PERCEPTIONS OF SUPPORTIVE NURSING BEHAVIORS BY

TERMINALLY ILL PATIENTS AND HOSPICE NURSES

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A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

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DENTON, TEXAS

MAY 1989

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DENTON, TEXAS

April 18, 1989
Date

To the Provost of the Graduate School:

I am submitting herewith a dissertation written by Helen K. Maher entitled "Perceptions of Supportive Nursing Behaviors by Terminally Ill Patients and Hospice Nurses." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

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We have read this dissertation and recommend its acceptance:

Accepted

Provost of the Graduate School

ACKNOWLEDGEMENTS

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ABSTRACT

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A descriptive survey was used to assess differences in
perceptions of supportive nursing behaviors by terminally
ill patients and hospice nurses. A sample of 20 adult
patients and 12 nurses completed the investigator-designed
Supportive Nursing Behaviors Scale (SNBS; α = .92) and
demographic data form. Data were collected in the patients'
homes or hospice inpatient unit over 8 months by the nurse
investigator who administered the instruments. Analysis of
the two groups on the perceptions of supportive nursing
behaviors using a Mann-Whitney $\underline{U}$ yielded a $\underline{U}$ = 70 ($\underline{p}$ =
.053). Although not statistically significant, there was a
difference in the mean ranks of the scores of patients and
nurses. Patients scored the items higher than did the
nurses which indicated that patients perceived supportive
nursing behaviors as more important than did the nurses.
There were no significant differences in scores on the SNBS
for patients grouped according to gender, religious

preference, diagnostic category, current residence, and length of illness. Race was not analyzed in relation to supportive nursing behaviors because of the homogeneity of the sample. Patient age was significantly related to the score on SNBS (r = .468; r^2 = .219; p = .01). The older the patient, the more important supportive nursing behaviors became. The comparisons of nurses' scores on the SNBS grouped by religious preference, hospice inpatient and home setting, and the relationship of age to SNBS scores were not significant. Gender and race were not analyzed in relation to supportive nursing behaviors because of homogeneity of the sample. The nurses' length of employment in the hospice was significantly related to the score on the SNBS (r = .608, r^2 = .396; p = .01). The longer a nurse was employed in the hospice setting, the more important supportive nursing behaviors became.

TABLE OF CONTENTS

CHAPTER

LIST OF TABLES

LIST OF FIGURES

Figure

CHAPTER 1

INTRODUCTION

Death is an inevitable fact of life. Everyone thinks about death, yet most people are uncomfortable dealing with the dying process. Medical and scientific advances in the study of specific diseases have made it possible to estimate the life-death interval. With three-fourths of all deaths in the United States occurring in hospitals and nursing homes and the time period between an initial diagnosis of a fatal illness and actual event of death widening, individuals involved in health care delivery are increasingly in need of effective supportive skills for dying patients (Caughill, 1976; Denton & Wisenbaker, 1977; Schultz, 1979).

Increasing numbers of persons with terminal illnesses have contributed to make dying a health care issue with which health providers and more specifically professional nurses must deal. The public expects the nurse to be capable of providing reassuring and humane care for the terminally ill (Thrush, Paulus, & Thrush, 1979). According to Quint (1967), these individuals, who are terminally ill and no longer need life-saving measures, now ask the professional nurse to assist in providing the comfort and

supportive measures needed to deal with death and the dying process.

The confrontation of the nurse with another person's death and dying often proves to be painful and difficult. This confrontation with death and dying reminds the nurse of self-vulnerability and also challenges the primary goal of the health professions, the preservation of life (Quint, 1967). A review of the literature identified words that are used to describe support as well as some supportive behaviors the nurse, staff, and relatives of terminal patients perceive as helpful (DeYoung & Dickey, 1967; Freihofer & Felton, 1976; Hampe, 1975; Irwin & Meier, 1973; Stockwell & Nishikawa, 1970). Yet no one has identified which nursing behaviors are supportive and which are not supportive to physical, emotional, social, and spiritual well being of terminally ill patients.

Gardner and Wheeler (1981, 1987) have begun to systematically identify supportive nursing behaviors. Findings show that patients selected from the medical, surgical, and psychiatric areas of a general hospital perceive supportive nursing behaviors differently by area and when compared to the respective nursing staff of the units. These findings lead to several questions: What is support for the terminally ill? How is support perceived by the

patient and are the perceptions of the nurse and patient the same? Answers to these questions can enhance the professional nurse's ability to provide quality patient care to terminally ill patients.

Problem of Study

The purpose of this study was to investigate the congruency of terminally ill patients' and their hospice nurses' perceptions of supportive nursing behaviors. Other areas that might influence patients' and nurses' perceptions of supportive nursing behaviors were also examined.

Rationale for Study

There is no agreement in nursing on the definition of support. A great amount of time is spent by teams in conferences to determine what the supportive activities are and who will provide these activities, to evaluate if the actions have occurred, and to teach the family and patient so they may continue these actions at home (Gardner & Wheeler, 1987; Ujhely, 1968). Many components of this definition have been identified in the literature. Hart and Reltweder (1959) described nursing support as needing to include the areas of the physical, emotional, social, and spiritual realms of life. Caplan (1974) and Cobb (1976) explored social support and described the individuals

network. This social network aids the person to feel cared

for and valued. Gardner (1979) reviewed supportive behav-

iors frequently mentioned in the nursing literature. These

behaviors included the nurse and patient participating in

problem solving activities; assisting the patient to express

feelings; being available and understanding; working with

the patient and family; providing information to the patient

and family; and helping the patient maintain control in

decisions. Gardner noted that the definition of support in

nursing was ambiguous and often left to the realm of

individual intuition.

A limited number of nursing studies have been reported

which focused on the nurses' perceptions of support (DeYoung

& Dickey, 1967; Funkhouser, 1976; Gardner & Wheeler, 1981;

Pearlmutter, 1974; Stockwell & Nishikawa, 1970). A list of

words and actions emerged which included the following

areas: accepting, expressing feelings, giving information,

showing empathy, understanding, helping, being friendly, and

reassuring. There is no agreement among nurses on the

importance of these areas nor on their use in various

patient settings. Grossman-Schultz and Feeley (1984)

reported a difference in supportive behaviors which nurses

described in their practice and the behaviors they actually

used to define the concept of support in a simulated case

study. The authors identified phases in the support model
which focused on the establishment of a nurse patient
relationship with the purpose of targeting health goals and
exploring ways for the patient to achieve those goals.

Families who are coping with an episode of illness or
crisis related to illness have been interviewed regarding
the concept of support. Fassler (1980) found that a program
of emotional support and information about hospitalization
reduced anxiety for preoperative children. Fuller and
Larson (1980) surveyed older adults and found that emotional
support does not "protect the person from negative conse-
quences of stressful life events" (p. 87). Irwin and Meier
(1973) compared relatives of oncology patients and their
respective health care providers and found that health
providers perceived the supportive actions differently than
the family members. The families rated the categories
consistently lower than did the professionals. There was a
significant difference between the various health providers
in the ranking of the categories. Hampe (1975) interviewed
spouses regarding the patients' needs during the final stage
of illness for their mates. Eight needs were identified.
No specific interventions were identified as supportive or
not supportive. The death event did not alter the needs or
concerns of the spouses. Identified needs included the

following actions: be with the dying person; be helpful; assurance of the comfort of the dying person; be informed of the mate's condition; be informed of the impending death; ventilate emotions; comfort and support of the family members; and acceptance, support and comfort from health professionals (Hampe, 1975).

Freihofer and Felton (1976), Skorupka and Bohnet (1982), and Kristjanson (1986) compared responses on supportive behaviors for terminally ill patients by their families. The groups consistently chose behaviors directed toward the patient rather than themselves as more helpful and they focused on the physical needs of the patient.

Few studies are available which focus on comparing perceptions of support between nurses and patients. Kyle (1964) compared responses of nurses and patients about support. The supportive approach was defined as spending more time with the patient and family as compared to standard nursing care. Patients in the experimental group reported more realistic plans for post-hospitalization and fewer negative reactions to having cancer than did those in the control group. Time spent with the patient was identified but not measured. Lierman (1982) noted similar results with women after a mastectomy. Time was identified but not measured as well as teaching, assessment, and postoperative

emphasis on empathy, reassurance, encouragement, trust, and confidence.

Gardner and Wheeler (1981, 1987) identified the need to explore the area of nursing and patient perceptions of support. In the first two studies, the authors found nurses perceived that providing nursing support to patients included expressing feelings, giving information, and being friendly. Gardner and Wheeler (1987) studied three patient groups in an acute hospital setting and nurses in the same areas. Eleven categories of support emerged: being available; promoting comfort, giving information; assisting in expressing feelings; performing specific nursing tasks; helping to solve problems; having a friendly and pleasant attitude; relieving pain; giving reassurance, individual care; and touching. Differences by areas also emerged. Physical measures were most important for patients on a surgical unit; whereas patients on a psychiatric unit emphasized problem solving and patients on a medical unit focused on the psychosocial aspect of friendliness.

Families and nurses began to describe supportive nursing actions and evidence showed disagreement on what these activities should include (Irwin & Meier, 1973). Gardner and Wheeler (1987) have begun to research nursing supportive behaviors for patients in medical, surgical, and

psychiatric acute care settings. However, no studies have
been reported in which perceptions of nursing supportive
behaviors by the terminally ill individual and the hospice
nurse were identified.

Conceptual Framework

Maher's Model of Nursing incorporates the systems
approach as the basis for all energy exchange and activity
across the boundaries (von Bertalanffy, 1968). The model
was influenced by the work of King (1981) who defined
nursing as

> a process of action, reaction and interaction whereby
> nurses and patients share information about their
> perceptions of a nurse and patient situation . . . and
> through purposeful communication identify specific
> goals, problems, or concerns . . . and explore the
> means to achieve the goals. (p. 2)

The focus of nursing is to support persons in maintenance of
their health so they can meet identified goals. Nurses use
knowledge and skills to support individuals and families in
meeting existing problems and developing methods or ways to
adapt to changing their health state.

An important concept identified by King (1981) was
perception. Perception is one's representation of reality.
Perception provides meaning to experience and influences
subsequent behavior; it acts as the basis for the gathering
and interpretation of data and is an integral part of the

nursing process of assessment, interpretation, and
development of a plan with patients for their care. Per-
ception is an initial step toward mutual goal setting.
Characteristics of perception include the following factors:
universality, because all persons perceive through their
senses other persons and objects in the world and these
pieces provide information about the universe; subjectivity,
because each individual selects those stimuli which pass
from the environment; and action oriented, from data cur-
rently available, and influenced by interests, needs, and
goals (King, 1981). The nurse and patient verify percep-
tions as they discover mutual goals. This verification is
important for the nurse because it is the basis for
gathering and interpreting information. Pain and medical
diagnoses may alter or cause a disturbance in perception
(King, 1981). Perception is critical in all human contacts,
and it influences the resulting behaviors (Lewin, 1952).

King (1981) proposed that within the process of
interaction, the nurse and patient each share perceptions
and information to meet their respective goals. When these
goals are not congruent, conflict or imbalance may occur.
The major elements in a theory of goal attainment come from
the interpersonal system of the nurse and patient. The
patient seeks health care and the goal is maintenance or

restoration of health. Therefore, the nurse and patient deliberately interact to establish and achieve goals.

Heider (1958) noted that "a balanced state designates a situation in which the perceived units and the experienced sentiments co-exist without stress; there is thus no pressure toward change, either in the cognitive or sentiment organization" (p. 176). When one interacts with another person, an existing pair relationship will be weakened or strengthened. According to Heider, a balanced state or situation is a "harmonious one, where the pieces or units comprising the situation and the feelings about them fit together" (p. 180). The units are identified through the individual's perception. For Heider, the units and the sentiments were interdependent so that as tension or stress arises, the focus will be on recreating balance and, where change is not possible, imbalance will result and produce tension (Heider, 1958). A state of balance tends to be preferred over imbalance and tension. Balance is something that occurs as a result of a relationship between elements, and it does not exist alone.

Rosenberg (1956) classed cognition into two groups: values, where the person has a strong opinion and considers it important; and objects, where the person has an opinion but it is not as important as the values. Usefulness and

relevance are the keys to the individuals who are incorporating the values and objects into their lives. Rosenberg's contribution for nursing lies in the fact that he focuses on the person's perspective, stresses positive and negative options and he "assumes that only the balanced structures will be stable and identifiable to others" (p. 370).

Maher's Model of Nursing depicts an open system with the capability for the exchange of energy by all the parts. The individual, family and community are in constant action and interaction with each other and the environment, and this action occurs throughout the life time. The nurse and the individual each perceive and identify components that are creating or causing an internal or external imbalance and, through a process of assessment, goal setting, inter-action, and evaluation, support the individual/family/ community to focus on maintaining or recreating balance in the system and thus promote health. When areas of imbalance are perceived and identified, the nurse and person work to eliminate or modify them by focusing on a common goal. The nurse may act as a liaison to enhance the coordination and integration of other health providers in the plan. The immediate goal is to maintain or recreate balance. If ill-ness occurs physiologically and or perceptually, the nurse

will focus with the individual on those interventions that support maintenance or recreation of health and balance. Maher's Model of Nursing is depicted in Figures 1 and 2.

The Maher model portrays an open system with the exchange of energy possible across all boundaries. All aspects share a common goal of balancing the system. The person or individual is seen as a complex human being who exists as a part of the self, a family unit or group, the community, and the environment. An individual is a living human being. A family is a group of individuals living together, and a community is all persons or individuals living in a designated geographical area.

The environment, as depiced in Maher's Model of Nursing, is comprised of the world community and the animate and inanimate aspects within the environment on earth and space. As the environment surrounds the individual, family and community, each has an internal and external component. The individual's internal environment is made up of all the genetic codes, as well as the physiological and thought processes. The individual's external environment is anything outside the body structure. The family's external structure is the community and any social or interactional group contact. The internal environment consists of individuals, their roles, relationships and goals. The

HEALTH

Environment

Community

Family

Person

BALANCE

BIRTH   DEATH
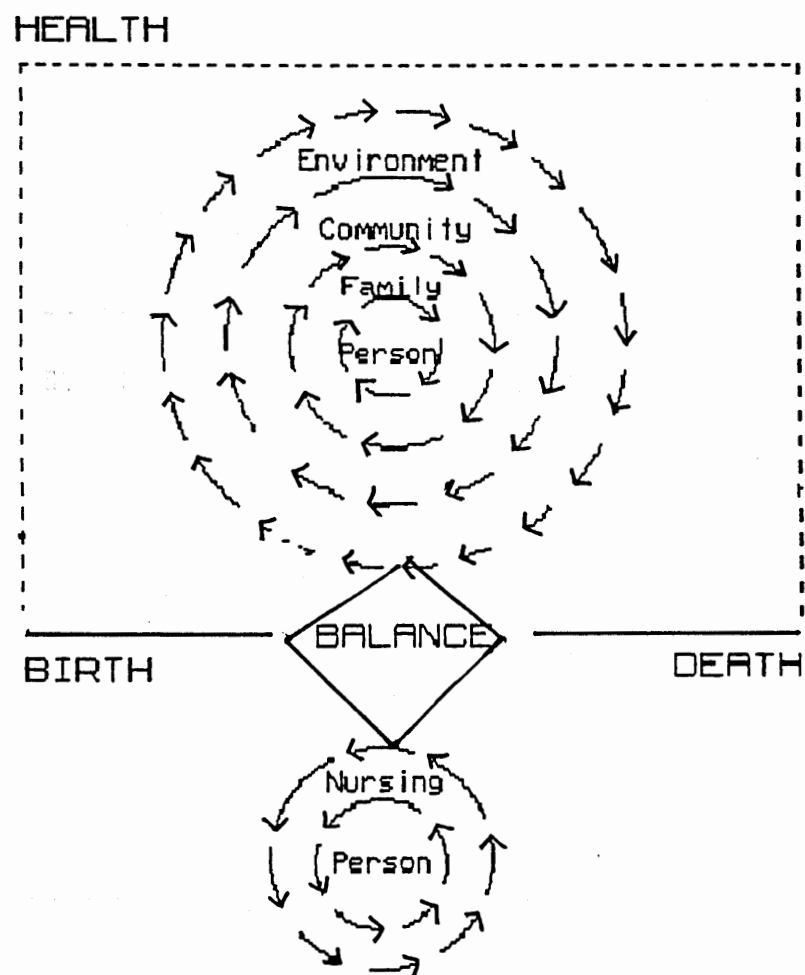
Nursing

(Person)

MAHER'S MODEL OF NURSING

Figure 1. Maher's Model of Nursing

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          <------------------------BALANCE<---------------------->
       <- |                          ^                           |  ^
        | |          SUPPORTIVE  NURSING  BEHAVIORS               |  |
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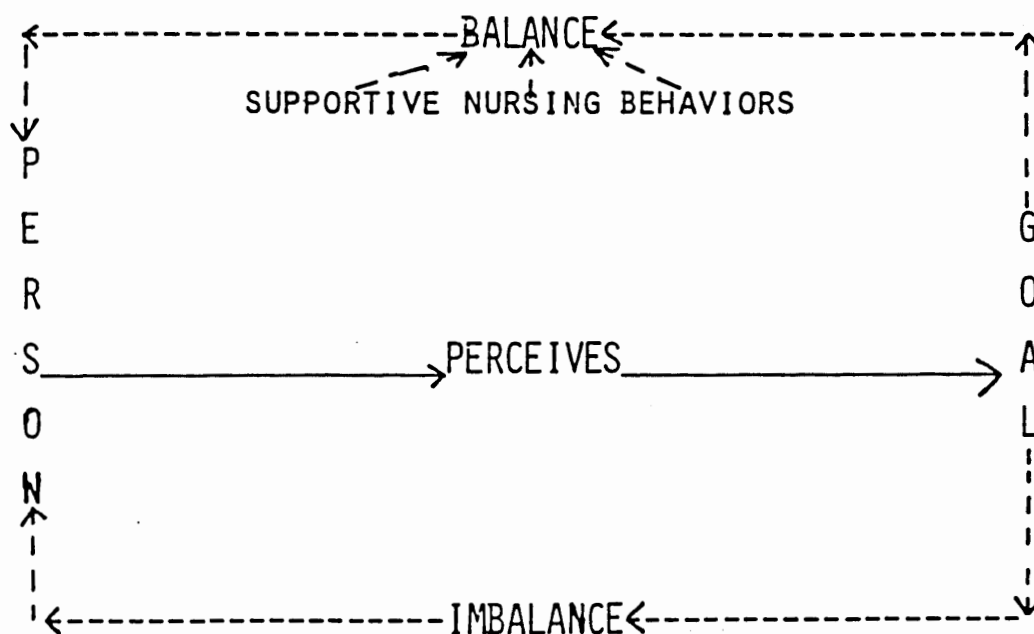
Figure 2.   The Construct Balance Related to the Person
             Taken from Maher's Model of Nursing

community's external environment is made up of all of the cultures and activities that occur outside the community's geographic borders. The internal environment is composed of individuals, families, and groups who live in the defined space.

Health is a process throughout the lifetime of the development and balancing of the individual's, family's, and community's internal and external environments. Life is seen as a continuum from birth through death. Perception is a cognitive and sentiment process which occurs when an individual/family/community identifies or determines through physiological/objective data or through individual/group sentiment where they exist in their achievement of goals and what goals they would like to attain. Balance is achieved when the individual's perceived cognitive and sentiment components are congruent with the identified goal. Illness is an alteration in balance based on sentiment and cognitive aspects, and it results in tension.

Nursing is the process that occurs throughout the lifetime and consists of individuals' perceptual assessment of the individual/family/community's health status and identification of existing and potential health problems. Diagnoses are developed and a plan is formulated that represents the individual/family/community needs.

Implementation of this plan through interventions involves all individuals in formulating, evaluating, and making appropriate revisions.

Works by von Bertalanffy (1968), King (1981), Heider (1958), and Rosenberg (1956) have contributed to the development of the framework of Maher's Model of Nursing. Additionally, Beardsley's (1975) logical arguments were applied to test the constructs of the model. Therefore, Maher's Model of Nursing was deemed to be a sound tool upon which health care providers can base an evaluation of the terminally ill individual, the family, and community. By understanding balance, the health provider can assess for its presence or absence. In addition, by using the concepts of perception and support, the provider may better understand the need for mutual and reciprocal behaviors. Finally, the construct of goal attainment provides the direction for all participants in the restoration or maintenance of health.

Maher's Model of Nursing can be helpful to nursing practice as it is adaptable to any setting where nursing professionals interact with individuals. It also identifies the roles of the nurse and the individual/family/community in the identification of the goals leading to a balanced state. The model acts as a guide to instruct nurses who are

caring for the terminally ill. Focus on the goal of balance provides direction for the nurse and patient to harness the energy of all participants toward health. Health in this case is not a condition where the patient is disease free, rather the person perceives that the tension has been relieved and the goal attained.

Assumptions

Assumptions upon which Maher's Model of Nursing are based include:

1. Perception is a component in all human contacts and influences resulting behaviors (Lewin, 1952).

2. Balanced states are stable and identifiable to others (Rosenberg, 1956).

3. A balanced state is preferred over imbalance or tension (Heider, 1958).

4. Balance is the result of a relationship between elements and does not exist alone (Heider, 1958).

Research Questions

The literature review and conceptual framework focused attention on questions to help define supportive nursing behaviors for the terminally ill. These questions were:

1. Is there a difference in the perceived importance of supportive nursing behaviors by terminally ill patients and hospice nurses?

2. Do perceptions of the importance of supportive nursing behaviors by terminally ill patients vary according to gender, religious preference, race, diagnosis, and current residence?

3. Are perceptions of the importance of supportive nursing behaviors by terminally ill patients related to age and length of illness?

4. Do the perceptions of supportive nursing behaviors by nurses employed by a hospice vary by gender, religious preference, race, and type of hospice setting in which they are employed?

5. Are the perceptions of the importance of supportive nursing behaviors by nurses employed by a hospice related to age and length of employment?

Definition of Terms

The following terms were defined specifically for this study:

1. Hospice: a place of shelter where care is given to people with a life-limiting illness; the focus is on comfort and symptom control (Rossman, 1979).

2. Hospice nurse: a professional nurse employed by a hospice to provide comfort and symptom control for the terminally ill person and family.

3. <u>Terminally ill</u>: an individual with anticipated 6 months or less to live (New Age Hospice, personal communication, September, 1988).

4. <u>Supportive nursing behaviors (SNB)</u>: those behaviors of the nurse which are perceived by the individual and/or family to facilitate or enhance their resources to recreate or maintain balance and thereby relieve tension for the individual/family/community, as measured by the score obtained on the Supportive Nursing Behaviors Scale.

Limitations

Limitations included the use of a convenience sample of patients and nurses from one hospice. Using only one hospice yielded a small number of subjects; therefore, the information obtained cannot be generalized beyond the sample (Kerlinger, 1973).

Delimitations

The sample for this study was delimited to all adult patients 18 years or older receiving care in one hospice located in a large metropolitan city in the southwest United States. These individuals were alert and oriented to time and place and able to respond to complete the questionnaire. Professional nurses employed by the same hospice comprised

the other group in the sample. The patients resided in a home setting or the inpatient unit leased by the hospice. The inpatient setting is located within a large community hospital in the same city.

Summary

The perceptions of supportive nursing behaviors by terminally ill patients and hospice nurses were the focus of this study. The rationale for the study as well as the conceptual framework for perception were described. Von Bertlanffy's (1968) systems theory formed the theoretical basis for the development of Maher's Model of Nursing. Assumptions relevant to the conceptual framework were identified and discussed. Five research questions were established for this study, and definition of terms as well as limitations and delimitations were discussed.

CHAPTER 2

REVIEW OF THE LITERATURE

This study was developed to describe supportive nursing
behaviors through the perceptions of terminally ill patients
and hospice nurses. An overview of death in modern Western
society is contained in this chapter. The evolution of sup-
port as reported in the literature in the areas of physical,
emotional, social, cultural, and spiritual realms is
surveyed. Finally a discussion of perceptions of supportive
nursing behaviors by individuals, their families, health
providers and, in particular, nurses is presented.

Death

Man as society knows him today will end his life
in a final act called death (Aries, 1974; Feifel, 1963,
1977). Western society has evolved from the 10th century
ritual where death was a natural event, one for which the
person prepared and directed the persons around him as to
his wishes, to today's setting where the individual rarely
dies at home but in a hospital surrounded by strangers
(Aries, 1974). In the hospital setting, death becomes a
technical phenomenon to be dissected into many parts (Cohen,
1978).

21

Death rituals peculiar to the United States, according to Feifel (1963, 1977), include the role of funeral director. The funeral director assumes the director role previously held by the dying individual, with the goals to follow the wishes of the deceased and to aid the survivors to return to their previous life. Other rituals include make up which is used to return the deceased individual to a former acceptable appearance and embalming which is routinely employed to prevent the decay of the body (Aries, 1974). Death is not to be hidden but is to be displayed with a mixture of commerce and idealism. Advertisements in the newspaper and on television stress prepayment and early selection of a burial plot so the person will not be a burden when the time comes. Death is now visited in special settings and participation is orchestrated by the approved funeral home procedures (Aries, 1974; Feifel, 1963, 1977).

Continuous technological developments have further disrupted the dying process. It has become more difficult to determine when a serious illness may in any given case be fatal. This hope for cure has moved the dying act from the home to the hospital (Backer, Hannon, & Russell, 1982; Seidel, 1981). The hospital today has become a medical center where people are healed and where one struggles against death. The doctors become the pivotal persons at

the death scene. Doctors are responsible for determining cause, time, and signing all official documents that pertain to the specific circumstances of the death event. Death itself has been partitioned into a series of steps, such as breathing, brain waves, and heart beat. It is increasingly hard to know which step was the real death--replacing the great dramatic death portrayed in art and literature (Tolstoy, 1904). Three fourths of all deaths in the United States now occur in the hospital or nursing home (Lerner, 1970). This shift in location came about between 1930 and 1950. Prior to 1930, the hospitals had been shelters for the poor and the homeless (Aries, 1974).

Patients with a life limiting or terminal illness experience a paradox. They are not only dying, they are living. How this remaining time is spent is often dependent on physical limitations, on the environment, and on the perceptions of the individual as well as those who provide the care (Nash, 1977). The dying process has key partici-pants which include the individual, the family and friends, and the health team. Nagy (1959) described a series of changes in self-concept a child experienced when diagnosed with a serious illness. Beginning at diagnosis when well, stage one begins when the child perceived self as seriously ill. Progressing to stage two, the child is seriously ill,

but knows he will get better. Following frequent episodes of illness and remissions, stage three is where the child is always ill, but will get better. Stage four the child is always ill, but will never get better. This stage occurs following the knowledge of the death of another child with the same disease. The final stage five is the actual dying.

Pattison (1977) noted that the dying label was not always applied to the individual all at once. The lack of brain waves on an EEG or the artificial assistance with a respirator depict aspects of the death label, however the person is still considered alive. Nor do all significant persons use the dead label at the same time. The family, minister and even the physician will accept or deny the actual condition of the patient depending on their own grief. Hope for cure may be retained by some members of the family and health professionals. Kalish (1985) described the freedom from restrictions that can occur when a person is labeled dying. Irritability is often ignored. People from the past make an effort to be near, even forbidden foods and beverages may be reinstated as they can cause no further harm.

Nash (1977) noted that health personnel, specifically nurses, are usually involved with the patient during the final days of life and can exert an influence on the

individual, the family, and friends. The influence may vary from giving information regarding the patient's physical status and treatments to providing time for privacy and visiting with all the family (Kneisl, 1968). This time may be a difficult period for the health personnel as they see their skills for better use for those persons who will potentially recover (Kastenbaum & Aisenberg, 1976). It is often easier for the nurse to perform a task than to sit with someone who is dying (Seidel, 1981). Quint (1967) noted that being busy with a task may provide a barrier for nurses who wish to avoid a confrontation with their own death.

<div align="center">Support</div>

There is no agreement in nursing on the definition of support. A great amount of time is spent in team conferences to determine supportive activities for the patient, who will provide these activities, evaluating if the actions have occurred, and teaching the family and patient so that they may maintain these actions in the home. Maintenance of home actions is determined by the provision that there is enough time for the individual who is close to death (Gardner & Wheeler, 1987; Ujhely, 1968).

Gardner (1979) identified supportive behaviors frequently used by nurses. These behaviors included several

actions: participation between the nurse and patient in problem-solving activities; assisting the patient to express feelings; being available; working with the patient and family; providing information to the patient and family; and helping the patient maintain control in decisions. From this list, it is clear that nurses provide support to patients and their families.

A limited number of nursing studies have been reported in which nurses' perceptions of support were the focus (DeYoung & Dickey, 1967; Funkhouser, 1976; Gardner & Wheeler, 1981; Pearlmutter, 1974; Stockwell & Nishikawa, 1970). From these studies, nurses have identified a list of words and actions describing support which included several areas, such as accepting, expressing feelings, giving information, empathizing, understanding, helping, being friendly, and reassuring. However, there is no agreement among nurses on the importance of these areas nor on their use in various patient settings.

Grossman-Schultz and Feeley (1984) supported Gardner's (1979) findings on the concept of support in nursing. Using a simulated case study method, the authors reported a difference in supportive behaviors nurses described in their practice and the behaviors they actually used to define the concept of support. They identified three phases in the

support model. Phase one was focused on the establishment
of trust between the patient and nurse. Phase two occurred
when the nurse and patient targeted the health goals, and
finally in phase three, the nurse and patient explored and
planned ways to achieve those goals. Confirming Gardner's
descriptions of support, the outcome of the patient and
nurse working together as a supportive intervention was
mentioned by only a few nurses in Grossman-Schultz and
Feeley's sample.

Looking for a method or system to categorize the lists
of supportive nursing behaviors, Hart and Reltweder (1959)
defined nursing support as including the physical, emo-
tional, social and spiritual realms of life. Physical
support is directed toward the goal of maintaining the
patient's physical comfort. Many of these actions are
universally perceived as nursing practice and are usually
taught as nursing skills. These tasks include the bed bath,
positioning, and skin care. The authors elaborated by
grouping specific aspects of physical care as supportive to
the patient: allowing the patients to be physically com-
fortable; relieving discomfort; and the availability of the
nurse. Henderson (1966) also addressed the importance of
nursing activities which focused on patient comfort. Some
of these actions included assisting the patient to breathe

normally; eat or drink sufficiently; eliminate body waste products regularly; and maintain mobility, comfortable positions, sleep, and rest.

The area of emotional support has been discussed in the literature (Cobb, 1976; Grossman-Schultz & Feeley, 1984; Kaplan, 1977; Ujhely, 1966). Emotional support includes those nursing actions geared toward aiding the patient attain a state of emotional well being. Ujhely identified units which may affect the nurse's ability to provide emotionally supportive actions. The nurses' educational preparation which includes theory as well as structured clinical exercises begins the formation of the skills and interest in the emotional aspects of support. Experience and continued interest of the nurse expands this knowledge and comfort with the area. The final unit was the actual communication employed between the nurse and patient during any given interaction.

In trying to prioritize emotional support, DeYoung and Dickey (1967) evaluated this area of support as a primary focus of nursing. In their survey different health providers were asked to rank words used to denote emotional support. Terms used to imply emotional support included acceptance, empathy, reassurance, encouragement, and warmth. Sympathy was considered least important. Pearlmutter

(1974), utilizing selected case study vignettes portraying patient anxiety, surveyed 94 nurses employed on medical and surgical units in three different hospitals regarding behaviors professional nurses would use to give emotional support. The nurses identified the need for patients to express feelings as most important. Other areas identified included the need for patients to tolerate or accept their own physical condition, the need to act on their own behalf, the need to be informed regarding treatments, and the need to assist in their own care and activities. The reciprocal relationship mentioned by Hart and Reltweder (1959) and Gardner and Wheeler (1981) was a key ingredient in identifying supportive nursing behaviors.

Another area of supportive behaviors mentioned in the literature was social and/or cultural support. These words are used interchangeably to define this area of supportive behaviors. The terms are often included with emotional support, but they are discussed separately. Social, cultural support include those actions by the nurse, patient, or family that enhance or restore comfort through assisting the patient in social integration and social functions (Caplan, 1974). Cobb (1976) indicated that persons who perceived that they were cared for, valued, and members of a social network felt supported. Both Caplan and

Cobb viewed the family as an important support system to the individual.

Caplan (1974), who noted that social support for the patient acted as a buffer against disease, identified three areas of actions that an individual would obtain from significant others. These areas included help to mobilize psychological resources and master psychological problems, share tasks, and provide extra resources. The idea was that a person who received support or needed support often denoted weakness. In this relationship, support is viewed as augmenting an individual's strengths to aid in mastery of the environment. This system was described by Caplan as "an enduring pattern of continuous or intermittent contacts that contribute in maintaining the psychological and physical integrity of the person over time" (p. 7). During a crisis, this system is activated and begins to respond in a spontaneous way. The professional enters to assist in channeling the energies in a planned, ordered pattern. For the terminally ill patient, this plan may include working with the family to safely provide the physical care needed to maintain comfort for the individual.

In the United States where separation of church and state is stressed, spiritual support is often over-looked to respect an individual's rights. There are a multiplicity of

spiritual beliefs and practices in the Western world. Munley (1983) conceptualized these diverse orientations as an atheist, one who rejected the concept of God and formal religions; a metaphysician, who believed in an orderly system of the universe but not a religion; and personal religion which described a system for those who left formalized institutional religion. In the personal religion the source of strength is from a personal God in whom one trusts. Munley described a final area as the blend of personalized religion and institutional religion. Individuals in this group draw comfort from a God and also trust an organized system of religious thought and practice. Institutional religion was for those who give attention to rituals, practices, and/or teachings of an organized religion with the focus on the institutional practice (Munley, 1983).

Kim (1982) focused on the individual and defined spirituality as the "life principle which pervades a person's entire being and which integrates and transcends the individual's biological and psychological nature" (p. 314). This integration influenced Conrad (1985) who categorized the areas of spiritual support for an individual as a search for meaning, a sense of forgiveness, hope, and love. Knowing these interpretations directs nursing actions

to be based on respect of different beliefs, willingness to discuss matters of spirituality with patients and families, and, where appropriate, provide for the rituals and sacraments of an organized religion.

Hart and Reltweder (1959) categorized support into the areas of physical, emotional, social, and spiritual, and they used these categories to identify the needs of a given individual. Data have emerged which begin to define those nursing upportive behaviors that are integral to each category. Perceptions of supportive behaviors by patients, families, and nurses were explored to add the reciprocal aspect of support.

Perceptions of Supportive Nursing Behaviors

The individual is the expert in defining what activities are supportive to self-well being. Studies which were focused on individual as well as group interpretation of supportive nursing behaviors are reviewed herein.

Throughout nursing literature, the individual patient is cited as the expert and key component in reaching health care goals (Gardner & Wheeler, 1981; Hart & Reltweder, 1959). Little research has been reported which was focused on the terminally ill patient's perceptions of these goals or the supportive nursing behaviors needed to attain them. Buckingham, Lack, Mount, MacLean, and Collins (1976)

employed an anthropologist who acted as a participant observer to address this issue. One investigator, who was not ill, assumed the sick role and was admitted to a surgical unit and later transferred to a palliative care unit for a terminal illness. In the account of the experience of being ill, Buckingham et al. noted the importance of the patient-to-patient support. Patients provided informal aid in explanations of treatments as well as the support of physical presence when others could not be there. Another area of support was provided by the family members who crossed biologic boundaries to provide aid to any other terminally ill individual. The description of this experience stressed the need for the patient to maintain individuality. The ability to have control over aspects of care assisted the patients in meeting their own goals and thus freed them to follow the prescribed treatments. The investigators concluded with the opinion that acute treatment wards offered a less supportive environment for the terminally ill as compared to the same individual's experience on a palliative care unit.

Kane, Bernstein, Wales, Leibowitz, and Kaplan (1984) compared terminally ill patients receiving care in a hospice unit or a conventional unit and noted no significant difference between groups in measures of pain, number of

symptoms, or activities of daily living. Kane et al. commented that hospice patients were more satisfied with care and appeared less anxious than those patients with conventional care.

Conrad (1985) noted selected accounts for spiritual support during a terminal illness. In these individual narratives, the frequency and type of supportive behaviors were contingent upon the patient's own values and beliefs as well as the progression of the illness. Conrad observed that with these persons, assessing the area of spiritual support provided the patient with future as well as present opportunity to explore the spiritual area.

In exploring the concept of supportive actions in relationship to families coping with an episode of illness or crisis related to a terminal illness, Irwin and Meier (1973) compared 20 relatives of oncology patients and 20 health care professionals using a Q-Sort methodology. The researchers found that health professionals perceived the supportive actions for the patient differently than did the family members. Supportive statements for the families emerged as being more desirable than others in aiding them during the fatal illness or death of a loved one. Those statements included the following: being honest with the family, giving clear explanations, keeping the family

informed, and answering questions. The supportive activities were grouped into three categories. The religious-philosophical area included phrases, such as, "assure me my relative is prepared to die", "speak to me of the hope of the resurrection" (p. 123). Phrases used in the nonverbal-action area included words, such as, "let me help in the care of my sick relative," and "stay with me when I feel I need them" (p. 123). Verbal-nonreligious phrases were those, such as, "kept me informed of my relative's condition," and "maintained hope when talking with me" (p. 123). The families rated the nonverbal-action category consistently lower than did the professionals. Families also rated the supportive value of the verbal-nonreligious area significantly higher than the professional. There was a significant difference between various health providers in ranking of the verbal-nonreligious statements. Nurses and nursing assistants tended to respond closer to the family responses than did physicians and chaplains.

Hampe (1975), Skorupka and Bohnet (1982), and Kristjanson (1986) in their separate studies interviewed families during the final stage of their loved ones' illness. The following identified needs emerged: be with the dying person, be helpful, receive assurance of the comfort of the dying person, be informed of the loved ones'

condition, be informed of the impending death, ventilate emotions, be comforted and supportive of the family members, and be accepting, supporting and comforting.

Freihofer and Felton (1976) also tried to determine supportive behaviors. They used a Q-Sort methodology and compared responses by 25 terminally ill patients and their families on supportive behaviors. Three areas of behaviors that were identified included providing for the physical needs of the patient as related to hygiene and comfort, understanding the emotional needs of the patient, and understanding the needs of the family in the grief/loss process. According to the authors, these results indicated the need to identify the actions the client deemed most helpful as the first step in planning the appropriate nursing actions that will be supportive.

Skorupka and Bohnet (1982) supported the findings of Freihofer and Felton with a similar study in which the family members consistently chose supportive behaviors directed toward the patient rather than themselves as more helpful. Kristjanson (1986), in a descriptive study, asked 20 families of patients receiving care on a palliative care ward to describe the experience of the illness for the patient and to identify the things that were important in the care of the patient and family. The caregiver behaviors

identified in the study supported the findings of Hampe (1975) and Skorupka and Bohnet. Additionally, the families identified the importance of giving information related to the illness by the health providers and viewed these same providers as the controllers of this information.

Few studies were available which were focused on comparing perceptions of support between nurses and patients. Kyle (1964) employed an experimental design to compare responses on perceptions of support by 8 nurses and 16 patients on a palliative care unit. The nurses in the experimental group used a supportive approach in providing care for patients with inoperable cancer as compared to the control group of nurses who provided standard nursing care for patients with inoperable cancer. Support was defined, although not measured, as spending more time with the patient and family. Patients in the experimental group reported more realistic plans for post-hospitalization and fewer negative reactions to having cancer than those in the control group. The factor of time spent with the patient was identified as important but was not measured.

Using an experimental design, Lierman (1982) studied adult women after a mastectomy. Lierman noted that women who received a supportive nursing method reported a positive mood and less emotional upset than did patients in the

control group. Support was described through patient interviews in general terms as time spent with the patient, as well as visits emphasizing empathy, reassurance, encouragement, trust, and confidence. Of note, on 1-month and 3-month follow-up visits, there was no significant difference found between the experimental and control groups on their perceptions of support.

Gardner and Wheeler (1981, 1987) identified the need to explore the area of nurses' and patients' perceptions of support. In their 1981 studies, the authors found that nurses perceived support to patients to include expressing feelings, giving information, and being friendly. Subsequently, Gardner and Wheeler (1987) studied three patient groups in acute hospital settings. The interview and follow-up questionnaire were completed by 119 patients. Eleven categories of support were described: being available; promoting comfort, giving information; assisting in expressing feelings; performing specific nursing tasks; helping to solve problems; having a friendly and pleasant attitude; relieving pain; giving reassurance, and individual care; and touching. Differences in priorities emerged related to the patient unit. Physical measures were most important for patients on a surgical unit, whereas patients on a psychiatric unit emphasized problem solving, and

patients on a medical unit focused on the psychosocial aspect of friendliness. Four areas were identified by the authors from the questionnaire and interviews: availability of physical care, information giving, problem solving, and friendly attitude. Factors that were not evident in the interviews were: control, confidence, and moral support.

Nurses' anxiety and attitude toward death were studied by Gow and Williams (1977). Their sample of nurses was obtained from community agency, nursing home, and acute care settings. In their two-phase survey, the authors used an anxiety scale and their own attitude toward death scale to measure nurses' anxiety about dealing with death and attitudes toward death to determine differences related to work settings. The authors reported 137 initial responses and 98 follow-up responses. Gow and Williams found that personal experience and attributes of the nurses influenced their attitudes toward death and dying rather than the settings wherein the nurses worked.

The studies of Gow and Williams (1977) and Gardner and Wheeler (1981, 1987) represent preliminary data using nonrandomized samples of supportive nursing actions for specific groups of patients. Possible differences due to type of illness or setting direct the need for further

comparisons of other patient groups and their respective nurses to identify supportive nursing activities.

Summary

This review of the literature was focused on the historical overview of the dying process in the modern Western culture. The evolution of support in the areas of physical, emotional, social, cultural, and spiritual realms was chronicled, and the perceptions of support by individuals, families, health providers, and nurses were described.

Researchers have begun exploring nursing supportive behaviors for patients in medical, surgical, and psychiatric acute care settings (Gardner & Wheeler, 1981, 1987). Families and nurses have begun to describe supportive nursing actions and the evidence shows disagreement on what these activities should include (Irwin & Meier, 1973). No studies have been reported in which perceptions of nursing supportive behaviors were identified by the terminally ill individual and the hospice nurse.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This study was classified as a nonexperimental,
explanatory, cross-sectional survey. Kerlinger (1973) noted
that survey research is focused on people, their facts,
beliefs, opinions, attitudes, motivation, and behavior. The
goal in survey research is to discover the incidence, dis-
tribution, and interrelationships between psychological and
sociological factors. This study had a nonexperimental
design; although there were two groups of subjects, neither
was a control group, a convenience sample technique was
used, and no randomization was possible because of the
limited number of hospice nurses and the changeable condi-
tion of the patient who is terminally ill (Kerlinger, 1973).

This study was designed to determine the perceptions of
supportive nursing behaviors by the terminally ill patients
and hospice nurses. In addition, age, gender, religious
preference, race, type of hospice setting, diagnosis, length
of employment in hospice, and length of illness were col-
lected for the terminally ill patients and hospice nurses.

Setting

The setting was a hospice located in a large metroplex in the southwestern United States. This agency was the largest of three in the city, and provided services to the 177,681 square mile area with a population of 3,120,000 people (Houston Chamber of Commerce, 1986). At the time of the study, the patient census for this agency varied from 5 to 40.

The patients were contacted by their primary nurse or the investigator at their current address depending on whether they were at home or in the inpatient area. The nurse or investigator distributed the questionnaire in the patient's home or inpatient room. The inpatient area was located on the ninth floor of a large community hospital, and this unit provided eight private and two semiprivate rooms. All areas were wallpapered, carpeted, and furnished with recliners, upholstered chairs, plants, colored televisions, and colorful pictures. The atmosphere was home-like where friends, relatives, and pets were welcomed at any hour of the day or night. There was a large living room area with refreshments available for anyone. The area is leased by the hospice and staffed with hospice employees. The home environment of individual patients varied with each person.

The nurses employed by the hospice were contacted and invited to participate during a weekly team meeting held in the administrative office building located near a medical center. The investigator distributed the instruments to the professional nurses during this meeting.

Population and Sample

Two target populations were used for this study. One of the populations was comprised of all adult patients, 18 years of age or older receiving care by a hospice, who were willing to participate in the study, able to respond to questions, alert, and oriented to time and place. The other population consisted of professional nurses employed by the same hospice.

Patient participation was dependent on being 18 years of age or older, alert, oriented to time and place, and willingness to participate. Many patients were unable to participate due to the lability of their physical condition, fluctuating energy level, and actual death prior to a scheduled appointment with the investigator.

The pool of hospice nurses in this city at the time of the study was 17, 3 of whom participated in the pilot study for this research. Of the hospice nurses, 12 were employed in one agency. The three remaining nurses provided care for both hospice and AIDS patients at another agency.

Convenience sampling technique was used to obtain the sample because of the physical condition of the patients and the limited number of nurses employed in the hospice. A total of 20 patients obtained from the daily census of the selected hospice, who met the study criteria and agreed to participate, comprised the patient sample. The 12 hospice nurses employed by the same agency who agreed to participate were selected as the the nurse sample. Thus, the total sample contained 32 subjects.

Protection of Human Subjects

Prior to data collection, permission for this study was solicited from the Human Subjects Review Committee of Texas Woman's University; the study was found to be exempt from committee review because all participants were adults (Appendix A). New Age Hospice agreed to participate and provided the investigator access to the nurses and patients through team meetings and daily reports (Appendix B). Participants' rights were protected by:

1. Designing the study to meet the requirements of the Human Subjects Review Committee at Texas Woman's University, and the hospice agency.

2. Explaining in the cover letter to each patient and nurse that their participation in the study was voluntary. Each person might decline to participate and this

decision would not alter the plan of treatment being provided by the hospice team nor their employment status with the hospice (Appendix C).

3. Informed consent was obtained by stating in the cover letter that completion and return of the questionnaire implied informed consent.

4. The only known risk to the participants of the study was the fear of disclosure of information. Any discomfort experienced by the patients would be addressed at the time of the administration of the questionnaire by the hospice nurse who was with the patient. If further follow-up was needed, the hospice team currently seeing the patient was responsible for the interventions. If the nurse experienced discomfort after completing the questionnaire, the investigator was available by phone or personal contact for assistance. If further follow-up was requested, a referral would be made.

5. Participants were told in the cover letter that all information would be held in confidence; however, numbers would be assigned to the participants' question-naires to correlate the data. No names were used on the questionnaires, and only the principle investigator had access to this master list. The list was destroyed upon completion of the study.

6. The investigator provided a phone number for the participants to use should they require additional information, have problems, or have any questions.

Instrument

The instrument used in this study was divided into two sections: demographic data and the Supportive Nursing Behaviors Scale (SNBS) (Appendix D). The demographic data section was included to determine if age, gender, race, religious preference, and other descriptive information about the patients and nurses was related to their perceptions of supportive nursing behaviors as reflected by the score on the SNBS. These data would provide a description of the respondents.

The items for the demographic data section were developed from factors which a review of previous research indicated were often influential in affecting individual's perceptions of supportive behaviors. The information requested from the respondents was related to personal characteristics and agency setting. The personal information elicited was age (Gow & Williams, 1977; Lester, 1966), gender (Freihofer & Felton, 1976; Lester, 1966; Skorupka & Bohnet, 1982), religious preference (Conrad, 1985; Freihofer & Felton, 1976; Irwin & Meier, 1973), and agency setting (Folta, 1965; Gow & Williams, 1977; Lester, 1966). Race was

not obtained in many of the studies, which may be related to the philosophy of health care agencies which states that they do not discriminate due to race. Information about the patient's diagnosis as categorized by primary cancer diagnosis (Silverberg & Lubera, 1989), length of illness, and the nurses' length of employment was added to the data base to further define the groups.

The items for the SNBS were developed by this investigator in two ways. First, a review of the literature was done to determine the categories and phrases to describe supportive behaviors (Conrad, 1985; DeYoung & Dickey, 1967; Folta, 1965; Freihofer & Felton, 1976; Gardner, 1979; Hampe, 1975; Irwin & Meier, 1973; Kristjanson, 1986; Pearlmutter, 1974; Skorupka & Bohnet, 1982; Stockwell & Nishikawa, 1970). Second, interviews were conducted with four hospice patients, two in an inpatient unit and two in a home care program, to determine their perceptions of supportive nursing behaviors. After giving their consent to participate and be audiotaped, this investigator asked each patient what nursing actions they would describe as supportive. The information was grouped into similar actions and phrases. Interrater reliability was established by asking a nurse who works with terminally ill patients at another agency to listen to and read the transcribed tapes and identify actions and phrases. The same actions and phrases were

identified by the investigator and the nurse expert. A 74-item Likert-type questionnaire was developed using the categories, actions, and phrases. Eight to 12 items were developed under each area with attention to the affective taxonomy (Krathwohl, 1964).

The items were arranged according to the categories of physical, emotional, social, and spiritual behaviors. A Likert-type scale from 1 to 5 was assigned to each question with 1 being the least supportive, 5 being the most supportive, and 3 as neutral. The investigator was unable to return to the original patients to test the questionnaire because all but one had died within a 2-week period and the one remaining individual was unable to respond.

The 74-item SNBS was pretested initially using 13 registered nurse doctoral students, nursing faculty, and 13 undergraduate nursing students; it was next tested with 8 hospice nurses and 5 terminally ill patients. The point biserial was run to correlate each item to the total score. Those items of 0.3 or greater were retained. In the pretest with nursing doctoral students, undergraduate students, and faculty, nine items were rejected as less than 0.3 and not significantly correlated to the total score. Five additional items were eliminated after the pretest due to

comments on clarity and duplication of the content. The resulting test contained 60 items.

The alpha correlation for the test was $\alpha = .97$ which indicated that the reliability of the items was positive and strong in measuring the concept. In the pilot study 27 items were eliminated as less than 0.3 and not significantly correlated to the total score. The alpha correlation was $\alpha = .817$ which indicated that the reliability of the items was positive and strong in measuring the concept. In this study, the alpha correlation was $\alpha = .92$ which was consistent with the previous pilot and pretest results. Sixteen items were eliminated as less than 0.3 and not significantly correlated to the total score. The difference between the results may have been due to the composition of the groups and to the sample size. The resulting test, after the pretest and pilot study, used in this study contained 44 items.

The factor analysis reduced a large set of variables to a set or cluster of items. Factors were extracted and rotated statistically. In the pretest, there was one factor at 30%, identified as greater than 5% of the explained variance. In the pilot study, four factors were identified as greater than 5% of the explained variance. In this study two factors emerged, factor one was 13.8% and factor two was

5.8% of the explained variance. For these samples the tools
appeared to have face and content validity in identifying
actions and phrases that describe supportive nursing behav-
iors. Small sample size is an inherent factor in working
with this population.

Data Collection

For this study a demographic sheet and the Supportive
Nursing Behaviors Scale (SNBS) were used with terminally ill
individuals receiving care through a hospice and their
hospice nurses. Following agency approval, and during a
regularly scheduled team meeting, the hospice professional
nurses were asked to participate in the study. Informed
consent was obtained from each participant. If the nurse
agreed, the investigator administered in person both the
demographic instrument and the Supportive Nursing Behaviors
Scale to the nurse subjects. The investigator remained in
the office while the nurses completed the instruments.
Informed consent was implied when the two instruments were
completed and returned to the investigator or placed in the
envelope located in the team conference area.

During a home visit or while providing care in the
inpatient setting, the hospice nurses with primary care
responsibilities for the patients or the investigator
asked the adult patients who were able to respond to

questions, alert, and oriented to time and place if they would like to participate in the study. The interviewer (the investigator) obtained informed consent by reading the cover letter. If the patient agreed, the investigator distributed/administered both the demographic instrument and the Supportive Nursing Behaviors Scale to the subjects. The investigator stayed with the patients at their request and provided mechanical assistance in reading items or writing the responses as needed. Data collection occurred over 8 months. Twelve hospice nurses and 20 terminally ill patients completed both instruments.

Treatment of the Data

The information from the two instruments included nominal, ordinal, and interval level data. For the demographic data, descriptive statistics were used which included frequencies, percentages, means, and modes. The mean age of the participants was calculated as well as the mean length of illness for the patients and the mean length of employment in hospice for the nurses. The mode was used for religious preference and race.

Several statistical treatments were applied to answer the five research questions. For all data analysis the level of significance was set at $p \leq .05$.

The first research question asked if there was a difference between terminally ill patients and hospice nurses in their perceptions of supportive nursing behaviors. The Mann-Whitney U test was used to determine if there was a difference between the two groups.

The second research question asked if there was a difference in the perceptions of supportive nursing behaviors by terminally ill patients grouped according to gender, religious preference, race, diagnosis, and current residence. A Mann-Whitney U test was used to determine if there was a difference in the mean ranks according to gender, religious preference, race, and current residence. A Kruskal-Wallis test was used to determine if there was a difference between perceptions of supportive nursing behaviors according to diagnostic category.

The third research question asked if there was a relationship in the perceptions of supportive nursing behaviors by terminally ill patients grouped by age and length of illness. A Pearson product-moment correlation was used to determine if there was a relationship.

The fourth research question asked if there was a difference in the perceptions of supportive nursing behaviors by hospice nurses grouped according to gender, religious preference, race, and type of hospice setting in

which they were employed. A Mann-Whitney U test was used to determine if a difference existed according to these variables.

The fifth research question asked if there was a relationship in the perceptions of supportive nursing behaviors by nurses employed by a hospice grouped according to age and length of employment. A Pearson product-moment correlation was used to determine if there was a relationship.

Summary

In summary, because of the lack of research in the area of supportive nursing behaviors for the terminally ill, the design of this study was a nonexperimental, explanatory, cross-sectional survey. The study was designed to determine perceptions of supportive nursing behaviors by terminally ill patients and hospice nurses using a two-part instrument developed from a review of the literature and interviews with hospice patients. The first part of the instrument was a series of demographic questions about the patients and the hospice nurses. These variables included age, gender, religious preference, and race for both patients and nurses. Diagnosis and type of hospice residence were also asked of the patients, and area of employment within the hospice and length of employment were asked of the nurses. The second

part of the instrument contained a series of questions related to the physical, emotional, social, and spiritual areas of support mentioned in the literature. These variables were chosen because parts have been used in previous studies, but not in this combination nor with any consistency.

CHAPTER 4

ANALYSIS OF DATA

Data from the sample of adult terminally ill patients and hospice nurses who participated in this study about perceptions of supportive nursing behaviors are reported in this chapter. Demographic data for the two groups are reported by using descriptive statistics. Data were analyzed based on the individual's ratings on the Supportive Nursing Behaviors Scale (SNBS).

The independent variables of patients' and nurses' religious preference, race, and age as well as patients' gender, diagnosis, current residence, length of illness, and nurses' employment setting and length of employment were used to test the research questions. Various statistical treatments were applied and are discussed with the findings.

Description of the Sample

There were 20 adult patients and 12 nurses who completed the study and comprised the sample. Over an 8-month period, 23 patients from the same hospice, approached by telephone or during a scheduled home visit by the hospice nurse or the investigator, were invited to participate in the study. Two patients declined, and one

55

patient was too ill during the scheduled visit and therefore was not included in the study. Throughout the data collection period the setting for the patients was either the hospice inpatient unit or the home of the patient.

The 12 nurses employed by the hospice were invited to participate in the study during a regularly scheduled team meeting. Questionnaires were distributed to all the nurses, and an envelope was placed in the conference area for the completed forms. All of the nurses completed the materials and placed them in the envelope within a 2-week period.

The 20 individuals in the patient group completed the SNBS. Ages of the patients varied from 51 years to 94 years with a mean age of 70.6 years ($SD = 12.2$). The majority (14; 70%) of the patients were males; 6 (30%) were females. The race of this group of patients was predominately white (19; 95%); 1 (5%) patient was black. The majority (15; 75%) of the patients were residing in their home at the time of data collection; however, 5 (25%) subjects were inpatients at the hospice. The length of illness for the patients varied from 5 months to 120 months, with a mean of 33.5 months ($SD = 32.7$).

Patients were grouped by primary cancer diagnosis. These diagnoses followed the guidelines of the American Cancer Society primary sites (Silverberg & Lubera, 1989).

Two diagnostic categories were identified by most of the patients: cancer of the lungs (6; 30%) and cancer of colon/rectum (5; 25%) (Table 1). The majority (16; 80%) of the patients were Protestant; 1 (5%) subject had no religious preference. The modal group for religious preference was Protestant.

Table 1

Distribution of 20 Patients by Primary Diagnostic
Category/Cancer and Religious Preference

Variable	$\underline{n}$	%
Primary Diagnostic Category/Cancer		
Breast	2	10
Rectum/Colon	5	25
Prostate	3	15
Head/Neck	1	5
Lung	6	30
Bladder	1	5
Pancreas	1	5
Ovaries	1	5
Total	20	100
Religious Preference		
Catholic	3	15
Protestant	16	80
None	1	5
Total	20	100

All 12 of the nurses employed by the selected hospice participated in the study by completing the questionnaire. Ages of the nurses varied from 27 to 53 years with a mean age of 37.4 years (SD = 8.4). The majority (11; 92%) of the nurses were female; 1 (8%) was male. The race of the majority (11; 92%) of the nurses was white; 1 (8%) nurse was black. Most (9; 75%) of the nurses were employed in the home care program at the time of data collection; only 3 (25%) nurses were employed in the inpatient unit. The length of time employed in the hospice varied from 3 months to 78 months with a mean of 31.5 months (SD = 20.9). Religious preference was also specified by the nurses (Table 2). Half (6; 50%) of the nurses were Protestant.

Table 2

Distribution of 12 Nurses by Religious Preference

Religious Preference	n	%
Catholic	5	42
Protestant	6	50
Other	1	8
Total	12	100

Findings

The purpose of this study was to compare perceptions and rankings of supportive nursing behaviors between adult terminally ill patients and their hospice nurses employed by the hospice. The Supportive Nursing Behaviors Scale (SNBS) was used to measure supportive nursing behaviors. Possible scores on the SNBS can vary from 1 to 300. Scores greater than 200 indicated more positive perceptions of supportive nursing behaviors.

Five research questions were established for the purpose of data analysis. Various statistical tests, with the probability level at $p \leq .05$, were used to analyze each research question. Because of the small sample sizes of the groups, cells with less than one subject were not analyzed. There were often cells with less than five subjects which were analyzed; however, no statistical manipulation was done to compensate for small cell size.

Research question number one asked: Is there a difference in the perceived importance of supportive nursing behaviors by terminally ill patients and hospice nurses? Scores on the SNBS of the 20 patients in this sample varied from 225 to 298 with a mean score of 262.95 ($\underline{SD} = 21.8$). The nurses' scores on the SNBS varied from 212 to 269 with a mean of 248 ($\underline{SD} = 18.5$). The mean rank on the SNBS for the

patient group was 19, while for the hospice nurses the mean rank was 12.3. A Mann-Whitney $\underline{U}$ test was used to compare the terminally ill patients' and hospice nurses' mean rankings on the SNBS. A value of $\underline{U} = 70$ ($\underline{p} = .053$) was found (Table 3). Although there was no significant difference between the groups on the ranking on the SNBS, the mean ranks of the patients were higher than the mean ranks of the nurses. Therefore, perceived importance of supportive nursing behaviors did not significantly differ between terminally ill patients and hospice nurses.

Table 3

Mann-Whitney $\underline{U}$ Comparing Mean Ranks on the SNBS of 20 Patients and 12 Nurses

Variable	Cases	Mean Rank	$\underline{U}$	$\underline{p}$
Patients	20	19.00	70.0	.053
Nurses	12	12.30		

Research question number two asked: Do perceptions of the importance of supportive nursing behaviors by terminally ill patients vary according to gender, religious preference, race, diagnostic category, and current residence? The analysis for race was not computed because there was only one black individual in the patient sample. The mean rank

on the SNBS by male patients was 11.0, and for females it
was 9.33. A Mann-Whitney $\underline{U}$ test was used to compare the
mean ranks on the SNBS of terminally ill patients when
grouped by gender, religious preference, and hospice set-
ting. A value of $\underline{U}$ = 35 ($\underline{p}$ = .601) was found (Table 4). No
significant difference existed between male and female
patients in the ranking on the SNBS. Therefore, perceptions
of the importance of supportive nursing behaviors by termi-
nally ill patients did not vary according to gender.

Table 4

Mann-Whitney $\underline{U}$ Comparing Gender and Mean Ranks on the SNBS
of 20 Patients

Variable	Cases	Mean Rank	$\underline{U}$	$\underline{p}$
Male	14	11.00	35.0	.601
Female	6	9.33		

Two religious groups emerged for the patient sample.
The mean rank on the SNBS for the Catholic group was 10.33,
while for the Protestant group the mean rank was 9.94. The
category of no religious preference was omitted in the
statistical analysis because only one individual selected
this option. A Mann-Whitney $\underline{U}$ yielded a value of $\underline{U}$ = 23
($\underline{p}$ = .91) (Table 5). No significant difference was found

between Catholics and Protestants in the ranking on the SNBS. Thus, perceptions of the importance of supportive nursing behaviors by terminally ill patients did not differ according to religious preference.

Table 5

Mann-Whitney $\underline{U}$ Comparing Religious Preference and Mean Ranks on the SNBS of 20 Patients

Religious Preference	Cases	Mean Rank	$\underline{U}$	$\underline{p}$
Catholic	3	10.33	23	.91
Protestant	16	9.94		

For statistical analysis, diagnostic categories of the patients were categorized into major cancer groups as identified by the American Cancer Society (Silverberg & Lubera, 1989): genito/urinary cancers, colon/rectal cancers, and lung cancers. The category of other was removed for analysis as there were two cases in the cell; one case was cancer of the head and neck and one was cancer of the pancreas. When grouped by diagnostic categories, the mean rank on the SNBS for patients with genito/urinary cancer was 11.29; for patients with colon/rectal cancer, it was 7.70; and for patients with lung cancer, it was 8.92. A Kruskal-Wallis test, which converts to chi-square with

small groups, was used to compare the patient diagnostic categories with the patients' ranking on the SNBS. A chi-square value of 1.423 (p = .4908) resulted (Table 6). No significant difference was found according to the diagnostic categories and patient ranking on the SNBS. Therefore, the importance of supportive nursing behaviors by terminally ill patients did not vary according to diagnostic category.

Table 6

Kruskal-Wallis Test Comparing Diagnostic Cancer Group and Mean Ranks on the SNBS of 20 Patients

Diagnostic Group	Cases	Mean Rank	Chi-Square	p
Genito/Urinary	7	11.29		
Colon/Rectum	5	7.70	1.423	.4908
Lungs	6	8.92		

The patients in this sample had two types of current residence: home and hospice inpatient. The mean rank on the SNBS by home patients was 11.33; for the hospice inpatients, it was 8.0. The Mann-Whitney U was used to test for differences in scores according to type of residence. Results indicated that U = 25 (p = .305) (Table 7). No significant difference according to current residence and

patients' ranking on the SNBS was found. Thus, perceptions of the importance of supportive nursing behaviors by terminally ill patients did not vary based on current residence.

Table 7

Mann-Whitney $\underline{U}$ Comparing Type of Current Residence and Mean Ranks on the SNBS of 20 Patients

Current Residence	Cases	Mean Rank	$\underline{U}$	$\underline{p}$
Home	15	11.33	25.0	.305
Hospice Inpatient	5	8.00		

The third research question asked: Are perceptions of the importance of supportive nursing behaviors by terminally ill patients related to age and length of illness? A Pearson product-moment correlation coefficient, a parametric test, was used to examine the relationship between patient age and the score on the SNBS. A coefficient of $\underline{r}$ = .468 ($\underline{p}$ = .01) was found (Table 8, Figures 3 and 4). There was a positive significant relationship between ranking on the SNBS in the patient group related to age. The $\underline{r}^2$ = .219, or 22% of the variance on the scores on the SNBS was accounted for by the age of the patient. The coefficient of nondetermination, or $1-\underline{r}^2$, was 78% which is the proportion of the

variance of the perceptions which cannot be predicted by the age of the patient. The perceived importance of supportive nursing behaviors by terminally ill patients was related to age.

Table 8

Pearson Product-Moment Correlation Coefficients Between
Age and Length of Illness and Scores on the SNBS
of 20 Patients

Variable	r	r^2	$1-r^2$	p
Age	.468	.219	78.0%	.01*
Length of Illness	-.057	.003	0.3%	.40

*$p \leq .01$

When relating the patients' length of illness with their scores on the SNBS, a Pearson product-moment correlation coefficient yielded r = -.057 (p = .40) (Table 8). No significant relationship was found between patient perceptions on the SNBS and length of patient illness. The r^2 = .003, or 0.3% of the variance on the scores on the SNBS was accounted for by the length of illness for the patient. The coefficient of nondetermination, or $1-r^2$ was 99.7% which is the proportion of the variance of the perceptions which cannot be predicted by the length of illness of the patient. Perceptions of the importance of supportive nursing
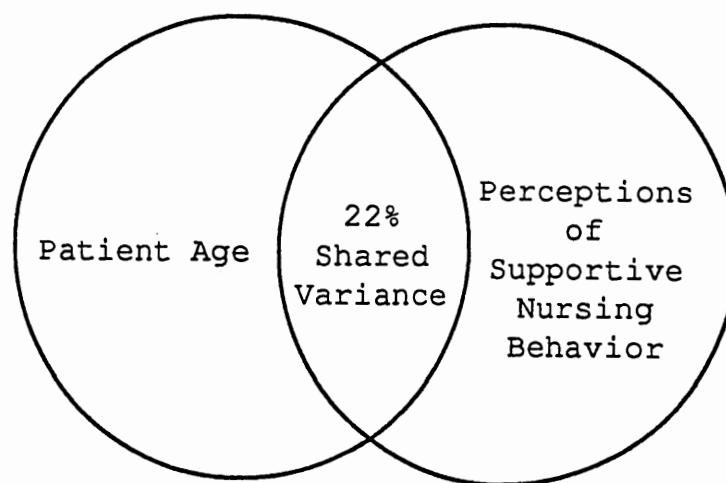
Figure 3. Venn Diagram Relating Patient Age and Perceptions
of Supportive Nursing Behaviors
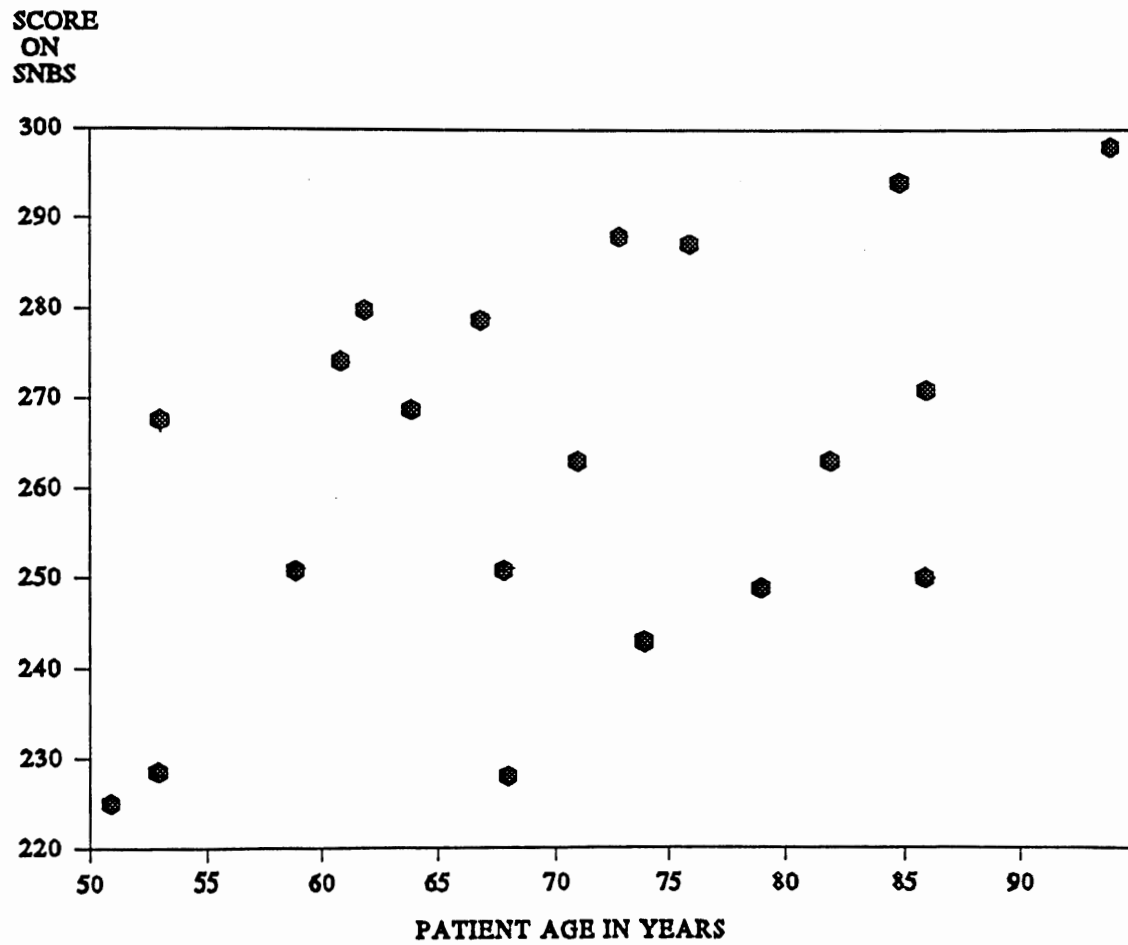
Figure 4. Scatter Plot of Patient Age Compared to
Scores on the SNBS

behaviors in terminally ill patients did not differ according to length of illness.

The fourth research question asked: Do the perceptions of supportive nursing behaviors by nurses employed by a hospice vary by gender, religious preference, race, and type of hospice setting in which they are employed? The analyses for gender and race were not computed because there was only one male nurse and only one black nurse employed in the hospice.

Two religious groups emerged from the nurse sample. The mean rank on the SNBS for the Catholic group was 4.0, while for the Protestant group the mean rank was 7.67. The category of other for religious preference was omitted in the statistical analysis because only one individual selected this option. A Mann-Whitney U yielded a value of U = 5.0 (p = .06) (Table 9). No significant difference between the Catholic and Protestant nurses on their rankings on the SNBS was found to exist. Therefore, perceptions of supportive nursing behaviors by nurses employed by a hospice did not vary by religious preference.

The nurses were employed in two types of hospice settings. The mean rank on the SNBS by home care nurses was 7.22, and for the nurses in the inpatient unit, it was 4.33. A Mann-Whitney U yielded a value of U = 7 (p = .28) (Table

Table 9

Mann-Whitney U Comparing Religious Preference and
Mean Ranks on the SNBS of 12 Nurses

Religious Preference	Cases	Mean Rank	U	p
Catholic	5	4.00	5	.067
Protestant	6	7.67		

10). No significant difference was found between nurses in the home care program and inpatient area in the ranking on the SNBS. Thus, perceptions of supportive nursing behaviors by nurses employed in a hospice did not differ by type of hospice setting in which they were employed. However, the groups were small and fairly unequivalent in size.

Table 10

Mann-Whitney U Comparing Type of Hospice Setting and
Mean Ranks on the SNBS of 12 Nurses

Hospice Setting	Cases	Mean Rank	U	p
Home Care	9	7.22	7.0	.280
Inpatient	3	4.33		

The fifth research question asked: Are the perceptions of the importance of supportive nursing behaviors by nurses employed by a hospice related to age and length of

employment? A Pearson product-moment correlation coefficient of r = .101 (p = .377) was found (Table 11). There was no significant relationship between age of the nurse and the score on the SNBS. The r^2 = .01, or 1% of the variance on the scores on the SNBS was accounted for by the age of the nurse. The coefficient of nondetermination, or $1-r^2$, was 99% which is the proportion of the variance of the scores which cannot be predicted by the age of the nurse. Thus, perceptions of the importance of supportive nursing behaviors by nurses employed by a hospice were not related to age.

Table 11

Pearson Product-Moment Correlation Coefficients Between
Age and Length of Employment and Scores on the SNBS
of 12 Nurses

Variable	r	r^2	$1-r^2$	p
Age	.101	.010	99%	.370
Length of Employment	.608	.369	63%	.018*

*p≤.05

Length of employment for the nurses in the hospice was analyzed in relation to the score on the SNBS. A Pearson product-moment correlation coefficient yielded r = .608 (p = .018) (Table 11, Figures 5 and 6). There was a

positive significant relationship between the scores on the SNBS and the length of employment of the nurses. The r^2 = .369, or 37% of the variance on the scores on the SNBS was accounted for by the length of employment of the nurse. The coefficient of nondetermination, or $1-r^2$, was 63% which is the proportion of the variance of the scores which cannot be predicted by the length of employment of the nurses. Therefore, a positive significant relationship did exist between perceptions of the importance of supportive nursing behaviors by nurses employed by a hospice and length of employment.

Summary of Findings

The mean age was 70.6 years for the 20 patients who participated in this study of perceptions of supportive nursing behaviors by terminally ill patients and hospice nurses. Most of the patients were white male Protestants who resided in homes at the time of this study. The primary diagnoses for the patients were cancer of the lungs and cancer of the colon/rectum, and length of illness varied from 5 to 120 months.

The mean age of the 12 nurses in the sample was 37.4 years. The majority of the nurses was White female; the group was equally divided between Protestants and Catholics.
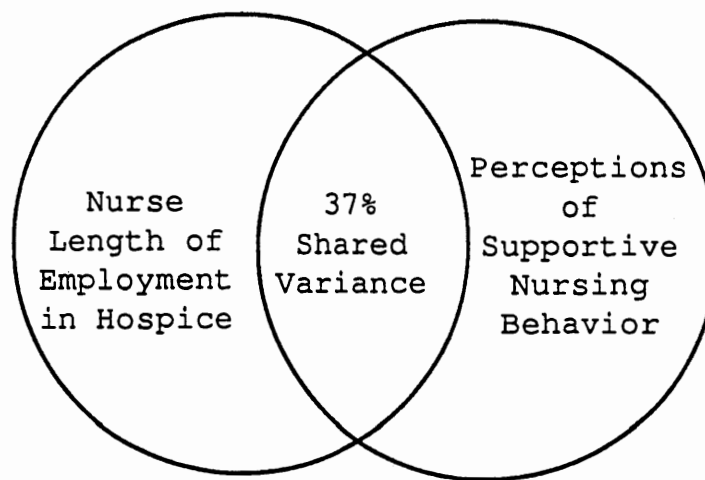
Figure 5. Venn Diagram Relating Nurses' Length of
           Employment in Hospice and Perceptions
           of Supportive Nursing Behaviors
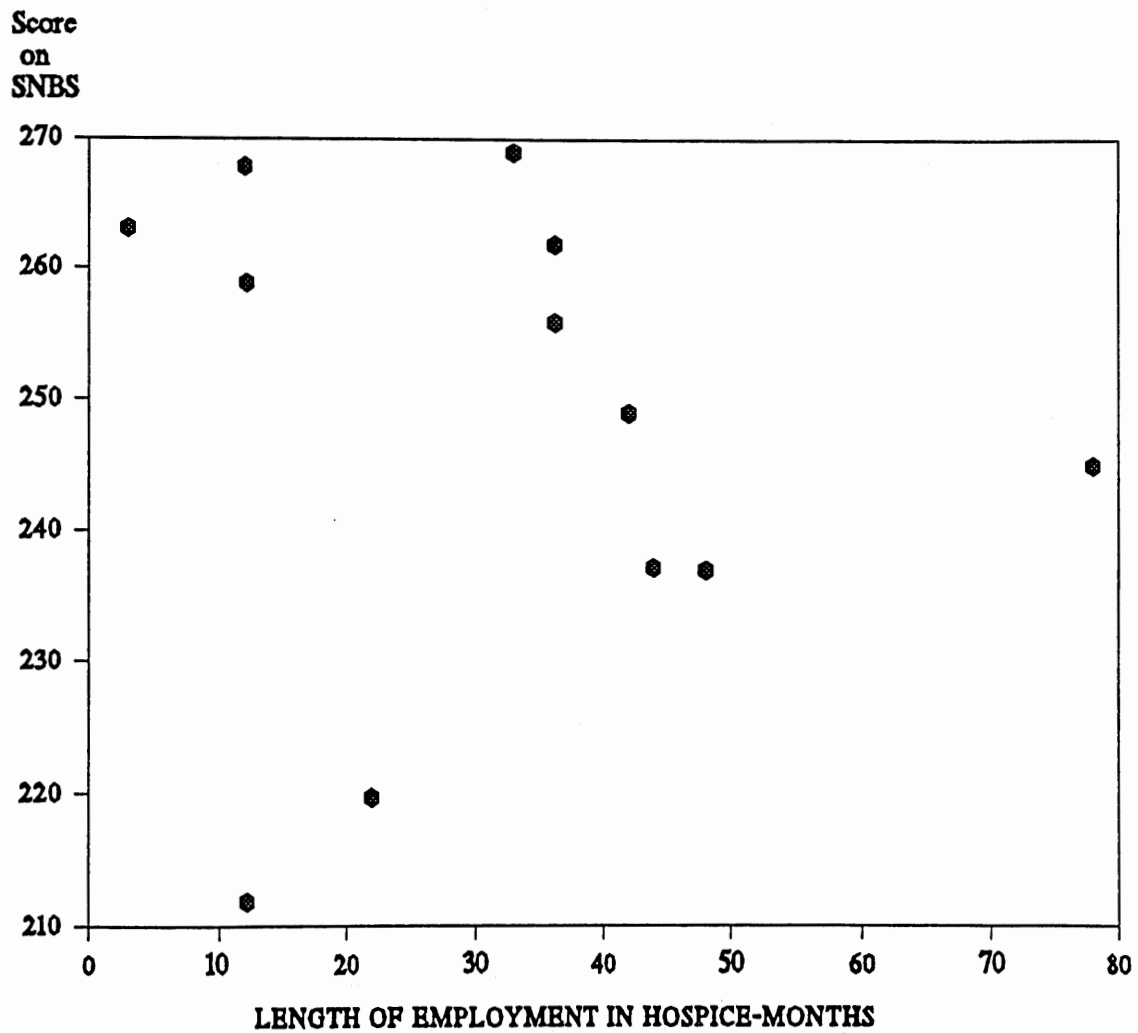
Figure 6.   Scatter Plot of Nurses' Length of Employment in
the Hospice Compared to Scores on the SNBS

Most of the nurses were employed in the home care program with a mean length of employment of 31.5 months.

The Supportive Nursing Behavior Scale (SNBS), with a maximum possible score of 300, was used to collect the data. Positive perceptions of supportive nursing behaviors were indicated by scores greater than 200. The SNBS mean score for patients was 262.95, and for nurses, it was 248. Five research questions were formulated for this study. Statistical treatments of Mann-Whitney U, Kruskal-Wallis, and Pearson product-moment correlation were used to analyze the research questions.

Perceived importance of supportive nursing behaviors did not differ between terminally ill patients and hospice nurses. Perceptions of supportive nursing behaviors by terminally ill patients did not vary according to gender, religious preference, diagnostic category, nor current residence. A Pearson product-moment correlation coefficient of $r = .468$ ($p \leq .01$) indicated there was a significant relationship between the importance of supportive nursing behaviors by terminally ill patients and age. However, terminally ill patients' perceptions of supportive nursing behaviors were not correlated with length of illness.

Perceptions of supportive nursing behaviors by nurses employed by a hospice did not vary according to religious

preference and hospice setting. Analyses for gender and race were not computed because 11 of the 12 nurses were female and 11 nurses were white. Perceptions of supportive nursing behaviors by the nurses employed by a hospice were not related to age. However, a Pearson product-moment correlation coefficient of $\underline{r}$ = .608 ($\underline{p}$≤.05) indicated a positive significant relationship did exist in nurses employed by a hospice between perceptions of the importance of supportive nursing behaviors and length of employment in the hospice setting.

CHAPTER 5

SUMMARY OF THE STUDY

The focus of this study was to identify and compare the perceptions of supportive nursing behaviors by terminally ill patients with their hospice nurses. The individual rankings of items on the Supportive Nursing Behavior Scale (SNBS) by both terminally ill patients and hospice nurses was the criterion variable with which other descriptive variables were compared. The samples were conveniently drawn from one hospice in a large city in the southwestern United States. The research design was a nonexperimental, explanatory, cross-sectional survey, and data collection occurred over an 8-month period. A summary of the findings follows.

Summary

A convenience sample of 20 adult terminally ill patients and 12 nurses employed in a hospice was used in this nonexperimental, explanatory, cross-sectional survey. All individuals were 18 years of age or older who were receiving or providing care through one hospice. All subjects were willing to participate, able to respond to questions, alert and oriented to time and place. No patients were contacted about the study until their

condition was such that they were physically able to voluntarily participate.

One nurse researcher distributed and collected all SNBS questionnaires. Where mechanical assistance of reading and/or writing was needed by the patient subjects, the same nurse provided this help and no attempt was made to alter the statements on the questionnaire. For most subjects the time needed to complete the instrument varied from 20 minutes for the nurses to one hour for the patients. For some patients, completion of the instrument was spaced over several days to conserve patient strength.

The 20 patient subjects had a mean age of 70.6 years. The majority of the patients were white male Protestants who resided in homes at the time of this study. Cancer of the lungs and cancer of the colon/rectum were the primary diagnoses of the patients. Their length of illness varied from 5 to 120 months.

The 12 nurse subjects had a mean age of 37.4 years. Most nurses were white females who were equally divided between Protestants and Catholics. The majority of the nurses were employed in the home care program, and they had a mean length of employment of 31.5 months.

The SNBS, used to measure supportive nursing behaviors, had a maximum possible score of 300. Patient subjects had a SNBS mean score of 262.95, and nurse subjects had a mean

score of 248. Possible scores on the SNBS can vary from 1 to 300; scores greater than 200 indicate more positive perceptions of supportive nursing behaviors. Five research questions were formulated for this study. The Mann-Whitney U, Kruskal-Wallis, and Pearson product-moment correlation were used to statistically analyze the research questions.

Discussion of Findings

The first research question was: Is there a difference in the perceived importance of supportive nursing behaviors by terminally ill patients and hospice nurses? In the present study, perceived importance of supportive nursing behaviors was not found to differ significantly between terminally ill patients and hospice nurses.

Findings of this study were comparable to those of Irwin and Meier (1973) who also studied perceptions of supportive behaviors. However, the authors compared 20 relatives of oncology patients and 20 health care professionals which included nurses. The authors found that nurses' responses on the Q-sort for support were more like those of the relatives than were the other health professionals' responses. No statistical measures were cited.

Gardner and Wheeler (1981; 1987) also investigated supportive nursing behaviors in both nurses and patients. Unlike the present study, findings were not compared between

patients and nurses; however, as in the present study, similarities between patient and nurse groups occurred. In their earlier study, Gardner and Wheeler (1981) investigated 100 nurses from three specialty areas: medical, surgical, and psychiatric units. In the initial study, the authors found that nurses perceived support to include only three areas: expressing feelings, giving information, and being friendly. In their later study, Gardner and Wheeler (1987) investigated 128 inpatients from three specialty areas in an acute hospital setting. In the second study, patients identified 11 areas which included expressing feelings, giving information, and being friendly. In both studies, the authors found a difference in perceived supportive nursing behaviors related to specialty areas among both their nurse subjects and their patient subjects.

The second research question of this study was: Do perceptions of the importance of supportive nursing behaviors by terminally ill patients vary according to gender, religious preference, race, diagnosis, and current residence? In this study, perceptions of supportive nursing behaviors by terminally ill patients did not vary according to the variables of gender, religious preference, diagnostic category, and current residence; race was not analyzed.

The findings of the present study are consistent with those of other researchers (Freihofer & Felton, 1976;

Gardner & Wheeler, 1987; Lester, 1966; Skorupka & Bohnet, 1982) who included the variable of gender in their analyses. However, unlike the present study, the above investigators inconsistently reported the importance of gender in identifying supportive behaviors.

Perceptions of hospice patients' satisfaction with interpersonal care and involvement in decisions were investigated by Kane, Bernstein, Wales, Leibowitz, and Kaplan (1984). As in the present study, these authors found no significant difference between religious preference and perceptions of satisfaction with interpersonal care and involvement in decisions related to their care by hospice patients and their significant others.

Findings in the present study did not indicate differences in perceptions of supportive nursing behaviors according to religious preference. Conversely, Freihofer and Felton (1976) noted a difference between Protestants and Catholics in responses on supportive behaviors by a sample of 25 terminally ill patients and their families. The Pearson product-moment correlation (r = .78; $p \leq .001$) and the Spearman rank order correlation (z = 7.28; $p \leq .001$) showed significant correlations between Catholics and Protestants in responses on supportive behaviors.

Diagnosis was not found to be significantly related to patients' perceptions of supportive nursing behaviors in the

present study. Consistent with this finding, Kane et al. (1984) noted no significant difference in perceptions of satisfaction with interpersonal care and involvement in decisions related to their care by hospice patients grouped by primary cancer site. Although scores were not given, these authors reported higher scores indicated greater satisfaction and hospice patients, when compared to other terminally ill non-hospice patients, had significantly higher overall satisfaction scores ($p \leq .05$).

Current residence, in the present study, also was not found to be significantly related to patients' perceptions of supportive nursing behaviors. Similar to the present study, Kane et al. (1984) compared 236 hospice and terminally ill non-hospice, hospitalized patients' perceptions of satisfaction with interpersonal care and involvement in decisions related to their care. Patients was randomly assigned to the two groups; no group totals were reported. However, unlike the present study, Kane et al., using two-tailed t tests, found differences between hospice and non-hospice patients in their perceptions of outcomes of care. These differences occurred in interpersonal care ($p \leq .004$) and involvement in decisions ($p \leq .02$). Like the present study, Larson (1987) also noted no significant difference in cancer patients grouped by hospital setting and their perceptions of nurse-caring behaviors.

The third research question was: Are perceptions of
the importance of supportive nursing behaviors by terminally
ill patients related to age and length of illness? In this
study, a significant difference was found between the
importance of supportive nursing behaviors by terminally ill
patients and the variable of age. Older patients had a more
positive perception of supportive nursing behaviors as
evidenced by higher scores on the SNBS.

Gardner and Wheeler (1987), using a sample of 110
patients, found that age was not significant when comparing
perceptions of supportive nursing behaviors by patients from
different acute hospital specialty areas. These authors
used a three-way analysis of covariance to analyze their
findings. Larson (1987) also found that age was not signif-
icant when compared to cancer patients' perceptions of
nursing behaviors. Lester (1966) also noted the inconsis-
tent reporting of this variable in the literature.

In the present study, there was no significant
relationship between perceptions of supportive nursing
behaviors by terminally ill patients according to length of
illness. The variable length of illness was not found to be
addressed in the reviewed literature.

The fourth research question was: Do the perceptions
of supportive nursing behaviors by nurses employed by a
hospice vary by gender, religious preference, race, and type

of hospice setting in which they are employed? In the
present study, perceptions of supportive nursing behaviors
by nurses employed by a hospice did not vary according to
religious preference and hospice setting.

Studies in which religious preference was compared with
nurses' perceptions of supportive nursing behaviors were not
found in the reviewed literature. Therefore, no comparison
of findings to those of the present study could be made.

Gow and Williams (1977) noted no significant difference
in nurses' perceptions of caring for the dying by care
setting. Gardner and Wheeler (1981) noted significant
differences in nurses' perceptions of supportive nursing
behaviors by specialty areas in a hospital. In the present
study, analyses for gender and race were not calculated
because of the lack of disparity in the sample. Of the 12
nurses in the sample, 11 were female and 11 were white.

The fifth research question was: Are the perceptions
of the importance of supportive nursing behaviors by nurses
employed by a hospice related to age and length of employ-
ment? In the present study, a positive significant rela-
tionship was found to exist in nurses employed by a hospice
between perceptions of the importance of supportive nursing
behaviors and length of employment in the hospice setting.
The longer the nurses were employed in the hospice, the more
positive the perceptions of supportive nursing behaviors as

indicated by higher scores on the SNBS. Studies in which length of employment was compared with perceptions of supportive nursing behaviors by nurses were not found in the reviewed literature. Therefore, no comparison of findings to those of the present study could be made.

In the present study, perceptions of supportive nursing behaviors by the nurses employed by a hospice were not related to age. Gardner and Wheeler (1981) also found no significant difference by age of the nurses in three different hospital settings and their ranking of supportive nursing behaviors. Gow and Williams (1977) found the age of the nurse to be significant in their perceptions of caring for the dying. Older nurses found working with the dying to be more rewarding.

Conclusions and Implications

The results of this study are a step in describing terminally ill patients' and hospice nurses' perceptions of supportive nursing behaviors. Conclusions for this sample include the following:

1. Both terminally ill patients and hospice nurses perceive supportive nursing behaviors to be important.

2. Gender, religious preference, diagnostic category, current residence and length of illness do not affect the perceptions by terminally ill patients of the importance of supportive nursing behaviors.

3. Age has a significant affect on terminally ill patients' perceptions of the importance of supportive nursing behaviors; the older the patient, the more important supportive nursing behaviors become.

4. Religious preference, hospice setting, and age do not affect hospice nurses' perceptions of the importance of supportive nursing behaviors.

5. Length of employment in hospice has a significant affect on hospice nurses' perceptions of the importance of supportive nursing behaviors; the longer a nurse is employed in the hospice setting, the more important supportive nursing behaviors become.

Based on the findings of this study, the following implications are made. The results of this study provide data, as Gardner (1979) suspected, that the concept of support in nursing can be addressed on a scientific level. The SNBS, after further validation and/or refinement, will offer additional classifications for Gardner's growing taxonomy of the constructs of support in nursing. The ability to label and rank supportive nursing behaviors has implications for nursing in the areas of practice, and research.

Identification of those supportive nursing behaviors that terminally ill patients perceive as important will aid

the nurse, patient, and family in coordinating the care activities as the patient prepares for death. Of note, much time which is spent in identifying these tasks may be eliminated, and the nursing activities can be focused on the goals the patient perceives as most important at this stage in life. Caregivers' awareness of priorities of the patients' perceived importance of supportive nursing behaviors may result in energy conservation for the patient and family, which in turn may ultimately reduce stress.

The SNBS could be used by nursing educators in structuring curricula to identify patient needs related to nursing support. During their interactions with patients and families, nurses must communicate the intent of their supportive nursing actions. With further refinement of the concept of nursing support, the practical goal of assisting patients may eventually be achieved on a planned basis versus the current situation in which much of nursing is based on intuition.

This study has implications for nursing administrators related to the effective use of nursing personnel. Knowledge of supportive nursing behaviors may be an initial step in identifying time needed in providing the care for terminally ill patients and may contribute to existing formulas for staffing. Length of employment of the nurse in the

hospice was found to be significantly related to their
perception of supportive nursing behaviors in this study.
Administrators have the ability to place nursing staff in
settings. The administrator's knowledge that an amount of
time is necessary for the nurse to learn the area and
develop skills will encourage more permanent placement in a
site as opposed to rotating shifts for greater flexibility.

A theory of support for nursing must incorporate the
interrelated factors of the identification of patients and
nurses by setting and the issue of perceptions. Implica-
tions for further research in the area of supportive nursing
behaviors with other groups of patients and other settings
emerged as a result of the findings of this study. Lewin
(1952) noted that perception was critical in all human
contacts and influenced subsequent behaviors. In this
study, terminally ill patients' and hospice nurses' percep-
tions of support provided data about nursing actions that
are supportive to hospice patients. King (1981) noted that
perception was the first step in goal setting; therefore,
when patients and nurses agree on the perceptions of sup-
port, care is often more directly related to the patients'
goals and more likely to be received and followed by the
patients. In 1984, Ellis (cited in Pressler & Fitzpatrick,
1988) noted that nursing technology needs to begin with
those behaviors required for effective practice regardless

of the setting and the patient. It is a goal of nursing research to provide nurses with the skills to support patients as they experience the crisis of illness.

Recommendations for Further Study

Results of the study form the basis for recommendations:

1. The study should be replicated in other hospice settings to increase the sample sizes since the average hospices tend to be small and the patients' conditions vary due to progression of the disease or approaching death.

2. This study should be replicated with a larger sample to continue to explore the importance of the demographic variables of gender, religious preference, and race which are inconsistently reported in other studies.

3. Replication of this study of terminally ill patients' perceptions of supportive nursing behaviors should include nononcology patients grouped by diagnostic category. Comparison of other patient groups' perceptions of supportive nursing behaviors may determine if similarities exist between patients in other life-limiting diagnostic categories.

4. Replication of the study should be undertaken to compare responses of terminally ill patients with other chronically ill patients receiving care in long-term care settings.

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APPENDIX A

PROSPECTUS APPROVAL

EXEMPT FROM HSRC REVIEW

If it is the decision of the research committee (for student research) or the department coordinator (for faculty research) that the proposed research is exempt from expedited or full review by the Human Subjects Review Committee (HSRC), please complete the following form. A copy of this properly signed form must be submitted to the chairman of the HSRC.

Principal investigator: Helen K. Maher, R.N., M.S.

Title of the research: Perceptions of Supportive Nursing Behaviors by Terminally

Ill Patients and Hospice Nurses

1. Give a brief description of the study (use continuation pages or attachments, if necessary). Describe the procedure that relates to the subjects' participation, i.e., what will the subjects do or what will be done to them. All subjects are adults, 18 years of age or over and able to consent to participate in completing the questionnaire regarding their perceptions of supportive nursing behaviors.

2. What are the potential risks to the human subjects involved in this research or investigation (use continuation pages if necessary) ?

The only potential risk in participating in the study is discomfort due to the topic.

I certify that this research meets the requirements for being exempt from review by the HSRC as specified in the Human Subjects Program Guideline (March 1986, revised). Three committee members sign for pro-paper or thesis, and five members sign for the dissertation research.

_____ Chairman, research committee, Date 2 · 88

_____ committee member

_____ committee member

_____ committee member

_____ committee member

or, in the case of faculty research

_____ Department Coordinator, Date_____

Department_____

| Date received by HSRC Chairman _____ | Initial _____ |

APPENDIX B

AGENCY APPROVAL

THE
NEW AGE HOSPICE

February 24, 1987

Mrs. Helen Maher, R.N., M.S.
4035 Falkirk
Houston, Texas   77025

Dear Helen:

I am writing to give you permission to audio tape inter-
view with six patients (three in the home care program
and three in the inpatient unit). I understand that
the interview will consist of one basic question: What
behaviors do you feel are supportive to your care at
this time in your life? You will explain the purpose
of your interview and obtain oral permission from the
patient. A staff member will not accompany you on the
interview.

We are looking forward to your working with us and
obtaining information that can improve our quality of
care.

Sincerely,

Cherry Hershberger
Executive Director

CH:ap

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER   HOUSTON CENTER
1810 INWOOD ROAD   1130 M. D. ANDERSON BLVD.
DALLAS, TEXAS 75235   HOUSTON, TEXAS 77030

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE __New Age Hospice_____

GRANTS TO __Helen K. Maher, R.N._____Doctoral_____
a student enrolled in a program of nursing leading to a ~~Master~~'s Degree at Texas
Woman's University, the privilege of its facilities in order to study the following
problem:

Perceptions of Terminally Ill Patients and Hospice Nurses of Supportive
Nursing Behaviors.

The conditions mutually agreed upon are as follows:

    1.   The agency ~~(may)~~ (may not) be identified in the final report.

    2.   The names of consultative or administrative personnel in the agency
          ~~(may)~~ (may not) be identified in the final report.

    3.   The agency (wants) ~~(does not want)~~ a conference with the student
          when the report is completed.

    4.   The agency is (willing) ~~(unwilling)~~ to allow the completed report
          to be circulated through interlibrary loan.

    5.   Other _____

          _____

          _____

Date: ___1/22/88_____   _Cherry Hershberger_____
                                       Signature of Agency/Personnel

___Helen K. Maher R.N._____
    Signature of Student   r

* Fill out and sign three copies to be distributed as follows: Original-Student;
  First copy - agency; Second copy - TWU College of Nursing.

/bc

APPENDIX C

COVER LETTERS

Dear Participant:

I am a doctoral student at Texas Woman's University and am conducting a study to examine supportive nursing behaviors. You are being asked to please complete the attached questionnaire.
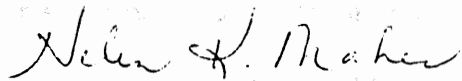
Participation in this study is voluntary. You may decline to participate, and this decision will not alter the current treatment you are receiving from the hospice team. The only perceived risk of participating is fear of disclosure of information. All information will be held in confidence, however, numbers will be assigned to the participants' questionnaires in order to correlate data. No names will be used on the questionnaires, and only the principle investigator will have access to the master list. This list will be destroyed upon completion of the study. Should you have discomfort after completing the questionnaire, the hospice nurse who is with you will provide any assistance. If further follow-up is needed, the hospice team currently seeing you will be responsible for the interventions. INFORMED CONSENT WILL BE IMPLIED upon completion and return of the questionnaire to the hospice nurse.

No compensation will be provided by Texas Woman's University or the hospice as a result of your participation in this study. This study will follow all

the rules and regulations of Texas Woman's University
and the Hospice while conducting the study.

Should you like additional information or have any
questions please contact me at (Home) 667-4322. Thank
you for your interest and consideration.

Sincerely,

Helen K. Maher, R.N., M.S.

Dear Participant:

I am a doctoral student at Texas Woman's University and am conducting a study to examine supportive nursing behaviors. You are being asked to please complete the attached questionnaire.

Participation in this study is voluntary. You may decline to participate, and this decision will not alter your current employment status at hospice. The only perceived risk of participating is fear of disclosure of information. All information will be held in confidence, however, numbers will be assigned to the participants' questionnaires in order to correlate data. No names will be used on the questionnaires, and only the principle investigator will have access to the master list. This list will be destroyed upon completion of the study. Should you have discomfort after completing the questionnaire, the investigator will be available by phone or personal contact for assistance. If further follow-up is requested, a referral will be made. INFORMED CONSENT WILL BE IMPLIED on completion and return of the questionnaire to the investigator.

No compensation will be provided by Texas Woman's University or the hospice as a result of your participation in this study. This study will follow all the rules and regulations of Texas Woman's University and the Hospice while conducting the study.

Should you like additional information or have any questions, please contact me at (Home) 6674322. Thank you for your interest and consideration.

Sincerely,

Helen K. Maher, R.N., M.S.

APPENDIX D

SUPPORTIVE NURSING BEHAVIORS SCALE (SNBS)

Patient Demographic Information

Age:_____

Gender: Male_____   Female_____

Religious Preference: _____

Race: _____

Diagnosis: _____

How long have you been sick?   _____

Are you currently receiving care through a

hospice?_____yes, _____no

a)   Type of hospice?   Home program _____ or

     In patient_____.

Nurses Demographic Information

Age:_____

Gender: Male_____   Female_____

Religious Preference: _____

Race: _____

In what area of hospice are you primarily

employed?

Home care program_____, Inpatient_____

How long have you been employed in

hospice?_____

SUPPORTIVE NURSING BEHAVIORS SCALE

The purpose of this questionnaire is to identify those
nursing actions you feel are most SUPPORTIVE to you at
this time in your life. Please CIRCLE the number which
best describes your opinion about the following nursing
actions.

THE NURSES:

1. Help me maintain a physically comfortable
    position.

    1   2   3   4   5

    least   most

    supportive   supportive

2. Take an interest in my room and surroundings.

    1   2   3   4   5

    least   most

    supportive   supportive

3. Assist me in doing as much as possible for my
    care.

    1   2   3   4   5

    least   most

    supportive   supportive

4. Regulate my pain medications so that I am physically comfortable.

1	2	3	4	5
least				most
supportive				supportive

5. Seem knowledgeable in providing care.

1	2	3	4	5
least				most
supportive				supportive

6. Do everything possible to provide the best possible care.

1	2	3	4	5
least				most
supportive				supportive

7. Assist me and my family in awareness of my medical condition and daily status.

1	2	3	4	5
least				most
supportive				supportive

8. Demonstrate care that includes comfort and symptom relief.

1	2	3	4	5
least				most
supportive				supportive

9. Spend time with me on a regular basis.

    1   2   3   4   5

    least   most

    supportive   supportive

10. Talk about any topic in which I show an in-

    terest.

    1   2   3   4   5

    least   most

    supportive   supportive

11. Express a personal interest in my welfare.

    1   2   3   4   5

    least   most

    supportive   supportive

12. Comfort my family.

    1   2   3   4   5

    least   most

    supportive   supportive

13. Perceive what the experience of illness means

    to me.

    1   2   3   4   5

    least   most

    supportive   supportive

14. Accept my feelings or ideas.

   1   2   3   4   5

least   most

supportive   supportive

15. Show signs of personal understanding of my needs.

   1   2   3   4   5

least   most

supportive   supportive

16. Notice changes in my mood.

   1   2   3   4   5

least   most

supportive   supportive

17. Understand me.

   1   2   3   4   5

least   most

supportive   supportive

18. Accept all my reactions from resentment to being OK.

   1   2   3   4   5

least   most

supportive   supportive

19. Compromise with me on a goal.

1	2	3	4	5
least				most
supportive				supportive

20. Answer questions honestly.

1	2	3	4	5
least				most
supportive				supportive

21. Cry with me.

1	2	3	4	5
least				most
supportive				supportive

22. Talk with me about my feelings.

1	2	3	4	5
least				most
supportive				supportive

23. Listen to me.

1	2	3	4	5
least				most
supportive				supportive

24. Recognize when I need to talk.

1	2	3	4	5
least				most
supportive				supportive

25. Recognize when I need to be silent.

    1   2   3   4   5

    least   most

    supportive   supportive

26. Hold my hand.

    1   2   3   4   5

    least   most

    supportive   supportive

27. Calm me when I am upset.

    1   2   3   4   5

    least   most

    supportive   supportive

28. Place me first in importance.

    1   2   3   4   5

    least   most

    supportive   supportive

29. Encourage me and my family to call.

    1   2   3   4   5

    least   most

    supportive   supportive

30. Recognize my personal qualities and needs.

    1   2   3   4   5

    least   most

    supportive   supportive

31. Inform me and my family about changes in my condition.

    1   2   3   4   5

    least   most

    supportive   supportive

32. Call my family for me, when I ask.

    1   2   3   4   5

    least   most

    supportive   supportive

33. Avoid me.

    1   2   3   4   5

    least   most

    supportive   supportive

34. Treat me as a disease rather than a person.

    1   2   3   4   5

    least   most

    supportive   supportive

35. Wear a bland facial expression.

    1   2   3   4   5

    least   most

    supportive   supportive

36. Devote time to the people who provide my care.

   1   2   3   4   5

   least   most

   supportive   supportive

37. Talk without it being an imposition.

   1   2   3   4   5

   least   most

   supportive   supportive

38. Provide prompt acknowledgment and attention to

   family members needs.

   1   2   3   4   5

   least   most

   supportive   supportive

39. Schedule time to talk about any topic.

   1   2   3   4   5

   least   most

   supportive   supportive

40. Are friendly and concerned.

   1   2   3   4   5

   least   most

   supportive   supportive

41. Act with the physician as my team.

    1   2   3   4   5

    least   most

    supportive   supportive

42. Comfort me when I am lonely.

    1   2   3   4   5

    least   most

    supportive   supportive

43. Lack concentration when we talk.

    1   2   3   4   5

    least   most

    supportive   supportive

44. Help me focus on a problem and we explore solu-

    tions.

    1   2   3   4   5

    least   most

    supportive   supportive

45. Take a personal interest in maintaining my normal

    life.

    1   2   3   4   5

    least   most

    supportive   supportive

46. Socialize with me.

| 1 | 2 | 3 | 4 | 5 |

least   most

supportive   supportive

47. Share feelings and ideas and beliefs with me.

| 1 | 2 | 3 | 4 | 5 |

least   most

supportive   supportive

48. Act as an interpreter for me as new procedures

arise.

| 1 | 2 | 3 | 4 | 5 |

least   most

supportive   supportive

49. Provide information on necessary emergency

measures.

| 1 | 2 | 3 | 4 | 5 |

least   most

supportive   supportive

50. Help me locate special equipment as needed.

| 1 | 2 | 3 | 4 | 5 |

least   most

supportive   supportive

51. Assure that nursing service is available 24 hours a day, 7 days a week.

1	2	3	4	5
least				most
supportive				supportive

52. Assure me that I can be readmitted to the hospital as my care requires.

1	2	3	4	5
least				most
supportive				supportive

53. Plan with me to talk about my feelings with other people facing the same problem.

1	2	3	4	5
least				most
supportive				supportive

54. Help me make future plans.

1	2	3	4	5
least				most
supportive				supportive

55. Help me face reality.

1	2	3	4	5
least				most
supportive				supportive

56. Stay with me during difficult times.

   1   2   3   4   5

   least   most

   supportive   supportive

57. Provide monitoring of my care.

   1   2   3   4   5

   least   most

   supportive   supportive

58. Pray with me.

   1   2   3   4   5

   least   most

   supportive   supportive

59. Talk about spiritual things.

   1   2   3   4   5

   least   most

   supportive   supportive

60. Provide for the rituals of my religion.

   1   2   3   4   5

   least   most

   supportive   supportive

61. Please list other supportive nursing actions that
    may have been omitted above.

   _____

   _____