

# **Important Nurse Caring Behaviors: Perceptions of Oncology Patients and Nurses**

**Sister Barbara A. Gooding, Maureen Sloan  
and Lucie Gagnon**

Le concept de soins ou de bienveillance est considéré comme une clé de voûte des sciences infirmières. Peu d'enquêtes systématiques ont cependant examiné les rapports existant entre la bienveillance professionnelle et l'acte de soigner. Cette étude a mis à profit une démarche corrélative et comparative afin d'explorer les divers pointages accordés par des patients et des infirmières de services d'oncologie aux soins prodigués par des infirmières. L'étude a également étudié les différences entre les pointages inférieurs obtenus. Quarante-deux patients et quarante-six infirmières ont participé à l'étude. Les résultats ont montré des différences et des similitudes quant aux pointages accordés par les deux groupes aux soins prodigués par les infirmières. Cinq nouvelles sous-échelles ont été reconnues et nommées en fonction du genre de soins prodigués par les infirmières. Les patients ont classé au premier plan les aspects cliniques des soins, suivis par l'empathie manifestée lors de ceux-ci. Les infirmières ont mis au premier chef l'empathie manifestée envers le patient, suivi de l'aspect continu des soins. Cette étude permet de mieux comprendre les perceptions qu'ont les patients et les infirmières d'oncologie sur les façons de soigner des infirmières.

The concept of care or caring is considered to be a salient feature of nursing practice yet there has been little systematic investigation of caring as related to nursing. This study used a correlational, comparative design to explore rankings of nurse caring behaviors by oncology patients and nurses including the investigation of differences between subscale scores of these caring behaviors. Forty two patients and 46 nurses participated in the study. The results demonstrate differences and similarities between these two groups in their ranking of nurse caring behaviors. Five new subscales were identified and labelled according to kinds of caring demonstrated by the nurse. Patients ranked as most important the clinical aspects of care followed by the empathetic manner of caring. Nurses chose as most important the empathetic manner of caring followed by the continuity of caring. This study provides increased understanding of the perceptions of oncology patients and nurses about nurse caring behaviors.

Care is a salient feature of the practice of nursing. Leininger (1977, 1988), Watson (1979), Brown (1981), Gaut (1984), and Benner & Wrubel (1989) are among those who have contributed to the current understanding of this concept. Their efforts notwithstanding, there has been little systematic investigation of this subject. Larson (1981, 1984) conducted an important study comparing the perceptions of nurses and patients regarding nurse caring behaviors. The current study is a replication and elaboration of that original work to obtain further information about this phenomenon.

---

*Sister Barbara Anne Gooding, N., Ph.D. Associate Professor, McGill University School of Nursing.*

*Maureen Sloan, N., M.Sc.(A), Family Faculty Section, McGill University School of Nursing*

*Lucie Gagnon, N., M.Sc. Chargée d'enseignement, Université de Montréal*

The conceptual framework of this project was based on the McGill Model of Nursing introduced by Dr. Moyra Allen in 1977 and elaborated upon by Gottlieb and Rowat (1987). Health is a learning process to enhance life and promote coping, and the health of the individual or family is the goal of nursing. The context within which health and healthy ways of living are learned comprises the environment for nursing. In this study, care was viewed as a component of that learning environment.

### **Literature Review**

The word "care" has been linked to the nursing profession since the time of Florence Nightingale, yet its usage remains elusive and leads to confusing interpretations (Forrest, 1989). Further research is needed to reduce these ambiguities and provide an understanding of caring that accounts for all aspects of nursing practices (Leininger, 1977).

Caring has been characterized as a natural and essential element of human existence that enhances growth and development towards actualization (Erikson, 1950; Gaylin, 1976; Heidegger, 1962; Mayeroff, 1971). Commonly discussed in the context of a relationship, psychologists and psychiatrists have identified caring within a familial (Erikson, 1950; Gaylin, 1976; Simon, 1976), or therapeutic (Gaut, 1984; May, 1969; Rogers, 1965) relationship, one that allows mutual attainment of goals (May, 1969). Several constructs such as touch (Simon, 1976), empathy (Rogers, 1965), positive regard (Jourard, 1971; Rogers, 1965), and congruence (Rogers, 1965) have been used to describe the concept of caring. Research has drawn upon these approaches to explain caring both in the universal sense and within the profession of nursing.

In the nursing literature, care is considered to be a prominent feature of the nurse-patient relationship (King, 1981; Orlando, 1961; Pepleau, 1952), one that is relevant for theory development and nursing practice (Leininger, 1986; Watson, 1979). Watson (1979) and Leininger (1977) suggested that further research is needed to identify caring behaviors that could enhance recovery, positive health behaviors, and health maintenance.

Numerous qualitative studies have examined the experience and perception of patients as recipients of care (Brown, 1981; Cronin & Harrison, 1988; Harris, 1989; Henry, 1975; Larson, 1979; Reimen, 1986; Watson, 1979). Patients referred to the quality of the nurse's presence that conveyed a sense of personal value to them (Reimen, 1986). Other studies have examined the nurses' perceptions of caring (Ford, 1981; Forrest, 1989; Ray, 1987; Watson, 1979); their view of caring incorporated "being with" rather than "doing to" a client. These two perspectives have contributed greatly to the identification and classification of nurse caring behaviors (Brown, 1981; Ford, 1981; Harris, 1989; Henry, 1975; Larson, 1979; Reiman, 1986; Watson, 1979).

The nurse caring behaviors were identified as expressive or instrumental according to the classification of Watson (1979) and Brown (1981) described above. According to Watson (1979) and Brown (1981) nurse caring behaviors can be classified along two dimensions: the task or instrumental dimension refers to those nursing activities that focus more on the physical and treatment needs of the client; the affective dimension alludes to the more psychosocially oriented behaviors, such as offering emotional support and listening. Both dimensions of care are equally important to the hospitalized clients (Brown, 1981; Harris, 1989).

Larson (1981, 1987) and Mayer (1987) examined the relative importance of specific nurse caring behaviors from the perspective of nurses and patients. The Care-Q Sort Instrument was developed by Larson (1981) to measure the ranked importance of 50 nurse caring behaviors classified under six themes of care: anticipates; comforts; explains and facilitates; develops and sustains trusting relationships; monitors and follows through; and is accessible. Fifty-seven oncology patients and nurses ranked the items by importance. Mayer (1987) replicated Larson's study with 28 oncology nurses and 57 cancer patients using this same instrument. The findings of both studies demonstrated that nurses and patients held different perceptions of important nurse caring behaviors. Nurses ranked expressive behaviors as indicators of care more frequently than did patients, whereas patients ranked instrumental nursing behaviors as most important (Mayer, 1987).

### ***Purpose***

The purpose of the study was to examine this phenomenon of care/caring as perceived by oncology patients and nurses. The current study used a correlational, comparative design to address the following research questions:

1. How do oncology patients and nurses rank caring behaviors in order of importance?
2. What is the relationship between these rankings of caring behaviors?
3. Are there differences between subscale scores of these caring behaviors for oncology patients and nurses?

### **Method**

A descriptive correlational and comparative study design was implemented to address the research questions. Descriptive statistics were used to illustrate the characteristics of individuals in the sample groups and to report the scores for individual Q sort items. An analysis comparing subscale scores for patients and nurses was conducted using t-tests.

The Care-Q Sort does not specify the nursing care setting in which the instrument should be administered. The oncology setting was chosen because it is an area of care where both patients and nurses place a strong emphasis on repeated nursing care behaviors. The patients were interviewed in an outpatient setting because: their perceptions would have developed over a period of time, they were likely to have an overall view of caring behaviors, and they would not be concerned that their responses would affect the quality of care they were receiving. This choice of setting also helped to ensure a relatively consistent state of well-being in the study sample; hospitalized patients demonstrate greater variability in their state of health.

The patient sample was drawn from two university teaching hospital outpatient departments. The inclusion criteria were:

1. Malignant tumor/disease diagnosed at least three months prior to Care-Q sort to permit time for internalization of the diagnosis (Weisman, 1979).
2. At least one hospitalization within the year to control for memory bias.
3. Alert as described by the clinic nurse; perceptions can otherwise be clouded by altered states of consciousness.
4. Willingness to participate.
5. Literate in the English language.

Nurses were selected for this study from various hospital units where care was provided to oncology patients. These units were in the same hospitals as those from which the patients were selected. All nurses who took part in the study were willing to participate and held a licence to practise nursing in the province of Quebec.

The convenience sample consisted of 42 oncology patients and 46 oncology nurses. Characteristics of the patient sample included: 23 males and 19 females; an age range of 18 to 74 years with a mean of 46.9 years for males and 55.6 years for females; 52.4% had greater than high school education; 33.4% was found to be functioning outside the organized labor market (including homemakers, students, and retired people); nearly one quarter held professional occupations; and 52.4% had been hospitalized within 3 months prior to their participation.

Fifty nurses from day and evening shifts completed Care-Q sorts, but four of these data sets were completed incorrectly and were omitted from the data analysis. The nurses practiced on 12 different hospital units. Characteristics of the nurse sample included: one male, and 45 females; an age range of 20 to 53 years with a mean of 27 years; 56.6% were educated in diploma

programs; more than 45% had three years or less experience; 82% worked full time; and 78.3% rotated through the various shifts. The sample as a whole was well experienced in nursing oncology patients.

### ***Instruments***

Each participant completed the Care-Q Sort Instrument designed by Larson in 1981. It is based upon Q-technique designed for ranking of items (in this case, nurse caring behaviors) according to perceived importance. Item identification was initiated by a Delphi survey of practicing nurses on caring. An expert nurse panel reviewed the instrument for validity and reached universal agreement on 60 of 69 items. A psychometric consultation panel provided clarification as needed, and a set of 52 items was submitted to a patient and nurse panel. Reliability of the Care-Q Instrument was addressed through a small test-retest study with nine undergraduate nursing students. A perfect correlation (+1.0) was found between the first and second sorting on items selected as most important and least important (Larson, 1981, 1984). The advantage of using Q-technique in this study is that it allows fine discriminations of caring behaviors. In addition, social desirability, response set bias, and missing data were eliminated with Q-technique because the items have to be ranked in a forced choice quasi-normal distribution (Dennis, 1986).

For the current study, each of the 50 nurse caring behaviors was printed on a 3" x 5" card. Participants were requested to sort the cards along a quasi-normal distribution into seven categories or ranks of importance, requiring a forced choice: the participants chose one most important and one least important caring behavior, then four each of fairly important and fairly unimportant, 10 each of somewhat important and somewhat unimportant, and the remaining items were ranked as neither important nor unimportant. A score of 7 was given to the one item considered most important and a score of 1 to the least important item. The scores in between were assigned to each category in the order just described.

### ***Data Collection***

Potential subjects were approached by oncology clinic nurses, and if they were willing a nurse researcher further explained the study to them and obtained informed consent. Demographic information was collected through interview. The Care-Q Sort was completed by the patient alone, in a designated quiet area of the clinic with the researcher available to answer technical questions related to the instrument. The entire procedure took approximately 20 to 45 minutes per subject.



*Table 1*

**Oncology Patients' (n=42) Perceptions of Most Important Nurse Caring Behaviors: The Five High Mean (Standard Deviation) Score Care-Q Items**

Care-Q Item	Mean	S.D.
Knows how to give shots, IVs, etc. manage equipment like IVs, suction machines, etc.	5.26	(1.36)
Gives a quick response to patient's call.	5.19	(0.94)
Gives the patient's treatments and medications on time.	5.05	(1.13)
Knows when to call the doctor.	5.02	(1.18)
*Is perceptive of patient's needs and plans and acts accordingly (e.g. gives anti-nausea medication when patient is receiving medication that will probably induce nausea).	4.93	(1.09)

\*Item also ranked in five highest mean items of nurses.

Nurse participants from various oncology units were notified about the study by their respective nurse managers. Nurses completed their Q-sort packets at home within a given period of time because of their busy work schedules.

**Results**

In response to the first research question, the five items with the highest mean scores (most important) and the five items with the lowest mean scores (least important) of the Care-Q instrument were chosen for examination. The caring behaviors which received the highest mean scores from the patients are shown in Table 1. Table 2 contains the items obtaining the lowest mean scores from patients. The corresponding ratings from the nurses appear in Tables 3 and 4.

*Table 2*

**Oncology Patients' (n=42) Perceptions of Least Important Nurse Caring Behaviors: The Five Low Mean (Standard Deviation) Score Care-Q Items**

Care-Q Item	Mean	S.D.
Checks out with the patient best time to talk with the patient about changes in his/her condition.	3.45	(0.94)
Offers reasonable alternatives to the patient, such as choice of appointment times, bath times etc.	3.30	(0.91)
Volunteers to do "little things" for the patient e.g. brings a cup of coffee, paper etc.	3.00	(1.17)
*Is professional in appearance – wears appropriate identifiable clothing and identification.	2.88	(1.25)
*Asks the patient what name he/she prefers to be called	2.45	(1.13)

\*Item also ranked in five least important nurse caring behaviors by oncology nurses.

**Table 3****Oncology Nurses' (n=46) Perceptions of Most Important Nurse Caring Behaviors: The Five High Mean (Standard Deviation) Score Care-Q Items**

Care-Q Item	Mean	S.D.
Listens to the patient.	5.91	(0.89)
Allows the patient to express his feelings and his/her disease and treatment fully and treats the information confidentially.	5.39	(0.95)
Realizes that the patient knows himself best and whenever possible includes the patient in planning and management of his/her disease.	4.93	(1.02)
*Is perceptive of patient's needs and plans and acts accordingly (e.g. gives anti-nausea medication when patient is receiving medication which will probably induce nausea).	4.76	(1.16)
Gets to know the patient as a person.	4.76	(1.28)

\*Item also ranked in five highest mean items of oncology patient group.

Both patients and nurses placed the item related to acting on patient's needs among the five highest mean scores, and professional appearance and calling the patient by a preferred name among the lowest mean scores.

In an effort to further explore the groupings of these nurse caring behaviors, five new subscales were identified and labelled according to kinds of caring demonstrated by the nurse. After each item was assigned to a subscale, the mean rankings of items by the patients and nurses were evaluated. Items showing low ( $<0.40$ ) correlations with the subscale scores were removed. The titles of the new subscales and the number of items contained in each were as follows: (a) clinical caring [7 items] (e.g., "Gives the patient's treatments and medications on time"); (b) attentive caring [7 items] (e.g., "Gives a quick response to the patient's call"); (c) continuity of caring [6 items] (e.g., "Tells

**Table 4****Oncology Nurses' (n=46) Perceptions of Least Important Nurse Caring Behaviors: The Five Low Mean (Standard Deviation) Score Care-Q Items**

Care-Q Item	Mean	S.D.
Is patient even with "difficult patients."	3.24	(0.79)
Is cheerful.	3.22	(1.19)
Suggests questions for the patient to ask doctor.	2.89	(1.04)
*Asks the patient what name they prefer to be called	2.76	(1.08)
*Is professional in appearance – wears appropriate identifiable clothing and identification.	2.54	(1.36)

\*Item also ranked in five least important nurse caring behaviors by oncology nurses.

the patient of support systems"); (d) empathetic manner of caring [4 items] (e.g., "Realizes that the patient knows himself best and includes patient in planning"); and (e) disposition of the nurse caring [5 items] (e.g., "Is cheerful").

The titles for these subscales were validated through review by two nurse experts. Intercorrelations for the new subscales were low and not significant (Table 5). No analysis was made to determine the significance of removing 21 items from the caring behaviors in order to establish the new set of subscales.

**Table 5**

**Pearson Correlation Coefficient Matrix of Current Care-Q Subscales**

	<b>Clinical</b>	<b>Attentive</b>	<b>Continuity</b>	<b>Disposition</b>	<b>Empathetic</b>
Clinical	1.00	-0.09	-0.43	0.26	-0.27
Attentive	-0.09	1.00	-0.24	-0.12	-0.20
Continuity	-0.43	-0.24	1.00	-0.08	0.06
Disposition	0.26	-0.12	-0.09	1.00	-0.15
Empathetic	-0.27	-0.20	0.06	-0.15	1.00

The scores of the oncology patient and nurse groups were compared on the basis of the new subscales (Table 6). Two-tailed t-tests revealed that there were statistically significant differences ( $p < .001$ ) between the patients and nurses with respect to their ranking of the subscales of clinical caring, disposition of nurse caring, and continuity of caring.

**Table 6**

**Comparison of Oncology Patients' (n=42) and Nurses' (n=46)  
Mean Subscale Scores (Standard Deviation)**

<b>Subscales</b>	<b>Patients</b>		<b>Rank</b>	<b>Nurses</b>		<b>Rank</b>	<b>Significance*</b>
	<b>Mean</b>	<b>(S.D.)</b>		<b>Mean</b>	<b>(S.D.)</b>		
Clinical Caring	4.44	(0.43)	1	3.91	(0.48)	4	$p < .001$
Empathetic Manner of Caring	4.17	(0.57)	2	4.32	(0.50)	1	n.s.
Attentive Caring	4.09	(0.57)	3	4.07	(0.33)	3	n.s.
Disposition of Nurse Caring	3.94	(0.65)	4	3.43	(0.73)	5	$p < .001$
Continuity of Nurse Caring	3.74	(0.35)	5	4.28	(0.43)	2	$p < .001$

\*Two-tailed test



## Discussion

Reimen (1986) supported the notion that perceptions of important nurse caring behaviours differ among nurses and patients in the clinical practice of oncology nursing. More studies are needed to clarify what the differences in perception of care mean to clinical practice. For example, the current study could be repeated to determine if perceptions of care vary with patient diagnostic group or treatment group. Mangold (1991) compared perceptions of senior nursing students and professional nurses, and a recent nursing study addressed nurse caring behaviors as perceived by family members in the intensive care setting (Gagnon, 1992).

In the current study patients emphasized the technical care given by the nurse as being most important in making them feel cared for. Perhaps patients had been socialized by the media to expect the nurse's job to center around the technical aspects of care, or perhaps they recognized that other aspects of caring are not appreciated until the basic physical needs are met. Clinical caring might be viewed as a stepping stone to the provision of other aspects of care. Clearly, more research is required to investigate such possibilities.

Conversely, nurses did not rank the clinical caring subscale highly. Perhaps they recognized that a certain level of expertise was necessary to care for the oncology patient and took clinical competence for granted, thereby underestimating the value of technical skills in making patients feel cared for. Social desirability may also have played a part in their rankings. At the time of the study, the departments of nursing at the two hospitals were attempting to implement a family-centered approach to health care with an emphasis on psychosocial aspects. Therefore, the nurses may have been influenced by this new emphasis.

Larson (1981) and Mayer (1987) also reported that patients valued technical skills more, and expressive caring behaviors less than the nurses did. The findings of the two aforementioned studies and the data from the current study support the notion that perceptions of caring behavior by oncology patients are similar from setting to setting.

Nurses emphasized the importance of continuity of caring significantly more than the patients did. While the study was underway primary nursing care, which emphasizes the continuity of care for the patient and family, was being implemented in both hospitals. Therefore the nurses' heightened awareness may have influenced their higher ranking of items in this subscale.

Patients assigned a lower priority to the continuity of caring subscale. Weisman (1979) suggested that oncology patients receiving active treatment

for their disease may not be able to envision life beyond the treatments. Therefore, they may not be thinking of their post discharge period, and would not expect the nurse to be doing so either. In addition, oncology patients may not expect hospital nurses to be concerned with support systems and resources outside the hospital. Finally, the approach of professionals to disease management during the acute phases may give the patient the message that they are more concerned with the disease process than with coping with daily living outside the hospital. Glaser and Strauss (1968) and Brown (1986) have supported this notion.

The oncology patients generally valued nurses' cheerfulness, calmness, and organizational skills (disposition of the nurse caring) more highly than did the nurses. This finding may be related to the results of a study by Brown (1981) in which patients valued equally the aspects of care that reflected "what the nurse does" and "what the nurse is."

The two subscales that showed no statistically significant difference in mean ratings between the two groups were empathetic manner of caring and attentive caring. The behaviors representative of these two subscales included, for example, a quick response to patient's call, a consistent approach to the patient, and the provision of basic comfort measures. These behaviors may represent the basis upon which a caring relationship between a nurse and patient is generally established. Further research within this area of study is required to substantiate this premise.

### **Implications**

The design and sampling procedures of this project preclude generalizing to other populations. However, the findings do suggest several implications for nursing practice. Firstly, perceptions of nurse caring behaviors are individual and varied and must therefore be explicated within the context of each nurse-patient interaction or relationship. Secondly, by recognizing that perceptions of important caring behaviors vary with the individual, the assessment, planning, implementation, and evaluation of care can be tailored to each oncology patient. Thirdly, differences in the way nurses perceive the importance of specific nurse caring behaviors may influence the way they interact with one another. And lastly, information about the importance given to various nurse caring behaviors by patients and nurses may be useful in planning educational programs for nursing students and practising nurses.

## Conclusion

This study contributes information to Larson's (1981) original study, which developed and tested the Care-Q Instrument. It contributes empirical evidence towards the body of knowledge related to caring behaviors, and suggests that further research is needed in the area of caring with other patient populations. Time spent caring for the oncology patient might become more meaningful for both patient and nurse if there is a greater understanding of caring behaviors as significant elements of the caring environment.

## References

- Benner, P., & Wrubel, J. (1989). *The Primacy of caring: Stress and coping in health and illness*. Menlo Park, California: Addison Wesley.
- Brown, L. (1981). Behaviors of nurses perceived by hospitalized clients as indicators of care. (Doctoral Dissertation, University of Colorado at Boulder, 1981). *Dissertation Abstract International*, 43, 4361B.
- Brown, L. (1986). The experience of care: Patient perspectives. *Topics in Clinical Nursing*, 8(2), 56-62.
- Cronin, S.N., & Harrison, B. (1988). Importance of nurse caring behaviors as perceived by patients after myocardial infarction. *Heart & Lung*, 17, 374-380.
- Dennis, K. E. (1986). Q-methodology: Relevance and application to nursing research. *Advances in Nursing Science*, 8, 6-17.
- Erikson, E. (1950). *Childhood and society*. New York: Norton.
- Ford, M.B. (1981). Nurse professionals and the caring process. (Doctoral Dissertation, University of Northern California, 1981). *Dissertation Abstracts International*, 42, 967B-986B.
- Forrest, D. (1989). The experience of caring. *Journal of Advanced Nursing*, 14, 815-823.
- Freihofer, P., & Felton, G. (1976). Nursing behaviors in bereavement: An exploratory study. *Nursing Research*, 25, 332-337.
- Gagnon, L. (1992). *Perceptions of nurse caring behaviors towards family members in the critical care setting*. Unpublished master's thesis, McGill University, Montreal, Quebec.
- Gaut, D.A. (1984). Development of a theoretically adequate description of caring. *Western Journal of Nursing Research*, 5, 313-324.
- Gaylin, W. (1976). *Caring*. New York: Knopf.
- Glaser, B. & Strauss, A. (1968). *Time for dying*. Chicago: Aldine.
- Gottlieb, L., Rowat, K. (1987). The McGill model of nursing: A practice-derived model. *Advances in Nursing Science*, 9(4), 51-61.
- Harris, J. (1989). *The caring behaviors of nurses as perceived by hospital clients*. Unpublished master's thesis, University of Mississippi, Jackson, Mississippi.
- Heidegger, M. (1962). *Being and the time*. (J. MacQuarrie & E. Robinson, Trans.). New York: Harper & Row.
- Henry, D.M. (1975). Nurse behaviors perceived by patients as indicators of caring. (Doctoral dissertation, Catholic University of America, 1975). *Dissertation Abstracts International*, 36, 02652B.
- Irwin, B.L., & Meier, J.R. (1973). Supportive measures for relatives of the fatally ill. *Communicating Nursing Research*, 6, 119-128.

- Jourard, S. (1971). *The transparent self*. New York: Nostrand.
- King, I. (1981). *A theory for nursing: Systems, concepts, process*. New York: John Wiley & Sons.
- Larson, P. (1981). Oncology patients' and professional nurses' perception of important caring behaviors. (Doctoral dissertation, University of California, San Francisco, 1981). *Dissertation Abstracts International*, 42, 568B.
- Larson, P. (1984). Important nurse caring behaviors perceived by patients with cancer. *Oncology Nurses Forum*, 11, 46-50.
- Larson, P. (1987). Comparison of cancer patients' and professional nurses' perceptions of important caring behaviors. *Heart & Lung*, 16, 187-193.
- Leininger, M. (1977). Caring: The essence and central focus of nursing. *Nursing Research Report*, 12, 2-14.
- Leininger, M. (1986). Care facilitation and resistance factors in the culture of nursing. *Topics in Clinical Nursing*, 8, 1-12.
- Leininger, M. (Ed) (1988). *Care – the essence of nursing and health*. Detroit: Wayne State University Press.
- Mangold, A. M. (1991). Senior nursing students' and professional nurses' perceptions of effective caring behaviors: A comparative study. *Journal of Nursing Education*, 30, 134-139.
- May, R. (1969). *Love and will*. New York: Norton.
- Mayer, D.K. (1987). Oncology nurses' versus cancer patients' perceptions of nurse caring behaviors: A replication study. *Oncology Nursing Forum*, 14 (3), 48-52.
- Mayeroff, M. (1971). *On caring*. New York: Barnes and Noble/Harper and Row.
- Orlando, J. (1961). *The dynamic nurse-patient relationship*. New York: Putnam & Sons.
- Pepleau, H. (1952). *Interpersonal relations in nursing*. New York: Putnam & Sons.
- Ray, M.A. (1987). Technological caring: A new model in critical care. *Dimensions of Critical Care Nursing*, 6, 167-173.
- Reimen, D. J. (1986). Noncaring and caring in the clinical setting: Patients descriptions. *Topics in Clinical Nursing*, 8, 30-36.
- Rogers, C. (1965). The therapeutic relationship: Recent theory and research. *Australian Journal of Psychology*, 2, 96-99.
- Simon, S. (1976). *Caring, feeling, touching*. Niles, Illinois: Argus Communications.
- Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston: Little and Brown.
- Weisman, A.D. (1979). *Coping with cancer*. New York: McGraw-Hill.