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HIV/AIDS Patients' Perceptions of Nurse Caring Behaviors

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ABSTRACT

HIV/AIDS PATIENT'S PERCEPTIONS OF NURSE CARING BEHAVIORS

By

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The purpose of this descriptive study was to examine which nurse caring behaviors HIV/AIDS patient's perceived as most important. Subjects were recruited from an HIV/AIDS clinic in a large Midwestern city. Twenty-three subjects completed Cronin and Harrison (1988) Caring Behaviors Assessment (CBA) along with a patient demographic questionnaire and an open ended question asking, "Is there anything else a nurse could do to make you feel care for or about? If so what?".

Results of this study suggest that HIV/AIDS patients perceive expressive nurse caring behaviors, such as, listening to the patient, treating the patient with respect, and knowing when to call the doctor as the most important. There were no significant relationships between demographic data and CBA subscale scores at the .05 significance level. A weak relationship was noted between education level and caring items. Subjects with a high school education or less rated caring behaviors higher than did subjects with some college education ($t = 2.65$; $df = 21$; $p = .01$).

Dedication

This thesis is dedication to my husband David, whose continued love, support, encouragement, and quick typing abilities made completion of this thesis possible.

You are my sunshine.....

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CHAPTER 1

INTRODUCTION

From the days of Florence Nightingale to the present, the concept of caring has been the emblematic role for the nurse (Dyson, 1996). Caring has been described as the central and unifying domain for the body of knowledge and the practice of nursing (Lenininger, 1981). Nursing theorist Jean Watson (1985) defines caring as, "the most universal, the most tremendous, and the most mysterious of cosmic forces" (p. 32). She believes that human caring is the moral idea of nursing, with the goal of caring being enhancement, protection, and preservation of humanity and human dignity.

According to Morse, Bottorff, Neader, & Solberg (1991) the concept of caring brings an increase in theory, practice, education, and research to the profession of nursing. The term caring has several definitions and meanings and is one of the least understood defining concepts used by the nursing profession. Morse et al.,

(1991) categorized the concept of caring into five subgroups: caring as a human trait; caring as an interpersonal interaction; caring as an affect; caring as a moral imperative; and caring as an intervention. Mullins (1996) describes caring in terms of nurse behaviors that are acknowledged by patients as being caring, such as, providing comfort and support, passing medications, and patient teaching. The use of nursing caring behaviors allows patients to feel cared for (Larson, 1987). A study by Larson & Fereketich (1993), found that the perceived degree of caring correlates with patient satisfaction. In a 1995 associated study, Langer and Hutelmyer consider patient satisfaction with healthcare one measurement of quality of care.

Nurses believe the care they provide offers healing, curing, and an improvement of health for the patient (Wolf, Giardino, Osborne, & Ambrose, 1994). Although several studies of nurse caring behaviors have been done, the majority of these studies were conducted in hospital settings and focused on nurses' perceptions of their own important caring behaviors. Few studies have been done concerning patient's perception of important nurse caring behaviors by individuals infected with the Human

Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS). HIV is the virus that causes AIDS. AIDS is a life threatening disease characterized by progressive and irreversible damage to the immune system. AIDS is diagnosed when a person infected with HIV exhibits one or more or the following: CD4 count less than 200 cells/mm^3 and/or signs of opportunistic infections, such as, Pneumocystis carinii pneumonia, cryptocoocal meningitis, or toxoplasma encephalitis (Godofsky, Gallant, Zurlo, Shaw, & Bergethon, 1996). Today, with increasing numbers of persons in the United States diagnosed with the AIDS syndrome, nurses are challenged with the task of providing this population with quality, theory-based care. According to Watson,(1985), human caring is required when a cure is possible, and is equally as important when a cure is not possible, as with the HIV/AIDS patient.

In 1988, The Denver Nursing Project in Human Caring (DNPHC) instituted a nurse-directed, outpatient health care facility dedicated to patients living with the HIV/AIDS virus (Neil, 1994). The DNPHC is based on Jean Watson's theory of human care nursing. The DNPHC gained popularity within the HIV/AIDS patient population as a place to come for acceptance, treatment, friendship, and belonging.

Schroeder & Maeve (1992) evaluated the DNPHC and found that patients, their families, extended families, friends, partners, and various staff from referring agencies described positive nurse caring behaviors as the following:

> flexibility, acceptance, unconditional support, lack of fear of contagion, touch, hugs, listening, competence, friendship, taking time out for clients, the ability to help clients make choices, and to be self-determined... (p. 27)

Studies indicate that patients and nurses differ on their perceptions of what constitutes caring behaviors (Larson & Ferketich, 1993). In a 1988 study by Cronin and Harrison, patients were found to give highest regard to caring behaviors that concerned or enhanced knowledge, skill, and judgment capabilities of the professional nurse. Nurses on the other hand, tend to feel that listening to patients, touching patients, and always putting the patient first are the most important nurse caring behaviors (vonEssen & Sjoden, 1991).

Problem Statement

As the impact of HIV/AIDS increases in the United States and throughout the world, it becomes increasingly

important to examine the health care perceptions and experiences of this population (Stone, Weissman, & Cleary, 1995). Nurses in outpatient settings are seeing an increase in the number of patients who are HIV positive or who present with AIDS defining illnesses (Laschinger, Goldenberg, & Bello, 1995). According to the U. S. Department of Health & Human Services (1994), the World Health Organization predicts that by the year 2000 there will be between 30-40 million men, women, and children infected with HIV world wide (pg. iii). For the year 1997, there were a total of 641,086 reported cases of persons infected with HIV in the United States (MMWR, 1997).

The stigma associated with HIV/AIDS can cause those infected to develop a sense of isolation, discrimination, defenselessness, and abandonment from society (Gillispie & Davis, 1996). By understanding patient's perception, the nurse can help provide an environment to relieve the HIV/AIDS patient from the stigmas of society.

Significance to Nursing

Nurse caring behaviors can increase a patient's ability to cope and deal with stress more effectively, thus having a positive impact on the patient's health. It is the nurses' role to join the patient in his or her journey, to share joy

and pain and to remain connected to the patient through the caring process (Schroeder & Malve, 1992). There needs to be a clearer understanding of which nursing behaviors convey caring (Cronin & Harrison, 1988). This can be done by examining the HIV/AIDS patient's perception of caring nurse behaviors.

Purpose

The purpose of this study is to determine which nursing behaviors are perceived by patients infected with HIV or AIDS as the most or least caring. This study will contribute to a body of knowledge that will serve to enhance the quality of nursing care to this population.

CHAPTER 2

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

REVIEW OF LITERATURE

While there are several studies concerning nurse caring behaviors, few are focused on the HIV/AIDS patients' perceptions of important nurse caring behaviors. This section includes a review of various caring assessments which address important caring behaviors from both the nurse and patient perspective.

Cronin & Harrison (1988) developed the Caring Behaviors Assessment (CBA) instrument to measure nurse caring behaviors as perceived by 22 hospitalized myocardial infarction patients. Along with the CBA, patients were asked the open-ended question "While in the coronary care unit, what things did nurses say or do that made you feel cared for and about?". The CBA instrument used a 5 point Likert-scale with five being the highest value placed on nursing caring behaviors. There was a total of 61 questions on the CBA with identified nursing caring behaviors subgrouped into seven categories congruent with Jean

Watson's (1985) Human Caring Theory: humanism/faith-hope/sensitivity, helping/trust, expression of positive/negative feelings, teaching/learning, supportive/protective/corrective environment, human need assistance, and existential/phenomenological/spiritual forces.

In the 1988 Cronin and Harrison study, patients ranked the human needs assistance subscale as the most important nurse caring behavior. This subscale contained items such as: "knows what they are doing", "make me feel someone is there if I need them", and "know how to give shots". The lowest ranking items on the CBA: "visit me when I move to another hospital unit", "ask me what I like to be called", and "touch me when I need it for comfort", were from the expression of positive and negative feelings subscale. There were no differences found at the .05 significance level between caring behaviors identified with the CBA instrument and demographic data such as; sex, age, education level, previous coronary care unit (CCU) experience, and length of CCU stay. Patients with previous CCU experience, however, rated expression of positive and negative feelings higher than those subjects who had no previous CCU experience.

Limitations to this study by Cronin & Harrison (1988) are its small sample size and first time use of the CBA tool. Another limitation of this study was the time needed to complete the survey. It was estimated that the survey took approximately one hour to complete.

The surgical patient's perceptions of perioperative nurse caring behaviors was studied by Parsons, Kee, & Gray (1993). A convenience sample of 19 patients over the age of 18 who were scheduled for surgical or diagnostic procedures and a hospital stay of less than 24 hours were used in this study. Participants were asked to complete a revised version of the Caring Behaviors Assessment (CBA) and rank their perception of the most to least important nurse caring behaviors during their perioperative experience. Eight items from the original 63 item CBA were eliminated for this study. Along with the CBA, participants were also asked to describe, in their own words, which nursing behaviors they perceived as caring during their perioperative experience.

Results of this study are parallel with the findings of Cronin & Harrison (1988). The highest ranking nurse caring behavior for surgical patients was equally ranked between "know what they are doing" and "be kind and considerate" with means of 4.947 and standard deviations of 0.229

(Parsons et al., 1993). The least ranking important nurse caring behaviors were listed as "understand when I need to be alone" and "visit me when I move to another hospital unit". Mean ranks equaled 1.947 and 1.316 with standard deviations of 1.224 and 0.671 respectively. Subjects identified teamwork, the provision of a relaxed environment, and the professional demeanor of the nurse as important nurse caring behaviors not included with the CBA measurement tool (Parsons et al., 1993).

A Kruskal-Wallis one way analysis of variance was used to determine if the seven subscales would be ranked differently if subjects were grouped by descriptive information such as: sex, age, education, and income levels. No significant differences were found.

A limitation to this study was its small sample size. In addition, the short time the patient is actually cared for by the nurse in perioperative surgery may lead the patient to make generalizations about nurse caring behaviors by relating them to past hospital experiences. This may not reflect the perceived needs of perioperative surgical patients toward nurse caring behaviors but more broadly determine which nurse caring behaviors are important to hospitalized patients.

Huggins, Gandy, and Kohut (1993) analyzed which behaviors performed by emergency department nurses were perceived by patients as caring. They replicated and extended the study done by Cronin and Harrison (1988) by substituting emergency patients for coronary care patients. This descriptive study obtained participants from two private urban emergency departments. A total of 288 patients were interviewed by telephone within 30 days of discharge. Subjects were divided into three groups depending on their acuity level; emergent, urgent, and non-urgent. A revised version of the Caring Behaviors Assessment (CBA) tool was used. The modified tool contained 53 nursing behaviors that patients rated on a 4-point ordinal scale from (1) unimportant to (4) an absolute must. This study used six subscales to reflect Watson's (1985) Carative factors versus the original seven subscales used by Cronin and Harrison (1988). The seventh subscale existential/ phenomenological/spiritual forces was not included in this study due to the brevity of the patients interaction with the nursing staff.

Results of this study are congruent with those of Cronin and Harrison (1988), and Parsons et al., (1993). Patients rated subscale six, human needs assistance, as the

most important nurse caring behavior with the highest rated items being "know what they are doing" and "treat you with respect" Huggins et al., (1993).

Limitations to the Huggins et al., (1993) study were that only patients with telephones were included, patient's caregivers were allowed to answer questionnaires, and time lapse between emergency room visit and time to telephone interview was extended up to thirty days. The ability to generalize from this study is also limited as only emergency room patients were used. The use of a modified CBA tool weakens the use of reliabilities and validity in relation to the original CBA.

Wolf et al., (1994) studied the dimensions of nurse caring using nurse and patient responses to the Caring Behaviors Inventory (CBI). The CBI is a 75 item questionnaire looking at dimensions involved with nurse caring behaviors as observed by nurse and patient perceptions. The study consisted of 541 subjects, 278 nurses and 263 patients, and was conducted in both secondary and tertiary health care settings. The study used a revised (CBI) that included 43 of the original 75 items. A 4-point Likert scale was used to measure responses to the

questionnaire with scoring as follows; (1) strongly disagree to (4) strongly agree.

Results of the CBI revealed five dimensions to the process of nurse caring. These five dimensions are: respectful deference to the other; assurance of human presence; professional knowledge and skill; positive connectiveness; and attentiveness to the other's experience. These five dimensions are congruent with Watson's (1988) theory of human caring and particularly linked to her theory of transpersonal caring. A limitation to the study by Wolf et al., (1994) was the use of convenience sampling technique rather than randomization.

Rosenthal (1992) studied coronary care patients' and nurses' perceptions of important caring behaviors by using Larson's (1986) Caring Assessment Inventory (Care-Q) tool. The Care-Q assessment involved a forced choice format and priority ranking of cards containing statements comparing most to least important nurse caring behaviors. The sample consisted of 30 patients and 30 nurses from three hospitals in a large western metropolitan city. Each group was asked to rank 50 identified nurse caring behaviors from most to least important.

Results indicated that patients and nurses differed on their perceptions of important nurse caring behaviors (Rosenthal, 1992). Patients chose instrumental care, such as, "knowing how to give shots", "managing equipment", and "responding to patient calls" as being the most important. Nurses perceived expressive care, "listening to the patients", "touching the patients when he or she needs comfort", and "knowing when to call the doctor" as the most important nurse caring behaviors.

A limitation to Rosenthal's (1992) study was the Care-Q's forced choice method. This method limited patient's and nurse's own ideas and expressions of nurse caring behaviors.

Larson's past studies, spanning 11 years, concentrated on the concept and critical dimensions of caring of the adult medical-surgical patient. The study by Larson and Ferketich (1993) expanded on Larson's previous studies. This 1993 descriptive correlation study involved 268 hospitalized adult medical-surgical patients from four hospitals located in the western United States. Inclusion criteria were age greater than 18, ability to read English, readiness for discharge within 48 hours, and willingness to complete the questionnaire.

The four hospitals from which subjects were recruited were categorized as: hospital A, ($\underline{N}$ = 88) a research and teaching hospital; hospital B, ($\underline{N}$ = 130) a research and tertiary care hospital; hospital C, ($\underline{N}$ = 32) a teaching and research hospital; and hospital D, ($\underline{N}$ = 18) a community hospital (Larson & Ferketich, 1993). Patients were asked to complete the Care Satisfaction Questionnaire (Care/Sat), a questionnaire containing 50 questions from a revised version of Larson's (1987) measurement tool, the Care-Q. The Care/Sat is a visual analog scale measuring overall satisfaction with nurse caring behaviors. Individual responses ranged from strongly disagree to strongly agree.

Results from the Care/Sat were positively skewed, indicating patients believed they had experienced nursing caring behaviors (Larson & Ferketich, 1993). The Turkey B post hoc test showed a .05 significant level of difference between patient satisfaction and nurse caring behaviors within the four hospitals. Patients in hospital D indicated they were more satisfied with their care than those patients from hospitals A, B, and C.

A limitation to the study was the pilot use of the Care/Sat tool. Another limitation was that the patients in hospital B were given the Care/Sat questionnaire post

discharge. This is important because hospital B had the largest number of participants, and the rest of the study participants received their questionnaires while still at the hospital.

Mullins (1996) conducted a descriptive study to identify which nurse caring behaviors were most desired by the HIV/AIDS patient. The study used the Caring Behaviors Assessment (CBA) tool developed by Cronin & Harrison (1988). Forty-six subjects were recruited from hospitals, private and public ambulatory clinics, infectious disease clinics, AIDS outreach clinics, and AIDS support groups. By using a 5 point Likert-type scale, subjects over the age of 18 with the diagnosis of HIV or AIDS were asked to rate their perception of the most to least important nursing caring behaviors using the CBA tool. Following Cronin and Harrison's original CBA tool, Mullins also added the open ended question asking "Is there anything else that nurses could do to make you feel cared for and about? If so, what?" (p. 20).

The most important nurse caring behavior identified by the HIV/AIDS patient was the item stating "treat me as an individual" with "visit me if I move to another hospital unit" as the least important nurse caring behavior (Mullins,

1996). The results of this study are congruent with the findings of Cronin and Harrison (1988) with human needs assistance being the highest ranked subscale and expression of positive and negative feeling ranking the lowest. The 11 survey items with the highest mean score ranged from 4.98 to 4.69 with the means of the ten lowest survey items ranging from 4.22 to 3.61.

Answers to the open-ended question ranged from: "just have patience and care", "realize my needs are unique and that I require as much love and support as they can give", "just never doubt how scared their patient really is and how you would feel if the shoes were on your feet" to "sometimes you might need to talk about things that seem important at the time" (Mullins, 1996, p. 21). The limitations of this study were the small sample size and the time required to complete the 63 item CBA questionnaire. It may have been too tiring for patients experiencing acute or chronic exacerbation of the HIV/AIDS virus.

Summary of Literature Review

In the review of literature concerning patient perceptions of nurse caring behaviors, the dominating behaviors perceived by patients as caring were instrumental behaviors such as "knowing how to give shots", "responding

to patients calls", "managing equipment", "doing what they say they will", and "giving treatments and medications on time". This may be explained by Maslow's hierarchy of needs in that safety and security become the emphasis as patients are dealing with basic needs (Rosenthal, 1992).

The majority of research has focused on the nurses' perspective of the HIV/AIDS patient. Mullins (1996) was one of the first nursing researchers concerned with the care of the HIV/AIDS patient. Nurses caring for HIV/AIDS patients must be knowledgeable about the disease, be skilled in technical and critical thinking, and be continuously aware of the patients body, mind, and sprit as they change and grow throughout the course of this fatal disease. Studying the desires of the HIV/AIDS patient in relationship to nursing care can help nurses identify which nursing care behaviors are deemed more important. Partial replication of studies using the CBA tool helps strengthen the validation between other nurse caring behavior studies.

Conceptual Framework

Jean Watson's (1985) theory of human caring provides the theoretical basis for this study. Watson's theory focuses on the human component of caring and the minute-to-minute interactions of the one providing care and the one

being cared for (Fawcett, 1993). Her theory is based on the assumption that human caring is the moral idea of the profession of nursing and without caring there is not nursing.

Watson's theory helps nurses understand the kind of relationship and transactions necessary between the nurse and patient to promote and protect the patient's humanity, therefore, the kinds of relationships that influence the patient's ability to heal. Using care as the moral idea of nursing, the outcome of nursing care becomes, protection, enhancement, and preservation of human dignity (1985). Watson's model of caring is based on both instrumental and affective nursing activities (Watson, 1979). Two types of expressive activities are identified: those that develop relationships characterized by trust, hope, empathy, faith, touch, warmth, sensitivity, and genuineness, and those, offering support such as surveillance and comfort. Instrumental nursing activities can be either physical action-oriented helping behaviors, such as procedures, or cognitive-oriented helping behaviors such as teaching.

Within Watson's assumptions of the human care theory (1985), she believes that care and love are the most universal, most tremendous, and most mysterious of all

cosmic forces. Watson believes caring can only be effective if it is done interpersonally. This phenomenon is called transpersonal caring and begins the moment the nurse enters the space or phenomenal field of the patient. The goal of transpersonal caring is the positive movement of the person to a higher sense of self and a greater sense of harmony with mind, body, and soul. Watson believes that transpersonal caring is accomplished through the use of Carative factors.

Watson (1979) identified 10 Carative factors that are considered the core principles to the actual nurse-patient relationship. Carative factors are combinations of nursing interventions related to the process of human caring and used in place of the medical term curative, to differentiate between nursing and medicine (Watson, 1990). They are intended to direct the human care process that enables the patient to attain or maintain health, or die a peaceful death.

The Carative factors were inspired from a humanistic philosophy and form a structure for studying and understanding the science of nursing as caring (Watson, 1979).

They are as follows:

1. formation of a humanistic-altruistic system of values
2. instillation of faith-hope
3. cultivation of sensitivity to one's self and others
4. development of a helping-trust relationship
5. promotion and acceptance of the expression of positive and negative feelings
6. use of scientific problem-solving method
7. promotion of interpersonal teaching-learning
8. provision of a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. human needs assistance
10. allowance of existential-phenomenological forces (p.9-10).

The four major concepts of human life, health, environment, and nursing can also be defined within Watson's (1985) theory of human caring. The following description of human life is based on Watson's definition of the soul:

> Human life is defined as (spiritual-mental-physical) being-in-the-world, which is

> continuous in time and space. Only to the extent that a person has fulfilled; the meaning that a being has to fulfill is something beyond the self, it is never just self (p.47)

Health is defined by Watson (1985) as the "unity and harmony within the mind, body, and soul" (p. 48). It is associated with the perceived self to the perception of experienced self.

Nursing is defined as a human science (Watson, 1985). The goal of nursing "is to help persons gain a higher degree of harmony within the mind, body, and soul which generates self-knowledge, self-reverence, self-healing, and self-care processes while increasing diversity" (p. 49). Nursing is directed at helping patients find meaning in their existence and experiences, to help discover inner control and power, and to excel at self-healing.

Environment is thought to have an effect on an individual's health (Watson, 1979). People have a need to be loved and belong. Illness can separate one from his or her environment. Caring is the key to empower individuals to cope with changes in their environment.

The goal of Watson's theory of human caring begins with the spiritual growth of the person, finding inner strength

and power, discovering meaning in one's life experiences, transcendence, and self-healing (Cohen, 1991). The focus of her theory is the relationship between person/nurse and person/patient. Watson's 10 Carative factors serve as the framework to guide nurse caring behaviors and cumulate as nursing interventions or caring processes brought by the nurse to the nurse/patient relationship. This caring occasion is defined as "the moment of coming together in a caring occasion presenting the two persons with opportunity to decide how to be in the relationship and what to do with the moment" (Watson, 1985, p. 59).

Nurse caring behaviors for this study were defined as the actions and communication techniques used by the nurse to convey caring to the HIV/AIDS patient. These behaviors were evaluated by the HIV/AIDS patient by use of Cronin and Harrison's (1988) Caring Behaviors Assessment instrument.

Research Question

The research question guiding this study was: Which nurse caring behaviors are perceived as the most important by patients infected with HIV or AIDS?

CHAPTER 3

METHODS

Research Design

This descriptive research study examined nurse caring behaviors perceived as important by patients with HIV or AIDS. The objective of descriptive research is to observe, describe, and document aspects of a condition as it naturally occurs (Polit & Hungler, 1995). Descriptive research can describe existing relationships and the frequency at which these relationships occur. It does not attempt to describe the causative relationship that one variable has upon another. Descriptive research often serves as the origin for hypothesis generation and theory development. A small study sample of under 100 subjects is adequate in capturing all relevant themes surrounding the phenomenon in a descriptive study (Polit & Hungler, 1995).

The greatest threat to descriptive research is external validity. In this study the greatest bias came from the

individual answering the questionnaire. Subjects may have felt compelled to answer the questionnaire in a less than truthful way in an attempt to anticipate what the "correct" response was.

Sample and Setting

A convenience sample of individuals was recruited from an HIV/AIDS hospital ambulatory clinic located in a large Midwestern city. The clinic used for this study was located in an office building separate from the administering hospital. The clinic offers care and counseling to approximately 385 patients with HIV/AIDS. Criteria for the sample population included individuals who: were 18 years of age or older, had a diagnosis of AIDS or HIV-seropositive status, and were mentally alert with the ability to read and write English. Twenty-seven patients received the study questionnaires and 23 were completed for a response rate of 85%.

Patients also completed a demographic data questionnaire that included questions concerning: age, sex, education, stage of illness or diagnosis, length of HIV infection, ethnic background, marital status or sexual preference, number of times hospitalized over the last year, number of medications currently taking, and an optional

question asking about history of intravenous drug use. This demographic questionnaire also included a question asking subjects to rate nursing care they received during prior hospitalizations using a Likert type scale from 0 - 10, with 0 equaling poor nursing care, and 10 equaling excellent nursing care. Forty-three percent of patients rated nursing care during prior hospitalizations as a 5 or higher and 57% ranked it 5 or lower. Mean average was 6.68 with a standard deviation of 3.61.

The sample consisted of 22 males and 1 female. Ages of the participating patients ranged from 26 to 62 with a mean of 38.65 years (SD = 9.14). Education levels varied with 50% of the subjects having a high school education or less. Thirteen subjects (56.5%) were infected with HIV and 10 (43.5%) were diagnosed with the AIDS syndrome. Length of HIV infection for the sample subjects varied between two months and 15 years with 51.7% having either HIV or AIDS for greater than seven years (M = 6.94, SD = 4.83). Sixteen (69.5%) of the subjects were Caucasian. Sixteen (69.5%) of the subjects were single and one (4.3%) subject was married. Twelve subjects (52.2%) were hospitalized at least one time over the last year; one subject (4.3%) was hospitalized three times, and eight subjects (34.8%) were hospitalized

one time. The number of medications individual subjects were currently taking ranged from 2 to 11 with a mean of 4.913 (SD = 2.74). Two (8.7%) subjects had a history of IV drug use. (See Table 1).

Table 1

Characteristics of Subjects (N=23)

Characteristic	Frequency (n)	Percent (%)
Sex:		
Male	22	95.7
Female	1	4.3
Stage of Illness:		
AIDS	10	43.5
HIV	13	56.5
Ethnic Background:		
American Indian	2	8.7
African-American	3	13.0
Hispanic	1	4.3
Caucasian	16	69.6
Other	1	4.3
Marital Status:		
Single	16	69.6
Married	1	4.3
Living with Significant Other	3	13.0
Divorced/Separated	3	13.0
History of IV drug use		
No	21	91.3
Yes	2	8.7

Instrument

For this study, two data collection tools were used, the Caring Behaviors Assessment (CBA) and a patient

demographic questionnaire (see description in previous section). The CBA was used to measure which caring behaviors HIV/AIDS patients perceived as important. Patients demographic information was obtained to determine sample characteristics.

The CBA was developed by Cronin & Harrison (1988) to assess desired nurse caring behaviors by myocardial infarction patients. The original CBA listed 61 nurse caring behaviors ordered in seven subscales that were compatible with Jean Watson's (1985) 10 Carative factors. The relationship between Watson's (1985) Carative factors, the CBA subscales, and CBA item number are illustrated on Table 2.

Based on results of Cronin and Harrison's, 1988 study, two additional items, question 50 "are gentle with me" and question 51 "are cheerful" were added to the Supportive/ Protective/Corrective Environment subscale bringing the total number of CBA items to 63. In congruence with Watson's model, the first three Carative factors, Humanism, Faith-Hope, and Sensitivity, were grouped together in one subscale within the CBA. Carative factor six, use of

Table 2

Relationship of Watson's Carative Factors to CBA Items

Watson's Carative Factors	Subscale	CBA Item
1,2,3	Humanism/Faith-hope/Sensitivity	1-16
4	Helping/Trust	17-27
5	Expression of Positive/Negative Feelings	28-31
7	Teaching/Learning	32-39
8	Supportive/Protective/ Corrective Environment	40-49
9	Human Needs Assist	52-60
10	Extential/ Phenomenological/ Spiritual Forces	61-63

Scientific Problem-Solving, was considered intrinsic to all aspects of nursing and was excluded as a subscale. Items within each of the seven subscales ranged from 3 - 16. The CBA uses a 5 point Likert-type scale with 5 equaling the most important nurse caring behavior and 1 equaling the least important caring behavior. The total possible score for the CBA is 315. The CBA is written at a sixth grade

level as determined by the Flesch Readability Formula and the Fog formula. Content and face validity were established by four content specialists schooled on Watson's conceptual model (Cronin & Harrison, 1988). The congruency of each behavior with its given subscale was rated by the panel and those items with interrater reliabilities of less than .75 were recategorized into more appropriate subscales. Internal consistency reliability was determined for the seven subscales by analyzing responses to the CBA utilizing Cronbach's alpha.

This researcher also examined internal consistency of the CBA instrument for this study population using Cronbach's alpha. Overall reliability coefficients for the CBA in this study was .95. For the seven subscales in Cronin and Harrison's (1988) study reliability coefficients ranged from 0.66 to 0.90 and from 0.69 to 0.89 for this study. See Table 3 for a summary of CBA subscales and item numbers with reliabilities from both Cronin and Harrison's (1988) study and from the current study.

The report of alpha coefficients in Cronin and Harrison's original study do not include the addition of the two items within the Supportive/Protective/Corrective Environment subscale. The original CBA designed by Cronin

and Harrison employed a mixture of nurse caring behaviors that would be acceptable for both hospital or ambulatory care nursing settings. For this study the CBA was divided into two sections with nurse caring behaviors focused more directly on ambulatory patient care comprising questions 1 - 53 and those focusing more on inpatient nursing care comprising questions 54 - 63. The original CBA questions 19, 20, 39, 40, 43, 45, 48, 57, and 59 were viewed as more inherent to hospital nurse caring behaviors and were renumbered as questions 54 - 63. The phrasing of the questions were not changed in any way. The above questions were separated to detect if HIV/AIDS patients viewed certain aspects of nursing care more important in hospital settings than in ambulatory settings. The nine inpatient focused questions were placed back in chronological order before being statistically analyzed. Permission to use the CBA for this study was granted in writing by Cronin and Harrison (See Appendix A).

An open ended question asking "while a patient at this clinic is there anything else your nurse could do to make you feel cared for and about? If so, what?", was included at

Table 3

Caring Behaviors Subscale Items and Reliabilities

Subscale (CBA Item#)	Cronbach alpha	
	Cronin & Harrison (1988)	Current Study
Humanism/Faith/ Hope/ Sensitivity (1-16)	.84	.87
Helping/Trust (17-27)	.76	.81
Expression of Positive/Negative Feelings (28-31)	.67	.88
Teaching/Learning (32-39)	.90	.73
Supportive/Protective/ Corrective Environment (40-51)	.79	.83
Human Needs Assistance (52-60)	.89	.69
Existential/ Phenomenological/ Spiritual Forces (61-63)	.66	.89

the end of the questionnaire for patients to list any additional important nursing care behaviors that may not have been included in the CBA.

Procedure

Subjects for this study were recruited as they entered the clinic for health care services. The clinic secretary gave each potential subject a packet containing the written intent and purpose of the study, the CBA questionnaire, and patient demographic survey (see Appendices B, C, & D). Subjects were informed on the purpose statement that their responses were anonymous and no names or other identifying markers were placed on any questionnaire by the researcher. Completion of the questionnaire was indicated as patient's consent to participate in this study.

Subjects independently read and answered the questionnaires. The researcher provided her name, the name and telephone number of her thesis chair, as well as, the name and telephone number of Grand Valley State University Chair of the Human Review Committee on the purpose statement for subjects to call if they had questions or concerns. Subjects were informed that neither completion or non-completion of the questionnaires would affect the quality of care they received at the clinic. Subjects were also

informed in the purpose statement that completion of the questionnaire would be used to help improve the quality of care administered by nurses and could be used as research in scientific nursing journals.

After completing the questionnaires patients were asked to place them in the collection box marked "Caring Behaviors Assessment" located in the clinic waiting room. An envelope for completed questionnaires was included in the research packet. Patients were informed that participation was strictly voluntary and that withdrawal from the study was possible up until the time they placed the questionnaires in the collection box. After such time withdrawal would be impossible due to the unidentifiable markings and anonymity of the questionnaire. Patients were also informed that after completion of the study a copy of the results would be placed at the clinic front desk for their reading.

Approval Process

Approval to conduct this research was obtained from the Human Research Review Committees of Grand Valley State University, the proposed clinic, and the clinics sponsoring hospital (see Appendix E). There were no physical risks to subject involved in this research. Emotional risks to subjects were minimized through the use of anonymity. While

the results of this study may add to the base of nursing knowledge in relationship to the care of patients, the subjects in this study did not receive any direct benefits from this research.

CHAPTER 4

RESULTS

The purpose of this research study was to identify which nursing behaviors were perceived by HIV/AIDS patients as the most important indicators of caring. Patients were asked to rank nurse caring behaviors as the most and least important on the Caring Behaviors Assessment (CBA). A total of 27 questionnaires were distributed and 23 questionnaires were completed for a return rate 85%. Statistical Package for Social Sciences (SPSS/PC+) was the software package used to analyze data for this study. A significance of $p < .05$ was used for all statistical testing.

Due to the small sample size of this study it was necessary to substitute real data values for missing values. Five items on the CBA out of a total of 1449 items were not circled. The missing data was determined to be random and missing values were replaced with the mean values for those items (Polit & Hungler, 1995).

Scores for the 63 CBA items ranged from 154 to 315. CBA items were ranked by mean scores from most to least important nurse caring behaviors. Means from the two most important items, "really listen to me when I talk" and "know what they are doing" were 5.00 and 4.87 respectively. "Talk to me about life outside the hospital" and " leave my room neat after working with me" were ranked as the least important nurse caring behaviors with means of 3.00 and 3.13. All 63 CBA items and their mean ranks are found in Appendix F. Table 4 summarizes patients' perceptions of the twelve most important nurse caring behavior and Table 5 summarizes the twelve least important nurse caring behaviors.

The overall means for each of the seven CBA subscales were calculated and ranked from most to least important according to their mean scores. Subscale one, Humanism/Faith-Hope/Sensitivity was ranked the most important with a mean score of 4.52. Subscale five, Supportive/Protective/ Corrective Environment was ranked least important with a mean of 3.81. See Table 6 for a ranking of the seven subscales from this study and Cronin and Harrison's (1988) study of myocardial infarction patients. Pearson's R Correlation was used to examine

answers to the CBA in relationship to the demographic variables; age, sex, education, stage of illness or

Table 4

Twelve Most Important Nurse Caring Behaviors for HIV/AIDS Patients

Item # on Current CBA Study	Nurse Caring Behavior	Mean	SD
17	Really listen to me when I talk	5.00	± 0.00
3	Know what they are doing	4.87	± 0.34
16	Treat me with respect	4.83	± 0.39
51	Know when it's necessary to call the doctor	4.83	± 0.49
50	Check my condition very closely	4.83	± 0.39
13	Be kind and considerate	4.78	± 0.52
47	Know how to handle equipment	4.74	± 0.54
11	Accept me the way I am	4.74	± 0.86
1	Treat me as an individual	4.74	± 0.69
31	Answer my questions clearly	4.70	± 0.88
32	Teach me about my illness	4.65	± 0.49
10	Ask me how I like things done	4.65	± 0.71

Table 5

Twelve Least Important Nurse Caring Behaviors for HIV/AIDS Patients

Item # on Current CBA Study	Nurse Caring Behavior	Mean	SD
56	Talk to me about life outside the hospital	3.00	± 1.91
59	Leave my room neat after working with me	3.13	± 1.94
58	Tell me what to expect during the day	3.17	± 1.97
57	Help me plan for my discharge from the hospital	3.22	± 2.00
55	Come into my room just to check on me	3.26	± 2.03
23	Visit me if I move to another hospital unit	3.30	± 1.55
62	Let my family visit as much as possible	3.52	± 2.11
19	Ask me what I like to be called	3.57	± 1.31
60	Give my pain medication when I need it	3.57	± 2.11
61	Check with me before leaving the room to be sure I have everything I need within reach	3.61	± 2.13
63	Help me feel like I have some control	3.74	± 2.05
41	Respect my modesty (for example, keeping me covered during exams)	3.78	± 1.31

Table 6

Ranking of CBA Subscales by Mean Values

Study Rank	Cronin & Harrison Study Rank	Subscale	Current Study Mean	Cronin & Harrison Study Mean
1	3	Humanism/Faith-Hope/Sensitivity	4.52	4.30
2	1	Human Needs Assistance	4.40	4.60
3	2	Teaching/Learning	4.33	4.39
4	4	Existential/ Phenomenological/ Spiritual Forces	4.22	4.18
5	7	Expression of Positive/Negative Feelings	4.10	3.80
6	6	Helping/Trust	4.03	3.88
7	5	Supportive/Protective/ Corrective Environment	3.81	4.12

diagnosis, length of HIV infection, ethnic background, marital status or sexual preference, hospitalizations within the last year, number of medications currently taking, and an optional question asking history of IV drug use. There were no significant relationships between any of the demographic variables and the CBA subscale scores at the .05 significance level. There was a weak relationship between caring behaviors and amount of education. Education was

divided into two groups, those with high school education or less and those with some type of college education. An independent t-test was used to determine if there were significant differences in the rating of caring behaviors between the two groups. Subjects with a high school education or less rated caring behaviors higher than did subjects with some college education ($t = 2.65$; $df = 21$; $p = .01$).

The open ended question, "Is there anything else that nurses could do or say to make you feel cared for and cared about?", was answered by three subjects. Individual responses included; "Just be themselves. Sometimes it can be very one-sided, the nurses/doctors know everything about me. It's nice to know some 'personals' about them to make the relationship more close and real so they seem more like a knowledgeable caring friend", "Follow physician's orders to the letter; focus on client centered care", and "Nurses and doctors need to treat people with AIDS/HIV as normal human beings. The worst experiences for myself were at "a" hospital. The nurses (some) were afraid of me! To touch me or even be in the same room. Knowledge is power".

Chapter 5

Discussion and Implications

Discussion of Findings

Results of this study suggests that HIV/AIDS patients perceive expressive nursing care behaviors as the most important. Expressive care includes such nurse caring interventions as "listening to the patient", "treating the patient with respect", and "knowing when to call the doctor". The results of this study differed from Cronin and Harrison's (1988) study which used myocardial infarction patients as subjects. In that study, subjects rated instrumental nursing care, such as "knowing how to give shots" and "managing equipment" as the most important.

The results of the studies by Parson et al., (1993), Huggins et al., (1993), Rosenthal (1992), and Mullins (1996) are all consistent with the findings of Cronin and Harrison (1988) and are not consistent with findings from this study. Subjects in these studies identified important nurse caring behaviors as those tasks that provide care in a technical,

competent, and professional manner. The difference in this study from previous studies may in part be explained by the differences in setting and type of subjects selected. Kyle (1995) believes patients often consider instrumental nurse caring behaviors as more important due to the fact that expressive behaviors are often "invisible" care behaviors and become noticeable only when they are absent. Hospital patients are surrounded by machines and frequently need interventions requiring nurses to DO something to them. In the ambulatory setting, patients are not surrounded as much by machines and frequently their clinic appointments are focused on talking about how their illness affects their daily life. This may be particularly true with HIV/AIDS patients whose primary concern is about coping with a chronic disease. For HIV/AIDS patients receiving care in the ambulatory setting instrumental care may be the invisible care factor in their relationship with the nurse, only becoming visible if "absent."

For this study and Cronin and Harrison's (1988) study, nursing behaviors such as "talk to me about my life outside the hospital" and "visit me if I move to another hospital unit" ranked lowest on the CBA.

For this study, Humanism/Faith-Hope/Sensitivity ranked the highest for the CBA subscales with Supportive/ Protective/Corrective Environment ranking last. In Cronin and Harrison (1988), Human Need Assistance was ranked the highest with Existential/Phenomenological/Spiritual Forces ranking last. The positive behaviors found in the Humanism/Faith-Hope/Sensitivity are non-physical nurse caring behaviors that reflect kindness and consideration, show acceptance and reassurance, and offer encouragement and praise. This suggests that HIV/AIDS patients value nurse caring behaviors that reflect positive attitudes of the nurse towards the patient. The Human Needs Assistance subscale, which ranked second on this study and first on Cronin and Harrison's study (1988), indicate that patients also felt that nurse caring behaviors directed at closely monitoring their condition and demonstrating professional competence through clinical skills were important. Ranking of items on the CBA for this study may differ with Cronin and Harrison's (1988) findings due to the use of chronically ill patients instead of critically ill patients as study subjects. Critically ill patients may feel hands-on technical skills are more important while chronically ill patients may place higher value on nursing behaviors that

incorporate more communicative, non-physical behaviors. The differences in study setting may also explain the variance in study findings. Critically ill patients are hospitalized often with the goal of nursing placed on quick-acting, life-saving technical skills. Ambulatory patients often visit nurses for less technical, more psychosocial based interventions.

There were no significant relationships between patients' demographic characteristics and caring behaviors for this study or for Cronin and Harrison's (1988) study. In this study, education level did show a weak relationship with the ranking of caring behaviors as most important. HIV/AIDS subjects with high school education or less ranked nurse caring behaviors as more important than those subjects with some college education. One possible explanation for this difference may be that patients with less education may have limited resources for networking and social support and thus may place a higher value on the care they receive from nurses at the clinic. Patient characteristics, ethnic background, inner psychological resources, and social network play an important role in how the patient deals with disease (Gray, 1996). Gray states that patients with HIV/AIDS cope with their disease better when they receive

social support from their peers. If HIV/AIDS patients are not receiving the support they need socially, they may look toward the nurse for support.

Caring behaviors have been studied in primary, secondary, and tertiary settings. Wolf et al., (1994) studied the dimensions of nurse caring from both the patient's and nurse's perspective using the Caring Behaviors Inventory (CBI). The research took place in both secondary and tertiary settings. Results of Wolf et al., (1994) differ from the results of the current study and are similar in theory to those of Cronin and Harrison (1988).

Rosenthal (1992) studied coronary care patient's and nurse's perceptions of nurse caring behaviors using Larson's (1986) Caring Assessment Inventory, the Care-Q tool. Again, the results of Rosenthal study were parallel to those of Cronin and Harrison (1988). Results indicated that patients chose instrumental nursing care as the most important while coronary care nurses felt that expressive nursing care behaviors were most important.

The results of the nurse's perceptions in Rosenthal's (1992) study are congruent with the patient's perceptions of important nurse caring behaviors in the current study. This may be secondary to nursing care in the coronary care unit

having a more technical focus; nurses may feel that these technical skills are just part of the everyday job and that personal communication and psychosocial aspects of nursing are the more important nursing interventions.

Mullins (1996) studied HIV/AIDS patient perceptions of important nurse caring behaviors. The study sample consisted of 46 subjects from various clinical settings including hospitals, private and public ambulatory care clinics, infectious disease clinics, AIDS outreach clinics, and AIDS support groups. Patients in Mullins (1996) study viewed caring behaviors from the Human Needs Assistance subscale as the most important. These findings are congruent with the findings of Cronin and Harrison (1988).

Although the subject population was similar in Mullins (1996) study to the current study, there were differences in study outcomes. Subjects in Mullin's study ranked items from the Human Needs Assistance subscale as the most important, while subjects in this study ranked items from the Humanism/Hope-Faith/Sensitivity subscale as the most important. The discrepancy in the findings may be secondary to the differences in settings in which the sample subjects were obtained. Mullins utilized subjects from a variety of inpatient and outpatient settings, while the current study

recruited subjects from a local outpatient HIV/AIDS clinic. Eleven subjects in the current study stated they had not been hospitalized within the last year and three subjects stated they had never been hospitalized to date. This may account for the subjects in this study ranking the Humanism/Faith-Hope/Sensitivity subscale higher than the Human Needs Assistance subscale. The types of nurse caring behaviors listed on the Human Needs Assistance subscale, technical behaviors of nursing, such as giving shots and managing equipment, are most often seen in the inpatient setting. Subjects in the current study ranked non-physical care concerned with inner psychosocial and spiritual care as the most important.

Nurses play an important role in helping HIV/AIDS patients cope with their illness. One way nurses can help patients cope is to help them develop a sense of spiritual well-being. In a study by Carson and Green (1992) spirituality and ability to find purpose and meaning in life promoted a type of emotional hardiness that assisted HIV/AIDS patients in accepting changes in their lives. Carson and Green further found that the more "hardiness" a patient has the more resistance they have to negative effects of stress which can affect the immune system and

decrease the HIV/AIDS patients risks of opportunistic infections. These findings are consistent with the goals of the Carative factors that comprise the Humanism/Faith-Hope/Sensitivity subscale. Results from the current study show that HIV/AIDS patients place great importance on nursing behaviors that can improve health not only of the body, but the mind and spirit, by subjects ranking the items in the Humanism/Faith-Hope/Sensitivity subscale as the most important. Examples from this subscale include such nursing interventions as, "treat me as an individual", "encourage me to believe in myself", "accept me the way I am", and "point out the positive things about me and my condition".

Discussion of Findings in Relationship to the Conceptual Framework

Jean Watson's (1985) theory of human caring provided the theoretical basis for this study. Watson believes people are unitary wholes who are subjective and unique and posses inner strength and resources that can be drawn on if faced with health challenges (Schroden & Maeve, 1992). Watson (1985) believes health refers to unity and harmony within the mind, body, and soul rather than an absence of disease. Watson further believes that it is the nurse's job to help patients gain harmony within the mind, body, and

soul. This harmony will generate self-knowledge, self-reference, self-healing, and a self-care process within the patient.

Watson (1985) believes the future of nursing belongs to caring more than to curing. In 1979, Watson developed 10 Carative factors for nurses to use as a framework for caring. The Carative factors are based on a humanistic value system and scientific philosophy, and are used to guide nursing actions. Watson believes that nurses use of Carative factors will promote health care, prevent illness, care for the sick, and restore health. Watson further believes these 10 Carative factors can be used by nurses to incorporate caring into practice and that these factors can be applied to any nursing practice regardless of the setting.

Results of this study indicate that HIV/AIDS patients feel expressive nursing care is the most important. Expressive care is identified in Watson's (1985) theory as activities that establish relationships that are characterized by trust, faith, hope, sensitivity, empathy, touch, warmth, and genuineness. Expressive nursing activities also include such behaviors that would support surveillance of the patient and promote comfort. Watson's

expressive behaviors are listed within the CBA subscale Humanism/Faith-Hope/Sensitivity which encompasses Carative factors one, two, and three.

Larson and Ferketich (1993) define caring as intentional actions that convey physical care and emotional concern while promoting a sense of security and safety in another. Caring behaviors begin from the initial interaction between the nurse and patient (Watson, 1985). Caring behaviors can be assumed to be any interpersonal interaction occurring between the nurse and patient.

Watson's (1985) theory of human caring was applicable to the care of the HIV/AIDS patient. By using the 10 Carative factors, specific areas of nursing care were identified as important to HIV/AIDS patients. Watson's conceptual framework provides the bases for care given to HIV/AIDS patients at the Denver Nursing Project in Human Caring (DNPHC). The DNPHC is a nurse-managed outpatient center providing care and services for patients with HIV or AIDS. All programs and services are based on Watson's theory of human caring. Utilizing a "care" based theory in this nurse run clinic for HIV/AIDS patients, has resulted in large growth and high levels of satisfaction for both the nurses and patients. The results from this study lend

further support to Watson's theory. Subjects in this study rank nurse caring behaviors as most important.

Limitations

This study recruited a small, non-randomized convenience sample from a single ambulatory HIV/AIDS clinic. Small samples and single data collection settings are less representative of the population under study and limit the ability to generalize the study findings (Polit & Hungler, 1995).

This study also utilized the use of convenience sampling. According to Polit and Hungler (1995), limitations to non-randomized convenience sampling is due to the use of "available" study subjects which may not be typical of the study population with regard to the phenomena studied. Using a convenience sample from a heterogeneous population of males and females may also increase the risk of bias.

The CBA was used as the measurement instrument in this study. The instrument used a 5 point Likert-type scale to rank important nurse caring behaviors from most to least important. Research that utilizes self-reporting instruments are subjected to reporting biases (Polit & Hungler, 1995). Scales that measure individual's

perceptions are threatened with variability and may not produce a totally accurate measure of the variables at study. Scales, such as the CBA, can be limited because of response set biases. A social desirability response set bias occurs when subjects misrepresent their response to questions by answering statements in a manner consistent with current social morals. Another type of response bias, known as acquiescence response bias, occurs when subjects agree with statements regardless of the content. Two subjects in this study rated all 63 nurse caring behaviors as most important. There was no use of counterbalancing for the wording of items on the CBA; this could contribute to acquiescence bias. Cronin and Harrison (1988) state that limitations to the CBA are the tool length and the variability in numbers of items under each subscale.

Several factors can contribute to errors of measurement on the CBA, such as situational and personal influences, thereby affecting scores on the CBA. Situational influences are influences that are within the patients environment at the time of the study. In this study, situational influences may have been conversation in the waiting room, ringing of the clinic telephone, or nurses calling for patients in the waiting room. Personal factors such as

severity of illness, pain, anxiety, fatigue, and ability to read and write can alter patients scoring on measurement scales. Length of the CBA may have contributed to patient fatigue which may in turn have lead to possible measurement of error.

Instrument clarity and fit was found to be a limitation to this study. Asking patients to "think back" to nursing care they had received over the last year and rating that care from most to least important may have contributed to an error of measurement. Also, the CBA was divided into two sections, one asking subjects to rate their nursing care at the clinic and the other asking subjects to rate important hospital nursing care they had experienced over the last year. Eleven subjects (47.8%) in this study had not been hospitalized over the last year and three patients stated that they had no history of previous hospital admissions. Patients with no history of hospitalizations within the last year may have made generalizations about nurse care on the CBA instead of rating inpatient and ambulatory nursing care separately.

Implications for Nursing

Nurses in nonhosptial settings are encountering increasing numbers of patients who are HIV-seropositive. To

ensure that caring remains the central and identifying focus of nursing, nurses must identify which nurse caring behaviors patients perceive as most important (Rosenthal, 1992). Nurses and patients do not always agree on which behaviors indicate caring. It is ultimately the nurse's responsibility to become connected with the patient during the caring process, and by finding out which nurse caring behaviors patients perceive as most important is the first step in establishing this connection. By utilizing important nurse caring behaviors, nurses can increase the patient's ability to cope with illness and deal with the stress of a chronic illness. This, in turn, will produce a positive influence on the patient's health. Research supports the premise that authentic caring relationships between nurses and patients can impact patients overall well being, physical comfort, and healing potential (Neil, 1994). This is in congruence with Watson's (1985) philosophy that nursing can help a patient gain a higher degree of harmony of the mind, body, and soul. Watson believes identification of important nurse caring behaviors will facilitate the patient and nurse coming together in a caring relationship.

Illness, especially chronic illness such as HIV/AIDS, is often associated with social stigmas and can separate a

patient from his or her familiar environment among family and friends. Caring is the key to empowering patients to cope with the physical and social changes associated with this chronic illness. Currently there is no cure for HIV. Nursing care of these patients needs to be directed at helping patients find meaning in their existence and past experiences, to help patients discover inner control and strength, and to help patients potentiate the self-healing process.

Recommendations

As the impact of the HIV epidemic increases throughout the world, the examination of important care experiences of the HIV/AIDS patient need to be explored. Nurses caring for HIV/AIDS patients need to understand which nurse caring behaviors are effective for meeting the care needs of this population. One way to do this is through the study of nurse caring behaviors. There needs to be continued study of the concept of caring and how nurses can effectively communicate caring to patients.

The 1988 study by Cronin and Harrison established a link between caring as a theory and caring as empirical nursing actions. By using Watson's 10 Carative factors, Cronin and Harrison were able to group specific nursing

actions into seven subgroups to create the CBA. As seen in this research and in previous studies, the CBA is effective at measuring patients perceptions of important nurse caring behaviors.

Further research is necessary to help nurses understand the complex care needs of the HIV/AIDS patient. Future recommendations for research would be to conduct more studies on nonhosptialized, nonacute subjects and determine if expressive nurse caring behaviors are becoming the defining elements to important nurse caring behaviors for the ambulatory population. The CBA may need to be revised with questions more specifically directed at ambulatory patient experiences. Addition studies using the CBA will strengthen validation of the instrument.

In conclusion, for nurse caring behaviors to remain the primary focus in nursing today, additional research in this area is needed. As healthcare shifts from an inpatient to an outpatient focus, nurses need to develop new instruments to measure caring and provide a solid connection between nursing theory of caring and caring as nursing interventions.

APPENDICES

APPENDIX A

Permission for Use of Instrument

BELLARMINE COLLEGE

2001 NEWBURG ROAD
LOUISVILLE, KY 40205-0671
(502) 452-8000

November 6, 1997

Jennifer Jordahl
1293 Marshwood Ct. 3B
Byron Center MI 49315

Dear Jennifer:

Thank you for your interest in the Caring Behaviors Assessment. Enclosed is a copy of the tool and additional information regarding its development. Please feel free to use the CBA. In return, we ask that you acknowledge its authorship (reference to the Heart & Lung article is sufficient) and, upon completion of your work, please send us a copy of your abstract. We would also appreciate the results of any further reliability and validity testing of the CBA.

We will be most interested in your findings. If we can answer any questions or be of any further assistance, please feel free to contact us.

Sincerely,
LANSING SCHOOL OF NURSING

[redacted]

Sherill Nones Cronin, PhD, RN, C
Associate Professor

Barbara Harrison, MSN, RN, C
Chair, BSN Program

/bsm
Enclosure

APPENDIX B

Cover Letter to Subjects

APPENDIX B

WRITTEN EXPLANATION OF RESEARCH FOR PATIENTS

My name is Jennifer Jordahl. I am currently a graduate nursing student at Grand Valley State University. As a part of my requirement for my master's degree I am conducting a study on nurse caring behaviors.

I am studying which nursing behaviors are perceived by HIV/AIDS patient as important indicators of caring. Results of this study will help improve nursing care.

I would appreciate your participation in this study. Your agreement to participate in this study would involve completing a 63 item questionnaire and a personal demographics survey. Completion of this questionnaire will take approximately 15 minutes of your time. Please return complete questionnaires and personal demographic surveys in the box marked Caring Behaviors Assessment located in the waiting room of the clinic.

Your participation in this study is strictly voluntary. Your decision to either participate or not participate does not affect the care you are receiving at this clinic. There are no costs or risks for your participation in this study. There is no placing of identifying marks anywhere on the

enclosed documents. All questionnaires and answers will remain anonymous. Completion of the questionnaire and personal demographics sheet is viewed as your consent to participate in this study. Withdraw from this study may be done up until the time the questionnaire is dropped into the collection box. After that, withdrawal would be impossible due to the unidentifiable markings and anonymity of this questionnaire.

Data collected for this research will be reported only in aggregate and a copy of the study results will be placed at the clinic front desk for your reading. Results of this study may be published in scientific nursing journals. If published there will be no placing of patients names or any mention of the clinic or affiliated hospital. It will be regarded as a hospital sponsored clinic in a Midwestern city.

I would like to take this opportunity to thank you in advance for agreeing to participate in this study. If you have any questions either concerning my research study or questions about the questionnaire, please feel free to contact my thesis chairperson, Dr. Charlotte Torres, at 616-895-3873. You may also contact Paul Huizenga, Chair of Human Research Review Committee for Grand Valley State

University at 616-895-2472 with any additional questions or concerns.

Sincerely,

Jennifer L. Jordahl, RN

APPENDIX C

Patient Demographic Questionnaire

APPENDIX C

PATIENT DEMOGRAPHIC INFORMATION SHEET

Please answer questions 1 - 11. This information is to remain anonymous. You do not need to include your name or any identifiable information on this sheet. Any such information, if included, will remain anonymous.

1. Age in years _____

2. Sex
   1. Male _____
   2. Female _____

3. Years of formal education _____

4. Please indicate number and stage of illness/diagnosis
   1. AIDS _____
   2. HIV-seropositive _____
   3. Number of chronic illnesses _____

5. How long have you been HIV infected? _____Years _____Months

6. Ethnic Background
   1. American Indian _____
   2. African-American _____
   3. Pacific/Asian _____
   4. Hispanic _____
   5. Caucasian _____
   6. Other Specify: _____

7. Marital Status/ Sexual Preference
   1. Single _____
   2. Married _____
   3. Living with significant other _____
   4. Divorced/Separated _____
   5. Widow/Widower _____

8. How many times were you hospitalized within the last year? _____

9. How would you rate the ***nursing*** care you received during your hospitalization(s)? Please indicate level of care by circling the appropriate number below.

Poor					**Average**					**Excellent**
0	1	2	3	4	5	6	7	8	9	10

10. Number of medications currently taking ? _____

11. History of IV drug use ? **(Optional)**

1. No _____
2. Yes _____

APPENDIX D

Caring Behaviors Assessment

APPENDIX D

CARING BEHAVIORS ASSESSMENT

Listed below are things nurses might do or say to make you feel cared for and about. Think back to the care you have received by nurses at the ***Clinic*** within the last year and decide how important each of these would be in making you feel cared for and about. For each item, indicate if it would be of:

Much Importance				Little Importance
5	4	3	2	1

1. Treat me as an individual.	5	4	3	2	1
2. Try to see things from my point of view.	5	4	3	2	1
3. Know what they are doing.	5	4	3	2	1
4. Reassure me.	5	4	3	2	1
5. Make me feel someone is there if I need them.	5	4	3	2	1
6. Encourage me to believe in myself.	5	4	3	2	1
7. Point out the positive things about me and my condition.	5	4	3	2	1
8. Praise my efforts.	5	4	3	2	1
9. Understand me.	5	4	3	2	1
10. Ask me how I like things done.	5	4	3	2	1
11. Accept me the way I am.	5	4	3	2	1
12. Be sensitive to my feelings and moods.	5	4	3	2	1
13. Be kind and considerate.	5	4	3	2	1

14. Know when I've "had enough" and act accordingly(for example, limiting office visit).	5	4	3	2	1
15. Maintain a calm manner.	5	4	3	2	1
16. Treat me with respect.	5	4	3	2	1
17. Really listen to me when I talk.	5	4	3	2	1
18. Accept my feelings without judging them.	5	4	3	2	1
19. Ask me what I like to be called.	5	4	3	2	1
20. Introduce themselves to me.	5	4	3	2	1
21. Answer quickly when I call for them.	5	4	3	2	1
22. Give me their full attention when with me.	5	4	3	2	1
23. Visit me if I move to another hospital unit.	5	4	3	2	1
24. Touch me when I need it for comfort.	5	4	3	2	1
25. Do what they say they will do.	5	4	3	2	1
26. Encourage me to talk about how I feel.	5	4	3	2	1
27. Don't become upset when I'm angry.	5	4	3	2	1
28. Help me understand my feelings.	5	4	3	2	1
29. Don't give up on me when I'm difficult to get along with.	5	4	3	2	1
30. Encourage me to ask questions about my illness and treatment.	5	4	3	2	1
31. Answer my questions clearly.	5	4	3	2	1
32. Teach me about my illness.	5	4	3	2	1
33. Ask me questions to be sure I understand.	5	4	3	2	1

34. Ask me what I want to know about my health/illness.	5	4	3	2	1
35. Help me set realistic goals for my health.	5	4	3	2	1
36. Help me plan ways to meet those goals.	5	4	3	2	1
37. Understand when I need to be alone.	5	4	3	2	1
38. Offer things to make me more relaxed/comfortable during my visit or hospitalization(ie, position change, blankets, coffee/juice, etc.)	5	4	3	2	1
39. Explain safety precautions to me and my family.	5	4	3	2	1
40. Encourage me to do what I can for myself.	5	4	3	2	1
41. Respect my modesty (for example, keeping me covered during exams).	5	4	3	2	1
42. Consider my spiritual needs.	5	4	3	2	1
43. Are gentle with me.	5	4	3	2	1
44. Are cheerful.	5	4	3	2	1
45. Help me with my care until I'm able to do for myself.	5	4	3	2	1
46. Know how to give shots, IVs, etc.	5	4	3	2	1
47. Know how to handle equipment (for example, monitors).	5	4	3	2	1
48. Give my treatments and medications on time.	5	4	3	2	1
49. Keep my family or significant other informed of my progress.	5	4	3	2	1
50. Check my condition very closely.	5	4	3	2	1
51. Know when it's necessary to call the doctor.	5	4	3	2	1

52.	Seem to know how I feel.	5	4	3	2	1
53.	Help me see that my past experiences are important.	5	4	3	2	1
54.	Help me feel good about myself.	5	4	3	2	1

*****For questions 55-63 think back to the care you have received from *hospital nurses* within the last year. Please indicate how important each nursing behavior would be in making you feel cared for and about.**

Much Important 5 ... Little Important 1

55.	Come into my room just to check on me.	5	4	3	2	1
56.	Talk to me about life outside the hospital.	5	4	3	2	1
57.	Help me plan for my discharge from the hospital.	5	4	3	2	1
58.	Tell me what to expect during the day.	5	4	3	2	1
59.	Leave my room neat after working with me.	5	4	3	2	1
60.	Give my pain medication when I need it.	5	4	3	2	1
61.	Check with me before leaving the room to be sure I have everything I need within reach.	5	4	3	2	1
62.	Let my family visit as much as possible.	5	4	3	2	1
63.	Help me feel like I have some control.	5	4	3	2	1

64. Is there anything else that nurses could do or say to make you fee cared for and cared about? If so, please describe below or on the back of this paper.

APPENDIX E

Human Subjects Review

GRAND VALLEY
STATE UNIVERSITY

1 CAMPUS DRIVE • ALLENDALE, MICHIGAN 49401-9403 • 616/895-6611

May 5, 1998

Jennifer Jordahl
10875 Shaner Ave.
Rockford, MI 49341

Dear Jennifer:

Your proposed project entitled "***HIV/AIDS Patients Perceptions of Nurse Caring Behaviors***" has been reviewed. It has been approved as a study which is exempt from the regulations by section 46.101 of the Federal Register 46(16):8336, January 26, 1981.

Sincerely,

[redacted]

Paul Huizenga, Chair
Human Research Review Committee

SAINT MARY'S
HEALTH SERVICES
A member of Mercy Health Services

HIV/AIDS Patients' Perceptions of Nurse Caring Behaviors

Reviewer #1

Question # 11 on the demographic survey.
This may be perceived as threatening to the subject. The addition of "(optional)" to the question is required.

Reviewer #2

Page 28 states that subjects may withdraw from the study at any time. This is not true in a study which provides anonymity as this one does. Once the envelope is dropped in the US Mail, it will be impossible to withdraw since the survey is intended to be unidentifiable. The researcher needs to include a statement with this rationale in the letter to patients that states that once the letter is mailed withdrawal will not be possible.

The letter to the patients needs to include a statement about what will be done with the data, such as being reported only in aggregate with no pt. names, or the name of the clinic or sponsoring hospital identified, and that the study may be published in scientific journals, etc.

Reviewer #3

Concurs with Reviewers # 1 & 2 with no additional comments.

Action: Nursing Research Committee (NRC) approves the study as expedited review as it is currently proposed with the changes listed above to be made to the demographic survey and letter to the patients. When the changes are made, copies of the revised documents are to be submitted to the NRC chairperson. At that time data collection may begin.

[redacted] 5-6-98

Juanita Bogart, chairperson Date

200 Jefferson S.E.
Grand Rapids
Michigan 49503
616 752-6090

SAINT MARY'S
HEALTH SERVICES
A member of Mercy Health Service

April 29, 1998

To Whom it May Concern,

This is to acknowledge that approval has been given to **Jennifer Jordahl**, a graduate nursing student at GVSU, to conduct her research study "HIV/AIDS: Patient's Peerceptions of Nurse Caring Behaviors" at the McAuley Clinic.

Sincerely,

[redacted]

Joan Borst MSW,CSW

For Cindy Arno MSW, MPA
McAuley Clinic Supervisor

[redacted] 5/19/98

APPENDIX F

Mean Ranks for Caring Behaviors Questionnaire

APPENDIX F

Mean Ranks for Caring Behaviors Assessment Questionnaire

RANK	ITEM #	MEAN	RANK	ITEM #	MEAN
1	17	5.00	34	49	4.26
2	3	4.87	35	14	4.26
3	16	4.83	36	36	4.22
4	51	4.83	37	52	4.22
5	50	4.83	38	42	4.17
6	13	4.78	39	53	4.17
7	47	4.74	40	38	4.17
8	11	4.74	41	8	4.17
9	1	4.74	42	26	4.09
10	31	4.70	43	40	4.09
11	32	4.65	44	39	4.09
12	10	4.65	45	15	4.09
13	22	4.65	46	21	4.04
14	5	4.65	47	27	4.00
15	48	4.61	48	43	4.00
16	18	4.61	49	24	4.00
17	46	4.61	50	28	3.91
18	4	4.52	51	37	3.87
19	30	4.52	52	41	3.78
20	20	4.52	53	63	3.74
21	34	4.48	54	61	3.61
22	12	4.48	55	60	3.57
23	35	4.48	56	19	3.57
24	9	4.48	57	62	3.52
25	45	4.43	58	23	3.30
26	2	4.43	59	55	3.26
27	7	4.39	60	57	3.22
28	29	4.39	61	58	3.17
29	33	4.35	62	59	3.13
30	25	4.35	63	56	3.00
31	44	4.30			
32	6	4.30			
33	54	4.26			

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