The Degree to Which Spiritual Needs of Patients Near the End of Life Are Met

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Purpose/Objectives: To determine to what degree the spiritual needs of patients near the end of life are met.

Design: Descriptive.

Setting: One inpatient and five outpatient hospices.

Sample: 62 female and 38 male hospice patients with a mean age of 67 years; 74% were dying from cancer.

Methods: Each subject completed the Spiritual Needs Inventory and rated life satisfaction via the Cantril ladder.

Main Research Variables: Spiritual needs and life satisfaction.

Findings: Women, patients residing in a nursing home or an inpatient hospice unit, and patients with lower levels of education reported a higher number of unmet spiritual needs. Needs that could be met independently by patients and were not related to functional status were met at a higher rate than those that were dependent on others and on functional status.

Conclusions: Spiritual activities are important to patients who are near the end of life, but these patients may have a variety of unmet spiritual needs that depend on many factors, including the care setting.

Implications for Nursing: Nurses must recognize the importance of spirituality to patients near the end of life. Assessment for specific spiritual needs can lead to the development of interventions to meet those needs. Meeting patients' spiritual needs can enhance their quality of life.

The goals of care for patients near the end of life (EOL) include the prevention of and relief from the multitude of symptoms that may occur. The primary focus of symptom relief often is on patients' physical symptoms, but symptoms may be related to spiritual and psychosocial needs as well as physical needs. Quality EOL care must address all dimensions of patients—physical, psychosocial, and spiritual.

Nurses are in a unique position to discuss spiritual issues because of the amount of time they spend with patients (Field & Cassel, 1997). The literature indicates that patients may desire spiritual care (Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999), but nurses and physicians frequently omit spiritual assessment and care (Ellis, Vinson, & Ewigman, 1999; Stranahan, 2001; Taylor, Amenta, & Highfield, 1995). Spiritual care may be neglected because of healthcare providers' lack of education (Sellers & Haag, 1998; Stranahan) or lack of time (Ellis et al.). Because patients may grow spiritually and find greater meaning in life as they near the EOL (Byock, 1997), this is an important area for intervention. The purpose of the current study was to determine to what degree the spiritual needs of patients near the EOL are met.

Key Points . . .

- ➤ Nursing care for patients near the end of life must address all aspects of individuals—physical, psychosocial, and spiritual.
- ➤ Spiritual activities are important to patients as they near the end of life.
- ➤ Patients near the end of life may need assistance in meeting spiritual needs, particularly as their functional status declines.
- ➤ Nurses can support patients in meeting spiritual needs by recognizing the existence of the myriad spiritual needs patients may be experiencing and providing an environment conducive to meeting those needs.

Background

Meaning of Spirituality

Interest in the concept of spirituality has increased recently. For many years, spirituality was equated with religion; however, researchers now recognize that spirituality is a broader concept and religion is subsumed under spirituality (Flannelly, Weaver, & Costa, 2004). Spirituality involves finding purpose and meaning in life (Taylor & Ferszt, 1990) and relates to a transcendent dimension (Reed, 1992). Spirituality is multidimensional in nature and involves individuals' physical and psychosocial characteristics (Wright, 1998). In the current study, spirituality was defined as the inherent quality of all humans that activates and drives the search for meaning and purpose in life. Spirituality involves all aspects of individuals as experienced in relationships with self, others, and a transcendent dimension. A spiritual need is something required or wanted by an individual to find meaning and purpose in life. Everyone can be considered to be spiritual in nature and therefore have spiritual needs (Walter, 2002).

Literature Review

The beneficial effects of spirituality have been reported in numerous studies. Spiritual well-being has been negatively

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correlated with loneliness (Miller, 1985) and anxiety (Kaczorowski, 1989). Positive correlations have been found between spiritual well-being and hardiness (Carson & Green, 1992) and hope (Mickley, Soeken, & Belcher, 1992). In their study, Fernsler, Klemm, and Miller (1999) found that patients with colorectal cancer who had higher levels of spiritual well-being reported fewer illness-related demands than those with poorer spiritual well-being. Less symptom distress also has been associated with spirituality in patients with lung cancer (Meraviglia, 2004) and patients with a variety of cancers (Laubmeier, Zakowski, & Bair, 2004).

Spirituality is closely related to quality of life (QOL) in patients with cancer. Spirituality was a key component of QOL in ovarian cancer survivors. In one study, ovarian cancer survivors reported that spirituality helped them cope by providing a source of hope (Ferrell, Smith, Juarez, & Melancon, 2003). In another study of more than 1,300 patients with various types of cancer, the effect of spiritual well-being on QOL was as great as physical and emotional well-being (Brady, Peterman, Fitchett, Mo, & Cella, 1999).

Individuals near the EOL have identified spirituality as an important component of care. A study of more than 1,100 patients with a life expectancy of six months or less identified spirituality or religiousness as a significant dimension of care (Emanuel, Alpert, Baldwin, & Emanuel, 2000). Patients in the last months of life who were dying of lung cancer or heart failure reported that spiritual issues were of importance to them (Murray, Kendall, Boyd, Worth, & Benton, 2004). Other researchers have found that dying patients rate the significance of their spiritual issues nearly as great as pain control (Steinhauser et al., 2000). Research among hospice patients supports the notion that spirituality is imperative to QOL. McMillan and Weitzner (2000) found that patients near the EOL reported that their relationship with God contributed the most to their QOL. In addition, patients reported the least number of problems with their social or spiritual well-being when compared to their psychophysiologic and functional well-being. Spirituality is related to maintaining hope in hospice patients. Using grounded theory methodology, Duggleby (2000) found that older hospice patients with cancer maintained hope by trusting in a supreme being and finding meaning. The patients reported that hope helped them deal with their pain.

Enhanced spiritual well-being helps patients to cope more effectively with terminal illness (Lin & Bauer-Wu, 2003). The importance of spirituality to patients at the EOL has been supported; however, additional work is needed to fully understand the specific spiritual needs of patients near the EOL (Sulmasy, 2002). The current study sought to answer the following questions.

- To what degree do patients near the EOL have spiritual needs?
- What spiritual needs in patients near the EOL are not met?
- How do patients near the EOL rate their life satisfaction, and how is life satisfaction related to spiritual needs?

Methods

Data for this descriptive study were collected as part of a study to test a newly developed instrument, the Spiritual Needs Inventory (SNI), which was designed to measure spiritual needs of patients near the EOL.

Procedure

All procedures were approved by a university institutional review board and the participating hospices. Plans for the study were presented to hospice staff members. Hospice nurses, social workers, and chaplains identified patients who met the inclusion criteria, asked whether they would be interested in participating, and forwarded their names to the investigator. The investigator visited each person at his or her current residence, explained the study, and obtained informed consent. Participants rated their life satisfaction, the SNI was administered verbally, and the investigator recorded the responses. Demographic and medical data were obtained from the patients and medical records. The referring hospice staff members provided the participants' health status.

Sample and Setting

This study was conducted over a six-month period in one inpatient hospice and five outpatient hospices in the southeastern United States. To participate in the study, patients had to be at least 18 years old, alert and oriented, able to communicate in English, and willing to be interviewed for 15–30 minutes.

Instruments

Spiritual Needs Inventory: The SNI, as administered to the current study's sample, is a 27-item scale developed to measure the spiritual needs of individuals near the EOL. Items for the SNI were developed from a qualitative study of spiritual needs of dying patients (Hermann, 2001). In the qualitative study, patients identified specific spiritual needs they were experiencing as they neared the EOL. The SNI was constructed by writing an item for each spiritual need identified by the patients. For each need, subjects responded to three different questions. In the first question, "In order to live my life fully, I need to (insert spiritual need here)," subjects indicated to what degree they needed each of the 27 spiritual items. For instance, subjects responded to the degree to which they needed to laugh, pray, be with friends, enjoy nature, etc. Responses were measured on a five-point Likert scale from never to always and were added to obtain a total scale score. After subjects indicated the degree to which they needed each item, they were asked, "Do you think this is a spiritual need?" The question served the purpose of supporting or refuting that the items on the instrument were spiritual needs as opposed to needs pertaining to the physical or psychosocial aspect of the individual. The third question asked, "Is this need currently met in your life?" The instrument concluded with an open-ended question that asked patients to report any other spiritual needs they were experiencing that had not been included on the 27-item SNI.

The psychometric properties of the SNI were examined using data from the current study's sample. A thorough discussion of the development and psychometric evaluation of the SNI are reported elsewhere (Hermann, 2006). Examination of the reliability and validity of the SNI and the subsequent revisions followed the method of instrument item selection outlined by Streiner and Norman (1995). The original SNI, as used with the present sample, contained 27 items. Psychometric analysis included assessment of internal consistency by examination of item-to-total correlations and the total scale Cronbach coefficient alpha. The Cronbach coefficient alpha

of the 27-item scale was 0.81. The item-to-total correlations, obtained by correlating each item with the total scale score, ranged from 0.07–0.65. All items with correlations less than 0.20 were deleted as recommended by Streiner and Norman; as a result, seven items were deleted during the first phase of psychometric testing. Prior to the second step of psychometric evaluation, factor analysis, one additional item was deleted because two items from that theme in the qualitative analysis had been eliminated as a result of item-to-total correlations that were too low. After using factor analysis on the 19-item instrument, two more items were removed because they emerged as specific factors. Finally, a 17-item SNI emerged that explained 63.7% of the variance. Communalities ranged from 0.52–0.76. The Cronbach alpha for the 17-item SNI was 0.85. Reliability was supported because item-to-total correlations ranged from 0.33–0.67. The subscales were examined by calculating a Cronbach alpha for each subscale and item-to-subscale correlations. Correlations between the subscales were low. The correlation between unmet spiritual needs and life satisfaction was 0.17 for the 17-item SNI. Results of the tests supported the reliability and validity of the SNI.

Cantril ladder: The Cantril ladder was used to measure QOL. Many measurement issues surrounding QOL exist, and several factors must be considered when choosing a QOL instrument (Varricchio, 2006). For the current study, QOL was operationally defined as life satisfaction. Life satisfaction has been used extensively in QOL research because it often is believed to be the most important factor in determining QOL (Ferrans & Powers, 1985; Laborde & Powers, 1980). The Cantril ladder was chosen because the single-item scale measures the most important aspect of QOL—life satisfaction. It provides a global rating of QOL from the patient's perspective, does not carry a significant response burden, and is appropriate for use with patients who are near the EOL.

The Cantril ladder consists of 10 steps, with the top rung of the ladder (10) representing the best possible life imagined and the bottom rung (1) representing the worst possible life. Descriptions of the worst and best possible life are obtained from patients, and key words from their descriptions are written at the top and bottom of the ladder. Using the personally defined end points, patients are asked to rate their life satisfaction at the present time on the ladder. Patients then rate their life satisfaction for the time period immediately before receiving the diagnosis of the disease from which they were dying. The Cantril ladder has been used in the United States as well as 12 other countries (Cantril, 1965; Laborde & Powers, 1980). Content validity has been supported by interview data from 3,000 people who were questioned as to their concerns and hopes for themselves personally as well as for their countries. Quantitative comparisons of elements have been performed on factors that make for a satisfying life (Penckofer & Holm, 1984). The face validity of the scale has been supported by the relationship between the nature of the scale and the concept of life satisfaction (Laborde & Powers).

Patient description data form: A form was used to collect demographic data, medical data, and patient status. Medical records provided the patients' county of residence, age, medical diagnosis, length of time in hospice, race, and gender. Patients were asked about their religious preference, education in years, and ability to meet basic financial needs. A hospice staff member provided patients' health status.

Results

Sample

The sample of 100 patients was almost two-thirds female and predominantly Caucasian and Protestant (see Table 1). The mean age of the patients was 67 years, with a range of 21–99. Patients reported an average of 10.6 years of education, and 69% reported that their financial status was sufficient to meet their basic needs. A majority of the patients were residing on their own or in a relative's home (69%). Seventy-four percent of the sample had some type of cancer as their major medical diagnosis. Their health status was judged as rapidly declining (10%), slowly declining (56%), or stable (34%) over the past month. Fifty-six percent of the sample had been hospice patients for fewer than four months.

The relationship between demographic variables and subjects' responses was examined. Specifically, the relationships among gender, socioeconomic status, education, length of time as a hospice patient, age, place of residence, the degree of perceived need (total scale score), number of unmet needs, and life satisfaction were explored. The Mann-Whitney/Wilcoxon test for comparing two groups was used to analyze response differences for the variables of gender and socioeconomic status (see Table 2). Women reported significantly higher total scale scores ($\overline{X} = 64.27$, SD = 9.62, p = 0.0117), indicating a higher degree of need for spiritual items and more unmet needs ($\overline{X} = 4.32$, SD = 3.21, p = 0.0406) than men. Life satisfaction scores did not differ significantly between men and women. Among the socioeconomic groups, life satisfaction, total scale score, and number of unmet needs were not significantly different.

Table 1. Sample Characteristics

Variable	n
Gender	
Male	38
Female	62
Ethnicity	
Caucasian	89
African American	9
Other	2
Religious preference	
Protestant	71
Catholic	18
Other	3
None	8
Socioeconomic status	
Basic needs perceived as met	69
Basic needs perceived as unmet	31
Place of residence	
Home (own or relative's)	69
Nursing home	20
Inpatient hospice unit	11
Medical diagnosis	
Cancer	74
Congestive heart failure, coronary artery disease, or cardiomyopathy	10
Chronic obstructive pulmonary disease	7
Other	9

N = 100

Table 2. Gender and Socioeconomic Status for Life Satisfaction, Perceived Needs, and Unmet Needs

	Life Satisfaction									Spiritual Needs Inventory					
	Previous			Current			Life Change			Total Perceived Needs			Total Unmet Needs		
Variable	$\bar{X}$	SD	p	$\bar{X}$	SD	p	$\bar{X}$	SD	p	$\bar{X}$	SD	p	$\bar{X}$	SD	p
Gender			0.0676			0.7405			0.5398			0.0117			0.0406
Male	7.39	2.51		5.75	2.88		2.00	3.40		57.09	13.66		3.11	3.26	
Female	8.54	2.84		5.92	2.81		2.62	3.87		64.27	9.62		4.32	3.21	
Socioeconomic status			0.5640			0.2453			0.1869			0.5535			0.3757
Basic needs met	8.09	3.11		6.03	2.81		2.18	3.88		62.59	10.34		3.87	3.55	
Basic needs unmet	8.31	3.08		5.40	2.84		3.03	3.25		59.83	14.13		4.10	2.81	

N = 100

Relationships among the remaining demographic variables (education, length of time in hospice, age, and place of residence) and life satisfaction, total scale score, and number of unmet needs were analyzed using the Kruskal-Wallis technique (see Table 3). A significant difference (p = 0.0353) was found in the number of unmet needs for those with 1–8 years of education ($\bar{X}$ = 4.97, SD = 2.98), 9–12 years of education ($\bar{X}$ = 3.55, SD = 3.35), and 13 years or more of education ($\bar{X}$ = 3.32, SD = 3.65). No other significant differences for education level were found. No significant differences existed in subjects' responses for length of time as a hospice patient and age. Relationships between subjects' places of residence and responses were analyzed, and a significant difference (p = 0.0037) was found in the number of unmet needs reported by subjects in different places of residence. Subjects residing on their own or in a relative's home reported a mean of 3.3 unmet needs (SD = 3.29). Those residing in a nursing home reported a mean of 5.35 unmet needs (SD = 2.50). Inpatient hospice unit subjects reported a mean of 5.36 unmet needs (SD = 3.91).

Degree of Perceived Need as Measured by the Spiritual Needs Inventory

Patients were asked to what degree they required each of the spiritual needs on the SNI. Subjects responded to a Likert scale of one (never) to five (always). The distribution of responses to each item appears in Table 4. Total scale scores were calculated and ranged from 30–81 (possible range = 17–85), with a mean of 61.7 (SD = 11.7). The mean and standard deviation of each of the 17 items are listed in Table 5. Of the 17 items, laughing was rated as a need by 100% of the patients. Six other items

Table 3. Education, Length of Time as a Hospice Patient, Age, and Residence for Life Satisfaction, Perceived Needs, and Unmet Needs

	Life Satisfaction									Spiritual Needs Inventory					
	Previous			Current			Life Change			Total Perceived Needs			Total Unmet Needs		
Variable	$\bar{X}$	SD	p	$\bar{X}$	SD	p	$\bar{X}$	SD	p	$\bar{X}$	SD	p	$\bar{X}$	SD	p
Education (years)			0.8199			0.0647			0.5989			0.7450			0.0353
1–8	7.39	2.42		5.43	3.16		2.62	3.81		61.27	10.93		4.97	2.98	
9–12	8.23	3.26		6.12	2.62		2.19	3.87		62.33	12.08		3.55	3.35	
13+	8.35	1.80		5.72	2.89		2.88	3.28		60.89	12.74		3.32	3.65	
Days in hospice			0.6527			0.1828			0.2984			0.6025			0.5918
1–120	7.90	2.16		5.40	2.93		2.66	3.40		60.61	12.30		3.70	2.84	
121–365	8.63	3.53		6.19	2.66		2.54	4.38		63.56	10.81		4.08	4.08	
366+	7.80	2.39		6.80	2.62		1.00	2.31		61.30	11.56		4.70	2.91	
Age (years)			0.6562			0.0709			0.1274			0.8350			0.0716
20–29	7.00	1.41		8.00	2.83		1.00	4.24		60.00	–		1.50	0.71	
30–39	9.00	1.23		4.60	1.95		4.40	2.41		67.80	8.53		6.20	4.44	
40–49	9.33	1.16		5.33	4.51		4.00	3.61		62.33	14.22		3.33	4.16	
50–59	7.72	1.97		6.44	2.31		1.28	3.12		57.28	14.32		2.39	3.79	
60–69	8.58	4.79		4.42	2.19		4.16	4.68		63.16	11.50		3.85	3.18	
70–79	8.10	1.59		6.44	2.69		2.00	2.88		61.61	12.15		4.28	2.98	
80–89	7.77	2.88		5.41	3.54		2.35	4.19		63.00	9.44		4.67	3.20	
90–99	9.50	0.71		9.50	0.71		–	–		62.50	2.12		0.50	0.71	
Residence			0.8209			0.3166			0.3833			0.1940			0.0037
Home	8.19	2.94		6.10	2.64		2.20	3.54		62.82	11.28		3.30	3.29	
Nursing home	7.95	2.72		5.10	3.26		3.05	3.92		61.11	11.83		5.35	2.50	
Inpatient hospice unit	8.36	1.75		5.55	3.05		2.82	4.46		55.50	13.16		5.36	3.91	

N = 100

Table 4. Degree of Perceived Need

Item	N[a]	Frequency That Item Is Needed				
		Never	Rarely	Sometimes	Frequently	Always
In order to live my life fully, I need to						
Sing or listen to music.	100	20	9	22	24	25
Laugh.	100	–	7	25	27	41
Read a religious text.	100	20	13	18	23	26
Be with family.	100	4	1	15	32	48
Be with friends.	100	4	3	27	38	28
Talk with someone about spiritual issues.	100	21	6	30	28	15
Have information about family and friends.	98	12	–	22	21	43
Read inspirational materials.	99	32	7	23	23	14
Use inspirational materials.	99	41	7	16	14	21
Be around children.	100	17	5	27	27	24
Be with people who share my spiritual beliefs.	99	12	3	17	32	35
Pray.	100	5	1	9	19	66
Go to religious services.	100	15	6	12	26	41
Think happy thoughts.	100	2	1	23	21	53
Talk about day-to-day things.	100	5	8	23	26	38
See the smiles of others.	100	3	1	11	24	61
Use phrases from religious text.	99	35	6	21	20	17

[a] Fewer than 100 attributable to missing data

were perceived as needs by 90% or more of the subjects. From 80%–89% of the sample perceived six additional items as needs. Thus, of the 17 items, 13 were rated as needs by 80% or more of the sample. One item, talk with someone about spiritual issues, was rated as a need by 79% of the patients. Two items dealing with inspirational materials were rated as needs by some patients. Reading inspirational materials was rated as a need by 68% of the patients, and 59% reported that using inspirational materials was a need. Sixty-five percent of the subjects reported that using phrases from a religious text was a need. Scores were calculated for each subscale on the SNI. Table 6 reports the range, possible range, and mean of responses for each subscale.

Perception of Needs as Met or Unmet

Subjects were asked whether each need currently was being met in their lives. Not one need was met for every subject, although the need to pray was met for 96% of patients. Five needs were perceived as met by 80%–89% of the sample: sing or listen to music, use inspirational materials, talk about

Table 5. Spiritual Needs

Item	Subjects Perceived Item as a Need (%)	Extent of Need[a]		Subjects Perceived Need as Met (%)
		$\bar{X}$	SD	
In order to live my life fully, I need to				
Sing or listen to music.	80	3.250	1.445	80
Laugh.	100	4.020	0.974	65
Read a religious text.	80	3.220	1.474	64
Be with family.	96	4.190	1.002	65
Be with friends.	96	3.830	1.006	64
Talk with someone about spiritual issues.	79	3.100	1.337	75
Have information about family and friends.	88	3.847	1.327	77
Read inspirational materials.	68	2.798	1.464	69
Use inspirational materials.	59	2.667	1.623	86
Be around children.	83	3.360	1.360	72
Be with people who share my spiritual beliefs.	88	3.758	1.302	74
Pray.	95	4.400	1.044	96
Go to religious services.	85	3.720	1.436	30
Think happy thoughts.	98	4.220	0.970	76
Talk about day-to-day things.	95	3.840	1.170	82
See the smiles of others.	97	4.390	0.942	81
Use phrases from religious text.	65	2.778	0.737	86

[a] Based on responses to a Likert scale from 1 (never) to 5 (always).

Table 6. Mean Subscale Scores

Subscale	Actual Range	Possible Range	$\bar{X}$
Outlook	8–25	5–25	19.8
Inspiration	4–20	4–20	13.4
Spiritual activities	3–15	3–15	8.3
Religion	2–10	2–10	8.1
Community	3–15	3–15	11.9

N = 100

day-to-day things, see the smiles of others, and use phrases from a religious text. Five items were met in 70%–79% of patients' lives: talk with someone about spiritual issues, have information about family and friends, be around children, be with people who share spiritual beliefs, and think happy thoughts. The items that reportedly were met in 60%–68% of subjects' lives were laughing, reading a religious text, being with family, being with friends, and reading inspirational materials. One item, the need to go to religious services, was met in only 30% of patients' lives.

Current and Prior Life Satisfaction

Of the 100 patients, 98 rated their current life satisfaction and 95 rated their previous life satisfaction on the Cantril ladder. A few individuals were unable to decide on a number. The mean current life satisfaction score was 5.8 (SD = 2.8, range = 1–10). Patients rated their current life satisfaction on the Cantril ladder as follows: 8 patients selected 1, 4 patients selected 2, 9 patients selected 3, 12 patients selected 4, 26 patients selected 5 or 6, 7 patients selected 7, 8 patients selected 8, 9 patients selected 9, and 15 patients selected 10. Life satisfaction scores for the time prior to diagnosis ranged from 1–10 with a mean of 8.1 (SD = 2.7). Most patients highly rated their previous life satisfaction, with 74% rating it as 7 or more.

The amount of change from previous life satisfaction to current life satisfaction was examined. Sixty-eight percent (n = 66) of the subjects rated their current life satisfaction lower than their previous life satisfaction, 11% (n = 10) reported that their life satisfaction was the same for both time periods, and 21% (n = 20) reported an increase in life satisfaction. Of those who reported an increase in life satisfaction, seven subjects (8%) rated their current life satisfaction four numbers higher than their previous life satisfaction. Thirteen percent of subjects increased their life satisfaction rating by three (n = 2), two (n = 6), or one (n = 4). The relationship between unmet spiritual needs and life satisfaction was r = –0.17.

Other Spiritual Needs Identified by the Subjects

The final question on the SNI asked subjects to identify other spiritual needs that they were experiencing that had not been discussed. Few additional spiritual needs were identified. The top five additional needs were talk with or visit with a minister (n = 9), be prayed for (n = 5), receive communion (n = 4), visit with a hospice chaplain (n = 3), and be healed (n = 3).

Discussion

The finding that the majority of demographic variables had no bearing on spiritual needs was unexpected. Socioeconomic status (basic financial needs met or unmet) did not affect spiritual needs, which is interesting. Perhaps no difference among the various socioeconomic groups was found because of the nature of spiritual needs. Many of the spiritual needs related to the presence of others or independent activities such as prayer or reading. Those needs can be fulfilled regardless of financial resources. In addition, all subjects were hospice patients, and the philosophy of hospice is holistic care. Effective interventions for spiritual needs may have been provided, thus meeting patients' spiritual needs even though other basic needs were perceived as unmet.

Women typically indicate higher levels of religiosity (Reed, 1986) and spirituality (Fernsler et al., 1999; Reed, 1987) than men. The findings of the current study support that assertion. Not only did women indicate more frequently than men that they needed to engage in the activities on the SNI for a fulfilling life, but they also reported a higher number of unmet spiritual needs.

Several needs on the SNI related to being with family, friends, or children and being with people to share or discuss spiritual beliefs. Therefore, the difference in the number of unmet spiritual needs for individuals in various residences was not surprising. Those needs could be met more readily in a private residence than a nursing home or inpatient hospice unit. Subjects with eight years of education or less had a higher number of unmet needs. Perhaps those subjects were less aware of the resources available to meet their spiritual needs.

The total scale score indicated that, to live their lives to the fullest, patients had a great need for the spiritual activities on the SNI. Variability in the responses was good, however, lending support to the sensitivity of the instrument. The variability in responses underscores previous findings that indicate that all individuals experience different spiritual needs as they move toward death (Vassallo, 2001). Five items on the SNI had means greater than 4.0, and three were in the outlook scale. Subjects clearly conveyed that the need to laugh, see people smiling, and think happy thoughts were of great importance. Items relating to reactions such as laughing and smiling typically are not included on other spirituality instruments, yet patients need these items a great deal, which is an important finding.

The need to pray was viewed by subjects as their most salient spiritual need. Many patients said that even if they could not do anything else, they could pray. Others said that they did not believe they could cope with their situation if they were unable to pray. Subjects reported praying for a variety of reasons such as relief from pain, forgiveness of sins, courage, a peaceful death, and the well-being of loved ones. Although the subjects overwhelmingly indicated the need to pray, healthcare professionals must recognize that prayer may be a source of conflict. Taylor, Outlaw, Bernardo, and Roy (1999) found that patients with cancer expressed many doubts about their prayers, including their appropriateness and effectiveness.

One item, be with family, had a mean of 4.19, indicating a high degree of need among the subjects; however, variability was obtained in the responses. Forty-eight percent of the subjects reported they always wanted to be with family, whereas 47% indicated their need was sometimes or frequent. Strength gained from relationships with family members was noted in patients with end-stage lung cancer or heart failure (Murray

et al., 2004); however, several subjects indicated their need for time away from family. Fifty-two percent of subjects did not rate the need to be with family as always, indicating that even dying patients need time to themselves or away from family members. Nurses must assess patients' desires related to visits from family as well as other individuals.

Subjects in the current study indicated that their spiritual needs were met at a moderate to high rate. Needs that could be fulfilled by subjects independently were met at a higher level than those that required the cooperation of others. For instance, the need to pray, which can done independently, was met in 96% of subjects' lives. The four individuals who reported that need as unmet stated that they were unable to concentrate because of medications and lack of uninterrupted, quiet time. The needs of using phrases from a religious text and using inspirational materials were met in more subjects' lives than the needs of reading a religious text and reading inspirational materials. The finding is interesting because the need to use those materials was reported by fewer subjects than was the need to read them.

Needs involving being with others often were rated as unmet. Again, lack of control over the ability to meet the needs contributed. The only item that was unmet in most of the subjects' lives was the need to go to religious services. Not only did dependence on others affect the fulfillment of this need, but subjects' functional status also impacted its fulfillment.

When subjects provided additional spiritual needs not listed on the instrument, they most frequently were related to religion. Visiting or talking with a minister was mentioned by several participants. A broader need for talking with someone about spiritual issues was included on the instrument as opposed to specifically talking with or having contact with a minister. Perhaps talking with a minister entails much more than merely talking about spiritual issues. In addition, although people increasingly view spirituality as encompassing much more than religion, spirituality does have a direct connection with religion for many people (Sulmasy, 2002). Another spiritual need subjects identified that was not on the SNI was the need to be prayed for. In his discussion of spiritual healing, Aldridge (1993) discussed the value of being prayed for. Patients with cancer currently being treated reported prayer to be an important part of a spiritual event designed for patients with cancer (Dann & Mertens, 2004). The value to the dying patient of being prayed for needs to be explored further.

The dying process brings the potential for growth and distress (Reed, 1987), which is supported by subjects' scores on previous and current life satisfaction. The number of subjects who rated their current life satisfaction higher than their previous life satisfaction was an unexpected finding. This investigator reviewed all of the ratings provided by all subjects to ensure their understanding of the scale but took care to ensure that the subjects who indicated higher current life satisfaction than previous life satisfaction understood the directions. Subjects whose life satisfaction scores increased from past to present were asked whether they could provide a rationale for an increase in life satisfaction even though they were dying. Subjects provided reasons such as "I've done a lot of soul searching," "I have things in the right perspective now," "I have my priorities straight," "I've grown so much through this," "I've gotten so much closer to God," "My relationship with my family has really improved," "I know what's important in life," and "I don't have much longer. I've decided I'm going to make the best of it." Positive feelings about QOL have been found in other studies of patients with advanced cancer (Spiroch, Walsh, Mazanec, & Nelson, 2000) as well as hospice patients (McMillan, 1996).

The negative correlation (–0.29 for the original 27-item SNI scale, –0.17 for the 17-item SNI scale) between life satisfaction and number of unmet spiritual needs demonstrated a trend that indicated that as the number of unmet needs increased, life satisfaction decreased. The correlation was not strong; however, it demonstrated a general trend of unmet spiritual needs leading to decreased life satisfaction. The Cantril ladder is a widely accepted tool for the measurement of QOL, but other tools are more multidimensional in nature. A more comprehensive measure of QOL may yield a different correlation with spiritual needs.

Limitations

One limitation of the current study is that data were obtained using the SNI, a newly developed instrument. Initial psychometric analysis indicates good reliability and validity of the scale (Hermann, 2006); however, further testing is warranted. The lack of variability in the sample limits generalizability of the study findings. The majority of the sample was comprised of Caucasian, Protestant women. Moreover, all of the subjects were hospice patients and were receiving multidisciplinary care provided by experts in EOL care. Dying patients who are not in hospice may have different needs related to spiritual care. In addition, the subjects in the study likely were the most functional and stable hospice patients. Those who were extremely debilitated or actively dying were not able to participate. Results of the current study might have been different with a random sample of all hospice patients. The elimination of patients closest to death always is a limitation of EOL research. Although most data collection occurred when the investigator was alone with the subjects, some interviews took place in the presence of others such as hospice staff or family members. Individuals may have responded differently while in the presence of others.

Nursing Implications

The findings of the current study suggest that spiritual activities are important to patients who are near the EOL. Spiritual needs are diverse and include concepts that nurses may not traditionally classify as belonging in the spiritual realm; therefore, nurses must be aware of the broadness of spirituality. Spirituality encompasses much more than formal religion. Patients may express spiritual needs in subtle ways such as asking why they have cancer or why they are suffering. Nurses must assess for spiritual needs with an open mind and be able to assist patients in exploring their needs from a broad perspective. Even individuals who do not view themselves as religious have spiritual needs. In fact, patients who have never had connections to formal religion and seem least likely to desire spiritual care may derive the most benefit from appropriate spiritual care (Kennedy & Cheston, 2003). However, many patients express their spirituality in religiously connected ways (Sulmasy, 2002), so assessing patients' desires for more traditional religious needs, such as communion, is essential.

Nurses must be aware that patients have different spiritual needs depending on many factors, including available support,

functional status, and care setting. Activities that can be performed independently by patients can be met more easily than those that require the presence of others. Nurses can encourage patients to use strategies they can employ independently, such as prayer, to meet their spiritual needs. Providing quiet time for prayer and reflection can be incorporated into patients' plans of care. Nurses must recognize that some spiritual needs cannot be met independently, and nurses must take action to facilitate meeting such needs. For example, functional status may prohibit patients near the EOL from attending religious services. Alternatives such as watching televised services or listening to recorded services can be explored. The recognition that dying patients frequently desire others to be present mandates that nurses ensure the environment is conducive to the presence of family and friends. Patient support systems should be assessed to identify those who could assist in meeting patients' spiritual needs that require the presence of others. However, as patient advocates, nurses also must support patients when they wish to be alone. Because patients in care settings other than their homes reported a higher number of unmet spiritual needs, nurses must be especially cognizant of environmental effects on patients' ability to meet their spiritual needs.

Spiritual needs extend far beyond religion; therefore, the use of a formal assessment instrument, such as the SNI, could assist in the identification of specific spiritual needs and lead to the development of useful interventions. A structured assessment tool is necessary because previous research has found that patients may not be able to relate to a broad question about spiritual needs (Hermann, 2001; Taylor, 2003). Patients have been found to have differing expectations concerning the role of nurses and other healthcare professionals in providing spiritual care (Murray et al., 2004; Taylor & Mamier, 2005). Nurses may be the initial screen for identifying spiritual needs (Logan, Hackbusch-Pinto, & De Grasse, 2006), but nurses must realize that not all patients may want spiritual care from nurses, even when spiritual needs are apparent. Not only is a careful assessment of spiritual needs important, but a determination of whether patients want nursing care directed at those needs must be made. Although nurses are obligated to perform some type of spiritual assessment, other members of the healthcare team, such as chaplains, may be consulted to intervene for identified needs (Sulmasy, 2002). Simple interventions such as taking the time to actively listen can help patients express their various spiritual needs (Tan, Braunack-Mayer, & Beilby, 2005). Showing kindness and respect (Taylor, 2003), creating a supportive culture (Logan et al.), and simply caring (O'Gorman, 2002) have been found to support spirituality. A unique finding of the current study is patients' desire for smiling and laughing. Patients near the EOL may desire cheerfulness. Caregivers, friends, and families may think laughing and joking are inappropriate with patients who are near death, yet patients expressed the need to smile and laugh. Nurses can serve as role models for the inclusion of general cheerfulness and possibly humor in the care of patients.

Nurses must be aware of groups that have a greater potential for unmet needs, such as women, those receiving care in institutions, and those with lower educational levels. Although lack of variability in the current study's sample made evaluating the effects of culture on spiritual needs impossible, spiritual beliefs and culture do influence how individuals view and prepare for death (Taylor, 2001).

Implications for future research include studies to further establish the psychometric properties of the SNI. Sulmasy (2002) noted the lack of available instruments to measure spiritual needs of patients at the EOL; therefore, additional development and testing of the SNI are needed. The correlation of unmet spiritual needs and life satisfaction decreased when the scale was reduced from 27 to 17 items, which may indicate that some of the deleted items should be reexamined for inclusion in future testing. In addition, using a more comprehensive measure of QOL may be warranted. Future testing needs to be conducted with a more diverse sample of dying patients. The spiritual needs of patients who are near the EOL and receiving hospice care should be compared with those of patients who are near the EOL but not in a hospice.

Few studies have examined the effectiveness of spiritual interventions. Studies are needed that examine the effects of spiritual interventions in helping patients cope at all points of the cancer trajectory, including at the EOL.

Conclusion

Care for patients near the EOL must address all aspects of individuals, including the spiritual dimension. The definition of spirituality has evolved in recent years to be much more inclusive than religiosity, but agreement about its precise meaning still is lacking (Bregman, 2004). However, spirituality is important for individuals as they near the EOL, and meeting spiritual needs may help them to achieve better QOL. Nurses are an integral part of spiritual care as they often are the healthcare professionals who spend the most time with patients and are present when spiritual needs arise. Nurses must recognize the breadth of spiritual needs and intervene appropriately to meet patients' needs. The time prior to death can be one of personal growth that leads to increased life satisfaction. Spiritual care is essential to facilitate well-being in patients near EOL. Nurses play an important role in the provision of that care.

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