treatment needs (Emblen & Halstead). The researchers, however, failed to describe what these responses meant.

Bauer and Barron (1995) used a quantitative tool to survey 50 community-residing older adults about what spiritual care interventions they would prefer from a nurse. The researchers found that general attitudes of respect and caring were ranked higher than activities that were more overtly religious in nature. Top-ranked nursing activities included showing a caring and respectful attitude, respecting religious beliefs, helping to promote hopefulness, listening when patients want to talk, and treating religious articles and practices respectfully. Spiritual care interventions that received low rankings included encouraging exploration of spiritual issues; offering prayer; asking about a relationship with or image of God or a higher power; and helping to explore meaning in life. Sellers' (2001) findings from an ethnographic study of 18 midwestern adults are similar: "Nurses can enhance spirituality by understanding the unique human experience of each person through the establishment of a caring human relationship characterized by the art of being present, listening, respecting, and giving of self" (p. 244).

Similar results were obtained in a dated study of 90 hospitalized adults completed by Martin et al. (1978). When asked how they thought nurses could help to address spiritual needs, participants most frequently identified listening or allowing them to talk, calling clergy, and being kind and polite. Nearly every informant (97%) agreed that "nurses give spiritual care by being concerned, cheerful, and kind" (p. 159). Considering contemporary trends in society, these dated findings may not be valid today.

Sodestrom and Martinson (1987) interviewed a small sample of 25 hospitalized patients with cancer. These subjects felt that it was important and appropriate for nurses to provide spiritual care by letting patients share or talk about feelings about God and being willing to listen (n = 19), referring to clergy for religious rituals (n = 14), providing privacy for prayer and assisting with praying as requested (n = 13), respecting patients' religious beliefs (n = 11), assisting patients with Bible reading as requested (n = 11), and comforting patients by being positive, kind, gentle, and giving good physical care (n = 8).

Reed (1991) asked 100 patients with cancer, "In what ways could hospital nurses help you with your spiritual needs?" Subjects were given seven response options and instructed to mark as many as desired. The most frequent response was arrange a visit with a minister, priest, or rabbi (28%), followed by allow time for personal prayer, meditation, or reading (20%); provide time for your family to talk, read, or pray with you (16%); talk with you about your beliefs and concerns (14%); read to you or with you (10%); help you attend the hospital chapel (6%); and other (6%). As with other studies described previously, these findings are limited by the use of predetermined and confining responses options.

Three studies obtained rankings from patients with cancer for preferred spiritual care providers and found that nurses rank lower than family, friends, and personal clergy but sometimes higher than chaplains and physicians (Highfield, 1992; Reed, 1991; Sodestrom & Martinson, 1987). These findings suggest that although many patients want and seek spiritual support, they may not always expect it from nurses.

The current study was influenced conceptually by the myriad of contemporary definitions for spirituality existent in nursing literature. These definitions distinguish spirituality (a broad term describing the innate human yearning for meaning through intra-, inter-, and transpersonal connectedness) from religion (i.e., codified and typically institutionalized beliefs and practices humans create to establish a meaningful worldview) (Reed, 1991; Taylor, 2002). The assumption that spirituality can be described in terms of recognizable needs that can be addressed by specific professional care strategies also was accepted. This assumption, which prevails in nursing (e.g., NANDA International's stance that "spiritual distress" can be diagnosed), is reflective of the thinking in the fields of chaplaincy and pastoral counseling, where dimensions of spirituality have been identified and approaches to spiritual assessment and diagnosis have been developed (e.g., Fitchett, 1993; Pruyser, 1976).

Methodologic Approach

This descriptive, cross-sectional study employed qualitative techniques to collect and analyze data. Because the desired outcome for this study was to reduce the data to a list of categories describing ways to provide spiritual care, an approach to content analysis was selected. This approach to research was not intended to lead to the creation of a formal theory or the understanding of the essential structure of a phenomenon but rather "to provide cognitive leverage on rich data" (Carey, 1997, p. 349).

Sample and Setting

Inclusion criteria for study informants were having a current diagnosis of a malignancy or being the primary family caregiver for an individual with cancer, being either Euro-American or African American, being able to hear and speak English, being at least 18 years old, and currently receiving nursing care. Informants who met these criteria were purposefully selected by the investigator to provide variation of experiences to sample. For example, an attempt was made to recruit informants with diverse religious or philosophical backgrounds.

Informants receiving care in inpatient units and outpatient chemotherapy clinics in a county hospital and a comprehensive cancer center were recruited from a large, southwestern, metropolitan area. Data from patients were collected at the bedside. Except for a mother and a wife who wanted their loved ones to hear their interview, family caregivers were interviewed privately in the patient's room or away from their loved one in a nearby, quiet room.

Procedure and Interview

After obtaining informed consent, the investigator completed an "Information About You" form with the assistance of the informants. This 1.5-page form (in patient and family caregiver versions) created by the investigator obtained cursory demographic and illness information. The form included questions about religiosity (i.e., religious tradition, service attendance, degree of connection to religious organization), illness distress (i.e., "How distressing is your illness and its treatments for you?"), and expected outcomes of treatment (i.e., "What do you think will likely be the outcome of your illness?").

A tape recorder then was turned on and the investigator started a semistructured interview beginning with an open-ended question: "Are there any spiritual needs that you may have had since being diagnosed with cancer (or your loved one was diagnosed)?" After several follow-up questions pertaining to specific spiritual needs were asked, the questions that prompted the data presented in this article were introduced: "How could a nurse help you with the spiritual concerns or needs you have identified?" and "What kinds of things would you like nurses to do if they were caring for your spiritual needs?" Unstructured follow-up questions ensued and often inquired about what the informants thought about nurses praying with patients, what they would not want nurses to do, and what kinds of things nurses could say to comfort patients spiritually. These interviews typically lasted one to two hours and were conducted by the investigator.

Analysis

Content analysis of the data occurred concurrently with data collection. After transcribing the data verbatim and checking it for accuracy, the investigator used Miles and Huberman's (1994) approach to analysis. Data reduction or concentration was performed by extracting and coding the passages from the data that offered information specifically about informants' perceptions of nurses and spiritual caregiving. The process of data display allowed themes created during coding to be organized and placed into categories. This process necessitated constant comparison between and within interviews. Conclusion drawing was aided by placing the themes and categories into a matrix that allowed comparisons to be made not only between categories but also between patients and caregivers as well as African Americans and Euro-Americans. Comparing data within the matrix also assisted in reducing the data further.

Findings

Of the 28 informants interviewed, 21 were patients and 7 were family caregivers. Ten of the patients were men, and all of the caregivers were women. Although most informants were Euro-American, six patients and one caregiver were African American. All but three of the informants had at least a college degree. A total of 5 Jews, 6 Roman Catholics, 14 Protestants, 1 member of the Church of Jesus Christ of Latter Day Saints, and 2 nonreligious people comprised the sample. Nine informants said that they attended religious services at least once every week, and 13 reported that they rarely or never went. Although all lived with a current diagnosis, the span of time since initial diagnosis ranged from four days to 12 years; 13 informants (or their loved ones) had received the cancer diagnosis less than one year prior. When asked to rate on a scale of 1 (not at all) to 5 (very) the distress the illness was causing, informants' responses ranged from 1–5 and averaged 3.3. Twelve informants perceived that they or their loved one would be cured, whereas eight acknowledged that they or their loved one would live with the cancer for some length of time and seven indicated "I really do not know." Eight patients had lymphoma or leukemia, whereas the others had solid tumors in various sites.

Informants' initial responses to the question about how nurses could help them with their spiritual needs yielded a continuum of responses. On one end of this hypothesized continuum were those who replied, "I don't know, I can't picture it" and "nothing derogatory about nurses, it's just the way I see it; I would expect my nurse to be the nurse. My spiritual needs would be, hopefully, taken care of through my friends, family, and priests, whatever." On the other end of the continuum were those who said, "Sure, now that you mention it, it'd be nice" or "Here's what a nurse could do [and would then describe something]." In between were those who gave qualifying, yet positive responses: "It's okay, if certain conditions are met." Spiritual care was equated with nurses giving unrequested spiritual advice or religious proselytization for those who thought it inappropriate for nurses to provide spiritual care. For example, one informant identified that she "would not want a nurse to push a patient to make a religious decision" or "push [the nurse's] religious agenda."

Six categories of nursing approaches for addressing spiritual needs were identified. These included kindness and respect, talking and listening, prayer, connecting, quality temporal nursing care, and mobilizing religious or spiritual resources. These categories, with illustrative verbatim excerpts or examples, are presented in Figure 1.

The most frequent, and most often the initial, response to the question about how nurses could help with spiritual needs reflected the informants' fundamental desire to be shown **kindness and respect.** Seemingly simplistic responses like "be kind" or "just be nice" were typical responses to the questions about what nurses could do to care for the spirit. As the excerpts in Figure 1 illustrate, this kindness and respect is shown in very simple ways. "Just being themselves and friendly," "the way they address you," "showing genuine concern," and "giving loving care" were some of the ways that

Kindness and respect
- "Being nice"
- "It's the little things . . ."
- "The way they address . . . and have a lot of respect for you"
- Show "care and concern."
- "A smile does a lot."

Talking and listening
- "She shared a little testimony with me."
- "Simple conversations with me . . . just sharing concerns . . . everyday chat"
- "The nurse should sit down with the patient . . . and you'd say, 'I understand you have this cancer. I understand your odds of this surgery, or whatever your treatment modalities, you have a percent cure rate of X. How can we help you to deal with this uncertainty?' . . . Then, the nurse could then say, 'could we have you meet with one of our [clergy] and talk to him about how we think religion could help with some of this?' . . . That's how I'd do it if I were you."

Prayer
- Being on a nurse's prayer list
- Nurse offering verbal prayer at bedside
- Nurse saying, "You're in my thoughts and prayers."
- Prayer "shows that they [nurses] care."

Connecting
- With symmetry
  - "Show a personal interest, not be a number"
  - Want to sense nurse "and I are working together"
- With authenticity
  - "Be genuine."
- With physical presence
  - "Just stay for a few minutes."
  - "Be there when you need it."

Quality temporal nursing care
- "Keep the rooms clean and take good care of you."
- "Not letting you suffer . . . coming back to check on you"

Mobilizing religious or spiritual resources
- Call in priest for anointing.
- "Get someone else with similar life experience in to listen."
- "Have Bibles in each room like hotels do."
- Have carts with devotional materials.
- Have inspirational magazines, posters, videos, etc., available in patient rooms or clinic waiting areas.

Figure 1. Nursing Approaches for Spiritual Needs

nurses "made a big difference in morale," "made one feel human," and gave the impression that the patient "was a real person." In these subtle yet powerful ways of showing kindness and respect, informants observed that their spirits were nurtured.

Patients' and caregivers' perceptions of ways that nurses can help with spiritual needs by **talking and listening** varied considerably. Whereas some described nurses' social chitchat or "superficial" inquiries about patients' families or everyday lives as helpful, others identified ways that nurses could facilitate conversation about spiritual concerns. African Americans especially appreciated nurses sharing personal religious experiences in an effort to comfort.

Informants' views of nurses offering **prayer** likewise varied. Although some indicated verbal, traditional prayers with them never would be welcome, others were enthusiastic about nurses praying with them. Some patients, especially female African Americans, did want nurses to pray with them, verbally and silently. A nurse who said, "You're in my thoughts and prayers" as she was leaving greatly comforted one informant who previously stated that a nurse praying with him would not be appreciated.

Informants also desired nurse-patient **connecting.** In addition to wanting connectedness that could occur while nurses remained physically present—even if for brief moments only—informants identified certain qualities to this connectedness that are requisite if nurses are to be spiritually nurturing. Several described how they wanted symmetry in their relationship with nurses (e.g., "not be a nurse, but be my friend"). Others recognized that nurses must enter this relationship with authenticity. As one stated, "Be genuine. . . . If you're talking to someone and you're connecting, there's that connection right there; it's a spiritual thing."

These informants identified more concrete actions that nurses could take or support that would care for spiritual needs. Noticeable acts reflecting **quality temporal nursing care** (e.g., giving a foot rub, providing a cot for a wife) were recognized by informants as a way to support the spirit. Likewise, **mobilizing religious and spiritual resources** (e.g., calling in clergy or offering inspirational readings) were considered helpful nursing approaches.

When discussing how nurses could help with spiritual needs, informants often identified requisites for nurses who plan to provide spiritual care. These requisites, which can be categorized as **personal** (i.e., the characteristics of the nurse), **relational** (i.e., the nature and views that both the nurse and patient bring to the relationship), or **professional** (i.e., the role of nursing), are listed with examples in Figure 2. Although many indicated that an established respectful and warm nurse-patient relationship must be present before care for spiritual needs could proceed, diversity existed regarding whether nurses needed to share the same or similar spiritual orientations. That is, whereas some indicated that nurses need only show respect for spiritual beliefs that differed from theirs, others thought that only nurses with similar beliefs could assist them.

Embedded in these data were reasons that some informants did not want nurses to be spiritual care providers, including

Personal requisites
- Have a personal spiritual awareness (e.g., "be spiritual herself").
- Have a similar spiritual or religious orientation as patients (e.g., "need to be on the same wavelength . . . you have to have a certain feeling or vibe").

Relational requisites
- Have a caring attitude and genuine interest in patients (e.g., spiritual care "would have to come from the heart and not be forced").
- Have first developed rapport or connection with patients (e.g., "would be offended if a nurse invited me to pray, a nurse that I just met—too personal").
- Convey warmth (e.g., be a capable, not a cold nurse).
- Show respect for patients' spiritual beliefs, even if they differ from nurses'.
- Assess to reveal patient receptivity (e.g., "assess that a patient had a real spiritual leaning").

Requisites for professional role
- Patients' and caregivers' expectations of nurses include spiritual care (e.g., "if it's part of what people expect they might do").
- Have had training in spiritual care (e.g., in nursing school).
- Have distinguished role as a spiritual care nurse (e.g., "Maybe if they had a roving nurse that walks around and says, 'I'd like to help you with your spiritual [needs], is there anything I can get you?' You might feel comfortable telling that person as opposed to a regular nurse who's supposed to be checking your blood pressure.").

Figure 2. Nurse Requisites for Spiritual Caregiving

the perception that nurses are not qualified and the assumption that differing spiritual beliefs between nurses and patients would make spiritual care impossible. One informant also recognized that, for some, spiritual care would not be wanted because it could be misconstrued as end-of-life care: "In our culture, raising such topics might make someone think, 'Oh! They know something I don't!'"

Likewise, a few of these informants identified reasons for why nurses should be spiritual care providers. One reason was that nurses recognized circumstances patients experience that would prompt a desire for spiritual care. For example, one mother wondered if her son had spiritual concerns at night, when only nurses would be present. Others recognized that patients in extremis or patients without family present would benefit from nurses' spiritual care. Others suggested that patients or caregivers who do not have a relationship with any clergy or were too far away for their clergy to visit also might appreciate nurses' spiritual support. One caregiver reflected, "After all, why did they ask us our religion in admitting? Just for stats?!"

Interpretations and Implications

These data offer a rich description of what the recipients of oncology nursing care expect with regard to spiritual caregiving. Although these data may disappoint nurses who are eager to provide spiritual care in traditional, overt ways, these informants give new meaning and value to nurses' therapeutic use of self. The adage that spiritual care is about being (versus doing) is supported. Patients and caregivers want kindness, warmth, respect, sharing conversation, prayerfulness, authenticity, presence, symmetry in relationship, and so forth—all ways of being. Yet, spiritual care also includes attending to the temporal by providing a cot for a wife to sleep on and giving a foot massage. Sometimes, nursing tasks plus kindness equal spiritual care.

Other studies have observed this linking of spiritual care with receiving respect and kindness from a nurse (Bauer & Barron, 1995; Conco, 1995; Sellers, 2001; Wright, 2002). Wright concluded that spiritual care for patients receiving palliative care "fundamentally seeks to affirm the value of each and every person based on nonjudgmental love" (p. 125). Sellers described how nurses ultimately are effective in spiritual caregiving only if they can "connect with another person and place the human being at the center of their actions" (p. 244). Sellers learned from informants that their spirits could be nurtured when nurses offered compassionate care, were present, actively listened, used humor, and were honest, sensitive, and respectful when providing individualized care. Although the present study findings correspond with these findings, they add further understanding to how patients perceive the more overt and religious spiritual caregiving approaches that nurses might offer.

Study findings also support nurses judiciously using religious practices overtly with patients and caregivers. That is, if certain requisites are met, patients and caregivers may appreciate nurses' prayers, introduction of spiritual coping strategies, or conversation about spiritual matters related to living with cancer. Of course, less intimate interventions such as a having a cart full of inspirational materials available on the unit or asking clergy to minister to religious needs also would be appreciated by many patients and caregivers. Indeed, Moller (1999) found that the number one spiritual need of patients who had been hospitalized for psychosis and their family members was to not have their spiritual leader abandon them. Even nonreligious patients and caregivers in this focus group study wanted nurses to contact a spiritual leader representing their preferred spiritual or religious community.

Although these findings describe patient and caregiver perceptions about spiritual care, comparing them with what oncology nurses think and practice is instructive. When asked to define spiritual care, 154 oncology nurse clinicians responded that it included promoting well-being and holistic caring (e.g., "It may be as simple as meeting the practical needs of the patient with a loving and caring heart" [Taylor, Highfield, & Amenta, 1994, p. 481]). These nurses also identified respecting patients' and caregivers' beliefs, sharing self (e.g., by being present or sharing personal experiences), talking to and listening about spiritual matters, assisting with religious needs, and providing emotional care for suffering as part of spiritual care. All of these nurse themes parallel the themes found in these data from patients and caregivers. Perhaps many oncology nurses intuitively or experientially know what patients and caregivers want from nurses for spiritual care.

The current study's data say much about patients' and caregivers' perceptions of nursing. Some do not expect anything overtly related to spirituality or religiosity to be within the purview of nurses. Nurses need to be prepared to educate patients and caregivers about why they practice holistic care. Furthermore, patients and caregivers can misinterpret what defines spiritual care. Spirituality can be confused with religiosity. Nurses who indicate that they are about to complete a "spiritual assessment" may offend patients and caregivers. Even asking assessment questions such as "Do you have any spiritual needs?" may not be helpful.

This study's findings about what patients and caregivers may consider requisites for nurses to provide spiritual care, especially the more emotionally intimate and religious forms of spiritual care, also can inform nursing practice. Although these requisites for nurses vary among patients and caregivers, nurses clearly need to establish some respect and relationship with patients prior to providing spiritual care. This finding may concern nurses who argue that current healthcare settings do not offer enough time to develop patients' trust, never mind provide care that supports spiritual health. Nurses, however, should remember that a trusting relationship can be developed quickly by expressing empathy, providing a caring touch, and being fully present, even during the fleeting moments it takes to give a knowing look (Taylor, 2002).

In addition to the implications for nursing practice, these findings offer direction for future research. Nurses need to know more about when and how to provide spiritual care of an overt or religious nature (e.g., prayer). Not only can empirical research inform nurses about when to offer such care and with which patients and caregivers, but theologic and ethical inquiries can guide when and how such care can be delivered.

Empirical research also can explore how demographic factors such as gender and ethnicity contribute to patients' and caregivers' desires for spiritual care. Study findings underscore the need for nurses to have enhanced skills for listening and being present. Although research reports about these topics exist in nursing and behavioral science literature, the "science" of spiritual care will benefit greatly by scholarly work that strives to apply this knowledge to spiritual caregiving.

Limitations

Many trustworthy findings emerged from these data. However, limitations to their transferability exist. Saturation of data about how nurses can help patients and caregivers with spiritual needs was not reached, although it did occur with regard to data about types of spiritual needs (the primary focus of the overall study). Although patients and family caregivers are all humans with spiritual needs that many not significantly differ from each other, larger numbers of caregiver and African American informants might have allowed for observations of differences between groups. Also, family caregivers' responses included suggestions that blended how nurses could help not only them but also their loved one, and, hence, determining the differences was impossible. The findings also may have been limited by the investigator's use of language (e.g., spiritual need), which never was defined for the informants.

Conclusion

An informant, a male police officer recovering from a bone marrow transplant, poignantly stated why he thought that oncology nurses needed to provide spiritual care.

> If there is any place that needs any spirituality, it's here. If there's a place that needs God's kindness, it's here. . . . Because you're at your end. Some of them are going to die. Some of them are not going to die, but still, in this time in life, you need someone to be able to be kind and show God's love [tears/chokes up]. Because otherwise, it would be hell . . . I couldn't stand to be here that many days without some kindness.

Patients wish that nurses provide kindness, connectedness, prayerfulness, physical support, and so forth. Some are eager for nurses to provide overt forms of religious support. Regardless of patients' preference, patients with cancer and caregivers perceive that oncology nurses can influence their spiritual health.

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