Prevalence and Associated Factors of Spiritual Needs Among Patients With Cancer and Family Caregivers

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Purpose/Objectives: To measure the prevalence of spiritual needs and identify factors associated with spiritual needs among patients with cancer and family caregivers.

Design: Descriptive, cross-sectional, quantitative.

Setting: Inpatients and outpatients at a university medical center in the southwestern United States.

Sample: 156 patients with cancer and 68 family caregivers who were primarily white and Christian and mostly perceived their cancer as not life threatening.

Methods: Self-report questionnaires, including the Spiritual Interests Related to Illness Tool and Information About You. Statistical analysis involved analyses of variance, correlations, and factor analysis.

Main Research Variables: Spiritual needs and desire for nursing help with spiritual needs.

Findings: The most important spiritual needs included being positive, loving others, finding meaning, and relating to God. The least important were needing to ask "why" questions and preparing for dying. Desire for nursing assistance with spiritual needs was moderate and varied. Variables correlated with spiritual needs and desire for nurse help included religiosity, being an inpatient, and perceiving the cancer as incurable. Desire for nurse help and importance of spiritual needs were directly correlated.

Conclusions: Distressing spiritual needs were reported least frequently. Certain factors appear to be associated with how much spiritual need is perceived and how much nurse help with those needs is wanted.

Implications for Nursing: Patients with cancer and family caregivers have similar spiritual needs that may require care. Spiritual assessment and therapeutics can target specific types of spiritual needs. A nurse's help with spiritual needs, however, is not always wanted.

Key Points ...

- Previous research about spiritual responses to cancer has documented the varieties of spiritual need. This study explored the prevalence of spiritual needs.
- Similar prevalence and similar types of spiritual needs were observed among patients with cancer and family caregivers.
- Prevalence of spiritual needs and desire for help with spiritual needs are directly correlated.
- Patients with cancer and family caregivers most receptive to receiving help with their spiritual needs include those who are religious and in the hospital and those who perceive that cancer is incurable.

All people have spiritual needs (International Work Group on Death, Dying, and Bereavement, 1990). Such spiritual needs have been variously categorized by chaplains and other healthcare professionals but generally include universal needs such as the need to give and receive love; to have meaning, purpose, hope, values, and faith; and to experience transcendence, beauty, and so forth. When spiritual needs are not satisfied, spiritual suffering or distress occurs (Bartel, 2004). When healthcare professionals address spiritual needs so as to promote spiritual health, they provide spiritual care.

Although mounting empirical evidence describes the spiritual needs of patients with cancer and their families (Moadel et al., 1999; Murray, Kendall, Boyd, Worth, & Benton, 2004; Taylor, 2003b), little is known about the prevalence of such needs. Less is known about what factors are associated with experiencing spiritual needs and whether patients and family members want nurses to address their spiritual needs. Knowing about the prevalence of care recipients' spiritual needs and understanding their expectations about nurses' roles in addressing such needs are foundational to fulfilling the professional and ethical mandates for providing spiritual care (Taylor, 2002).

The current study addressed the following questions. How prevalent are the spiritual needs of patients with cancer and family caregivers, from their perspective? What demographic and illness-related factors are associated with type and frequency of perceived spiritual needs? What are the patients' and family caregivers' expectations regarding nurses addressing their spiritual needs?

Theoretical and Empirical Background

The Institute of Medicine defined spiritual need as "the needs and expectations that humans have to find meaning, purpose and value in their life" (Murray et al., 2004, p. 40). The definition recognizes that all people have ways of believing that give them meaning and purpose, regardless of whether they are religious. A patriarch of chaplaincy identified four broad categories of spiritual need, including the need to have meaning and purpose; a sense of the sacred; a trusting connection

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with others, nature, and an ultimate other (for most, "God"); and an authentic self developed through creativity, awareness, and inner freedom (Clinebell, 1966). The definitions allow that a spiritual need may cause spiritual *dis*tress or *eu*stress, as Taylor (2002) proposed. An individual with spiritual eustress, for example, can have a spiritual need to express inner joy outwardly or to be grateful.

Several authors have suggested that spirituality manifests itself as spiritual needs at different levels (Koenig & Pritchett, 1998; Nolan & Crawford, 1997; Reed, 1992). That is, spirituality manifests in how a person relates to self, to others, and to that which is transcendent (i.e., that which is beyond, above, ultimate, or supreme). Examples of intrapersonal spiritual needs include the need to have purpose, to have hope, and to transcend challenges. Spiritual needs at the interpersonal level include the desire to forgive and be forgiven and to love and be loved by others. The desire to relate to and worship an ultimate other (often "God") illustrates a transpersonal spiritual need. Nolan and Crawford suggested that groups have spiritual needs, too. For example, groups need to contribute positively to their world and perceive that their contributions are valued.

When Taylor, Amenta, and Highfield (1995) surveyed 181 oncology nurses about how they perceived spiritual needs as manifesting themselves among patients, the nurses provided a broad range of indicators. Although the nurses identified overt indicators (such as obvious religious clues, the mention of God or faith, the search for meaning, or expressions of hopelessness or guilt), they also identified more subtle expressions of spiritual need (e.g., anxiety, anger, restlessness, sadness, withdrawal, difficulty coping). Perhaps more important, however, is how the recipients of nursing care describe their spiritual needs.

Researchers have described the varied and unique spiritual needs of people living with cancer (Feher & Maly, 1999; Ferrell, Smith, Juarez, & Melancon, 2003; Hermann, 2001) as well as family caregivers (Harrington, Lackey, & Gates, 1996; Murray et al., 2004; Soothill et al., 2002; Strang & Strang, 2001). The descriptive research indicates that spiritual needs are not only diverse but also important from the perspective of patients and family caregivers. Taylor (2003b) offered a categorization of spiritual needs of patients with cancer and family caregivers representative of such research. The author identified seven categories of spiritual needs: needs associated with relating to an ultimate other; need for positivity, gratitude, and hope; need to give and receive love from other people; need to review beliefs; need to create meaning and find purpose; religious needs; and the need to prepare for death.

Numerous studies have measured spiritual well-being and its relationship to quality of life and other variables (Taylor, 2003c), but only one investigation has quantified the spiritual needs of people with cancer (Moadel et al., 1999). Moadel et al. developed seven items to measure self-reported spiritual or existential needs and surveyed 248 ethnically diverse, urban patients with cancer. Items inquired about whether help was wanted with overcoming fears or finding hope, meaning, or spiritual resources. Items also explored whether having someone to talk to about dying or finding peace or meaning was wanted. Prevalence was assessed by whether a respondent indicated yes to an item. The least prevalent spiritual need was wanting someone with whom to talk about dying (25%), whereas wanting help with overcoming fears (51%) was the most prevalent need. Patients who reported having at least five spiritual needs (71%) were more likely to be Hispanic or African American, newly diagnosed, and unmarried. The findings, however, present information about only seven needs and about how comfortable patients are with receiving help for those needs. Findings from Taylor and Mamier's (2005) research indicate that about half of patients with cancer and family caregivers may want help with spiritual needs. Having a spiritual need does not equate with wanting a healthcare professional's help with that need.

Although some patients with cancer and family caregivers may not want healthcare professionals to address their spiritual needs, some do (Reed, 1991; Taylor, 2003a). Since 1998, national posthospitalization surveys of patients (N = 1,732,562 in 2001) have shown that patients rank the need to have staff address their emotional or spiritual needs second in priority, after responding to concerns or complaints (Clark, Drain, & Malone, 2003). The degree to which emotional and spiritual needs were met was highly correlated with overall patient satisfaction (r = 0.75). Findings from two small descriptive studies (Highfield, 1992, N = 21; Sodestrom & Martinson, 1987, N = 25) of patients with cancer suggest that patients rank nurses after personal clergy, family, and friends as spiritual care providers. The findings suggest that, although patients may not usually view nurses as spiritual care providers, most want their spiritual needs to be addressed.

Methods

This cross-sectional, descriptive study employed quantitative methods to explore the prevalence and associated factors of spiritual needs.

Sample Criteria

Adults currently being treated for cancer and family caregivers of adults being treated for cancer who met the following study criteria were recruited to participate: at least 18 years of age, able to read English, and self-identified as African American or Euro-American. Exclusion criteria included a diagnosis of mental illness. Patients and family caregivers could participate without the other's involvement in the study.

Instruments

The **Spiritual Interests Related to Illness Tool (SpIRIT)** was developed for the study. Patient and family caregiver versions of the SpIRIT questionnaire are identical, except a few items read "your illness" or "my loved one's illness" as appropriate. Items were developed to reflect the spiritual needs identified in a qualitative study designed to explore the extant spiritual needs of patients with cancer and family caregivers (Taylor, 2003b). Items were clustered together in categories that reflected the themes identified in Taylor's (2003b) study and given 5-point Likert response options (1 = not at all through 5 = a great deal). The categories of items included needing positive perspective (six items), needing relationship with God (six items), giving love to others (five items), receiving love from others (four items), reviewing beliefs (five items), finding meaning (seven items), practicing religion (six items), and preparing for death (four items). A stem of "How important is it now to . . ." preceded each cluster of items. After each cluster, an item inquired how important it was to "have my [or my loved one's] nurse help me satisfy these spiritual interests" (eight items). The term interests was used instead of needs throughout the questionnaire to avoid an inadvertent negative interpretation (e.g., having a spiritual need is bad). Also,

although the survey used "God" language, a caveat was made in the instructions allowing participants to "change it to reflect the ultimate force, being, or value that is in your life." A panel of seven nurse researchers, most with experience investigating spirituality among patients with cancer, reviewed the SpIRIT for clarity and validity (content validity index = 0.88). The results of factor analysis presented in this report support the construct validity of the SpIRIT. Internal reliability for each cluster of items (subscales) generated by the factor analysis was supported by coefficient alphas of 0.76–0.96. A coefficient alpha of 0.95 for the SpIRIT total (42 items) shows its strong internal reliability. The eight items about a nurse helping with spirituality ("Nursing Spiritual Care") had a coefficient alpha of 0.98.

A one-and-a-half-page **Information About You** form was designed by the investigator to assess various demographic and illness-related variables, including age, gender, ethnic background, education, religion, frequency of attendance at religious services, setting for receiving health care, perceived outcome of illness, and overall distress related to illness (measured by one 5-point Likert item). The patient version included items about diagnosis, time since diagnosis, and current status of illness. Caregivers were asked how many hours per week they provided care to their loved ones. Most of the items have been used successfully in previous research.

Procedure

The institutional research board's approval for the study mandated that a person who was not a member of the research team approach all participants. The person inquired whether potential participants would be interested in speaking to a member of the research team or in simply taking the packet of instruments. All participants chose to receive the packet without talking to a member of the research team. Although some family caregiver participants were approached directly by the neutral party, others were introduced to the study by their loved ones with cancer. The packet included the SpIRIT, the Information About You form, a return envelope, and an anonymous consent form (which stated that consent would be assumed if the questionnaires were completed and returned). All participants completed the self-report instruments without assistance from a member of the research team and returned them to the neutral party.

Data Analysis

Data were statistically analyzed using SPSS® (version 11.5) (SPSS Inc., Chicago, IL). First, measures of central tendency were computed for all items from the Information About You form and the SpIRIT. After checking the intercorrelations of all SpIRIT items (and deleting one item that correlated poorly with most other items), factor analysis using the Varimax (with Kaiser normalization) rotation method was conducted to determine whether the theorized clustering of items of the SpIRIT was valid. The items in the resulting factors were submitted to intercorrelational analysis (rs ranged from 0.27–0.89), and coefficient alphas were computed for the new subscales. The items in each subscale were summed and averaged before use in subsequent statistical testing. Pearson correlations (two-tailed) and analyses of variance (ANOVA) then were calculated to measure relationships and associations among study variables.

Results

The sample included 156 patients with cancer and 68 family caregivers recruited from an outpatient radiation and proton therapy clinic and an inpatient oncology unit at a university medical center located in the southwestern United States. Patients were primarily white men with prostate cancer (67%) who had been diagnosed during the prior year (82%) and were receiving care in an outpatient clinic. Caregivers were mostly white women; 60% reported spending less than 5–10 hours per day caregiving. Most believed that they (76%) or their spouses (72%) would be cured. Most were Christians (87%) and lived with others (86%). Table 1 presents further information about the mostly Euro-American, well-educated, moderately distressed sample.

Prevalence of Spiritual Needs

ANOVA comparing patient and family caregiver means for each SpIRIT item revealed no statistically significant differences (criteria: $p < 0.01$). Thus, means for each SpIRIT item were computed for the combined sample (see Table 2). The data indicate that the spiritual needs with the lowest means (and widest standard deviations) were those about asking "why?" or thinking about the unfairness of their tragedy, as well as those about religious rituals and thinking about death. In contrast, the remaining items about the importance of relating to God, having a positive perspective, and giving and receiving love were rated highly.

Table 1. Sample Characteristics

	Patients (N = 156)			Caregivers (N = 68)		
Variable	**$\bar{X}$**	**SD**	**Range**	**$\bar{X}$**	**SD**	**Range**
Age (years)	63.6	11.60	22–82	57.8	15.0	18–82
Education (years)	15.3	2.70	3–20	14.2	2.4	9–20
Distress[a]	2.3	1.02	1–5	3.1	1.3	1–5
Variable	**n**	**%**		**n**	**%**	
Gender						
Female	28	18		50	74	
Male	125	82		18	26	
Ethnicity						
Euro-American	132	87		55	82	
African American	9	6		4	6	
Other	11	7		8	12	
Frequency of attendance at religious services						
Weekly	68	44		28	41	
Frequently	14	9		7	10	
Occasionally	16	10		5	7	
Rarely or never	58	37		28	41	
Current status						
Just diagnosed	5	3		–	–	
In treatment	141	91		–	–	
Finished treatment	9	6		–	–	
Healthcare setting						
Inpatient	23	15		11	17	
Outpatient	131	85		55	83	

[a] Distress caused by illness was rated on a scale of 1 (not at all distressing) through 5 (very distressing).

Note. Because of rounding, percentages may not total 100.

Note. Because of missing data, n values may not total 156 or 68.

Table 2. Means and Standard Deviations for the Combined Sample on the Spiritual Interests Related to Illness Tool

Item	$\bar{X}$	SD
Needing Positive Perspective		
Keep a positive outlook.	4.76	0.59
Have hope that I/my loved one will get well.	4.77	0.60
Count my blessings.	4.73	0.70
Tell others about the good things in my life.	4.45	1.30
Have faith within myself.	4.65	0.73
Have my/my loved one's nurse help me satisfy these spiritual interests.	2.63	1.60
Needing Relationship With God		
Get right with God.	4.09	1.30
Believe that God has healed or will heal me/my loved one.	4.20	1.30
Remember how God has guided or helped me/my loved one.	4.31	1.20
Feel that there is a God out there looking after me/my loved one.	4.46	1.10
Know God's will.	4.04	1.30
Accept that God is in control of my/my loved one's illness.	4.05	1.40
Have my/my loved one's nurse help me satisfy these spiritual interests.	2.42	1.50
Giving Love to Others		
Make the world a better place.	4.32	0.87
Return others' kindnesses.	4.69	0.64
Protect my family (including my ill loved one) from seeing me suffer.	4.09	1.30
Try to help others.	4.52	0.76
Get right with others (e.g., forgive or be forgiven).	4.24	1.10
Have my/my loved one's nurse help me satisfy these spiritual interests.	2.43	1.50
Receiving Love From Others		
Become more comfortable about receiving care from other people.	3.83	1.10
Know that others are praying or thinking positive thoughts for me/my loved one.	4.39	0.93
Be appreciated by others.	4.05	1.10
Be with others I consider to be family.	4.41	0.90
Have my/my loved one's nurse help me satisfy these spiritual interests.	2.39	1.40
Reviewing Beliefs		
Review what I believe.	3.70	1.40
Think about whether my beliefs about God are correct.	3.12	1.60
Ask "why?" questions (e.g., Why me/us? Or why not me/us? Or why did I/we deserve this?).	1.98	1.20
Think about what it means to live spiritually (e.g., to have faith, to forgive).	3.75	1.30
Think about the unfairness of what has been happening.	1.77	1.20
Have my/my loved one's nurse help me satisfy these spiritual interests.	2.14	1.40
Finding Meaning		
Reevaluate my life.	3.24	1.30
Find helpful explanations for why this illness happened to me/my loved one.	2.66	1.50
Realize that there are other people who are worse off than me/my loved one.	4.00	1.30
Get beyond asking "why me/us?"	3.21	1.70
Try to make life count.	4.45	0.97
Sense that there is a reason for me/my loved one being alive now.	4.21	1.20
Become aware of positive things that have come with my/my loved one's illness.	4.22	0.99
Have my/my loved one's nurse help me satisfy these spiritual interests.	2.32	1.40
Practicing Religion		
Receive prayer or a religious ritual (e.g., communion) from a religious leader.	3.21	1.60
Attend a spiritual meeting or religious service (e.g., at a church, mosque, or temple).	3.37	1.60
Listen to religious programs or music on television or radio.	2.69	1.60
Pray privately.	4.28	1.20
Read scripture or other materials that nurture my spirit.	3.50	1.50
Have quiet time to reflect or meditate.	3.87	1.30
Have my/my loved one's nurse help me satisfy these spiritual interests.	3.87	1.30
Preparing for Death		
Make sure my/my loved one's personal business is in order.	4.11	1.10
Balance thought about my/my loved one's dying with hoping for health.	3.41	1.50
Know that there will be a purpose for my loved one's death, whenever it happens.	3.37	1.50
Think about what happens after death in the afterlife.	3.06	1.50
Have my/my loved one's nurse help me satisfy these spiritual interests.	2.18	1.40

N = 224

Note. Range for all items is 1–5.

To simplify and strengthen the validity of the findings, factor analysis was computed for the SpIRIT, without items about having a nurse help. The rotation converged in eight iterations to produce eight factors with Eigen values greater 1.0 that together explained 68% of the variance. Although the analysis supported most of the original clustering of items, it showed that a few items belonged in a different cluster, and it broke the cluster about reviewing beliefs into two separate factors (see Table 3). One item, "Think about what it means to live spiritually . . ." loaded adequately on two factors and was placed with the factor it loaded second highest on because of theoretical fit. Subsequent subscale internal reliability testing confirmed the wisdom of the placement. Descriptive statistics for each subscale are provided in Table 4. The means for each subscale again indicated that the most important spiritual needs were being positive, loving others, finding meaning, and relating to God. The least important were those about searching for answers to questions such as "why?"

Demographic and Illness-Related Factors Associated With Spiritual Needs

Total SpIRIT scores were correlated with frequency of attendance at religious services ($r = 0.50$, $p < 0.001$) and number of months since diagnosis (for patients, $r = 0.44$, $p < 0.001$). Only the asking "why" and preparing to die subscales

Table 3. Factor Loadings of Items on the Spiritual Interests Related to Illness Tool

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7	Factor 8
Remember how God has guided . . .	**0.89**	0.18	0.14	0.07	0.19	0.08	0.12	0.10
Feel that there is a God out there . . .	**0.88**	0.17	0.07	0.09	0.12	0.01	0.04	0.03
Know God's will.	**0.83**	0.15	0.25	0.07	0.08	0.05	0.09	0.03
Accept that God is in control . . .	**0.83**	0.19	0.19	0.06	0.10	0.07	0.08	0.07
Believe that God has healed . . .	**0.81**	0.09	0.13	0.13	0.14	0.05	0.12	0.10
Pray privately.	**0.81**	0.09	0.15	0.19	0.16	0.11	0.02	−0.21
Get right with God.	**0.72**	0.21	0.13	0.21	0.14	0.13	0.26	0.04
Read scripture . . .	**0.59**	–	0.52	0.17	0.14	0.28	−0.06	−0.03
Have quiet time to reflect . . .	**0.50**	0.15	0.25	0.40	0.12	0.19	0.01	0.07
Try to help others.	0.22	**0.77**	0.07	0.29	0.13	0.07	0.03	−0.05
Make the world a better place.	0.22	**0.71**	0.08	0.27	0.11	0.08	0.03	0.12
Return others' kindnesses.	0.30	**0.71**	0.14	0.24	0.22	0.03	0.02	−0.04
Be appreciated by others.	0.13	**0.70**	0.32	−0.09	0.09	0.10	0.14	0.17
Protect my family from seeing me suffer.	0.04	**0.66**	−0.02	−0.13	0.13	0.30	0.18	0.06
Get right with others . . .	0.28	**0.43**	0.14	0.45	0.18	0.06	0.28	0.05
Receive prayer or religious ritual . . .	0.48	0.07	**0.68**	0.07	0.07	0.15	0.16	0.05
Listen to religious programs . . .	0.43	0.11	**0.66**	0.16	0.00	0.20	0.10	0.14
Attend a spiritual meeting . . .	0.53	0.13	**0.65**	0.04	0.06	0.10	0.18	−0.05
Become more comfortable about receiving care . . .	0.11	0.34	**0.53**	0.14	0.12	0.07	0.27	0.16
Know that others are praying . . .	0.36	0.40	**0.52**	0.04	0.19	0.06	0.15	0.05
Be with others I consider to be family.	0.17	0.39	**0.41**	0.28	0.17	0.25	−0.01	−0.01
Become aware of positive things . . .	0.31	0.05	0.11	**0.69**	0.17	0.03	0.18	0.08
Try to make life count.	0.22	0.43	0.07	**0.60**	0.12	0.24	0.06	−0.07
Get beyond asking "why me?"	0.01	0.08	0.14	**0.56**	−0.09	0.31	0.15	0.22
Sense that there is a reason for . . . being alive.	0.38	0.20	0.05	**0.55**	0.26	0.25	0.10	0.03
Realize that there are other people who are worse off . . .	0.08	0.14	0.02	**0.44**	0.18	0.23	0.35	0.19
Keep a positive outlook.	0.15	0.15	0.13	0.10	**0.80**	−0.07	0.19	−0.10
Have hope . . .	0.09	0.09	0.19	0.11	**0.79**	−0.04	−0.06	0.04
Have faith within . . .	0.21	0.21	−0.14	−0.10	**0.77**	0.13	0.09	−0.12
Count my blessings.	0.26	0.16	0.05	0.18	**0.75**	−0.02	0.02	−0.09
Tell others about the good things in my life.	0.23	0.38	0.34	0.24	**0.40**	−0.03	−0.05	0.07
Balance thoughts about dying with hoping for health.	−0.05	0.17	0.11	0.06	–	**0.77**	0.12	0.23
Know that there will be a purpose for . . . death . . .	0.29	0.14	0.10	0.22	0.02	**0.65**	0.20	0.08
Make sure . . . business is in order.	0.15	0.16	0.14	0.29	−0.12	**0.62**	−0.11	0.02
Think about what happens after death . . .	0.22	0.02	0.13	0.12	0.07	**0.61**	0.44	0.07
Think about whether my beliefs about God are correct.	0.21	0.10	0.05	0.11	0.09	0.13	**0.76**	0.31
Review what I believe.	0.18	0.19	0.29	0.23	0.08	0.20	**0.70**	0.11
Reevaluate my life.	0.15	0.05	0.36	0.39	−0.03	0.06	**0.49**	0.28
Think about what it means to live spiritually . . .	0.57	0.23	0.28	0.30	0.03	0.04	**0.40**	0.05
Think about the unfairness of what has been happening.	0.08	0.02	–	0.01	−0.08	0.10	0.09	**0.88**
Ask "why?" questions . . .	0.06	0.06	0.06	0.08	−0.08	0.05	0.17	**0.86**
Find helpful explanations for why . . .	0.01	0.15	0.14	0.25	−0.06	0.31	0.19	**0.58**

Note. Factor 1 = relating to God; factor 2 = loving others; factor 3 = receiving love and spiritual support; factor 4 = finding meaning; factor 5 = maintaining positive perspective; factor 6 = preparing for death; factor 7 = reevaluating beliefs and life; factor 8 = asking "why?"

Note. Bolded numbers indicate how items loading > 0.40 were clustered to form subscales.

were correlated with overall illness-related distress ($r = 0.20$, $p = 0.004$, and $r = 0.15$, $p = 0.03$, respectively). Analyses of covariance (ANCOVA) demonstrated associations between the SpIRIT (total) and gender ($F = 7.74$, $p = 0.006$), living situation ($F = 5.18$, $p = 0.02$), and setting for health care ($F = 6.7$, $p = 0.01$), indicating that women, those who lived with others, and inpatients perceived spiritual needs to be more important. Although ANCOVA indicated that Hispanic and African American participants had higher SpIRIT scores than Asian Americans and Euro-Americans, the inadequate number of non-Euro-Americans in the sample made the findings spurious. No other relationships or associations were observed between the SpIRIT and other demographic or illness-related study variables.

Expectations Regarding Nurses Addressing Spiritual Needs

The items about having nurses help with spiritual needs consistently indicated varied and tempered enthusiasm (see Table 2). Together, the items showed that participants' average response was for nurses to help satisfy their spiritual needs "a little bit" to "some" ($\bar{X} = 2.34$, SD = 1.4, range = 1–5). Pearson correlation of the SpIRIT total score with Nursing Spiritual Care items suggests a moderately strong relationship ($r = 0.52$, $p < 0.001$), indicating that the more important spiritual interests were to participants, the greater the desire for nurses to help with such needs. A relationship was found between the Nursing Spiritual Care items and frequency of attendance at

Table 4. Descriptive Statistics for Subscales of the Spiritual Interests Related to Illness Tool

Subscale	Coefficient Alpha	Range[a]	$\bar{X}$ (SD)	$\bar{X}$ of $\bar{X}$ (SD)[b]
Relating to God	0.96	9–45	36.8 (9.7)	4.1 (1.1)
Loving others	0.85	6–30	25.9 (4.2)	4.3 (0.7)
Receiving love and spiritual support	0.85	6–30	22.0 (6.0)	3.7 (1.0)
Finding meaning	0.79	5–25	20.1 (4.5)	4.0 (0.9)
Maintaining positive perspective	0.81	5–25	23.2 (2.8)	4.6 (0.6)
Preparing for death	0.76	4–20	14.0 (4.3)	3.5 (1.1)
Reevaluating beliefs and life	0.83	4–20	13.8 (4.6)	3.5 (1.1)
Asking "why?"	0.78	3–15	6.4 (3.2)	2.1 (1.1)

[a] The actual ranges observed in the sample, which are also the possible ranges

[b] Mean of the mean was computed by dividing a subscale's mean by the number of items in the subscale.

religious services ($r = 0.24$, $p = 0.001$), suggesting that religiosity is weakly related to how much people may want nurses to assist with spiritual needs. ANOVA indicated that inpatients and those who believed cancer was incurable were significantly more desirous of having nurses assist with spiritual needs ($F = 5.49$, $p = 0.02$, $df = 1,177$, and $F = 4.69$, $p = 0.004$, $df = 3,174$, respectively). No significant differences were found between patients' and family caregivers' Nursing Spiritual Care scores.

Discussion

The findings portray patients with cancer and family caregivers as having similar spiritual needs. The most prevalent spiritual needs—or spiritual "interests" perceived as at least "quite a bit important"—were those about keeping a positive perspective, giving love to others, finding meaning, and understanding or relating to God. In contrast, the needs of receiving caring love from others, reevaluating beliefs and life, preparing for death, and thinking about the unfairness and the "why" of having cancer were a little to somewhat important. This intimates that psychospiritually distressing spiritual needs were not frequent in a sample in which about three-quarters of the participants thought cancer would be cured.

Although perception of distress was not related to overall spiritual need, it was weakly related to thinking about "why" and dying. Also, being hospitalized, thinking that the cancer would kill in a short time, and length of time living with cancer were associated with increased importance of spiritual needs. In concert, the findings suggest that the strain of illness, or at least incurable illness, is linked with an increase in the importance of spiritual needs, especially the more spiritually painful ones. The same factors also were associated with wanting nurses to help address spiritual needs. The strong relationship between importance of spiritual interests and the desire for spiritual care from nurses suggests that, if spiritual needs can be indicated by spiritual "interest," those who perceive more spiritual needs may be most receptive to nurses' spiritual caregiving.

The data also show that religious people (as indicated by frequency of attendance at religious services) not only are more apt to consider spiritual needs important but also have more desire for nurses' assistance with such needs. Conjectured explanations for the finding include that people predisposed to needing religion are those with greater spiritual needs. Religiosity provides an awareness, cognitive schema, emotional comfort, and language for experiencing spiritual needs; therefore, religious people are better equipped to self-report spiritual needs. People who frequently attend religious services also are likely to be used to accepting spiritual support from other people. This may explain why religious participants were more receptive to nurse-provided spiritual care.

Results mesh with and extend findings from other studies of people with cancer. A less-than-enthusiastic desire for nurses to provide spiritual care has been documented (Highfield, 1992; Reed, 1991; Taylor & Mamier, 2005). Moadel et al. (1999) also observed a lack of desire for assistance, especially with the discomforting topics of death and meaning, when they surveyed patients. The current study extends nursing knowledge by pinpointing who is most likely to not want spiritual care (i.e., those with low perceptions of spiritual need, those who are less religious, outpatients, and those who do not view their cancer as life threatening).

Much of the literature describing spirituality among people with cancer identifies making meaning as integral or salient (Halstead & Hull, 2001). The present findings differentiate between "asking why" and "finding meaning" and indicate that the painful "asking why" need is less prevalent than the more edifying need to ascribe positive meaning. Perhaps this parallels observations by breast cancer survivors who mostly go through a phase of asking "why" and move on to ascribing positive meaning, whereas a minority get "stuck" ruminating about "why" (Carpenter, Brockopp, & Andrykowski, 1999; Taylor, 2000).

Limitations and Future Research

The findings are limited by the skewed sample of primarily Euro-Americans, Christians, and patients and family caregivers for whom cancer was experienced as not life threatening. Future research needs to explore the spiritual needs of people from diverse ethnic and religiocultural backgrounds and their expectations of nurses regarding spiritual caregiving. Further investigation also should identify effective interventions for spiritual needs that are appropriate for nurses to provide.

The newly developed SpIRIT offers a unique and useful method for measuring spiritual experience, but participants' responses raise the question of whether inquiring about "how important is it now to . . ." adequately assesses prevalence of spiritual needs. A qualitative study of 28 patients with cancer and family caregivers exposed how not all were fully aware of their interior spiritual lives (Taylor, 2003a). Data may suggest that responses indicate what spiritual issues are valued or are comfortable to acknowledge. To illustrate, respondents ranked asking distressing "why" questions very low. Was that because the spiritual needs are upsetting or repressed or because they know they are not helpful to consider? Although the problem cannot be controlled simply by including a measurement of social desirability, future research using the SpIRIT may benefit from including a measurement of denial mechanisms to check for potential bias.

Indeed, other aspects of reliability and validity should be tested to further establish the merit of the SpIRIT. The current study was limited by the use of a new, previously untested instrument. In addition to further establishing the tool's psychometric properties, future studies should produce a shorter version for use in clinical settings. Such a tool could be employed for spiritual assessment and screening for spiritual or religious distress needing intervention.

Implications

The findings from the study provide not only direction for future research but also guidance for current clinical practice. Nurses must be educated to recognize and nurture various spiritual needs. The categories of spiritual needs generated by the factor analysis during the study provide a "handle" for recognizing nebulous spiritual needs. Although thorough spiritual assessment often is unnecessary and impossible for nurses to conduct, the findings suggest which care recipients may be at the highest risk for spiritual distress and which would benefit from more-focused spiritual assessment (Massey, Fitchett, & Roberts, 2004; Taylor, 2002). Numerous therapeutic approaches for spiritual caregiving are available to nurses who need to provide spiritual support (McEwen, 2005; Taylor, 2002; Taylor & Mamier, 2005). Just as different pathologies typically require different treatments, one spiritual need may not be addressed by therapeutics that are beneficial for a different spiritual need. For example, encouraging patients to talk about how helpful their beliefs are may be appropriate for those who are reevaluating them but may be less helpful for those only striving to give love to others.

The results provide information about what factors are associated with care recipients not wanting spiritual care from nurses. This informs nurses about which care recipients may prefer referral for spiritual care and which may need to be approached with greater sensitivity and educated about the potential of nurse-provided spiritual care. Given that spiritual care often is about ways of being (e.g., empathic listening, being present, sharing humor, authenticity, respect) and given that it is what care recipients want very much, the caution about warily approaching patients with spiritual care may be necessary only when nurses assess needs for more overt forms of spiritual or religious support (Taylor, 2002; Taylor, 2003a; Taylor & Mamier, 2005).

Conclusion

The findings provide oncology nurses with evidence about the prevalence or perceptions of patients' perceived spiritual needs and their expectations of nurses in meeting the needs. The information can improve the delivery of spiritual care. By addressing spiritual needs sensitively and intelligently, nurses undoubtedly will promote not only spiritual health but also holistic healing.

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