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Perspectives on Hope of Hospice and Palliative Care Nurses

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PERSPECTIVES ON HOPE OF
HOSPICE AND PALLIATIVE CARE NURSES

BY
KATHERINE MARGARET PAQUETTE

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
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DOCTOR OF PHILOSOPHY DISSERTATION

OF

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Abstract

Fostering hope for clients experiencing end of life is an essential component of Hospice and Palliative Care nursing practice. There is a limited repertoire of literature that describes the perspectives on hope held by Hospice and Palliative Care nurses. The purpose of this doctoral research study was to describe the perspectives on hope of Hospice and Palliative Care nurses who work in one Hospice and Palliative Care organization in the northeast. The specific research questions that guided this inquiry included: How do Hospice and Palliative Care nurses describe the concept of hope? In what ways do the nurses think that hope is helpful to clients? What nursing interventions do nurses utilize to facilitate clients' hopes?

A qualitative methodology utilizing a self-report questionnaire on hope was used to collect data from Hospice and Palliative Care nurses who work in inpatient and home care settings. Manifest content analysis was the research methodology utilized for analysis of the data from nine open-ended surveys returned by the nurses. The perspectives on hope of the Hospice and Palliative Care nurses illuminated two potentially new critical attributes of hope to include spirituality and interconnectedness. The nurses described hope as being helpful to clients by allowing them to stay positive, stay in control, feel safe and find meaning in their circumstances. Descriptions of nursing strategies that foster hope did not consistently demonstrate integration of the elements of connectedness and spirituality into their interventions. Organizational issues, such as decrease in Hospice client lengths of stays, with a resulting increase in client acuity and conflicting end-of life-care plans may have been factors that impacted on these nurses' descriptions. It is not known what individual factors may have influenced

the Hospice and Palliative Care nurses' perspectives on hope. Further research is required to understand the circumstances that may impact on Hospice and Palliative Care nurses' perspectives on hope.

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and your caring have made all the difference in keeping me balanced and focused on completing this dissertation.

One encounters many other doctoral students throughout their program of study. I have been fortunate to meet some extraordinary nurses who have always been caring and supportive. My thanks to Lisa, Diane, Joyce, Claire, and Lynn for their words of encouragement and sessions of commiseration.

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highest respect for being fierce advocates for your patients and for our profession. This work is dedicated to all of you.

Preface

There are times when being a critical care nurse is an arduous endeavor. It can be a frustrating, exhausting, demanding and sometimes harsh journey into the suffering of others where one questions the futility of health care, the meaning of life and the purpose of caring. It was at a critical point in my clinical practice when I was most disillusioned with critical care nursing that the phenomenon of hope emerged. I was taking care of Richard, who was 23 years old and admitted to our Intensive Care Unit with acute granulocytic leukemia and sepsis. He was young, vibrant, and frightened as he had rarely been ill, even as a child. I remember his sense of humor when his relentless diarrhea became a problem. I could see the sinking of his eyes into the soul of his body as his strong immune system became weak. I remember how we set up a card game for him and his friends, complete with turning off the monitors and dressing him in his own clothes, so he could be sure to see all his friends and have them remember him “in a good way”. I can still see his mother’s face straining to smile, remaining upbeat but with the dullness of pain and anger in her eyes. When the hematologist scheduled a family meeting to discuss Richard’s circumstances and painted the grim picture we all did not want to imagine, I began to lose faith in my own ability to remain his nurse. Fortunately, my wonderful colleagues came to the rescue when I asked for a change in assignment under the guise of needing a break from Richard. Sally, the pragmatic, organized and competent senior ICU nurse just looked at me and said “You may need a break but Richard needs you;” and so I stayed with Richard and cared for him and his family for what ended up being the last three weeks of his life. I listened as Richard described his hopes and dreams as if they were likely to happen the next day, followed by a realization

that they might never happen. Richard was not afraid of death; he just hoped it would not be painful and that his mother would be able to “deal with it.” In those precious days before he began to experience a change in his level of consciousness, we talked about so many things; preparing for the possibility of death became preparing for the inevitability of it. Nothing was working from a medical intervention perspective and he started having problems with bleeding. That was the worst and the only time I saw Richard become rattled—when he vomited a large amount of bright red blood and the tears in his eyes said it all. Some days Richard would hope for a little strength to sit up for a few minutes and talk to his buddies on the telephone and other days he would hope for an eternal card game and wondered if gambling was legal in heaven. I will never forget the peacefulness that seemed to envelop him when he could no longer speak or breathe and ended up on a ventilator. His mother could not let go. Richard had told me to let her do whatever she wanted because when it got to that point, “I’m pretty much done anyway, so I don’t want her to have any regrets.” It was only a few days later that Richard, now comatose from a massive intracerebral hemorrhage, had a cardiac arrest and died. We all cried for Richard and spoke of the valiant struggle he endured during his illness. The sorrow I felt at that moment was overwhelming.

That is when I started thinking about hope. I began to ask myself, how do patients and families do this? I saw it every day, over and over, rejoicing and despairing, bargaining and praying, hanging on to the unraveling threads of life and weaving a new blanket of warmth for their souls. It was during this time that I questioned what it was that allowed people to cope with the crisis of acute illness. I came to believe that it was

hope and that this hope has many forms, dimensions and qualities. I realized that hope was about finding possibilities and nursing enabled possibilities.

It is now many decades later and Richard is still guiding me through my scholarly inquiry into the phenomenon of hope. He is a testimony not only to the power of hope but to the fundamental beauty of clinical nursing practice where our patients teach us more about nursing than any textbook can. He is the predecessor of hundreds of patients that I have cared for where I have considered fostering hope as an essential component in my plan of care. I remain deeply committed to understanding hope and how this phenomenon is experienced by patients and embedded in our nursing practice.

I was fortunate to have the opportunity to visit Romania in 2011 and engage in professional relationships with Hospice and Palliative care nurses in Bucharest and Brasov. I accompanied many nurses on home visits with patients at end of life where financial resources for care were meager. During these experiences, I came to recognize how instrumental the nurses were in facilitating hope for their patients regardless of the circumstances. I became interested in how Hospice and Palliative care nurses perceive hope and its role in their professional practice. These Romanian nurses were dedicated to their work and committed to easing the suffering of their patients. I wondered whether the nursing interventions they selected to foster hope were influenced by their unique perspectives on hope.

My clinical practice background has focused on critical and acute care nursing and these may be seen by others as completely differing from Hospice and Palliative care nursing practice. What I discovered is that we shared many common issues and concerns related to end of life care. As a critical care nurse, I have participated in

supporting patients and families through end of life and the grief associated with dying. I have provided physical care to patients that focused on ameliorating suffering, restoring dignity, enhancing quality of life and creating a peaceful death. These strategies are consistent with those implemented by Hospice and Palliative care nurses as we share a camaraderie of commitment to connecting with the human spirit at end of life. My experiences with the Romanian Hospice and Palliative care nurses have served as the foundation for my doctoral work examining nurses' perspectives on hope.

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Chapter I

Introduction

Hope springs eternal in the human breast;
Man never Is, but always To be blest:
The soul, uneasy and confin'd from home,
Rests and expatiates in a life to come.

-Alexander Pope,

An Essay on Man, Epistle I, 1733

All persons throughout the life cycle and through the health-illness continuum, including at the end of life, need hope (Fitzgerald Miller, 2007). The primacy of hope for clients experiencing the crisis of illness and end of life is readily acknowledged in the nursing literature (Fitzgerald Miller, 2007; Nekolaichuk, 2005; Pilkington, 1999). Hope has been identified as a core phenomenon in nursing practice (Duggleby, Cooper & Penz, 2009; Fitzgerald Miller, 2007; Herth, 2001) since nurses often assume the primary care of clients at end of life. Subsequently, it is imperative that nurses reflect on how they perceive hope and how they foster hope at end of life.

Hospice and Palliative Care Nursing Practice and Hope

Hospice and Palliative Care nurses are faced with caring for patients at end of life on a daily basis. There is a limited repertoire of literature that describes the perspectives on hope and hope-inspiring nursing strategies held by Hospice and Palliative Care nurses. An integrated review of hope in Palliative Care was conducted by Kylmä, Duggleby, Cooper, and Molander (2009) to determine the current status of research on hope in Palliative Care. The majority of the research focused on client's hope and factors that influence the client's hope. These authors noted that research regarding the perspectives on hope of nurses in Palliative Care is negligible and more

research is needed on interventions to engender hope (Kylmä et al., 2009). Nursing interventions that have been proposed to foster hope in Hospice and Palliative Care include: affirmation of the patient's worth (Herth, 1990) attainable goal setting (Duggleby & Wright, 2007; Herth, 1990), symptom management (Duggleby & Wright, 2007), supporting spirituality (Davis, 2005; Duggleby et al., 2009), teaching (Desbiens, Gagnon, & Fillion, 2012) and exploring options (Johnson, 2007). These strategies have primarily been described in qualitative research exploring hope for individuals experiencing the crisis of illness or end of life.

Mok et al. (2010) explored Palliative Care health professionals' perspectives on the meaning of hope for patients with advanced cancer (Mok et al., 2010). Thirteen of their 23 participants were nurses. Strategies to foster hope identified by the participants included affirmation of worth, relational connectedness, partnership, religious support and resolving unfulfilled family responsibilities. Hope allowed patients to achieve a sense of peace, calmness and transcendence and facilitated living a normal life, goal attainment and preparing for death (Mok et al., 2010).

Turner and Stokes (2006) examined the self-reported hope-promoting strategies utilized by nurses caring for older adults in acute and long-term care settings (Turner & Stokes, 2006). These nurses identified touching the lives of others, connecting with their inner being, journeying with them and building trust over time and the way you do things rather than the things you do as strategies to facilitate hope. The authors suggested these strategies were not unique to hope promotion and that "further studies be undertaken which explore the hope facilitation practices of Registered Nurses within all practice settings" (Turner & Stokes, 2006, p. 370).

Penz and Duggleby (2011) explored the hope experiences of 14 registered nurses who provided Palliative Care services in community settings. The Palliative care nurses “found that the concept of hope was complex and, at times, difficult to put into words” (Penz & Duggleby, 2011, p. 286). These nurses described hope as a realistic understanding of future possibilities, an active process, and something that gives meaning and purpose to clients’ lives. Hope was facilitated through maintaining their own sense of hope, interconnectedness with clients, seeing the bigger picture and trying to make a difference (Penz & Duggleby, 2011). The Palliative Care nurses in this study did not described how hope was helpful to clients. The authors acknowledged that there is a “lack of evidence on the meaning of hope for health care professionals, and, in particular, understanding hope in the context of Palliative and end of life care delivery” (Penz & Duggleby, 2011, p. 281). This gap in the literature on nurses’ perspectives on the concept of hope, how hope is helpful to the client and what particular nursing strategies they feel are effective in fostering hope provides the basis for further inquiry.

Purpose of this study

The purpose of this doctoral research study was to describe the perspectives on hope of Hospice and Palliative Care nurses who work in one Hospice and Palliative Care organization in the northeast. After receiving approval from the University of Rhode Island Institutional Review Board (Appendix A), self-report questionnaires (Appendix B) were used to collect data on Hospice and Palliative Care nurses perceptions on hope. This questionnaire was based on an identified need for understanding how these perceptions may impact nurses’ decision-making during the phases and enactment of deliberation in Kim’s (2010) practice domain.

Research Questions

Exploring the phenomenon of hope from the perspectives of a group of Hospice and Palliative Care nurses will contribute to a better understanding of this fundamental concept, ways that nurses think hope is helpful to clients as well as the nursing interventions that engender hope and the outcome of hoping for clients. The following questions provided the foundation for this research study:

1. How do Hospice and Palliative Care nurses describe the concept of hope?
2. In what ways do the nurses think that hope is helpful to clients?
3. What nursing interventions do the nurses utilize to facilitate client's hopes?

The Significance of the Study for the Discipline of Nursing

Kim (2010) has articulated a typology that is the underpinning of knowledge development in nursing. She identified four domains that are essential to understanding the nature of nursing and these include the client, client-nurse, practice and environment domains. The practice domain describes the nature of nursing practice and the aspects of the nurse as an engaged participant in practice. There is purpose and meaning in the activities that a nurse selects and implements in endeavoring to meet individual client needs. This process of decision-making and action requires the nurse to integrate theoretical and experiential knowledge as it is situated in a specific client and health care circumstance. According to Kim (2010) "Nursing work refers to nurses' practice, which includes the cognitive, behavioral, social and ethical aspects of professional actions and activities performed and/or experienced by nurses in relation to patient care" (p. 169). How nurses make decisions on what to implement in practice and how the implemented practice results in desirable outcomes for the client are questions that Kim has identified

as foundational to understanding nursing work. Cognitive construction of a mental landscape that spans the scope of the nurse's theoretical and experiential knowledge is an antecedent to determining what interventions will or should be implemented in the practice setting.

Kim (2010) has configured the practice domain utilizing three sets of structures: the philosophies, the dimensions and the processes (Kim, 2010). These structures include the essential values, ways of knowing and methods of selecting and delivering care that foster clarity in understanding the phenomenon of practice. This typology is useful in identifying specific components in the practice domain for scientific inquiry and establishing their relationship to the domain as a whole.

The process structure in the practice domain is concerned with the factors that influence the progression of analysis of client needs to the delivery and evaluation of nursing interventions. "It involves both mental and behavioral aspects of actions, which are interlinked with the agent of practice, the client and the client's situation, the content of practice, and the nursing perspectives" (Kim, 2010, p. 179). This process has two distinct phases: the phase of deliberation and the phase of enactment. These phases are interactive and nonlinear, a relationship that is necessary for the nurse to provide care that is contextually relevant. Movement between the phase of deliberation and the phase of enactment is similar to the concept of praxis, which involves reflection in action and reflection on action as a means to achieving a sense of what is salient in a particular client situation. As nurses, we are constantly deliberating on the scientific and experiential knowledge that we possess and the client's needs when nursing actions are selected and implemented. Client responses to specific care activities can be discreet and

readily discernible, such as a verbalized decrease in pain level as identified on the numeric pain level scale, or subtle and ascribable to a plethora of causes, such as a disinterest in learning diabetic self-care management. The nurse must be able to make sense of each client's response as it is occurring, consider all the variables, and make decisions as to how this will impact the plan of care for the client. The challenge for the nurse is that this deliberation and enactment must occur while attending to the client, the environment of practice, and the nurse's own feelings, perspectives or needs. There is an expectation that the nurse will have the capacity to focus and to engage in this internal discourse and clinical decision-making despite conflicting distractions. What compensates for this seemingly overwhelming expectation is the nurse's commitment to connecting with the patient on a human-to-human level. When the nurse "knows the patient," the process of deliberation is simplified to the degree that the nurse is selecting from a narrower and more specific repertoire of knowledge to identify salient actions. The concept of phronesis, or the development of practical wisdom and understanding regarding a particular client situation, allows the nurse to integrate scientific knowledge that is relevant and can form the foundation for intelligent, morally sound nursing interventions.

The process of enactment describes the performance of nursing care activities. It is distinguished from the phase of deliberation by the temporal and provisional variables that emerge as care is being delivered. "Nurses, regardless of their deliberation, need to adapt actual performances of nursing actions to situational contingencies that exist at an immediate environment" (Kim, 2010, p. 189). Enactment requires the nurse to make on the spot modifications to their actions, depending upon the client behavior, responses or

the emergence of unanticipated and conflicting priorities. Nurses as enactor agents will possess a varying degree of clinical knowledge and expertise that is layered upon their ability to deliver care, as they develop clinical expertise according to Benner's novice to expert paradigm. Organizational skills, psychomotor competency, compassion fatigue, and personal habits are additional factors that can confound implementation of the intended plan of action.

There is a paucity of literature that describes the perspectives of nurses on hope. During the phase of deliberation, the nurse either consciously or unconsciously integrates her/his individual life history and professional experiences into one's assessments and care planning. Development of a nursing plan of care is predicated on the assumption that the nurse understands the scope of the client's issues and has knowledge of interventions that are evidence-based. In regards to the concept of hope, this understanding should include knowledge of the conceptual foundations of hope, how hope is helpful to clients, and interventions that facilitate hope.

Definition of terms

The terms "hope" and "hoping" are often used interchangeably in the literature and this practice has led to confusion and difficulty in articulating a universal definition of hope. Hope has been described as both a process and an outcome. Hope, as a noun, is the "expectation of something desired...desire combined with expectation...what which is hoped for...objects of hope" (Oxford English Dictionary [OED], 1982).

A typology of hopes has emerged from qualitative research on client experiences with hope. Generalized hopes are those that give the individual the motivation to carry on with life's responsibilities and tend to be more global and spiritual in nature while

particularized hopes are specific, goal directed statements that affirm what a person perceives is most important in the current life circumstance (Dufault & Martocchio, 1985). Particularized hopes provide direction to the person's own energies and those of others who care for them, as they often are expressed as goal statements.

Hospice and Palliative Care nursing is defined as “nursing practice that promotes and improves the client's quality of life through the relief of suffering along the course of illness, through the death of the patient, and into the bereavement period of the family” (American Nurses Association and Hospice and Palliative Nurses Association [ANA & HPNA], 2007, p.1). Hospice and Palliative care nurses have a professional responsibility to identify salient nursing interventions to foster hope for the individuals during their end of life experiences.

Summary

The phenomenon of hope is central to nursing practice. There are few research studies that specifically describe nurses' perspectives on hope, how hope is helpful to clients and strategies that facilitate hope. This research study will examine the perspectives on hope of Hospice and Palliative Care nurses. Such inquiry will contribute to nursing knowledge development regarding the phenomenon of hope as actualized in Hospice and Palliative Care nursing practice.

In Chapter II the philosophical and theoretical foundations of the concept of hope and salient qualitative and quantitative research literature that informs our understanding of this concept are examined. A historical perspective on hope, the philosophical positioning of hope as embedded in nursing practice, content analysis on hope, development of instruments to measure hope, lived experiences of hope, variables

associated with hope, hope intervention programs, and hope in Hospice and Palliative Care nursing practice were explored.

Chapter II

Literature Review

In Chapter I, it was argued that Hospice and Palliative Care nurses' perspectives on hope and subsequent implementation of hope-inspiring strategies received limited attention in the literature. This is particularly striking considering the extensive exploration of hope that is evident in the literature, including areas such as philosophical underpinnings, concept analyses, instrument development, descriptive correlational studies, qualitative research, hope intervention programs, and nursing strategies that engender hope. This exploration has been enlightening in demystifying the concept of hope and providing a foundation for the development and implementation of effective hope-inspiring nursing strategies.

In this chapter, the historical perspectives of hope are reviewed, the concept analyses on hope are discussed, and working assumptions and a proposed process of hoping are articulated. Client perspectives on hope, the development of instruments to measure hope, descriptive correlational research on hope, and hope intervention programs are discussed. Hope as situated in the context of terminal illness and Palliative and Hospice nursing care models and strategies are reviewed. Understanding the nature of Palliative and Hospice care nursing is germane to this doctoral research regarding the perspectives on hope of Hospice and Palliative Care nurses.

Historical Perspectives on Hope

The phenomenon of hope has been recognized as a juggernaut in the human condition. Throughout history, hope has generally been regarded as a positive force, a place of solace during suffering, and a means to eternal salvation. The Judeo-Christian

tradition places hope along with the extolled virtues of faith and charity as examples of the essence of human existence (Snyder, 2000). In the mid-13th century, Saint Thomas Aquinas described hope as a movement or a stretching forth of the appetite towards an arduous good (Aquinas, 1947). He did not consider hope a virtue, but rather a disposition that fuels the journey towards everlasting life with God as our ultimate goal. This journey was considered arduous, wrought with sacrifice and suffering, as humans endeavor to achieve communion with God. Aquinas was concerned that hope might be focused on earthly desires and this deviation would distract from the mission of salvation. Hence, hope developed theological boundaries in being considered a positive and desirable phenomenon.

Hope was also viewed from a negative perspective as providing a false sense of purpose and meaning to life. In Greek mythology, the story of Pandora's box describes the role of hope as being what remained when the evils of the world were released and hardship ensued. Certainly, the Greeks had some speculation as to whether hope did eventually escape from Pandora's box, and if so, what did it have to offer them. The ancient Greeks' ambiguity concerning hope was related to their pessimistic and fatalistic worldview, as life was difficult, capricious, and often times cruel (Alexander, 2008). Sophocles and Plato, and later Neitzche, considered hope as a tormenting extension of inevitable suffering and completely without merit.

Despite the duality of hope as envisioned throughout history, the prevailing perspective remains one that embraces the sanguine power of hope. In contemporary times, the ability of hope to impact on individual's decision making in coping with life experiences gained the attention of the disciplines of nursing, medicine, and psychology.

In the 1950s and 1960s, psychiatrists and psychologists began to frame hope in a goal attainment paradigm (Snyder, 2000). A positive expectation of goal attainment emerged as the accepted definition of hope (Stotland, 1969). Medicine retained its skepticism towards hope as having any role in the medical plan of care, although some physicians acknowledged the healing power of hope. In 1966, Sister Madeline Clemence published an article in the *American Journal of Nursing* that described existentialism as a philosophy of commitment in nursing. In this article, she discussed the primacy of hope as imperative to the client's becoming an authentic being despite the crisis of illness. Clemence identified the role of nursing in fostering hope as part of this existential transformation and healing (Clemence, 1966). This illumination of the relationship between nursing and hope, and the articulation of hope-inspiring strategies, provided the foundation for subsequent nursing inquiry on hope.

The next three decades realized a tremendous upsurge of scholarly energy in nursing focused on understanding the phenomenon of hope. The initial concept analysis published by Miller and Powers (1988) and the seminal qualitative research of Dufault and Martocchio (1985) that delineated a typology of hope, were the basis for a robust program of research on hope. Quantitative research was conducted to examine the phenomenon of hope focused on the development and testing of multiple hope assessment instruments, description of relationships between hope and salient variables and testing of hope intervention strategies for effectiveness in improving levels of hope (Herth, 2000, 2001; Tollet & Thomas, 1995). The development of valid and reliable instruments to measure hope was significant in quantitative research, allowing for operationalizing the construct of hope for measurement in descriptive, correlational and

quasi-experimental designs (Benzein & Berg, 2005; Herth, 1992; Kavradim, Özer, & Bozcuk, 2013; Miller & Powers, 1988; Nowotny, 1989; Rustøen & Wiklund, 2000; Wang, Chang, Shih, Sun, & Jeng, 2006). Relationships between the variables of hope, functional status, stage of disease, fatigue, psychosocial adjustment, pain, coping, well-being, quality of life, and depression were explored. The results of these studies have contributed to the understanding of the complex nature of hope and the factors that impact on the client's hopefulness.

In concert with the quantitative research on hope, qualitative researchers examined the concept of hope utilizing a variety of methodologies. Understanding client experiences and identifying salient variables or concepts associated with hope contributed to enhancing the scope of quantitative research and instrument revision. In fieldwork and ethnographic research, hope has been described as a culturally and personally situated phenomenon (Miyazaki, 2004; Perakyla, 1991). Semi-structured interview and grounded theory approaches have identified emergent themes and social or psychological processes that describe hope from the client's perspective (Henricson, Segesten, Berglund, & Määttä, 2009; Herth, 1995; Verhaeghe, van Zuuren, Defloor, Duijnste, & Grypdonck, 2007). A descriptive phenomenological approach has been employed to understand core concepts related to hope that were embedded in the lived experiences of clients and families (Baumann, 2004; Parse, 1999). Researchers using an interpretive phenomenological methodology have sought to enhance our understanding of meanings, themes, and essences that emerge from client interviews and descriptions of hope as unfolding in response to changing life challenges (Holtslander & Duggleby, 2009; Little & Sayers, 2004; Seibaek, Peterson, Blaaker, & Hounsgaard, 2012).

Hope as a phenomenon worthy of our attention and understanding has continued to flourish in this postmodern era. There has been an outpouring of publications in nursing, the social sciences, behavioral sciences and medicine regarding hope. Cultural, behavioral, social, psychological, and philosophical perspectives have been considered as the scholarly community endeavors to maximize validity, reliability, generalizability, and trustworthiness of research on the phenomenon of hope. In nursing, this has significantly enhanced our professional practice and our ability to assess, plan, implement, and evaluate care that is focused on fostering hope for our clients.

Philosophical Foundations of Hope in Nursing

It is important to discuss the philosophical foundations of hope to develop a comprehensive understanding of this essential nursing concept. The predominant philosophical perspective related to hope that appears in the nursing literature is existentialism. To understand this perspective, it is necessary to clarify the basic tenets of existentialism while recognizing the vast diversity among existential philosophers. The critical elements of most contemporary existential thinking reflect the understanding of the basic judgment “I am.” “*I* (that which is, the essence) and the *am* (the fact that the essence is, its existence) are co-principles of being” (Clemence, 1966, p. 501). If a being exists then one must have an essence, which is reflected in the familiar existential tenet “existence precedes essence.” This statement provides the foundation for understanding the following principles: 1) all individuals have worth, 2) the individual is responsible for the shaping of self through freedom of choice, and 3) individuals are forever *becoming*. The authentic *being* must accept the responsibility of existence and demonstrate “the courage to face adversity and suffering and to accept the full

responsibility for one's actions with integrity" (Clemence, 1966, p. 502). The atheist perspective on existentialism suggests that man's endurance of suffering is futile, it leads to nothingness, and freedom of choice is only valued as an activity, not as achieving an ultimate goal. Based on the theist perspective, purported by Gabriel Marcel, participation in existence and endurance of suffering results in personal growth.

"According to Marcel, every person finds himself in a given situation, which constitutes the person's *existence*...and human existence is goal directed...our specific goal as human beings is to pass from existence, which is passively received, to *being*...this passage is effected by commitment." (Clemence, 1966, p. 504). This belief in *being* as a consequence of the goal directed nature of human existence opens the individual to self, to life, and to the acceptance of both as part of the commitment to, or responsibility for one's life. Marcel distinguishes between to *be* and to *have* in describing this belief:

To be is, to use existential terminology, to be self-accepting, with insight, capable of bearing all the consequences of one's actions without excuses or alibi; open to love; open to life with all its richness and diversity but also to its concomitant suffering. To have is to shield one's self from the deep realities of existence—sorrow, joy, love, dread, the prospect of one's own death—behind the values extrinsic to the person: wealth, social prestige, knowledge or accomplishments. (Clemence, 1966, p. 504)

Theist existentialism lends itself to embracing and celebrating life's full range of experiences, in transcending to *being* and in achieving the *I-Thou* relationship in mutual human connections and the co-creation of meaning.

The writings of Gabriel Marcel have been instrumental in understanding the nature of humans and hope (Cutcliffe, 1997; Lohne & Severinsson, 2006; Pilkington, 1999; Stephenson, 1991). Born in 1889, Marcel was a French philosopher, playwright, drama critic, editor, and musician whose propensity for philosophical discourse was

evident in his associations with Paul Ricoeur and Jean-Paul Sartre. The development of Marcel's philosophical perspectives paralleled his life experiences.

Marcel attributes three characteristics of his thought to the circumstances surrounding his childhood. The differences in temperament and opinion to which he was exposed made him realize that life presents radical incompatibilities that cannot be resolved by means of intellectual formulae or conventional thought. Secondly, the religious aridity of his home and school life stirred in him a kind of nameless discomfort and anxiety that became largely the basis for his conversion to Catholicism in 1929. Finally, the death of his mother remained painfully present to him and gave rise to an awareness of the "hidden polarity between the seen and the unseen" which he considers a major influence in his philosophical development (Murchland, 1959, p. 342).

Subsequent philosophical writings by Marcel reflected what Sartre referred to as "Christian existentialism" in his publication *Existentialism is a Humanism* (Treanor, 2014, para. 1). As a young professor of philosophy, Marcel was dissatisfied with the prevailing philosophical arguments of idealism and the rigid epistemology of empiricism. His experiences as an auxiliary Red Cross worker in World War I found him in constant contact with the dead and the bereaved. Meaning and experiences as manifest through the human condition became central components of Marcel's discourse on the philosophy of Being. "The Being by which one is radically constituted can be discovered only when the other, far from being another, becomes a thou for me" (Murchland, 1959, p. 343). The human relationship and the intersubjectivity of experience emerged as key concepts in Marcel's philosophy. Hope is embedded in the notion of Being through the concepts of fidelity and presence. "Hope... is characterized

by a forthgoingness which results from a renewal of the bond with Being...hope is a kind of vision of a distant end...fidelity is remaining faithful to this end while yet journeying towards it” (Murchland, 1959, p. 351). Presence is described as a spiritual availability and an awareness that life transcends its worldly anchors, thus perpetuating man’s recognition of his freedom.

Marcel married and continued to lecture and write on existential philosophy, published in works such as *The Mystery of Being*, *Creating Fidelity*, and *Homo Viator*. His wife died of a terminal illness in 1947, an event that proved to solidify his early beliefs on enduring spiritual presence. Marcel’s personal life experiences with illness, suffering, and death parallel the experiences of nurses in practice. The irony of this connection only serves to strengthen the incorporation of his existential philosophy on hope into a nursing philosophical perspective.

In *Homo Viator*, Marcel explored the phenomenology and metaphysics of hope from a Judeo-Christen perspective (Pilkington, 1999). Marcel describes hope as a mystery, with spiritual undertones, that evolves in response to personal trials. He distinguishes hope from despair, optimism, and expecting. “In contrast to the solitariness of despair, hope entails communion and reciprocity: unlike optimism, it is rooted in faith and belief, and unlike expecting, it is characterized by humility and patience.” (Pilkington, 1999, p. 13).

The temptation to despair is the genesis for hope. “Hope is the act by which this temptation [to despair] is actively or victoriously overcome” (Marcel, 1962, p. 36). Marcel argues that hope is not a form of denial or an obstinate refusal to accept intolerable circumstances, nor is it capitulation to the futility of the present

circumstances. One might argue that hope is no different from optimism and Marcel is careful to clarify this relationship. Optimism is one-dimensional and speaks of a desired outcome only in the sense that the outcome is possible. Hope speaks of a multidimensional process, and engagement in one's internal as well as external environments, where possibilities are present through self-reflection and communion with others. This distinction has served as the foundation for theory development on hope and optimism. Optimism has been defined as the cognitive process of distancing the self from negative outcomes as compared to hoping, which is focused on reaching future positive, goal related outcomes (Snyder, 2002).

Hope and despair form a paradox; hope creates the possibility of despair and despair fosters hope. "Where despair denies that anything in reality is worthy of credit, hope affirms that reality will ultimately prove worthy of an infinite credit." (Treanor, 2014). Marcel believed strongly in the intersubjectivity of human relationships. These connections are the foundation of hope; the essence of hope is not to hope for X but merely to hope (Treanor, 2014). Marcel deviates from Sartre's existentialist perspective on the state of being of man. Sartre's man is surrounded by nothingness and despair, whereas Marcel's man embraces opportunities and possibilities, where the potential to be hopeful perpetually exists (Cutcliffe, 1997). Marcel also describes hope as dynamic, reality based and, temporally oriented to the future. He is careful to distinguish between the idea of being and having in relationship to hope, purporting that when one hopes, one does not have hope, one is hope. The spirit of Marcel's philosophical discourse can be realized in his definition of hope:

Hope is essentially the availability of a soul which has entered intimately enough into the experience of communion to accomplish in the teeth of

will and knowledge of the transcendent act-the act establishing the vital regeneration of which this experience affords both the pledge and the first fruits. (Pilkington, 1999, p. 13)

Here we see Marcel speak of hope in terms of spirituality, personal strength derived from relationships with others and the possibility of future good.

Evans (1984) offered an affirmative description of the role of despair that expands on Marcel's existential philosophical perspective (Evans, 1984). He proposed that to understand hope one must clarify and describe types of despair. There exists despair as a "way of life" and despair as a "moment in life" (Evans, 1984, p. 65). Despair, as a way of life is consistent with the atheist and nihilistic existential philosophies of Camus and Sartre, which emphasize the futility of existence. To hope is to regard despair as only a moment in human existence and is consistent with the theist existential perspective of Marcel (Evans, 1984). When an individual engages in hoping in a moment of despair, they are acknowledging the meaning of their life, which Evans (1984) refers to as the "call of life." "The call of life comes in a thousand wildly diverse forms: in moral experience, in personal relationships (friendship and erotic love), in the wonder of birth, in the ecstasy of music, in poetic communication with nature" (Evans, 1984, p. 66). This call of life would suggest a contemplative self-reflection and a willingness to transcend the circumstances that have created the despair. This is a matter of choice and hoping is a conscious decision to search for meaning. Uncovering the opportunity to engage in hoping is predicated on being open to the clues, or possibilities, that bathe the inner and outer world of the individual. This journey, this quest for understanding, and choice that the individual makes to embark on the journey, reflect the theist existentialist viewpoint. *Homo Viator* literally means "man the traveler." During

this pilgrimage, there may be many moments of despair. By choosing himself, man seeks a foundation for existence that gives his life meaning and opens his mind and heart to the world of possibilities. This openness of spirit and obligation to self and the world are conditions that allow hope to flourish in moments of despair. Man believes in the innate value of himself as a human being, a human being with a special place in the world. The nothingness of nihilism is ultimately confusing to him.

In a very profound sense, when an individual recognizes his responsibility for who he is and what he has become, and when he sees his obligation to become the person he ought to become, then he has already found the road that leads away from meaninglessness. (Evans, 1984, p. 96)

Marcel believed that the basis for this responsibility and for the belief in possibilities is anchored by faith. This faith in God, in God's ultimate power to forgive, allows the individuals to be able to forgive themselves. This liberation leads to self-love, and in turn the ability to love others. Evans (1984) described the concept of faith from three perspectives: "Cognitively expressed, faith is belief. In the area of emotional and personal experience, faith is trust. Seen in volitional and social aspects, faith is love" (Evans, 1984, p. 113). Each aspect of faith is reflected in Marcel's discourse on hope. The individual believes in the possibilities of hope, trusts in self and others for the support derived from human connections and experiences the beauty of love in self-transcendence.

Concept Analysis of Hope

Critical attributes of the concept of hope have been delineated through multiple and extensive concept analyses (Cutcliffe, 1997; Dufault & Martocchio, 1985; Farran, Herth, & Popovich, 1995; Miller & Powers, 1988, 2007; Morse & Doberneck, 1995;

Nekoliachuk, 2005; Wang, 2000). Several of the critical attributes identified as related to the concept of hope are addressed in the selected literature used for nursing intervention development and reflect utilization of analogous references (Appendix C, Table 1). The attributes of multidimensionality, dynamism and future orientation are identified most frequently and reflect the concurrent use of Dufault and Martocchio's (1985) conceptual framework as a theoretical foundation.

In delineation of the critical attributes regarding hope, theoretical and ontological discrepancies in the hope related contemporary nursing literature emerge. References to hope and the process of hoping frequently appear simultaneously, without distinction between process and outcome attributes. Lohne and Severinsson (2006) validated this dilemma and suggested "the phenomenon of hope be viewed as consisting of two different dimensions: the substance of hope and the hoping process" (p. 316). Eriksson (1986), as cited in Lohne and Severinsson (2006, p. 316), described the process of hoping to include "different milestones along the road to hope: from imagination to wishes, then onto awareness and intentions." Kim, Kim, Schwartz-Barcott, and Zucker (2006) recognized the multiple orientations from which hope is conceptualized, identifying philosophical, psychological and nursing perspectives. Hope was presented as a dynamic, dialectical process where patterns of hoping emerge through discourse and reflect the changing nature of feelings and experiences as they are contextually situated. Patterns of responses that are unique to the individual or to a similar group of individuals reflect the hoping process as dynamic and subjective. Kim et al. (2006) adopted a relativist ontology that challenged the belief "that hope can be expressed by individual

elements, or attributes and that hope strategies are applicable as general approaches to all types of patients” (p. 549).

The multiple definitions of hope that are evident in the literature present a quandary when trying to identify a conceptual definition to guide scholarly inquiry. Characterizations of hope and attributes of hope are often articulated without a definition of hope. Dufault and Martocchio’s (1985) definition of hope has been utilized most prominently in the nursing literature. “Hope is...a multidimensional, dynamic life force that is characterized by a confident yet uncertain expectation of achieving good, which is realistically possible and personally significant” (p. 418). This definition reflects the most frequently identified attributes of multidimensionality and future orientation that describe the concept of hope. Further delineation of the terms “multidimensional” and “life force” need to be pursued to clarify this definition. Limited consensus on definitions may be one of the reasons for the lack of a middle range theory on hope. Underpinning this issue is the need for clearer articulation of a comprehensive process of hoping that supports selection of personally significant hopes. This has implications for Kim’s (2010) practice domain and for identification of nursing care activities that may foster hope at various stages throughout the process.

Hope and Hoping

The terms “hope” and “hoping” are often used interchangeably and this practice has led to confusion and difficulty in articulating relational concepts and definitions of hope. Marcel (1962) has described hope as both a process and an outcome. Traditional definitions of hope and hoping also allude to this distinction. Hope, as a noun, is the “expectation of something desired...desire combined with expectation...that which is

hoped for” (OED, 1982). This distinguishes hope as an outcome and would imply that what one selects as a hope is something that is hoped for. It is a future possibility that is anticipated as either a tangible result or a desired state of being. Hope, as a verb, is also described with similar terminology. Hope is “to entertain expectation of something desired, to trust and have confidence...to look forward to something in the future” (OED, 1982). Thus, hoping is active, and involves a cognitive prognosis of a future that is anticipated as positive. Hope as an adjective “I remain hopeful we will succeed”, refers to a state of engagement in hoping. “Hope here is an attitude, and can thus be distinguished—though perhaps not separated—from specific things hoped for” (Godfrey, 1987, p. 8).

The French have two words for hope—*espoir* and *esperance*. The translation of *espoir* describes hope as a noun, a specific selected hope. *Esperance* is more consistent with being hopeful as a selected approach to personal circumstances. Godfrey (1987) suggested that being hopeful does not mean that hopes must be explicit (Godfrey, 1987). What is inherent in this statement is the premise that in order for one to be hopeful, one must be engaging in hoping, regardless of whether identified hopes are articulated. This idea has significant implications in the development of instruments to measure hope. A state of hopefulness cannot be determined simply by the amount of hopes an individual can identify. Hopefulness, as a measured phenomenon, may represent the individual’s engagement in the process of hoping. Identifying factors which impact on the individual’s ability to engage in hoping would be more useful to Hospice and Palliative Care nurses in caring for clients during end of life. For the purpose of this research

study, hope (n. a hope) has been defined as a future possibility that is anticipated as either a tangible result or a desired state of being.

Assumptions Regarding Hope

Articulating assumptions regarding the phenomenon of hope may be useful in addressing the major themes that emerge from concept analyses and theoretical perspectives. Assumptions are a set of statements reflective of foundational beliefs that must be engaged in order to assign credibility to theoretical thinking (McEwan & Wills, 2006). These statements can be based on a priori knowledge, such as philosophical perspectives or personal beliefs. Assumptions are not empirically tested, but can be argued philosophically (McEwan & Wills, 2006). These assumptions are not intended to be prescriptive; rather they have been delineated to offer a perspective on hope that acknowledges and synthesizes the contributions of many of those scholars who have engaged in inquiry regarding hope. Assumptions regarding hope as a noun and hope as a verb are presented.

1. Hope is a response to serious life circumstances.

When we speak of hope in relation to the personal struggle of individuals, we are identifying hope as a serious matter. This hoping is not trivial, such as “I hope it will not rain today” where the hope is not central to the individual’s ability to cope with life circumstances and ascribe meaning to experiences. This type of hope certainly is future oriented and based in possibilities and one might argue that it has personal significance for the individual. A great deal more is at stake for the person who has a serious illness and is trying to understand what is happening and identify an approach to handling the situation that maintains one's integrity as a human being. Godfrey (1987) referred to this

connotation of hope as “deep-grounded hope” to emphasize its importance and justify a need for reverence in regard to understanding the nature of this type of hope (Godfrey, 1987). For nursing, it is this deep-grounded hope that is most germane to our patients and to our practice. Although some of the assumptions regarding hope may be applied to less significant circumstances, the focus here is on articulating assumptions regarding hope in the context of an illness experience. “Gabriel Marcel maintains that hope, if it is not trivial, is situated—as despair also is—within a context where there is an impossibility, not necessarily of moving or even of acting in a manner which is relatively free, but of *rising to a certain fullness of life*” (Godfrey, 1987, p. 29). Impossibility arises from a perceived obstacle towards personal fulfillment, be it environmental, psychic, or illness related. Although the future is unknown and the present turmoil impedes movement towards a future goal, there is an expectation that a future will indeed occur. The formulation of the structure of that future is founded in hope.

2. Hope is essentially a cognitive process.

Hope as cognitive process supports the contemplation, self-reflection, and transcendence that are the basis for Marcel’s philosophy. This cognitive perspective is founded on certain antecedents. The primary assumption inherent in this process is that the individual has the cognitive capacity to engage in the hoping. This is not to say individuals with developmental disabilities, organic brain dysfunction or altered states of consciousness do not hope. It has been argued that hope can be viewed as a neurophysiologic process where the expectation of a future good in the form of pleasant somatic sensations can be experienced (Cousins, 1989) Cognitive appraisal in hope that

is situated in the context of an illness experience shares this anticipatory expectation of a future. One future is cognitively formulated and the other is a physiologic response. Both are process mediated. While the neurophysiological explanation for hope does allow for inclusion of a wider range of individuals, the assumptions regarding hope as a cognitive process are limited to those individuals with cognitive capacity.

If individuals cannot articulate their hopes, it cannot be assumed that they are not hoping. The client who has experienced a left sided stroke, with damage to Broca's area in the left frontal/ temporal lobe, has lost the ability to formulate speech, otherwise referred to as expressive aphasia. Numerous communication strategies have been developed and effectively utilized by nurses to understand these clients' needs through visual and tactile methods. The challenge this creates for nurses in regards to hope is readily apparent. Visual methods are developed using standardized responses and pictures that the individual can identify in response to questions regarding physical and emotional needs that are anticipated in the circumstances of a stroke. These tools may be inadequate in the context of hope where individual hopes are not standardized. In a situation where articulation of hopes is not possible, it must be recognized that the cognitive process may still occur.

Farran et al. (1995) have identified hope as having four central attributes and these attributes are expressed in terms of processes. Although these terms can be seen to contribute to some of the existing confusion between the concepts of hope and hoping, this conceptual framework offers empirical support for the cognitive nature of hope. Hope was described as an experiential process, where a life event that exposes an individual to the trial of suffering is the progenitor of hope. A potentially hopeless

situation is transformed into one of possibilities through the mobilization of hope (Farran et al., 1995). This experiential process of hope has been described as the “pain of hope.” It has been suggested that the consequence of this pain and suffering is the creation of meaning. Viktor Frankl’s experiences as a Jewish psychiatrist in concentration camps during WWII were the impetus for his work on meaning making and remain powerful exemplars that lend significant credibility to the linkages between hope and meaning making. Frankl described the individual’s “will to meaning” as the primary motivation in life (Burbank, 1988). This perspective was in direct contrast to his professional contemporaries Freud and Adler, whose will to pleasure and will to power (respectively) were proposed as fundamental motivators for human behavior. Frankl was a self-reported existentialist and the theist philosophical perspective is evident throughout his work. This perspective is consistent with the philosophical foundations of hope in the nursing literature.

Frankl (1984) quoted Nietzsche “He who has a why to live for can bear almost any how” (p. 126), supporting his belief that man requires a struggle to find purpose and establish goals to endure whatever suffering or circumstances are experienced within his life. Man evaluates what he has achieved and what he ought to achieve as essential to the state of becoming and creation of meaning. Meaning is freely chosen and is part of what it means to be human. Man has the freedom to change at any instance and does not simply exist, but is self-determining.

The search for meaning requires a degree of responsibility for understanding the nature of one’s existence. “Each man is questioned by life, he can only answer to life by answering for his own life” (Frankl, 1984, p. 131). Finding meaning should be a

contextual dynamic where the individual looks for meaning within the circumstances of his/her own unique existence. What is meaningful is always personally significant and unique to the individual. Uniqueness and personal significance are also attributes associated with hope. Delineation of the relationships between these two phenomena merits conceptual consideration.

Hope can be viewed as a spiritual or transcendent process, where uncertainty is embraced and faith in the self, in others and in a religious doctrine creates the foundation for hope (Farran et al., 1995). Uncertainty as a positive and motivating force has been developed theoretically. The Uncertainty in Illness theory explains “how patients cognitively process illness related stimuli and construct meaning in these events” (Mishel, 1988, p. 225). Mishel’s original theory addressed uncertainty in the acute illness experience. As the theory evolved and was found germane to the chronic illness population, a reconceptualization was formulated to explain the application of the theory in this patient population (Mishel, 1990). The Mishel Uncertainty in Illness Scale was developed to operationalize the concept of uncertainty for research inquiry.

This middle range nursing theory identifies three components to the experience of uncertainty in illness: antecedents, cognitive appraisal, and coping with uncertainty/adaptation. Antecedents set the foundation for the perception of uncertainty. The primary antecedent is the stimuli frame, which includes symptom pattern, event familiarity, and event congruency. These components allow the patient to construct a cognitive schema to understand the illness experience and to decrease uncertainty (Neville, 2003). Cognitive capacities (intellectual processing) and structure providers (credible authorities, social supports, and education) are antecedent variables that impact

on the stimuli frame. Uncertainty is in neutral state at this point; cognitive appraisal occurs to define the nature of the uncertainty for the individual. According to Mishel (1988), uncertainty can be appraised as either an opportunity or a danger. This cognitive appraisal is influenced by the concepts of inference and illusion. Uncertainty as danger is seen as harmful and coping strategies are directed at decreasing uncertainty (Mishel, 1988). Uncertainty as opportunity implies a positive outcome and creates possibilities; therefore coping strategies are directed at maintaining uncertainty for successful adaptation. Embedded in the notion of hope as a spiritual or transcendent process is the primacy of cognition as essential in uncertainty to energize one's faith in "being able to live contextually" (Farran et al., 1995, p. 8).

Hope as a rational thought process has been defined utilizing the acronym GRACT where G = Goals, R = Resources, A = Active Process, C = Control, and T = time (Farran et al., 1995). Identifying realistic goals, possessing physical, social and emotional energy, engaging in active participation in goal attainment, feeling a sense of control, and engaging in learned process thinking as a result of contemplating past, present, and future experiences describe the rational process of hope. This perspective on hope is predicated on purposeful cognitive activity and is based on the Snyder's (1994) original work on a theory of hope. Snyder (2000) developed an interest in the goal directed nature of hope through his inquiry into pathways thinking. Pathways thinking can be defined as an individual's willingness to identify workable routes towards achieving a goal along with the willingness to engage in utilization of those pathways in goal achievement. Snyder described these components as pathway and agency, the latter associated with the motivational force that drives the pathways

thinking. Likewise, pathways thinking can contribute to generating motivation as the individual anticipates goal attainment (Snyder, 2002). These assumptions were the foundation of Snyder's definition of hope: "Hope is a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy) and (b) pathways (planning to meet goals)" (Snyder, 2002, p. 250). Interestingly, Snyder believed that hope goals needed to have some perceived uncertainty. This identification of uncertainty as a mediating factor in hope also emerged in the work of Farran et al. (1995).

Some discrepancies may exist between Snyder's (2002) model of hope and the experiences of hope by individuals (Tong, Fredrickson, Chang, & Lim, 2010). Tong et al. (2010) conducted four studies to examine the relationships between pathways thinking, agency thinking, and hope. Agency thinking was found to be correlated with higher levels of hope, whereas pathways thinking was not related to higher levels of hope. The authors suggested that individuals can remain hopeful even if they are not able to take action to meet their goals. This proposed spiritual nature of hope has been acknowledged by Snyder as a component of emotion. An individual's perceptions regarding their goal-directed activities can influence subsequent emotions, which, in turn, can impact on the hope (Snyder, 2002). Snyder's work has described the phenomenon of hope in general, not the hope that is related to serious life circumstances. It would appear that the role of spirituality emerges when there is much more at stake in actualizing one's hope.

Hope as an affective state has been described as an explanation for the emotionality that surrounds the concept of hope. "Emotion is often understood to include

intentionality...emotions are aimed at someone, have a focus or target...emotions are specified by their targets...The intentional object of hope is usually said to include the elements gathered in Aquinas' classic definition: hope's intentional object is what is agreeable, future, arduous, and possible of attainment" (Godfrey, 1987, p. 34). This emotionality supports the cognitive nature of the hope. Likewise, Snyder (2002) recognized the cognitive underpinnings of emotion as it impacts on hope. "Goal-directed cognitions elicit particular emotions...those emotions are in turn shaping and informing the cognition of the person who is in the throes of a goal pursuit. This role of emotions has been described as functional" (Snyder, 2002, p. 254). Functional emotions are those that direct our interaction with others and the environment. They are generated through reflective processing to facilitate pathways and agency in the pursuit of hopes.

Scioli, MacNeil, Partridge, Tinker, and Hawkins (2012) examined the potential role of the emotional resource of hope on the wellbeing of individuals with human immunodeficiency virus (HIV). The theoretical perspective on hope as an emotion was developed by Scioli (2007) and incorporates the motives of attachment, mastery, survival, and spirituality. The individual moves through a hierarchical process of appraisal, evaluation, decision-making, and trusting to achieve mastery through empowerment, support and collaboration, attachment through an openness and connectedness with the universe, and survival through protection from others and the self, and self-regulation (Scioli et al., 2012). Spirituality is considered a sub-network, an underlying foundation that supports the will to hope, the resiliency to hope, and the openness to hope. The cognitive aspects of Scioli's work are evident in the intentionality of the individual's movement through the levels of hope.

The fourth attribute identified by Farran et al. (1995) related to the concept of hope describes hope as a relational process. Hope can be fostered through relationships with others where support, guidance, and trust are engendered. An individual can positively influence another's hope through therapeutic use of self, communicating positive expectations or displaying confidence in the person's ability to endure (Stotland, 1969). These attributes provide the support structure for enabling cognition and enable agency thinking.

3. Hope is a future oriented process.

In nursing practice, clients who experience a change in health status or an illness experience that creates disequilibrium, stress, or is a perceived threat to internal stability, is consistent with the notion of a serious life circumstance. Utilizing a process approach to examine hope may be useful for nurses to assess, plan, implement, and evaluate nursing care activities that are focused on fostering hope. This is particularly relevant to Kim's (2010) practice domain. The practice domain is concerned with the nature of nursing thought and actions when providing care to clients. Within the framework utilized to organize the practice domain, Kim has identified philosophies, dimensions, and processes as structural components of the domain. Philosophies of therapy "provides the guidelines for the aspect of practice that are goal-oriented and strategic and are aimed at solving or attending to client's specific problem(s)" (Kim, 2010, p. 176). The philosophy of care is oriented towards caring for clients as unique human beings, valuing their individuality, being respectful and vigilant, all in the context of relieving or ameliorating pain and suffering. The dimensions of nursing practice are concerned with the moral and ethical standards of providing nursing care based on application of the best scientific

evidence in the context of the individual client's circumstances. Nursing practice as a process involves the mental and physical aspects of identifying and implementing nursing actions that are directed towards client goals. For each of these processes within Kim's practice domain, visualizing hope from a process perspective is beneficial in understanding the client experience and developing a plan of care based on client's needs as they engage in hoping.

The process of hoping can be proposed to consist of several phases (Appendix D, Figure 1). An awakening phase occurs when the individual has recognized his or her illness related circumstances and is engaging in appraisal of the situation as it impacts on his or her well-being. This phase is associated with the concept of uncertainty and a temporal orientation in the present as the individual contemplates the nature of what has happened while gathering information regarding his or her situation, identifies personal and external resources, and braces for negative outcomes. The inspiration phase follows as the individual moves towards a future orientation. This phase is associated with self-reflection, recognition of possibilities, and an anticipation of actualizing these possibilities as critical to finding a context for the illness experience. The realization phase occurs as the individual selects and actualizes hopes that are personally significant, future oriented, and realistic within the circumstances of their illness. These hopes can be explained utilizing a generalized/fundamental or particularized/ultimate typology. Fundamental hope can be described as an openness of spirit, a readiness and availability with respect to the future, consistent with Marcel's perspectives (Godfrey, 1987). Ultimate hope is hope that has a purpose, a goal for future attainment. The deliberation in making the critical decision as to which ultimate goal is most important

or valued is contextual. “Calculation of possibility and of desirability both bears on hope’s being preferred, and consequently on hope’s super- or sub-ordination” (Godfrey, 1987, p. 56). Dufault and Martocchio (1985) described these as spheres of hope. Generalized hopes are those that give the individual the motivation to carry on with life’s responsibilities and tend to be more global and spiritual in nature. Particularized hopes are specific, goal directed statements that affirm what a person perceives is most important in the current life circumstance. These particularized hopes provide direction to the person’s own energies and those of others who care for them, as they often are expressed as goal statements. Individuals sustain hope in periods of crisis through the ability to move between the two spheres of hope as meaning in the illness experience is constructed. Movement between the spheres is equivalent to a reactivation of the hoping process, where reawakening, inspiration, and realization of new hopes is initiated when a selected hope does not occur, as in a particularized hope that may be a specific goal, or when the illness circumstances change and temporal orientation moves back to the present. Individuals can realize either fundamental or ultimate hopes or both as the inherent value of the each type of hope is embedded in its personal significance for the individual. When the individual is able to select meaningful hopes, whether it is one or many hopes or it is one time through the hope process or a reiterative experience, this engagement is essential to the client’s ability to make meaning out of his or her illness experience.

The process of hoping is influenced by internal and external factors that can impact at each stage of the process. Factors can be categorized as either fostering or hindering and can impact on the initiation of the hoping process, movement through the

process and completion of the process (Herth, 1995, 2000). Overwhelming situational crises, pain or other uncontrolled symptoms, spiritual distress, denial, perception of senseless suffering, and nihilism are factors that have been found to hinder the awakening of hope. These factors can create an internal struggle in which the dynamic interaction between appraising threats and embracing uncertainty and recognizing resources becomes distorted, imbalanced, or does not occur. This leads to silenced hoping. Silenced hoping implies that the individual's motivation to hope has been significantly repressed. It is suggested that this can lead to a shift in temporality to the past, despair, a poor quality of life, a threat to survival, and even death. Factors that can foster the awakening of hope include access to health related information (Verhaeghe et al., 2007), a philosophical perspective of optimism, an openness of spirit and belief in self and in a future good, which allows the individual to mobilize internal psychic, emotional, and physical energy to discover what is possible.

During the inspiration phase, factors that can hinder the hoping process include social isolation, lack of supportive relationships, overwhelming changes in health status that impede future orientation, and shift internal energy as well as inadequate resources to identify what could be possible. Support of family and friends, meaningful relationships, feeling cared for, a positive relationship with health care providers, and identification of past hopes as applicable again to the future are factors that can foster the individual's movement through this process. Forging a connection with the client, establishing a trusting relationship, conveying a sense of commitment, affirming the individual's worth, and promoting self-reflection (Cutcliffe, 1997) are nursing strategies

that have a powerful impact on the client's ability to achieve progress through the inspiration phase.

The realization phase, where hopes are formed and realized, can be hindered by the repeated need to reestablish hopes related to rapid changes in health status that specifically impinge on the realization of particularized hope(s) as they may quickly become unrealistic. This constant need for reappraisal and deliberation can tap internal psychic energy and may lead to despair. Realizing hopes has been associated with healing (Cutcliffe, 1997), empowerment, self-transcendence, effective coping, increased self-esteem (Fitzgerald Miller, 2007), and improved quality of life. Factors that foster the realization process are similar to those during the inspiration phase relating to relationships that are supportive and sustaining to the individual. The maintenance of hopes requires the individual to continuously evaluate for signs that reinforce the selected goals, with a determination to endure (Morse & Doberneck, 1995). This will to endure supports the realization phase of hoping.

4. Hope can be impaired.

The individual can encounter several cognitive, psychological, and emotional barriers when attempting to hope. Silenced hoping has been described as an inability to engage in the awakening phase and move towards the inspiration phase in the proposed conceptualization of the hoping process. During the inspiration and realization phases, factors that can hinder the hoping process have been identified. Hopelessness, as a NANDA approved nursing diagnosis, is defined as "a subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on his or her own behalf" (Ackley & Ladwig, 2006, p. 626). This

description emphasizes the individual's cognitive disruption in the ability to engage in hoping and not merely being without a hope. Many of the defining characteristics of hopelessness are behaviors that are associated with maladaptive coping, apathy, and depression. Nursing interventions are focused on client outcomes such as identification of goals, use of positive language, engaging in self-care activity, and interacting with others. Impaired hoping as a nursing diagnosis allows the practitioner to recognize the preconditions, phases involved in generating hopesm, and identify the specific nursing interventions that would relate to each part of the process.

The suggested Nursing Interventions Classification for hope instillation are defined as “assist the client/family to identify areas of hope in life; demonstrate hope by recognizing the client's intrinsic worth and viewing the client's illness as only one facet of the individual; expand the client's repertoire of coping mechanisms” (Ackley & Ladwig, 2006, pp. 627). These interventions are focused on assisting the client with identifying personally significant hopes by implementation of strategies to support the factors that foster hope throughout the phases of the proposed hoping process. Assessment of the client's philosophical perspectives on life and discussion of the meaning of their illness experience should be included as nursing interventions to facilitate the client's engagement in hope selection.

5. Hope is valid and realistic.

False hope is a misnomer that reflects the projection of assumed hope to the hoping person. Often times this term is used to describe circumstances in which an individual's hope is not in concordance with the beliefs of the health care providers. The term “false” implies that the hope is invalid and must be challenged in order for

individuals to have a realistic perspective on their circumstances. False hope also implies that the health care provider already knows what the individual is hoping for and has judged that hope to be false. Nurses should advocate for the client and family by conducting an assessment of their hopes prior to any discussion of their illness circumstances.

Wishing describes the circumstances in which an individual selects a desired outcome that may or may not be realistic. The distinction between hoping and wishing lies in the degree of probability of achieving what is wished or hoped for and in the cognitive energy required for each activity. Determining what hopes are realistic is contextual and must be based on an appreciation of the multiple factors that are impacting on the individual at any one given moment. Snyder (2002) challenges the false hope viewpoint using a similar rationale. Individuals with hope will often calibrate their goal expectations according to “relevant boundary conditions” (p. 64). The distinction between hoping and wishing does not intend to challenge the client’s perception of reality, but embrace the spirit of hoping as a sustaining force in the crisis of illness. Wishing can be considered a passive cognitive activity, without pathways or agency thinking and can be limited in breadth (Farran et al., 1995). Allowing the client to wish for a miraculous recovery is considered a protective hope-inspiring strategy in circumstances where the client is overwhelmed with current illness crises. (Fitzgerald Miller, 2007). Wishing can therefore be considered a strategy for hope inspiration and not a false hope.

Hope Qualified: Client Experiences with Hope

Qualitative research on the phenomenon of hope has provided nurses with insights into the nature of hope as it unfolds in an illness experience. Baumann (2004) compared six Parse research method studies (descriptive phenomenology) on the lived experiences of hope of clients from five different countries. Anticipation of expanding possibilities, anticipating an unburdening serenity amid despair, envisioning possibilities, and persistent anticipation of contentment emerged as core concepts in describing the structure of hope (Baumann, 2004). These were consistent with additional research from Parse (1999) describing the lived experiences for family members of patients in a chronic care facility, identifying the lived experience of hope as persistently anticipating possibilities amid adversity (Parse, 1999).

The power of hope through attributes such as future orientation, inner strength and endurance, the ever-present nature of hope, and the willpower to maintain hope through physical illness are themes identified by patients one year after sustaining a spinal cord injury (Lohne & Severinson, 2006). The meaning and importance of hope and caring practice to nurture hope for people in the Dominican Republic was explored using Leininger's four phase approach to conducting ethnographic research and analyzing data (Holt, 2000; Holt & Reeves, 2001). Themes abstracted from the data included hope as an essential life force, God as the primary source of hope, hope as supported by relationships, working together, economic resources and hard work, and hope resulting in energy, accomplishments, and happiness.

The hope experiences of individuals with a cancer diagnosis have been studied using qualitative methodology. Older bereaved women who cared for a spouse with

terminal cancer found hope through the inner processes of finding balance, finding new perspectives, and finding meaning and purpose (Holtslander & Duggleby, 2009). Little and Sayers (2004) conducted extensive narrative interviews with cancer survivors, their partners and caregivers (Little & Sayers, 2004). Hope was always for the future and always for life over death. When death is imminent, hope evolves into hope for a “good death.” The hope for life was complicated by post-cancer distress with death salience, a phenomenon survivors experienced of anticipatory grief regarding recurrence of cancer and threats to mortality (Little & Sayers, 2004). Patients awaiting bone marrow transplantation found religious practices and family members as their primary sources of hope during this particularly stressful period of time anticipating an invasive treatment associated with significant morbidity and mortality (Saleh & Brockopp, 2001). Hope was facilitated through connection with God, affirming relationships, staying positive, living in the present and a sense of accomplishment in activities. Participants identified anticipation of survival as a future oriented aspect of hope (Saleh & Brockopp, 2001). The lived experiences of women undergoing surgery for ovarian cancer during the preoperative and postoperative phases revealed the theme of “Hoping for the best, preparing for the worst” (Seibaek et al., 2012, p. 360). Preparation for surgery and for caring for themselves after surgery involved practical, physical, relational, and reflective activities that contributed to the hoping process. Trust in health care providers and supporting relationships with those providers was found to be a source of hope (Seibaek et al., 2012).

Chronic illness for an older adult impacts on life patterns and expectations. Individuals with chronic obstructive pulmonary disease, diabetes, stroke, arthritis, and

visual loss were interviewed and commonalities regarding their experiences were identified (Forbes, 1999). Challenges to hope included experiencing exacerbations, fear, uncertainty, suffering, and physical decline. Participants found that losing, maintaining, and regaining hope was a reflective process that involved appraisal of the impact of their illness, valuing their hopes, and focusing on the future (Forbes, 1999). Making peace with the situation, letting go of old hopes, and reestablishing new hopes allowed participants with chronic illness to redefine their reality.

Children living with juvenile chronic arthritis and the psychosocial processes of living with chronic pain were explored through interviews with 22 children experiencing chronic pain (Sällfors, Fasth, & Hallberg, 2002). Grounded theory analysis of the transcripts revealed a core category of “oscillating between hope and despair.” Experiencing pain and controlling pain consumed a significant portion of their daily lives and restricted activities with peers. The remission and exacerbation of symptoms and the uncertainty of them and where this will occur and for how long undermined their hopes and exhausted their mental abilities (Sällfors et al., 2002). Teachers, friends, and healthcare providers who acknowledged their circumstances and respected their subjective pain experiences contributed to hopeful feelings.

Hope as a double edged sword, and hope described as forked, not feathered were analogies used to describe the possibility of holding contradictory beliefs and experiences regarding the same phenomenon and the dynamic nature of hoping (Kelly, 2007). This conundrum was posed by a significant other caring for a person with acquired immune deficiency syndrome (AIDS) dementia. An ethnographic exploration of the significant other’s perspectives was revealing regarding the nature of hope.

Sometimes the significant other hoped for reversal of his partner's dementia and sometimes he hoped for his death (Kelly, 2007). As his partner's dementia improved slightly with treatment, his realization of the illness circumstances increased and this created grief and depression. The significant other then hoped for death as liberation from the ravages of the disease. The conflicting nature of hope and how hopes that are realized may come with unexpected challenges was evident in the significant other's voice.

The phenomenon of hope has been explored in the care of seriously ill clients. Perakyla (1991) examined the social meaning of death in a hospital and the role of the health care staff in fostering hope using participant observation and informal interviews with staff and patients. Hope work was described as a product of the interactional work between staff and patients that can result in a shared interpretation of the manageability of the patient's condition, leading to either establishing or dismantling hope. Curative and palliative hope emerged as a typology of hope work; when a patient is beyond recovery, curative hope is dismantled, and palliative hope can be maintained. The assumption that hope is something external given to a patient during an interaction and that hope is passive, specific, and static resulted in interpretation of data from a biomedical perspective and departed from the accepted critical attributes of the concept.

Henricson, Segesten, Berglund, and Määttä (2009) interviewed patients who had been in the intensive care unit regarding the meaning of receiving tactile touch as part of a larger study on implementation of tactile touch as a complementary therapy in the intensive care unit (Henricson et al., 2009). Participants found tactile touch to facilitate

being connected to others and to life. Through this connectedness, they were able to gain hope, despite their critically ill circumstances.

The process and meaning of hope for family members whose loved one has experienced a traumatic coma and is admitted to the intensive care unit was identified through semi-structured interviews with 22 family members (Verhaeghe et al., 2007). Hope was defined as the cognitive process of keeping a positive outcome in mind. Uncertainty was an antecedent of hope and hope was an evolutionary phenomenon (Verhaeghe et al., 2007). Family members hopes changed dramatically after receiving report of the trauma and then seeing the patient in the intensive care unit. From that point on, changing hopes were dependent on the patient's condition. Identifying hopes was based upon information they received from healthcare providers regarding the clinical status of their loved one.

Hope has been studied in the homeless population. Although these individuals are not experiencing an illness circumstance, the vulnerability and stress associated with homelessness can have a similar effect on physical health and mental well-being. Herth (1995) interviewed 52 families initially and ten families over a nine-month period of time to explore hope in individuals who are homeless (Herth, 1995). Families described hope as “a power within the self that mobilizes one to move beyond the present situation and to envision a better tomorrow for one's self and other” (Herth, 1995, p. 743). Hope was fostered through interconnectedness with others, personal attributes such as hardiness, cognitive strategies including setting attainable goals, taking advantages of energizing moments, and affirmation of worth. These families were also able to identify factors that impacted on their ability to have and sustain hope. Lack of energy,

hopelessness in others, feeling devalued, and repeated losses were threats to their hope (Herth, 1995). Herth (1998) found similar results when specifically examining hope in homeless children. Having an inanimate hope object, such as a teddy bear or piece of jewelry, that was meaningful to the child was an additional hope-engendering strategy that differed from the strategies identified by homeless adults (Herth, 1998).

The qualitative literature on hope elucidates the primacy of this phenomenon for children, adults, and those experiencing chronic and acute illness and cancer.

Commonalities emerge from the voices of these individuals. Hope is a power that fuels possibilities and anticipation of a future. It is ever-changing and is cultivated through one's inner strength, willingness to endure, spirituality, and connectedness with others. These attributes are consistent with the attributes of hope identified in concept analyses (Appendix C, Table 1). Some of the earlier qualitative work on hope contributed to the initial concept analyses by offering insights into the characteristics of the phenomenon.

Hope Quantified

Instruments to measure hope.

Data collection in quantitative research is founded on the concept of measurement. The ontological and epistemological underpinnings of this assumption rest in the belief that our reality can be reduced to events which can be recorded in a manner that is representative of the degree to which they exist. Nursing inquiry conducted in this paradigm strives to develop and implement measurement methods which are valid, meaningful, and which maximize the integrity of their depiction of reality. Several instruments have been developed to measure the concept of hope over the past four decades (Appendix C, Table 2) (Farran et al., 1995).

Medicine, psychiatry, psychology, and nursing have contributed a variety of perspectives in instrument development. Historically, the development of instruments to measure hope has evolved as the conceptual understanding of the phenomenon expanded. The first instruments developed by Gottschalk (1974), Stoner (1982), and Erickson, Post, and Paige (1975) were based on Stotland's conceptualization of hope in the context of goal attainment (Herth, 1992). Qualitative research in the 1970's and 1980's provided rich descriptions of client experiences with hope. Common themes emerged from this work that contributed to operationalizing hope from a multidimensional perspective. "Specific dimensions of hope identified in these studies were the interpersonal element, the time-oriented, future focus of hope, and the goal-achievement expectation of hope" (Herth, 1992, p. 1252). It was during this period that nurse researchers developed the Miller Hope Scale (MHS) (Miller & Powers, 1988) and the Nowotny Hope Scale (NHS) (Nowotny, 1989) to address these additional foundational dimensions of hope.

Miller Hope Scale. The MHS is a 40-item scale using a five point Likert format ranging from strongly agree to strongly disagree. The higher the score, the higher the degree of hope the individual possesses. The tool is grounded in the domain of hope as specified in theological, philosophical, psychological, socioanthropological, biological, and nursing perspectives (Miller & Powers, 1988). The authors did not articulate how each of these perspectives informed the instrument development and it is questionable that such an amalgamation is possible.

The MHS was pretested on 75 university students to establish clarity of items and directions, readability, and preliminary reliability. Reading level was not articulated.

Empirical determination of the Flesch-Kincaid grade level and reading ease scores would have allowed for more accurate evaluation of the appropriateness of this tool for use in a variety of populations (Polit & Beck, 2008). Preliminary reliability yielded a Cronbach's internal consistency alpha coefficient of .95 and test-retest reliability at a two week interval of .87 (Miller & Powers, 1988). The stability of an instrument reflects how consistent the results will be over a period of time. Test-retest reliability involves administering the same measure twice to the same sample and comparing scores. Reliability coefficients over .80 are generally considered good (Polit & Beck, 2008). Issues with test-retest reliability include modification of subjects views over time that are independent of the measurement stability, as well as subjects changing as a result of administration of the instrument. Internal consistency describes the degree to which scale items are measuring the same critical attribute. Cronbach's alpha is the most accepted method for evaluating internal consistency and higher alpha coefficients (range of .00–1.00) indicate a higher internal consistency (Polit & Beck, 2008). The preliminary testing of the MHS demonstrated a high degree of stability and internal consistency. A revised MHS was administered to a convenience sample of 522 university students, representing a sample of healthy adults. Cronbach's alpha on this sample was .93 and two week test-retest reliability (308 subjects) was .82, confirming preliminary results and establishing sound psychometric parameters to demonstrate reliability. The authors intended to test the instrument on healthy adults and recommend further testing with representative samples in terms of age, sex, culture, and various health problems (Miller & Powers, 1988).

Content validity was established through rigorous review by four judges with expertise in the area of hope (three university professors and a clinical nurse specialist in cardiovascular nursing), resulting in a reduction of the original 47 items down to 40 items. Six experts in measurement, each of whom had developed and tested instruments measuring psychosocial phenomenon, critiqued the scale using detailed criteria, resulting in editing and language revisions (Miller & Powers, 1988). Content validity is the degree to which the measurement tool is representative of the subject, or in this case concept, it intends to measure. Although content validation is essentially judgmental, competent judges, using specific evaluation criteria, can provide relevant feedback in this process (Kerlinger & Lee, 2000). The MHS was subjected to thorough content validation in an effort to ensure measurement integrity. Content validity of the MHS could also have been quantified through utilizing agreement indices of judge's evaluations using Cohen's *Kappa* (Kerlinger & Lee, 2000) and content validity indices at the item and scale levels (Polit & Beck, 2008).

Miller and Powers (1988) utilized concepts from the multitrait-multimethod matrix method to establish construct validity (Polit & Beck, 2008). Convergent validity was established by correlation of the MHS to the Psychological Well-Being Scale (PWBS; alpha coefficient of .89), the Existential Well-Being Scale (EWBS; alpha coefficient of .78), and a one item 10-point hope assessment scale. Convergence indicates that evidence from different sources gathered in different ways all indicate similar meanings to the construct. Miller and Powers (1988) also refer to this as criterion related validity, which may be more accurate as they are referring specifically to concurrent validity in correlating the test scores of these instruments which do not

directly measure hope. The lack of availability of alternate instruments to measure hope may have impeded obtaining true convergent validity, especially in light of the evolutionary nature of hope instrument development. Correlation of the MHS to the PWBS, $r = .71$, to EWBS, $r = .82$, and to the one item self-assessment of hope, $r = .69$ supported concurrent validity (Miller & Powers, 1988). Divergent validity was established using the Beck Hopelessness Scale (HS) with $r = -.54$. This illustrated the appropriate differentiation of hope and hopelessness as negatively correlated dichotomous concepts and supported the criteria for discriminability (Kerlinger & Lee, 2000).

Maximum likelihood factor analysis with oblique rotation was used by Miller and Powers (1988) to determine underlying dimensions of the MHS (Miller & Powers, 1988). Maximum likelihood factor analysis is a subset of confirmatory factor analysis that tests hypothesis driven item clustering as opposed to empirical item clustering in explanatory factor analysis. The authors were not testing any specific theoretical model, nor did they identify categories of factors prior to the factor analysis, so it is unclear why this specific approach was utilized. The correlation matrix of hope items ranged from .30 to .58. Oblique rotation in factor analysis enhances the clustering of items with an associated factor and strengthens the correlation. Five to six factors emerged utilizing the Scree test, where a sharp drop off in the percentage of explained variance illuminates an appropriate termination point (Polit & Beck, 2008). Further relevant variance was evaluated using Lawley's ratio of the sums. Lawley's ratio for a three factor solution was .82 and this indicated that other factors would provide little contribution to understanding the variance (Miller & Powers, 1988). Eigenvalues for the three factor

solution were 6.45, 3.30, and 1.59 and none of the factor solutions had trivial factors. The three factor solution explained a total of 28.34% of the variance (Miller & Powers, 1988). The number of factors extracted should explain at least 60% of the total variance (Polit & Beck, 2008). The variance of individual factors was not described. For any factor to be meaningful, it must account for at least 5% of the variance. Reliability analysis suggests that correlations of less than .30 indicate little congruence with the underlying construct while correlations of greater than .70 suggest over-redundancy (Polit & Beck, 2008). Twenty-two items loaded on Factor I, but four of them had correlations of greater than .70 which may indicate redundancy and these items should have been revised. Factor II loadings ranged from .30 to .64 and Factor III loadings ranged from .30 to .41. Miller and Powers (1988) did recommend reducing the length of the instrument by removing items with low item to total alphas with subsequent reevaluation of the overall internal consistency (Miller & Powers, 1988).

Nowotny Hope Scale. The NHS was developed based on a six dimensional definition of hope; each dimension correlated with the Nowotny's described characteristics of hope (Rostøen & Wiklund, 2000). The NHS is a 29 item, 4-point Likert scale that was initially tested on well adults and adults with cancer (N = 302). Internal consistency was established with Cronbach's alpha coefficient of .89 and subscale reliabilities ranging from .51-.75 (Farran et al., 1995). Content validity was evaluated with a panel of six members who were experts on hope and measurement. Construct validity through factor analysis with orthogonal rotation revealed six factors which supported the theoretical construct of the subscales and divergent validity of the NHS with the HS was $r = -.47$ (Farran et al., 1995).

Nursing inquiry on the phenomenon of hope continued to generate further concerns regarding the conceptual components included in measurement tools. Dufault and Martocchio (1985) and Farran and Popovich (1990) studied hope in ill older adult populations. Their work suggested several important elements of hope that were not included in existing instruments. These attributes included:

(a) a more global, non-time oriented sense of hope; (b) hope despite diminished or absent interpersonal relationships; (c) hope as a sense of 'being' available and engaging in relationships, as opposed to 'doing' for oneself and others; and (d) potential of hope for controlling behavioral or emotional responses as opposed to the control of events or experiences. (Herth, 1992, p. 1252)

Subsequently, Herth (1991) incorporated these attributes into the development of the Herth Hope Scale (HHS). The complexity of the items on the HHS, as well as its length, were deterrents to the clinical utility of the instrument, especially in ill populations and with clients of varying educational and reading levels.

Herth Hope Index (HHI). The HHI is a 12 item summated rating scale that is an adaptation of the original 30 item (HHS). The parent tool is based on Dufault and Martocchio's conceptual framework of hope. Their six dimensions of hope were combined into three categories for item generation (Herth, 1992). Psychometric evaluation of the HHS was sound and factor analysis yielded three factors as originally conceptualized during item development. The author did not elaborate as to whether high and low alphas on factor analysis were the basis for revision of items. The shortened instrument was developed for clinical utility (including larger than normal print for increased readability), simplicity, and relevancy for adults with health issues (Herth, 1992).

Content validity for the HHI was established through evaluation by a panel of measurement experts and a panel of nurse clinicians and patients. The reading level of the revised tool was identified at a sixth grade level using the Flesch Readability Formula (Herth, 1992). The HHI was piloted on a convenience sample of 20 ill adults with Cronbach's alpha of .94. It was then administered to a relatively heterogeneous sample of 172 adults that supported the 10 respondents per item recommendation to stabilize covariation of the items (Polit & Beck, 2008).

Construct validity was established through concurrent criterion-related methods to assess correlation of the HHI to the EWBS ($r = .84$), the parent HHS ($r = .92$), and the Nowotny Hope Scale (NHS) ($r = .81$). Comparison with instruments that also measure hope strengthened the convergent validity. The HS was utilized to establish divergent validity with correlation of the HHI to HS ($r = -.73$). Maximum likelihood factor analysis with varimax rotation was used to further assess construct validity. The three factor solution was consistent with the original three subscales for item generation and supported the theoretical model with all eigenvalues greater than one (Herth, 1992). The three factor solution explained a total of 61% of the variance, significantly strengthening construct validity as compared to the MHS. The three factors identified were

1. Temporality and future, 2. Positive readiness and expectancy, and
3. Interconnectedness with self and others.

Internal consistency and stability over time was established with a Cronbach's alpha coefficient of .97 and with two-week test-retest reliability of .91 respectively (Herth, 1992). Reliability of the three factor subscales ranged from .78–.86.

Selection of instruments for use in quantitative research on the phenomenon of hope requires careful review of validity, reliability, and theoretical congruence of existing measurement tools. The MHS does not have the same ease of use or psychometric strength as the HHI. The HHS and HHI have been utilized frequently in descriptive and correlational quantitative nursing research on hope. Quantitative study and the utilization of instruments to measure hope has expanded to international research, with the MHS translated into Swedish and Chinese and the HHI translated into Swedish (Farran et al., 1995). Van Gesttel-Timmermans, Van Den Bogaard, Brouwers, Herth, and van Nieuwenhuizenan (2010) developed a Dutch version of the HHI and evaluated psychometric validity and reliability in a sample of people with severe mental illness (N=341). Psychometric reliability was similar to the original HHI results, with Cronbach's alpha coefficient of 0.84 and test-retest reliability of $r = 0.79$. Convergent validity was determined with highest correlations found between hope and health-related self-efficacy beliefs ($r = 0.72$), perceived quality of life ($r = 0.56$), and mental health ($r = 0.59$) (Van Gesttel-Timmermans et al., 2010).

Benzein and Berg (2003) assessed the reliability and validity of the Swedish version (HHI-S) of the HHI. The HHI-S, Miller Hope Scale (MHS), and Beck's Hopelessness Scale (HS-S) were administered to 40 patients with cancer in palliative care and 45 family members of patients with cancer in palliative care. An internal consistency for the HHI-S was established with a Cronbach's alpha coefficient of 0.88. Concurrent criterion-related validity was assessed by correlating the HHI-S with the MHS ($r = 0.82$) and discriminant validity was assessed by correlating the HHI-S with the

HS-S ($r = -0.69$) (Benzein & Berg, 2003). The authors acknowledged the linguistic and cultural difficulties encountered with instrument translation.

The psychometric properties of the Norwegian version of the HHI (HHI-N) were evaluated in a representative sample of the Norwegian population (Wahl et al., 2004). The internal consistency of the HHI-N, estimated by Cronbach's alpha, was 0.81. Concurrent correlation between hope and overall quality of life was 0.48 and divergent correlation between hope and fatigue severity was -0.30. Reliability was similar to the parent English version of the HHI and issues with language translation were cited (Wahl et al., 2004).

The HHI has also been translated into Japanese, Spanish, and Portuguese (van Gestel-Timmermans et al., 2010). The brevity and psychometric strength of this instrument is attractive to researchers on hope from a global perspective. The language difficulties encountered in instrument translation can be attributed to lack of literal words that translate from English to the chosen language. Some items on the instrument, such as “I can see a light at the end of the tunnel” may be figures of speech in English that do not have the same cultural and contextual referents.

Several questions remain regarding development of instruments to measure hope that can be classified according to the key client characteristics of age, gender, and ethnicity. The HHI has been translated into a variety of languages with acceptable psychometric testing results. Qualitative research on hope in various cultures could serve as a foundation for development of hope measurement instruments in native languages where cultural context can be clarified. The MHS was tested on a sample with a demographic profile of 70% females and 27 % males (Miller & Powers, 1988). The

gender distribution from the HHI pilot sample was 64% female and 36% male (Herth, 1992). The authors did not address the predominantly female sample and how gender may have factored into the results. It is unknown whether lesbian, gay, bisexual, or transgendered individuals completed the instruments. Specific focus on the impact that gender may have in understanding and measuring hope should be pursued.

Most of the instruments to measure hope have been tested and utilized with young adults and older adults. Snyder et al. (1997) developed and tested a 12-item Children's Hope Scale, based on the original Snyder Hope Scale, with items exemplifying pathways thinking and agency thinking. A pilot study was conducted with 8 to 16-year-old children and the instrument was revised to simplify sentence structure and clarity of meaning. Further testing of the Children's Hope Scale was completed on a sample of 372 children ages 9 to 14 years old. Principal component analysis with varimax rotation yielded a two-factor solution and items with weak loadings were discarded. (Snyder et al., 1997) The final version of the Children's Hope Scale contained six items, three pathways related and three agency related. Further testing across six samples found Cronbach's alpha coefficients of 0.72–.086, establishing internal consistency. Concurrent validity with the Self-Perception Profile for Children (SPP-C) found a positive correlation between higher hope scores and scores on the subscales of the SSP-C. Divergent validity with the Children's Hope Scale and The Child Depression Inventory (CDI) ranged from $r = 0.27$ to 0.48 . (Snyder et al., 1997) Healthy children and children with physical and psychiatric illnesses were represented during instrument testing. Although the Children's Hope Scale is a valid and reliable instrument to

measure agency and pathways thinking related to goal attainment in children, it does not address the multidimensional attributes of hope recognized in the literature.

Herth (1998) utilized methodological triangulation to study the meaning of hope in the homeless population through the eyes of the children. Semi-structured interviews and drawings were utilized to collect data on 60 homeless children (6-16 years old) currently residing in homeless shelters. The central question for this study was: How do homeless children describe hope and how to they engender and maintain their hopes (Herth, 1998)? Metaphor and symbolism were used to describe hope by the children. The tree is like hope metaphor was exceptionally powerful and was similar to the use of the coffee plant metaphor as a description of hope from the perspective of people from the Dominican Republic (Holt, 2000). Hope was described by children as an ever-changing process that provides sanctuary from the stressors of life and is nurtured when shared with others. Connection with others and hope objects were extremely important to fostering hope. Younger children's hopes were present oriented and older children's were more future oriented. The theme of connectedness was common to all age groups and children felt hope when they were cared about and valued.

Herth's (1998) work revealed many considerations regarding assessing hope in children. The developmental age of the child impacts on their cognitive understanding of conceptual terms and statements. Instruments to measure hope in children may required age-appropriate language and terminology as children progress from literal to abstract thinking. The strong appearance of metaphor and symbolism might require creation of instrument items that allow children to connect with their meaning. The role of

relationships and interconnectedness as paramount to fostering hope in children needs to be considered in future instrument development.

Application of established instruments to measure hope in adolescents has been explored. Hendricks et al. (2005) described the psychometric properties of the MHS administered to rural Southern well adolescents in seventh and eighth grade. Internal consistency reliability revealed a Cronbach's alpha coefficient of 0.92, consistent with an alpha of 0.93 obtained by Miller and Powers (1988). Construct validity was established utilizing a two-factor confirmatory factor analysis (CFA), eliminating nine items and completing a repeat three-factor CFA with Normed Fit Index (NFI) and Comparative Fit Index (CFI) values greater than 0.90, indicating an adequate fit of the model (Hendricks et al., 2005). The three-factor structure confirmed the original psychometric testing of the instrument. A reduced-item MHS (31 items) was recommended to measure hope in adolescents. The MHS demonstrated sound psychometric properties in this adolescent population and may be useful in the study of hope in additional adolescent populations. Application of the MHS to study hope in adolescents with physical or psychiatric illness requires further exploration.

Phillips-Salimi, Haase, Kinter, Monahan, and Azzouz (2007) examined the use of the HHI to measure hope in adolescents and young adults newly diagnosed and at various stages of treatment for cancer. Reliability was established with Cronbach's alpha coefficients of .84 and .78, consistent with established psychometric properties. Construct validity was supported by correlations between the HHI and measures of uncertainty in illness, symptom distress, resilience, and quality of life. Results of a four-factor CFA suggested that a one-factor solution best fit the data for the sample (Phillips-

Salimi et al., 2007). Item revision was suggested to result in a seven-items instrument that should undergo further psychometric testing. It was determined that the HHI was a reliable instrument to measure hope in adolescents and young adults with cancer.

Several of the instruments to measure hope have been tested on populations with mental health concerns (Erickson, Post, & Paige, 1975; Gottschalk, 1974; Grimm, 1984; Obayuwana et al., 1982; Snyder et al., 1991). Recently, additional selected instruments to measure hope in patients with psychosis have emerged. Schrank et al. (2012) developed and tested the Integrative Hope Scale (IHS) for utilization in individuals with severe mental illness. The IHS, originally developed in German, is comprised of 23 items rated on a six-point Likert scale. The instrument is based on key dimensions of hope, and was presented as more comprehensive than the HHI and SNHS as well as shorter than the MHS. For these reason, the IHS was deemed suitable for people with psychosis. Participants were patients with a diagnosis of schizoaffective disorder and schizophrenia spectrum disorder. Reliability results yielded a Cronbach's alpha coefficient of 0.92, with two-week test-retest reliability of 0.84 (Schrank et al., 2012). Initial CFA with four factors was completed and results indicate need for item revision. The final CFA demonstrated acceptable results with the adaptations of the factor model.

A trend towards brevity as a preferred quality for an instrument to measure hope in patients with schizophrenia was promulgated by the development of the Schizophrenia Hope Scale (SHS-9) (Choe, 2014). The limited focus of the SNHS and HHI, as well as the length of the MHS, were cited as deterrents to utilization of these instruments with a psychiatric population. The author suggested that the attributes of hope for individuals with severe mental illness are different and hope in people with

schizophrenia has more emotional and spiritual meanings (Choe, 2014). The preliminary scale was developed with 40 items, determined by extensive literature review, qualitative research, and a panel of experts to ensure content validity. Pilot testing and psychometric evaluation was completed in three phases, with acceptable reliability (Cronbach's alpha 0.97) and CFA performed to achieve goodness of fit with nine items. Convergent validity was established with the State-Trait Hope Inventory and the IHS ($r = 0.61$). Construct validity was confirmed with PCA demonstrating one factor accounting for 61.77% of the total item variance. CFA on the final IHS indicated that the instrument accurately represented the data for hope (Choe, 2014). The IHS is focused on the emotional and spiritual aspects of hope, with only one item addressing future planning. The development of the IHS raises the question of the universal nature of hope. Perhaps, as suggested by Choe (2014), certain attributes of hope are more germane to specific client populations. Quantifying their hope would be achieved with increased specificity in hope instrument development.

Understanding and measuring the concept of hope remains an ongoing challenge. Determining levels of hope as correlated with concepts of interest to researchers has been useful for establishing the primacy of hope in well and ill client populations. The significance of specific hope scores attained on a particular instrument requires further clarification (Farran et al., 1995). The more hope an individual possesses improves their ability to envision and undertake adaptive coping strategies in the face of significant life stressors (Farran et al., 1995). Scores on the SNHS are related to goal attainment and these reflect the typology of particularized hopes as outlined by Dufault and Martocchio (1985). The HHI and MHS include additional items that address the spiritual and

relational nature of hope. These are consistent with Dufault and Martocchio's (1985) conceptualization of generalized hopes. The selection of an appropriate hope measurement tool may need to be predicated on a comprehensive analysis of the client population of interest. The cultural, social, economic, religious, developmental, and illness-specific circumstances of the individual can impact on their propensity to engage in different hope related activities. Choe (2014) proposed development of hope instruments tailored to attributes of hope that are relevant to particular client populations. Instrument development that is congruent with the commonalities of experience for groups of individuals should be explored.

Descriptive correlational research on hope.

The ability to measure hope, despite any issues with instrument development, has led to a body of research that endeavors to identify the relationship between hope and concepts that are germane to nursing and the care of clients. Descriptive correlational design has been the primary research method used to generate relevant data related to research questions regarding hope (Appendix C, Table 3). The HHI has been utilized as the preferred instrument to quantify hope in most research studies (Appendix C, Table 3).

Increased levels of hope were correlated with decreased uncertainty for survivors of breast cancer (Wonghongkul, Moore, Musil, Schneider, & Deimling, 2000) and increased net family income, knowledge of disease, feeling of improvement, and perception of satisfactory family support for patients with cancer (Kavradim et al., 2013). Self-care behavior, religious beliefs, marital status, and increased social support in patients awaiting heart transplant (Wang, 2006) were significant predictors of hope.

Alberto and Joyner (2008) also found a positive relationship between hope and self-care in persons with chronic obstructive pulmonary disease attending a support group. Quality of life and health work positively correlated with hope in stroke survivors and spouses (Bluvol & Ford-Gilboe, 2004). The ability to engage in self-care and health related behaviors has a significant impact on hope. Wu (2011) utilized the SHS to determine the relationships between hope, quality of life, post-traumatic stress disorder (PTSD), coping, and resilience in family members of victims of man-made trauma. Hope had a significant impact on quality of life, and increased PTSD symptoms were negatively correlated with hope (Wu, 2011). Hope can be seen as a positive mediator in the individual's perception of quality of life in coping with changes in health status for individuals and family members.

Rustøen and Wiklund (2000) used the NHS to describe levels of hope in Norwegian patients with a recent cancer diagnosis. Higher levels of hope were found in patients who did not live alone. The demographic variables of married status, female gender, and older age, as well as higher FEV1% were associated with higher hope in cystic fibrosis patients (Rustøen, Wahl, Hanestad, Gjengedal, & Moum, 2004). However, Benzein, and Berg (2005) found decreased hope in older family members of patients with cancer receiving palliative care. These differences may be attributed to the impact of illness on the individual versus a family member. Lohe, Miaskowski, and Rustøen (2012) examined caregiver role strain and hope in family members of patients with advanced cancer. Family members who lived with the patient experienced an increase in caregiver role strain and had lower hope scores. It may be important to consider the role of family members when developing a nursing plan of care that

includes their unique experiences with hope. Rustøen et al. (2004), along with Rustøen, Howie, Eidsmo, and Moum (2005) studied hope in older Norwegian adults with heart failure. Self-assessed health and satisfaction with life emerged as predictors of hope in this patient population.

The concept of spirituality as embedded in hope is a recurring theme (Farran et al., 1995; Fitzgerald Miller, 2007). The EWBS has been utilized in several studies to examine the relationship between spiritual well-being and hope. Pipe, Kelly, LeBrun, Schmidt, Atherton, and Robinson (2008) found a positive correlation between hope and spiritual well-being among hospitalized patients on admission and at six weeks post discharge. This positive relationship also emerged for older adult women (Davis, 2005) and personal care aides who provide direct care to older adults (Duggleby et al., 2009). Hope and spiritual well-being are concepts with overlapping attributes that can be seen to have a synergistic relationship.

Fostering Hope: Hope Intervention Programs and Nursing Strategies

Hope intervention programs.

Limited nursing research exists on specific hope intervention programs. The majority of the current hope intervention literature has been generated by the disciplines of psychology and social work (Appendix C, Table 4). It is interesting to note the proliferation of hope intervention strategies as evidence of the primacy of fostering hope for disciplines that deal with clients in the crisis of illness.

Herth (2001) described the development and evaluation of a Hope Intervention Program (HIP), a specific nursing intervention program designed to enhance hope (Herth, 2001). This program was piloted on a sample of 38 adults with first-time

recurrent cancer who were receiving cancer treatments (Herth, 2001). There was a significant difference in the levels of hope ($p = 0.02$) immediately after and at three, six and nine months post intervention.

The HIP was implemented over an eight-week period of time, with group meetings each week. The HIP curriculum was developed integrating the four central attributes of hope as outlined by Farran et al. (1995). These attributes describe hope as an experiential process, a spiritual or transcendent process, a rational process and a relational process (Farran et al., 1995). The eight sessions included building a sense of community, searching for hope, connecting with others, expanding the boundaries, building the hopeful veneer, and reflecting and evaluation (Herth, 2001). Specific hope-engendering exercises and activities were included in each of the sessions. Participants evaluated the program at the end of the eight-week period and at three, six, and nine month intervals post intervention. Most participants (98%) rated the program as extremely helpful in fostering hope.

Tollett and Thomas (1995) conducted a quasi-experimental study to determine if a specific nursing intervention to instill hope would positively influence levels of hope, self-efficacy, self-esteem, and depression in homeless veterans (Tollett & Thomas, 1995). The MHS was selected as the instrument to measure hope. A specific nursing intervention was designed to instill hope, increase self-efficacy and self-esteem, and lower depression based on strategies selected from the literature (Tollett & Thomas, 1995). The intervention consisted of a reality surveillance exercise that assisted veterans to identify reasons to hope followed by defining and refining goals utilizing success mapping to develop an action plan to achieve hopes/goals (Tollett & Thomas, 1995).

The intervention was implemented through twelve 60-minute small groups sessions. There was a significant difference in levels of hope between the intervention and control groups, with the intervention group exhibiting higher levels of hope (Tollett & Thomas, 1995).

Duggleby et al. (2007) evaluated the effectiveness of a hope intervention program called the “Living with Hope Program” (LWHP) in older, terminally ill cancer patients. The LWHP consisted of viewing an acclaimed video entitled “Living with Hope” and working on a hope related activity over a week time frame. The hope related activities included writing a letter to someone, beginning a hope collection, and beginning an “about me” collection (Duggleby et al., 2007). A convenience sample of 60 elderly patients with advanced cancer receiving palliative home care services was randomly assigned to a treatment and a control group. The principal investigator utilized three registered nurses to complete the 120 site visits with the treatment and control groups. Each visit lasted approximately 60 to 90 minutes to complete the research protocol. The treatment group participated in the LWHP at the first visit and received an informational pamphlet, while the control group only received the pamphlet. Both groups completed the HHI and the Magill Quality of Life Questionnaire (MQOL).

On the second visit, the treatment group completed the HHI and the MQOL, as well as a qualitative interview regarding whether the activity impacted on their hope. The control group also completed the HHI and MQOL and received the LWHP.

Initial HHI and MQOL scores for both groups were not significantly different. One week post intervention, the treatment group had HHI ($p=0.005$) and MQOL ($p = 0.027$) scores that were significantly higher than the control group (Duggleby et al.,

2007). Qualitative data analysis supported this finding, with 61.5% of the participants reporting that their hope had increased post intervention. Ease of use, cost-effectiveness, self-administration, and increasing hope and quality of life were identified benefits of integrating the LWHP into clinical practice (Duggleby et al., 2007).

Rustøen, Cooper, and Miaskowski (2011) examined the effectiveness of a hope intervention (HOPE-IN) on levels of hope and psychological distress in community dwelling participants with cancer. Most of the participants were married females dealing with breast cancer. The HOPE-IN program consisted of eight group sessions, each lasting two hours, conducted weekly. These sessions included an introductory session and six subsequent sessions, each focused on activities to foster hope including believing in oneself, emotional reactions, relationships with others, active involvement, spiritual beliefs, and acknowledgement of a future (Rustøen et al., 2011). During the final session, previous discussions were summarized and participants were asked to reflect on the future and to complete a course evaluation. All group leaders and co-leaders participated in a two-day training session on the HOPE-IN program and group facilitation.

The HHI–Norwegian version and the Impact of Event Scale (IES) were administered to participants before the intervention, immediately after the end of the HOPE-IN program and at three and 12 months post intervention. Hope scores increased immediately post intervention, then decreased slightly at the three-month and 12-month intervals, but still remained greater than the baseline hope scores (Rustøen et al., 2011). It was suggested that “booster sessions” may be required to sustain the effect of the intervention on participants’ hope scores (Rustøen et al., 2011).

The majority of these hope intervention programs require a significant amount of time and resources and, therefore, are not realistic to implement in an acute care clinical setting. Hospice and Palliative Care nurses may be in a position to implement these programs based on the extended length of time they may be working with the client. Providers who administer the hope interventions must be consistent in their content delivery and approach to avoid issues with reliability. This necessitates a professional and financial commitment from the health care organization. Additional outcome measures need to be identified that justify the cost-benefit of these programs, above and beyond improving hope, quality of life and psychological distress. The LWHP demonstrated qualities that fostered clinical utility and ease of integration into the client's plan of care. Components of the sessions could be individualized and discussed with clients in acute care settings during routine care delivery.

Nursing strategies to foster hope.

Nurses have been identified as sources of hope by individuals throughout the lifespan and across the spectrum of health and illness (Farran et al., 1995; Fitzgerald Miller, 2007; Herth, 2001). Nurses have been described as “enablers of hope” who create a vision of hope and facilitate safe passage during the hope journey (Akinsola, 2001). Providing support, allowing individuals to express their fears and expectations, recognizing factors that threaten hope, setting realistic goals, and identifying internal and external resources to create sustainable hope were identified as vital for the care of people living with AIDs and their families in Africa (Akinsola, 2001).

Turner and Stokes (2006) identified and examined hope intervention strategies utilized by nurses caring for older adults in acute and long-term care facilities. Touching

the lives of others, connecting with their inner being, journeying with the patient and building trust over time, and the way you do things rather than the things you do were identified as general hope facilitation approaches to caring for this patient population (Turner & Stokes, 2006). All the nurses in the study identified hope as integral to the lives of older adults. Their approaches to hope facilitation varied, dependent upon the clinical setting. Nurses in acute care settings focused on talking with patients, giving them encouragement, offering choices, listening, and maintaining a positive attitude as effective hope-inspiration strategies (Turner & Stokes, 2006). The nurses practicing in long-term care facilities expressed a need to show the person love and affection, developing relationships of trust over time, sharing intimate stories, and empathy as appropriate hope-inspiration strategies in this clinical setting. A Steinian approach to empathy has been described as “recognizing a lived experience and standing side-by-side with that person,” utilizing affective resonance and cognitive understanding to connect with the another’s emotional and physical reality (Richardson, MacLeod, & Kent, 2012). This type of empathic comportment is fundamental in establishing a caring client-nurse relationship at end of life.

Time spent with the patient emerged as a significant variable when selecting hope-inspiring strategies for older adults (Turner & Stokes, 2006). This suggests a hierarchy of hope intervention strategies that is dependent upon the length and quality of the relationship with the patient. Acute-care settings have shorter lengths of stay and multiple demands on nurses that may impact on their ability to develop relationships with patients. A more pragmatic approach may be necessary to facilitate hope in these clinical settings. It cannot be assumed that the willingness to engage with the patient and

the ability to effectively integrate therapeutic use of self into the plan of care in facilitating hope are skills that every nurse possesses. Creating a culture that values hope-facilitation can be achieved through curriculum and professional development that fosters knowledge of, and competency in, engendering hope (Turner & Stokes, 2006).

Attributes of the nurse that facilitate hope inspiration have been examined in the practice of psychiatric mental health nursing. Cutcliffe (1998) established the relationship between hope and movement towards resolution of bereavement for individuals experiencing loss in their lives. Linking hope inspiration with bereavement counseling for psychiatric mental health nurses creates a therapeutic environment that promotes empathy, genuineness, and unconditional positive regard and ultimately facilitates hope-inspiration (Cutcliffe, 1998). The ability to foster hope can be considered an inherent quality in the practice of psychiatric mental health nursing (Cutcliffe & Grant, 2001). The therapeutic potential of hope inspiration for psychiatric mental health nurses has been examined in caring for cognitively impaired older adults in a continuing care environment. Cutcliffe and Grant (2001) presented a conceptual model that emerged from grounded theory methodology to describe the core variables that were essential attributes of the psychiatric mental health nurse engaging in hope inspiration for this patient population. Applied humanistic code (humanistic values of the nurse), pragmatic knowledge (expertise in clinical practice), interpersonal relationships (making contact and human interaction), and nurse as utilizer (utilizing the environment) were identified as fundamental aspects of psychiatric mental health nursing practice. These core variables created the underpinnings for fostering hope in cognitively impaired individuals (Cutcliffe & Grant, 2001).

The importance of the therapeutic relationship in fostering hope for psychiatric mental health nurses has been studied in homeless people with suicidal ideation (Collins & Cutcliffe, 2003). The primacy of relational aspects in hope inspiration were particularly significant as antecedents to cognitive behavioral therapy in providing care for this client population. Dealing with hopelessness (ongoing assessment of suicidal risk, creating cognitive dissonance and use of Socratic questioning) and focusing on problem solving (generating alternatives and evaluating effectiveness) were cognitive strategies that enable coping and inspired hope in homeless people with suicidal ideation (Collins & Cutcliffe, 2003).

Miller and Happell (2006) incorporated use of participant photography in the nursing care of individuals with schizophrenia. Interestingly, use of photography in qualitative research has been a methodology to stimulate discussion of hope in adolescents (Turner, 2005). Mobilizing hope for individuals with schizophrenia has been associated with improved perceptions of health and quality of life (Miller & Happell, 2006). Participants were asked to take photographs over a period of one to two weeks of anything that reminded them of hope. Recording moments of hope through photography allowed participants to reflect on what hope meant to them and to utilize symbolism as a therapeutic strategy for hope instillation. The participants photographed simple images of ordinary things, such as a clock, a spoon, the kitchen, and a coffee cup. These images were effective in generating discussions regarding hope for the participants. Participant photography was found to be a powerful strategy for psychiatric mental health nurses to utilize in facilitating hope at a very personal level (Miller & Happell, 2006).

Two key components to hope inspiration emerge from the literature describing nursing strategies to foster hope: the qualities of the individual nurse and the strategies they identify as facilitating hope. Nursing qualities such as positive regard, empathy, genuineness, and a willingness to engage with the client in developing meaningful, trusting relationships are essential in connecting with the client, embracing their suffering, finding hope, and co-creating meaning. This relationship is foundational to the actual implementation of hope-inspiring strategies such as providing support, listening, devising and revising goals, and journeying through the situation with the client. These two components are relevant to the phases of deliberation and enactment in Kim's (2010) practice domain.

Exploring hope as situated in Hospice and Palliative Care nursing practice will provide a contextual understanding of how this concept is perceived and the nursing attributes and strategies that are essential in fostering hope for clients receiving Hospice and Palliative Care.

Hope in Palliative and End of Life Care

Nursing practice in Palliative and Hospice Care is the foundation of a multidisciplinary approach that serves as the framework for intervening with clients and families experiencing life-threatening and life-limiting illnesses. Often, the terms Palliative care and Hospice care are used interchangeably and it is necessary to articulate the primary focus of each aspect of care. Palliative care is an “approach that aims to improve the quality of life of patients and their families facing the problems of life-threatening illness through prevention and relief of suffering” (Dobrina, Tenze, & Palese, 2014, p. 75). This is accomplished through judicious assessment of pain and

other physical, psychosocial and spiritual issues and implementation and evaluation of a comprehensive plan of care to meet those needs. Hospice care is part of this continuum, albeit focusing on the care of clients and families during the final stages of life, when end of life is imminent. In both Palliative and Hospice care approaches, the client and family are central and nursing care is focused on ongoing assessments and interventions that are anticipatory and individualized.

Hope in terminal illness.

As described earlier, the concept of hope has been extensively deliberated throughout the nursing literature and several concept analyses have been presented to elucidate attributes of hope that may contribute to an enhanced understanding of this oftentimes elusive concept. Exploring hope in terminal illness is beneficial in understanding the contextual significance of the concept as situated in Palliative and Hospice care nursing practice. Johnson (2007) utilized a Rogerian evolutionary concept analysis methodology and thematic content analysis to examine hope in the context of terminal illness (Johnson, 2007). While hope has been studied in clients with cancer, conceptual foundations of such work have been based on an amalgamation of perspectives on the attributes and nature of hope.

Terminal illness is a period of time in a client's illness trajectory that can be a fragile and vulnerable journey towards death. Attributes of hope that are specific to this time in life have been proposed (Johnson, 2007). Ten essential attributes of hope in terminal illness have been identified and these include:

1. Positive expectation—a future outlook that framed priorities in life
2. Personal qualities—inner strength and determination
3. Spirituality—faith and finding meaning
4. Goals—short-term and long-term goals, preserving a sense of future

5. Comfort—Pain alleviation and symptom management
6. Help/caring—Feeling worthwhile, sharing an appreciation of beauty, presencing
7. Interpersonal relationships—loving relationships with family and friends, faith in caregivers
8. Control—Autonomy and self-determination in decision-making
9. Legacy—the need to be remembered
10. Life review—acknowledging the value and worth of one’s life.
(Johnson, 2007, pp. 454-456)

The utilization of the term “attribute” in this context is somewhat confusing, as Johnson described these attributes more in terms of determinants of hopefulness and interventions that would facilitate hope for clients with terminal illness. Several of the “attributes” identified by Johnson (2007) are congruent with previous concept analyses of hope, where the distinction between attributes and strategies is equally as muddy (Appendix C, Table 1). Despite this semantic conundrum, referents such as comfort and control, and legacy and life review were unique to the analysis of hope in the context of terminal illness, reflective of the need to maintain physical, psychosocial and spiritual integrity of the self at end of life. The practice of Palliative and Hospice Care nursing is predicated on these fundamental beliefs in preserving the dignity of the human body and spirit (Ferrell & Coyle, 2010). Understanding the importance of comfort, control, legacy, and life review as hope-inspiring strategies in terminal illness can impact on the nurse’s thought processes and care delivery during Kim’s (2010) phases of deliberation and enactment in the practice domain.

Models of Hospice and Palliative Care Nursing.

Several models of Hospice and Palliative care nursing have been identified in the literature. These models serve as a basis for understanding the relationship between the nurse and the client and family during the period of time leading up to and immediately

preceding end of life. Desbiens et al. (2012) developed the shared theory model, blending Bandura's social cognitive theory and Orem's conceptual model (Desbiens et al., 2012). This model examines the concepts of nursing competence, nursing self-competence, nursing interventions, palliative self-care behaviors, physical/emotional symptoms, and quality of life and how these concepts define the nurse-client relationship in Palliative care (Dobrina et al., 2014). The intellectual, as well as clinical knowledge of the nurse, the ability to engage in reflective evaluation one's ability to cope with suffering, and a holistic approach to managing self-care deficits are nursing attributes that frame the shared theory perspective. Nurses partner with clients in promoting self-management skills through education and empowerment. Timely and respectful symptom management enhances the nurse-client relationship and impacts on quality of life (Dobrina et al., 2014).

Reed (2010) integrated the unitary caring theoretical framework into a model for provision of Palliative care by advanced practice nurses (Reed, 2010). This model respects the uniqueness of each person's experiences and patterns and allows for recognition of the holistic nature of care provision. Authentic, genuine caring behaviors of the nurse are the medium for transformation, transcendence, and meaning creation during the journey of life-threatening illness and end of life (Dobrina et al., 2014). This model suggests a synergistic relationship between the client, family, and the nurse, with the nurse as the provider of therapy, the therapist, and the therapy itself.

Murray (2007) developed the transitions model of Palliative nursing care that integrates concepts of chronic care management of clients with life-threatening illnesses other than cancer (Murray, 2007). The model places the focus of care on patient

decision-making and coordinated care throughout the trajectory of the illness “changing the patterns and intensity of service delivery depending on the patient’s situation and capability to self-care” (Dobrina et al., 2014, p.77).

Nursing competency in end of life care delivery should be accomplished through ongoing education and certification. Knowledge of health care policies, reimbursement structures, and the scope of available resources will facilitate quality client care at end of life (Dobrina et al., 2014).

Core concepts integral to Palliative and Hospice Care nursing that emerged from these models included: patient uniqueness, wholeness and autonomy, nursing presence, non-judgmental approach and self-reflection and nurse-client therapeutic relationships, sharing of self, existential growth, and formulating realistic hopes form a collective representation of a theoretical framework for Palliative and Hospice care nursing (Dobrina et al., 2014). This systematic and comprehensive approach to clinical practice may promote therapeutic, caring relationships, effective symptom management, ease of suffering, and transformative care for clients with life-threatening illnesses and those at end of life. These approaches are consistent with the espoused strategies that foster hope.

Nursing interventions to foster hope in terminal illness.

Herth (1995) explored the perspectives of home care and Hospice nurses regarding effective hope-inspiration strategies in the care of chronically and terminally ill individuals (Herth, 1995). A sample of 158 nurses from six Hospice and six home care facilities were asked to rate fifteen proposed hope interventions as to their frequency of use and perceived effectiveness. These interventions were derived from an extensive review of qualitative literature where clients identified strategies that were

hope inspiring. "No studies are reported in the literature addressing, from the perspective of the nurse, the use or effectiveness of specific interventions designed to engender hope in chronically or terminally ill individuals" (Herth, 1995, p. 33).

Providing comfort and pain relief emerged as the most important hope-inspiration strategy identified specifically by both home care and Hospice nurses. Hospice nurses also identified facilitating a sense of sustained connectedness with others, helping to see the positive small joys in life, assisting to redefine hopes and facilitating expression of spiritual beliefs and practices, helping redefine hope when specific hopes not attained, helping to take each day as it comes, encouraging sharing hopes and fears, sharing positive and inspirational stories (reminiscing), and assisting to identify areas of hope in life as among the top ten most important hope-inspiring interventions (Herth, 1995). In another study, Herth (1995) found that feeling devalued as a person, abandonment and isolation, lack of direction, and uncontrolled pain and discomfort profoundly decreased hope in individuals with terminal illness. There is a professional and moral obligation to identify barriers to hope and engage in co-creation of hope in clients with terminal illness. Nurse often provide meaningful relationships with individuals and these relationships can facilitate creating a sense of future, control, and dignity in end of life (MacLeod & Carter, 1999).

The congruence between nursing perspectives on hope-inspiring strategies and the perspectives of terminally ill individuals regarding hope-inspiring strategies has been explored (Buckley & Herth, 2004). Sixteen adults receiving palliative care were interviewed and the transcripts were analyzed using a data reduction technique. Categories of hope-fostering strategies emerged from this analysis included love of

friends and family, spirituality/having faith, setting goals and maintaining independence, positive relationships with professional caregivers, humor, and personal characteristics of determination (Buckley & Herth, 2004). Lack of interest, poor communication, and dismissive comments by nurses and other health care providers made individuals feel devalued and hindered hope facilitation (Buckley & Herth, 2004). It is paramount for all health care providers to be aware of the profound effect their behavior has on individuals at end of life, especially those who are in a facility other than their homes. For our clients who die in an institution, most die with unmet needs for symptom management, physician communication, emotional support, and respectful treatment (Yeager et al., 2010).

Nurses ranked assisting individuals to devise and revise manageable or stepwise goals as eleventh out of 15 hope-inspiring strategies (Herth, 1995). There should be some consideration of goal setting and fostering independence when assisting individuals to revise hopes as a hope-inspiration strategy. Developing goals, mourning lost goals, accomplishing meaningful goals, and developing alternate goals have been identified as engendering hope during the dying process (Feudtner, 2005; Gum & Snyder, 2002).

Nurses' perspectives on hope and the hope experiences of clients may not be accurate or may reflect a medical hegemony devoid of consideration for the individual's reality during end of life. Duggleby and Wright (2009) described the processes by which older patients receiving palliative care with advanced cancer, live with hope (Duggleby & Wright, 2009). Interview data were collected from 10 individuals and analyzed using a grounded theory approach. The main concern that emerged was described as living

with hope, where participants identified the willingness to endure; and focus on day to day living as important components of living with hope (Duggleby & Wright, 2009). Transforming hope defined the core category as a means for resolving how to live with hope. Hope was described as dynamic, future oriented, and involved acknowledging life the way it is. “The process of transforming hope was facilitated by controlled symptoms, supportive relationships, and spirituality” (Duggleby & Wright, 2009, p. 210). Nursing strategies identified in the literature (Buckley & Herth, 2004; Herth, 1995) to foster hope in end of life facilitate the process of transforming hope.

Summary

The positive nature of hope throughout history has been challenged from philosophical and cultural perspectives. Hope has endured as a powerful source of strength and an integral component of professional nursing practice. This allegiance to hope as a positive life force is supported through the theist existentialism of Gabriel Marcel. Individuals believe in the possibilities of hope derived from trust in self, others, and from human connections. This philosophical perspective is clearly aligned with the professional practice ethic of nursing. The concept of hope has been subjected to multiple concept analyses. The critical attributes of multidimensionality, dynamism, future orientation, reality based, spirituality, goal orientation, and interconnectedness have emerged as consistent descriptors of this phenomenon. Assumptions regarding hope as a response to serious life circumstances and a cognitive process and future oriented process that yields realistic and valid hopes have been discussed. The experiences of hope for clients coping with cancer and acute and chronic illness have

enlightened concept analysis and instrument development. Hope is seen as possibilities, a future good and as a spiritual endeavor.

Early concept development in the 1980s led to an outpouring of scholarly work developing instruments to measure hope. The HHI has emerged as the preeminent tool to measure hope, demonstrating sound psychometric properties, ease of use, and adaptability for translation in global research on hope. Ensuing quantitative research regarding hope and related concepts of interest in nursing followed. Increased levels of hope have been associated with increased quality of life, increased spiritual-well-being, increased coping, and decreased uncertainty. These findings support the primacy of hope in professional nursing practice.

Fostering hope for clients has been accomplished through formal hope intervention programs. These programs are lengthy, time consuming, and may have limited application in an acute care environment. Utilization of such prescribed strategies may be beneficial in a Hospice and Palliative Care client population. The LWHP demonstrated pragmatic properties that could facilitate integration into clinical practice. Nursing strategies that foster hope are interdependent on the nurse as a therapeutic agent. Trust, empathy, genuineness, caring, and connectedness in the nurse-client relationship form the foundation for hope inspiration.

Hope in the context of terminal illness revealed specific attributes of the concept for those clients at end of life. Comfort, control, legacy, and life review have been identified as significant components of hope that are important to integrate into Palliative and Hospice care nursing practice. Conceptual models of Palliative and Hospice Care nursing speak to common themes such as client uniqueness, nursing

presence, and the nurse-client therapeutic relationship. Nursing strategies to foster hope in end of life include symptom management, especially pain, preserving the dignity and value of the individual, nurturing supportive relationships, and engaging in life review.

This doctoral dissertation examined the perspectives on hope of Hospice and Palliative Care nurses. There are limited studies that examined hope from the perspective of the nurse. The qualities of the nurse that facilitates hope as well as the strategies they implement that foster hope have been proposed in the literature. Whether these qualities and interventions are identified as components of hope inspiration by Hospice and Palliative care nurses is undetermined. This gap creates an opportunity to examine Hospice and Palliative Care nurses' perspectives on hope and whether there is congruency with proposed qualities and interventions espoused in the literature, as well as identify qualities and interventions that have not been identified in the literature as salient to hope inspiration.

Chapter III discusses the methodological approach used to describe the perspective on hope of Palliative and Hospice Care nurses. A qualitative descriptive approach is outlined, including the study design, survey development, sampling, and data collection processes. Content analysis as an appropriate strategy for qualitative survey data analysis is reviewed. Content analysis can generate replicable and valid inferences from data related to the context for the purpose of providing knowledge and insights on the perspectives on hope of Palliative and Hospice Care nurses.

Chapter III

Methodology

The purpose of this study was to describe the phenomenon of hope from the perspectives of a group of Hospice and Palliative Care Nurses and the interventions they use to facilitate hope.

The specific research questions were:

1. How do Hospice and Palliative Care nurses describe the concept of hope?
2. In what ways do the nurses think that hope is helpful to clients?
3. What nursing interventions do the nurses utilize to facilitate client's hopes?

Research Design

A qualitative descriptive design was utilized for inquiry regarding the perspectives on hope of a group of Hospice and Palliative Care Nurses. An open-ended, self-report questionnaire was developed to gather data related to the research questions. An open-ended questionnaire was selected to facilitate the nurses' reflection on action through the process of writing. Writing about experiences "may be a useful tool for studying reflection because it enables practitioners to make explicit the knowledge that is implicit in their actions" (Atkins & Murphy, 1993, p. 1191).

Advantages of open-ended survey questions include encouraging the respondents to use descriptive language and depth in written responses. Unexpected responses to open-ended questions may suggest possibilities of relations and hypotheses that were unanticipated (Kerlinger & Lee, 2000). Open-ended survey questions must relate to the research questions, use clear language, solicit knowledge the respondents possess, and encourage responses that are honest and contextually accurate. Disadvantages to

utilizing open-ended questionnaires can include use of language that cannot be clarified before the respondent provides an answer. The same question can frequently have different meanings for different people (Kerlinger & Lee, 2000). Low response rates and dislike of expressing oneself in writing can impact on the quantity and quality of data collected for analysis. Since lengthy surveys are often a deterrent to respondents' participation (Kerlinger & Lee, 2000), the questionnaire was limited to five questions to encourage depth of answers without requiring excess time to complete.

The self-report questionnaire included a demographic section and five questions related to the phenomenon of hope (Appendix B). These questions included:

1. As you think about the concept of hope, how would you describe it to a nursing student?

2. Briefly describe an experience where a patient shared with you what he or she was hoping for.

3. In what ways do you think hope is helpful to patients?

4. Do you think that hope helps patients to make sense of their circumstances or find meaning in their illness experiences? Please describe.

5. Please describe ways that you have helped patients and families find hope.

Duggleby and Wright (2007) explored the descriptions of hope of professional palliative caregivers from different disciplines. "There seems to be a link between the hope of professional caregivers and the quality of care they provide" (Duggleby & Wright, 2007, p. 48). The qualitative component of their data collection consisted of an open-ended survey developed by the authors and included six questions related to hope. Questions one and five of this survey were revised from the original survey to focus

specifically on nursing. The questions were selected based on the purpose of this research study. Palliative caregivers described their personal hope as peace, a better future, spirituality (faith, finding meaning, and purpose), and making a difference. They also used symbols from nature (wind, sunshine) to describe their hope. The participants reported that their own hope helped them foster positive relationships and communication with palliative patients and families, provide comfort, and offer hope (Duggleby & Wright, 2007).

Recruitment and data collection.

Once approval by the University of Rhode Island Institutional Review board was obtained, this researcher contacted Sandra Wilkerson, RN, who is the Chief Operating Officer of a Home and Hospice Care facility. The researcher was familiar with the organization and was referred to Ms. Wilkerson through professional contacts. The purpose of the study was discussed and permission to collect data from Hospice and Palliative care nurses employed at the organization was requested. A short proposal outlining the study was developed and sent to Ms. Wilkerson. The organization does not have a formal IRB committee for reviewing and approving research proposals. The process for obtaining permission included Ms. Wilkerson presenting the proposal to the organization's Ethics Committee for their approval. When approval was obtained from the Ethics committee, Ms. Wilkerson contacted this researcher and provided a document outlining the schedule of meetings for the Hospice and Palliative care teams, along with patient care managers contact information to arrange meeting attendance. This researcher and Ms. Wilkerson discussed various methods to recruit study participants and it was decided that attendance and recruitment at the team meetings would facilitate

optimal participation. Per Ms. Wilkerson's recommendations, the researcher also met with small groups of nurses on the inpatient Hospice unit to solicit their participation.

The researcher contacted the patient care managers of three home care teams and two long-term care teams and arranged to be placed on the agenda of their interdisciplinary team meetings for a 15 minute presentation on the study. The inpatient patient care director identified a date and time where walking rounds would be completed on the unit. The researcher and the inpatient patient care manager agreed that this would be the optimal time when nurses would be available to speak with regarding the research project.

It was anticipated that six or seven nurses would be present at each team meeting. The actual number of nurses attending the meetings varied due to extenuating circumstances. On the inpatient unit, five nurses were approached and agreed to listen to the presentation on the study. At each of the team meetings and the small group inpatient meetings, the researcher reviewed the purpose of the research study, discussed any risks or benefits, and answered any questions. It was stressed that participation was voluntary and if anyone did not want to complete the questionnaire one could withdraw without recourse. Informed consent forms were completed prior to data collection.

The nurses were instructed to be as descriptive as possible. The researcher stressed that the nurses' responses were valued and to make their responses legible. At one of the long-term care team meetings, several nurses looked at the questionnaire and remarked that the questions looked "hard." Two nurses expressed their dislike of expressing themselves in writing and stated they would have preferred being

interviewed. It should be noted that no questionnaires from the long-term care nurses were completed and returned to the researcher.

A self-sealing, addressed, and stamped envelope was provided and the nurses were instructed to place the completed questionnaire in the envelope, seal it, and place it in the mail. The envelopes were identical to ensure anonymity. The nurses were given the option to complete the survey immediately and place the sealed envelope in a sealed box or complete the survey at a more convenient time and mail the envelope to the researcher. The nurses at each meeting chose to complete the surveys at a later time. The team meetings focused on discussion of the plan of care for their patients and there was not adequate time to devote to completing the survey at that time. The nurses on the inpatient unit were engaged in direct patient care and requested to complete the survey at a later date. The nature of the questions on the survey required the nurses to reflect on their clinical practice. This focused thinking would have been difficult to achieve during the team meetings and direct patient care. After attending the meetings, additional follow-up phone calls were placed to the patient care managers asking them to remind the nurses of the study and to consider participation. Forty-three questionnaires were distributed at the six formal meetings and the informal meetings with the inpatient nurses. Nine questionnaires (18%) were returned for data analysis.

Respondents.

A purposeful convenience sample was used. According to Sandelowski (2000), the goal of purposeful sampling is to obtain cases deemed information rich for the purposes of the study. A total of nine nurses participated in the study, six from the home care teams and three from the inpatient unit (Appendix C, Table 5).

Respondents were between the ages of 30 years old and 60 plus years old. Five of the nurses were 50 years and older. All nine participants were white females. Six of the respondents possessed an associate degree education and three completed baccalaureate education. The nurses were very experienced; five indicated they had 21 or greater years of clinical practice. The nurses practiced in a variety of roles, with eight indicating they had direct patient care experience. Their areas of clinical practice included home care, nursing homes, and hospitals. All of the nurses indicated working in Hospice and considered Hospice their area of nursing specialty.

Data analysis.

Qualitative content analysis was utilized to analyze data from the written responses on the questionnaires. Content analysis was first utilized as a method for analyzing hymns, newspaper and magazine articles, advertisements, and political speeches in the 19th century (Harwood & Garry, 2003). Contemporary use of content analysis is evident in qualitative research in the fields of communication, sociology, psychology, business, and nursing. Critics of content analysis cite a lack of statistical rigor and simplistic technique as undermining the trustworthiness of this methodology. Despite these concerns, content analysis has emerged as a legitimate and effective method with an established position in nursing research (Elo & Kyngas, 2007). “Content analysis...offers researchers several major benefits. One of these is that it is content-sensitive (Krippendorff, 1980) and another is its flexibility in terms of research design” (Elo & Kyngas, 2007, p. 108). The process of conducting content analysis used in qualitative research can proceed in an inductive or deductive manner. Deductive content analysis can be utilized when the purpose of the study is related to theory testing (Elo &

Kyngas, 2007). It is based on a prior theory or model and progresses from the general to the specific. Inductive content analysis, which was used for this study, is recommended when there is not enough current knowledge regarding a phenomenon or that knowledge is incomplete (Elo & Kyngas, 2007).

According to Sandelowski (2000) and Hsieh and Shannon (2005) qualitative content analysis is the analysis of choice in qualitative descriptive studies (Hsieh & Shannon, 2005; Sandelowski, 2000). For this study, manifest content analysis was used. Although there are different approaches to content analysis, each author emphasizes a systematic approach (Graneheim & Lundman, 2004; Krippendorff, 2013, Schreier, 2012) consisting of the following steps: formulating the research questions, selecting the sample, determining data collection approaches, coder training, coding the data, implementing the coding process, and analyzing the results of the coding process.

Manifest content analysis was utilized to analyze the responses for each question on the survey. In manifest content analysis, the researcher identifies the appearance of particular words or phrases in textual material. Manifest content analysis was achieved through coding and categorizing data. With this type of analysis the researcher stays as close to the written text as possible (Graneheim & Lundman, 2004).

Initially, the researcher and an experienced qualitative researcher independently read each of the questionnaires a number of times. In order to obtain a sense of the data, immersion was imperative. This was achieved through multiple readings of each questionnaire so that a saturated familiarity with the data was obtained. Responses to each open-ended question were read and initial impressions written in the margins. This process continued until all responses to the first question were completed. The responses

to the first question were then examined and coded using a content analysis template (Graneheim & Lundman, 2004). The same process continued for the remaining four open-ended questions. In the final phase, the two researchers discussed their analyses and reviewed data together until there was 100% agreement.

The entire written response for each question on the surveys completed by nurses was considered the unit of analysis. Graneheim and Lundman (2004) recommended that the unit of analysis, or meaning unit, be large enough to be considered as a whole and small enough to identify meaningful components. Content analysis facilitates identification of key issues in textual data that can be categorized for analysis. Creating categories, or groups of content that share similar textual expression, can yield subcategories and themes that are embedded in the coded text. Krippendorff (1989) suggested that categories be exhaustive and mutually exclusive for qualitative research while Burnard (1996) recommended no more than twelve headings or categories.

Trustworthiness

A flexible, yet stepwise approach has been advocated to enhance the rigor and trustworthiness of qualitative content analysis methodology (Graneheim & Lundman, 2004; White & Marsh, 2006). White and Marsh (2006) and Graneheim and Lundman (2004) refer to the criteria developed by Lincoln and Guba (1985) that subsequently have been used by other researchers to address trustworthiness. Credibility evaluates the focus of the research and the effectiveness of data analysis in addressing the intended focus. Peer debriefing between the researcher and an experienced qualitative researcher regarding possible researcher biases, as well as clarification of interpretations during the content analysis process was accomplished to establish credibility. In this study,

credibility could have been enhanced by triangulation techniques (Lincoln & Guba, 1985). Utilization of multiple sources of data collection may have facilitated a deeper understanding of the Hospice and Palliative Care nurses' perspectives on hope. Semi-structured interviews and participant observation would have provided opportunities for elaboration of perceptions on hope and for observation of nurses' providing hope inspiration.

Member checks are a critical technique for establishing credibility (Lincoln & Guba, 1985). This technique involves testing data analysis, interpretations, and conclusions with groups from whom the data was originally collected. The ability of informants to recognize their experiences in the research findings is central to credibility (Krefting, 1991). Member checking was not accomplished during the scope of this dissertation. The researcher has made arrangements with the patient care managers of the Hospice and Palliative Care organization to return and present the data and findings at a later date. Ethical considerations regarding this strategy will be taken into consideration. The Hospice and Palliative Care nurses may not be conscious of the information discovered about their perceptions on hope and these insights may be disconcerting to them. It is incumbent upon the researcher to make a sound decision regarding sharing of research findings that may be harmful to the well-being of the participants (Krefting, 1991). It is not anticipated that sharing the data analysis and interpretations that result from this dissertation research will cause any undue stress for the Hospice and Palliative Care nurses.

Objectivity in data analysis and congruence between independent analysts of the data is addressed in the criteria of confirmability. Lincoln and Guba (1985) suggested

utilization of the confirmability audit as a process to establish confirmability (Lincoln & Guba, 1985). This researcher created an audit trail to organize and systematize data collection and analysis so that a process was created that demonstrated the findings were grounded in the data. The experienced qualitative researcher served as the auditor, employing ongoing dialogue, returning to the literature on hope for confirmation of theoretical constructs, and discussion of Kim's practice domain considerations throughout the process. Findings were then traced back to the original raw data. In assessing confirmability, the auditor may "reach a judgment about whether inferences based on the data are logical, looking carefully at analytical techniques used, appropriateness of category labels, quality of interpretations, and the possibility of equally attractive alternatives" (Lincoln & Guba, 1985, p. 323). Confirmability in this study was also established during the data coding and analytic process, with the researcher and the experienced qualitative researcher discussing coding, categories, and interpretations until 100% congruence was achieved.

Dependability deals with the temporal consistency of data collection and the ability to replicate the data collection process. Dependability was established through dense description of the research methods, questionnaire development, contact with Hospice and Palliative Care organization, recruitment of participants, presentation of the study to potential participants, questionnaire completion and submission, data organization, data coding, and data interpretation. Similar to confirmability, dependability can also be established through a dependability audit, where another researcher can clearly follow the "decision trail" and thought processes embedded in the research study (Lincoln & Guba, 1985; Krefting, 1991). The ability to follow a stepwise

replication of the research process ensures dependability. The experienced qualitative researcher collaborated closely with the researcher throughout the development and implementation of this research study, challenging the researcher to achieve clarity in methodology development and description of the research process. Dependability is also enhanced through triangulation strategies. In this research study, establishing dependability would have been strengthened through use of triangulation.

Transferability refers to the extent to which findings can be transferred to other settings or groups (Graneheim & Lundman, 2004). The decision to include transferability among the criteria for establishing trustworthiness is dictated by the original assumptions of the research study. If the research findings are primarily descriptive, as may be the case in ethnographical or phenomenological inquiry, generalizations regarding the findings are irrelevant. “In such a case, data are of descriptive worth in and of themselves” (Krefting, 1991, p. 220). The research design, methodology, and data analysis in this research study are consistent with the assumption of generalization of findings and should be subject to evaluation of transferability.

A key variable in transferability was the representativeness of the participants to the larger population (Krefting, 1991). Additional strategies such as a nominated sample, time sampling, and member checking can be utilized to support transferability. It is interesting to note that the ultimate decision regarding transferability does not rest in the researcher’s hands. It is not the researcher’s job “to provide an index of transferability; it is his or her responsibility to provide the data base that makes transferability judgments possible on the part of potential appliers” (Lincoln & Guba, 1985, p. 316).

Summary

In summary, the perspectives on hope of Palliative and Hospice Care nurses have been explored utilizing a qualitative descriptive design. An open-ended survey was developed to gather data on nurses' definition of hope, description of an experience where a patient shared what he or she was hoping for, hope and making sense or finding meaning in an illness experience, and nursing strategies that foster hope. The process of sampling and data collection was developed to maintain anonymity, confidentiality, and enhance credibility of the findings. An inductive approach to content analysis was utilized to analyze the data for this qualitative study regarding the perspectives on hope Palliative and Hospice Care nurses. Emerging categories, subcategories, and themes embedded in the coded text were identified. Examining trustworthiness in qualitative research is essential to enhance quality and integrity. The process for ensuring trustworthiness of the data analysis included evaluation of credibility, confirmability, dependability, and transferability. Peer debriefing, confirmability and dependability auditing, dense description of the research process, including coding and interpretation of the data were strategies utilized to establish trustworthiness in this research study.

Chapter IV will review the results of the data analysis and discuss the significance of the findings as they relate to the research questions regarding the perspectives on hope of Hospice and Palliative Care nurses.

Chapter IV

Findings and Discussion

Findings

The purpose of this doctoral research study was to describe the perspectives on hope of Hospice and Palliative Care nurses who work in one Hospice and Palliative Care organization in the northeast and the interventions they utilized to facilitate clients' hopes. A qualitative approach using self-report questionnaires was used for this study. The results are based on nine open-ended surveys completed by Hospice and Palliative Care nurses who practice in home care and inpatient settings. Manifest content analysis was utilized for data analysis.

The specific research questions that guided this inquiry included:

1. How do Hospice and Palliative Care nurses describe the concept of hope?
2. In what ways do the nurses think that hope is helpful to clients?
3. What nursing interventions do nurses utilize to facilitate client's hopes?

Descriptions of the Concept of Hope

Descriptions of the concept of hope were written in response to the first open-ended question "As you think about the concept of hope, how would you describe it to a nursing student?" The question seemed to be challenging to the participants. Participant responses included a combination of descriptions of attributes of hope as well as descriptions of what people hope for and what actions fosters hope.

The concept of hope was described as future oriented in a wish/desire/expectation for a positive outcome by three of the home care nurses and one of the inpatient nurses. Statements regarding this aspect of hope included:

“Hope is the expectation and yearning for good. Positive outcomes.”

“Hope is the wish or desire for something to happen or something not happen. Usually we hope for good and pleasant things.”

“Attaining a personal goal or alleviating a symptom.”

“Hope is...based on one’s expectation that good and positive outcomes will occur in one’s life.”

Hope was described as enduring in statements from two home care nurses expressing that “Hope is to never give up” and “Hope gives the will to go on.” One inpatient nurse also described hope as enduring in the statement “Hope is not lost at end of life.” Hope was described to have a dynamic nature by two of the home care nurses and one of the inpatient nurses. Statements regarding this attribute included:

“You don’t lose hope at end of life, the focus of what you hope for just changes.”

“In dealing with Hospice patients and families the term hope takes on a different meaning of focus. Hope is experienced at a more basic level of life and death.”

“Hope in Hospice and Palliative Care can mean one of many things. For one, it may mean physical symptom improvement while another it may be an emotional or spiritual symptom that may need to be controlled.”

The primacy of relationships in conceptualizing hope was expressed by several nurses. One inpatient nurse identified the role of the nurse as integral to the concept of hope in the statement “Nurses are hope in the eyes of patients.” Two of the home care nurses described family relationships as supporting hope, as evidenced by the responses “Hoping for family to be around as often as possible” and “Hope that everyday they (the patient) will wake up and see their family members.” Hope and faith have been described as synergistic concepts by the Hospice and Palliative Care nurses. Two of the

home care nurses described this notion in the statements “Hope is blind faith” and “A person’s faith can play a role in how they hope.”

What Patients Hope For

Client exemplars described individual situations in which specific hopes were articulated in response to the second survey question: “Briefly describe an experience where a patient has shared with you what he or she was hoping for.”

Accepting wishes as hopes was described by one of the inpatient nurses who shared a story about a beloved leukemic patient who was “hoping and praying for a miracle. He longed for remission and return to his life.” The story of a 72-year-old patient with gastric cancer was described by one of the home care nurses. This patient’s “wish/hope/dream was she would beat the cancer even with the poor prognosis.”

Goals attached to self and significant others were instrumental in facilitating hope as described by two home care nurses. The first client experience was that of a 34-year-old female who was dying of colon cancer. Her goal was “to get her symptoms under control and future goal was to be symptom free so that she could hold her [three year old] son “one more time”... and she hoped he [her son] was successful.” The second client was a 52-year-old woman who “hoped to live until her youngest daughter was 16 and would be better able to care for herself.”

One of the inpatient nurses who responded shared the story of an 11-year-old boy who was dying of AIDS. “He had been too sick to go back to school for a while and wanted to see his friends...the school and his grandparents made arrangements for [him] to return for a day...he told me how excited he was to see them again.” Another inpatient nurse described caring for a 100-year-old female patient who “was hoping to

see her 101st birthday that was in two weeks...the patient ended up passing away the day after her birthday.” Additionally, one of the home care nurses in answering the question on how hope is helpful to patients expressed that “hope keeps them [patients] goal oriented in whatever they believe in.” Although this does not speak to specific client examples of goals, it does support the goal oriented nature of hope as articulated by the Hospice and Palliative Care nurses in their client stories. Of the nine nurses who completed the questionnaire, one did not respond to the question regarding a patient experience and two of the nurses provided a response that did not answer the question.

Nurses Thoughts About How Hope is Helpful to Clients

Descriptions of how hope is helpful to clients were examined from the written responses to the third and fourth open-ended questions: “In what ways do you think that hope is helpful to patients?” and “Do you think that hope helps patients to make sense of or find meaning in their illness experiences? Please describe.”

The question that asked specifically about how hope is helpful to clients revealed a number of different responses. Hope was described as something that helps clients stay positive by three of the home care nurses in the following statements: “Hope helps us stay positive;” “Hope...keeps them focused on a positive thought. Hope is positive which allows them to never give up,” and “Hope = positive outlook.” Staying positive was also identified by one of the home care nurses in sharing a client experience, describing the patient as keeping a “positive mind-set.”

Hope as helping the client stay in control was expressed by one of the home care and one of the inpatient nurses. “Hope is helpful to [patients] because during their last few months/weeks/days left on earth, hope is the one thing they can control” and hope

“lets one feel he/she is still in control” exemplified this response. Hope as something that makes the client feel safe was described by one of the inpatient nurses who wrote that hope “brings comfort and safety” to patients. One of the inpatient nurses, in answering the question on the concept of hope, addressed the idea of providing safety in describing hope as “caring, support and safety.” Hope as providing a purpose for living was expressed by two of the home care nurses who stated that hope was helpful because it “is a reason to continue to live despite adversity” and hope “makes life worth living.”

The question regarding hope and making sense or finding meaning in an illness experience specifically asked the nurses to reflect on hope and meaning making. Hope as facilitating positive meaning making was expressed by two of the inpatient nurses in the following statements: “Hope gives perspective to otherwise life threatening illnesses. Hope allows one time to understand and accept life’s situation,” and “Feeling hopeful helps patients from falling into the dark abyss. They may circle that abyss but hope prevents them from falling directly into it.” Three of the home care nurses stated that:

“Patients who have hope are better able to try to find something meaningful about their illness experience...and...are usually better at finding a positive aspect of their illness.”

“I definitely think it [hope] helps. They hope for something and seem to hold onto that hope to the end.”

“Hope does help patients make sense of their circumstances and find meaning in their illness experience...Having hope makes the transition, if you will journey, much easier on patient, family and caretakers.”

One of the home care nurses did not respond to the question on hope and meaning making.

Nursing Interventions that Facilitate Clients' and Families' Hopes

Descriptions of nursing interventions that facilitate hope were written in response to the fifth open-ended question "Please describe ways that you have helped patients and families find hope?" Two of the home care nurses did not respond to this question. Six categories of nursing interventions emerged as facilitating hope.

Open communication.

Two of the inpatient nurses stated "open communication and discuss feelings...sharing belief and listening to what others say" and "listening, opening up dialogue..." helped clients and families find hope. One home care nurse described hope-inspiring strategies as "talking to patients about their disease process, transition, and journey...encouraging patients to open up about their feelings including spiritual and emotional."

Providing comfort and symptom management.

Comfort measures and symptom management were identified by three of the home care nurses as interventions that foster hope. Two home care nurses expressed that "reassuring [the patient and family] that Hospice nurses and staff will work very hard to manage symptoms like pain, nausea, restlessness" and "Letting patients know I care about them and want them to feel comfortable and safe" helped engender hope. Another home care nurse shared this sentiment:

"Comfort is the goal. I want them to know we are all here to make their last days as comfortable as possible. Some patients ask me as soon as they come on service if I will be with them until they die, followed by please keep me comfortable."

Humor: Making the patient laugh and smile.

Nurses identified the importance of humor as a hope engendering strategy. Two of the inpatient nurses stated “Making a patient laugh is frequently my goal because it’s the best way to develop a rapport and get patients to smile” and “Bringing cheer into the room in a way to get patients to smile and laugh. Laughter is the best medicine” were hope-inspiring strategies. Both nurses did not elaborate on exactly how they behaved or what type of humor they used to make the patient smile and laugh.

Providing patient and family education and support.

Three home care nurses expressed how patient and family education and support was integral to hope facilitation. These thoughts were evident by the following statements:

“Offering support during their journey.”

“Reassuring...that the nurse, social worker and spiritual care will assist patient and family to cope with the dying process, this helps family and patient feel reassured and confident and hopeful...reassuring the family that they are doing a great job caring for the patient and they will have what they need to keep the patient comfortable.”

“Families need support/ encouragement when taking care of a loved one at home. It’s very difficult for some families to utilize morphine and do not want to “kill” their loved one. I teach/review morphine pamphlets with the family and that gives them hope and confidence that they can continue to keep their loved one home.”

Setting the goal of a peaceful death

Two of the home care nurses described setting the goal of a peaceful death as helping to foster hope for clients and families receiving Hospice and Palliative Care. Statements such as “Help the patient and family feel reassured and confident and hopeful...that a peaceful, comfortable death is assured” and “Helping patients/families redefine their goals so there is hope that they can be achieved. Goal of a peaceful death

rather than living longer” exemplified these nurses’ thoughts on the goal of a peaceful death as inspiring hope.

Connecting with the client.

Making a connection with the patient was a nursing strategy to foster hope that emerged from the nurses’ responses to the fifth question. Two of the inpatient nurses described “listening...opening up dialogue” and “sharing belief and listening to what others say” as ways in which open communication, as well as the willingness to make a connection with the patient, facilitates hope. One of the inpatient nurses stated “Hope is the gift I give by letting patients know I care about them” describing caring as a component of hope inspiration. In answering question one regarding the concept of hope, this same inpatient nurse identified nursing strategies to foster hope through connecting with the client in similar statements such as “Hope is caring...kindness and compassion...nurses ‘are’ hope in the eyes of patients.” A home care nurse described connecting with the patient throughout their journey: “Talking to patients about their...transition and journey...offering support during their journey” as fostering hope.

Discussion of the Findings

The inpatient and home care Hospice and Palliative Care nurses provided descriptive responses to the questions on the hope questionnaire. Each of the first four questions had some respondents who offered their perspectives on hope but did not directly answer the question. This was not the case with the fifth question regarding nursing interventions that foster hope. It can be argued that this question asked for more concrete knowledge that required less reflection and therefore may have been easier to answer.

The concept of hope.

The nine Hospice and Palliative Care nurses from the inpatient unit and home care teams identified many of the salient attributes of hope as described in the literature. A comparison of the critical attributes from selected nursing literature (Benzein & Berg, 2005; Davis, 2005; Kim et al., 2006; Lohne & Severinsson, 2006; Rustøen et al., 2005), attributes of hope in terminal illness as delineated by Johnson (2007), and those articulated by the Hospice and Palliative Care nurses revealed a cluster of frequently identified attributes (Appendix C, Table 6). Multidimensionality, dynamism, and future orientation were the most frequently identified attributes in the selected nursing literature. Attributes of hope in terminal illness were consistent with these critical attributes of hope. The attributes described by the Hospice and Palliative Care nurses included dynamism and future orientation. Spirituality, interconnectedness, and goal-oriented were identified by Johnson (2007), and the home care and inpatient nurses. as attributes of hope, although for the nurses, goal-oriented did not emerge in answering the question regarding the concept of hope but was identified when sharing their perspectives on how hope is helpful to clients. Hope as providing meaning was an identified critical attribute and was also described by the nurses when answering the question on hope and making sense or finding meaning in an illness experience. There is a lack of clarity in the literature regarding “hope” as an outcome and “hoping” as a process, attributes of hope versus dimensions of hope, and strategies that foster hope versus outcomes of hope inspiration. This lack of clarity can certainly explain why the elements of the concept would emerge throughout answering the five questions on the hope questionnaire.

The frequency of identification of the additional attributes of spirituality (hope and faith as described by the home care and inpatient nurses), interconnectedness (described as primacy of relationships from the nurses and interpersonal relationships by Johnson, 2007), and goal-orientation when describing the concept of hope requires a preliminary expansion of the original critical attributes of hope to include multidimensionality, dynamism, future-orientation, spirituality, interconnectedness, and goal-orientation. Johnson (2007) and the Hospice and Palliative Care nurses identified personal characteristics such as strength, determination, and the will to endure as attributes of hope. Intrapersonal qualities as elements of hope have been described as personal spirit (Nekolaichuk, Jevne & Maguire, 1999), inner strength and energy (Benzein & Saveman, 1998), positive personal attributes (Owen, 1989), personal attributes (Herth, 1990), and a determination to endure (Morse & Doberneck, 1995). The preponderance of references to personal characteristics as relevant to the concept of hope necessitates an additional expansion of the critical attributes to include intrapersonal qualities.

The attributes of hope as identified by the Hospice and Palliative Care nurses can be contrasted with the attributes/processes of hope described by Farran et al. (1995). Hope was described as an experiential process, where a life event that exposes an individual to the trial of suffering is the antecedent of hope. This is consistent with one of the home care nurse's description of hope as dynamic and experienced at a more basic level of life and death. The degree of suffering that is necessary to initiate the process of hoping has not been established. It can be postulated that a client approaching end of life may be experiencing physical, psychological or spiritual suffering. "Persons ...

confronted by life-changing events are individually challenged by these afflictions ...persons who learn to hope despite an unknown outcome will probably be permanently changed” (Farran et al., 1995, p. 7).

Hope has been described as a spiritual or transcendent process, where faith in the self, in others, and in a religious doctrine creates the basis for hope (Farran et al., 1995). Two of the home care nurses identified faith as playing a role in how clients hope. Recognition of faith as impacting on the nature of client’s hope is consistent with the perspective of hope as a spiritual process.

Hope as a rational thought process includes identifying realistic goals, engaging in active participation in goal attainment, and feeling a sense of control (Farran et al., 1995). Hope as goal oriented and helping clients feel a sense of control emerged from the nurses’ descriptions of how hope is helpful to clients. This perspective on hope is also congruent with Snyder’s (2000) theory elucidating the goal directed nature of hope and the role of pathways thinking as well as Herth’s (1996) work on hope in the homeless population where hope was fostered through setting attainable goals.

The fourth attribute identified by Farran et al. (1995) related to the concept of hope describes hope as a relational process. Hope can be fostered through relationships with others where support, guidance and trust are engendered. The importance of sustaining relationships in the facilitation of hope has been established in the literature (Holt, 2000; Holt & Reeves, 2001; Saleh & Brockopp, 2001; Seibaek et al., 2012). One inpatient and two home care nurses also described the relational aspects of hope.

Nurses thoughts about how hope is helpful to clients.

Hospice and Palliative Care nurses' descriptions on how hope is helpful to clients provided insights from the perspective of the provider. Two nurses described client exemplars where clients' hopes were for unrealistic outcomes. Wishing describes the circumstances in which an individual selects a desired outcome that may or may not be realistic. The distinction between hoping and wishing lies in the degree of probability of achieving what is wished for. Allowing the client to wish for a miracle is considered a protective hope-inspiring strategy in situations where the client may be overwhelmed with their circumstances (Fitzgerald Miller, 2007). It can be argued that facing end of life would qualify as an overwhelming circumstance. In these instances, wishing can be considered a strategy for hope inspiration and not a false hope. The nurses did not use any language in describing what clients hope for that would suggest value judgments regarding their client's having hopes that were wishes. This acceptance of wishing could be influenced by the nature of Hospice and Palliative Care nursing. The willingness to accept that clients may hope/wish for a miracle may emerge from a commitment to preserving hope until the very end of life, regardless of whether it is realistic or not.

“Health-care professionals are able to enhance, maintain, or destroy hope in patients through their attitudes, behaviors, and ways of communication” (Mok et al., 2010, p. 877). Respect for the fragility and vulnerability of clients at end of life may be the basis for eschewing the notion of false hope in exchange for the comfort that hoping for a miracle brings to the client. Anecdotally, at one of the long-term care meetings, three nurses stated that they use the terms “wish” and “hope” interchangeably, especially in asking the clients what they wish for as a means of identifying their hopes. Use of the

term “wish” may infer something different to clients other than a synonym for hope. The serendipitous outcome in this discourse could be conveying a tacit acceptance of hoping for an unrealistic outcome, or wishing. The language issue could actually facilitate selecting a wish as a hope or it could infer that the nurse believes in miracles or that a miraculous recovery is possible.

Roscigno et al. (2012) evaluated parents’ and health care providers’ descriptions of hope following counseling of parents at risk of delivering an extremely premature infant (Roscigno et al., 2012). Parents identified having hope as something that gave them the energy to cope with recommended treatments and the possibility of a premature delivery or a poor prognosis for the baby. Several parents stated that they did not want to be given “false hope.” “False hope was information that was too optimistic and given simply to make parents feel better at the time without acknowledging or preparing the parent(s) for any potential negative outcomes” (Roscigno et al., 2012, p. 1236). The need to have realistic hopes emerged as extremely important for these parents. Family members of traumatic coma patients in the ICU identified the need for correct and complete information to avoid uncertainty and “false hope” (Verhaeghe et al., 2007). This contextual nature of hope requires the nurse to carefully evaluate the individual client, as well as family and health circumstances to determine whether the use of wishing is therapeutic, nontherapeutic or a symptom of denial prior to supporting client’s wishing.

Hope was described by the Hospice and Palliative Care nurses as helping clients to stay positive, stay in control, and feel cared for. Patients awaiting bone marrow transplantation identified that hope was facilitated through connection with God,

affirming relationships, staying positive, living in the present, and having a sense of accomplishment in activities (Saleh & Brockopp, 2001). Hope as a positive force and a catalyst for action was identified in the literature on hope in patients after trauma, with a critical illness, or a terminal illness (Cutcliffe, 1996; Elliott & Olver, 2002; Morse & Doberneck, 1995; Verhaeghe et. al, 2007). Maintaining a positive outlook can be powerful in coping with an illness situation. The nurse must be vigilant in assessing whether this “positive attitude” may be concealing underlying suffering or unresolved feelings that have not been addressed, especially in end of life situations where temporal constraints exist.

Open, caring relationships have been identified as crucial to the mobilization, support, and maintenance of hope (Herth, 1995). Hope as providing a sense of safety has not been specifically identified in the literature, although safety can be inferred to mean care, security, and well-being. Increased levels of hope have been found to increase feelings of well-being (Davis, 2005; Vellone, Rega, Galletti, Iuisa, & Cohen, 2006) and spiritual well-being (Pipe et. al, 2008). Further clarification of the meaning of the term “safety” for the Hospice and Palliative Care nurses would enhance understanding of the relationship between hope and safety.

Feeling a sense of control as an outcome of hope was identified by one inpatient and one home care nurse. Brockopp, Hayko, Davenport, and Winscott (1989) found a positive correlation between perceived level of control, hope, and information seeking in cancer patients (Brockopp et al., 1989). Forbes (1999) interviewed six community-dwelling older adults with chronic illness regarding their experience of hope in living with their chronic illness (Forbes, 1999). One of the emerging themes from the data

analysis included “taking back control” in which hope allowed the participants to take action, realize their strength, and make peace with their loss. A sense of control in end of life maintains the personal integrity and self-determination of the client.

Five of the Hospice and Palliative Care nurses identified hope as helping the client feel a purpose for living and as facilitating positive meaning making. Frankl (1984) suggested that the consequence of pain and suffering is the creation of meaning. From the existentialist perspective, individuals reflect on their life achievements and what they ought to continue to achieve as fundamental to the state of becoming and creation of meaning. Finding meaning is a contextual phenomenon where the individual looks for meaning within the circumstances of their specific experiences. What is meaningful is always personally significant and unique to the individual. “The need for meaning making is essential when perilous conditions...violate core assumptions about how the world functions and shatter beliefs about a person’s security, invulnerability, and sense of predictability” (Armour, 2010, p. 441). Facing end of life is the ultimate extreme in physical existence. Hope “helps the person maintain a future orientation, which is essential in order not to give up on life” (Plattner & Meiring, 2006). This positive meaning making in end of life has been associated with psychological well-being (Thomas & Cohen, 2005). Duggleby and Wright (2007) described the processes by which older palliative home-care patients with advanced cancer live with hope (Duggleby & Wright, 2007). The process of transforming hope included searching for meaning. Participants described this search for meaning as reflecting on and finding value in their lives (Duggleby & Wright, 2007).

Nursing interventions that facilitate clients' and families' hopes.

All nine Hospice and Palliative Care nurses described how they helped clients find hope. These responses addressed the third research question “What nursing interventions do nurses utilize to facilitate client’s hopes?” Strategies that emerged were consistent with hope-inspiring strategies identified in the literature. Open communication and encouraging sharing of feelings was described as engendering hope. Making the patient laugh and smile was a component of using humor to inspire hope. Providing comfort and symptom management, and providing client and family education and support were strategies that the inpatient and home care nurses utilized to foster hope. These strategies have been extensively delineated in the literature (Duggleby & Wright, 2007; Herth, 1990; Herth, 1995; Macleod & Carter, 1999; Turner & Stokes, 2006).

Setting the goal of a peaceful death was found to be a salient nursing intervention. Elderly palliative care patients have defined their hope as “expectations such as not suffering more and having a peaceful death” (Duggleby & Wright, 2007, p. 205). Devising and revising goals are established nursing interventions to foster hope (Duggleby & Wright, 2007; Herth, 1990; Herth, 1995; Macleod & Carter, 1999; Turner & Stokes, 2006). All nine of the Hospice and Palliative Care nurses in this study did not describe goal setting in general among the ways that they facilitate hope. They did describe how having goals was helpful to the client; these goals were generated by the client or facilitated by other people significant to the client. There could be an assumption by the nurses that in providing comfort, education and open communication

that they are engaging in goal-directed behavior and therefore are fostering hope on several dimensions.

Connecting with the client emerged as a nursing strategy to foster hope. Relational connectedness (Mok et al., 2010), presencing (Turner & Stokes, 2006), facilitating a sense of sustained connectedness with others (including the nurse) (Herth, 1995), nursing the totality of the person within the context of a formed partnership (Cutcliffe, 1995), and positive relationships with professional caregivers (Herth, 2004) exemplify the primacy of connecting with the client and therapeutic use of self as paramount to hope inspiration. Clemence (1966) suggested that an existential philosophy of commitment is a responsibility of the nurse in facilitating the movement from existence to *being* as a means to hope (Clemence, 1966). The nurse's therapeutic use of self can only be implemented by "the truly committed one who is open to involvement" (Clemence, 1966, p. 505). Marcel (1949) described the nature of connecting with others as being "presences." "The person who is at my disposal is the one who is capable of being with me with the whole of himself when I am in need; while the one who is not at my disposal seems merely to offer me a temporary loan raised on his resources" (Marcel, 1949, p. 26). Hospice and Palliative care nursing models support this genuine engagement as foundational to caring for clients at end of life. Authentic, genuine caring behaviors of the nurse are the medium for transformation, transcendence and meaning creation during the journey of life-threatening illness and end of life (Dobrina et al., 2014).

Connecting with the client in the provision of end of life care and fostering hope for Hospice and Palliative Care nurses is based on moral and ethical obligations and

professional expectations. As such, this hope-inspiring nursing intervention should be identified by all Hospice and Palliative Care nurses in clinical practice. Use of humor and open communication may be strategies to inspire hope utilized by the Hospice and Palliative Care nurses in this study that suggest a openness to connecting with the client. Giving of self, connecting with those that are suffering, sharing in the client's journey towards end of life while providing symptom management, client and family education and support, participating in life review, and co-creation of meaning requires an extraordinary amount of personal and professional time and energy.

In previous studies, time spent with the patient emerged as a significant variable when selecting hope-inspiring strategies for older adults (Turner & Stokes, 2006). Selection of hope intervention strategies was found to be dependent upon the length and quality of the relationship with the patient. The Hospice and Palliative Care organization where the home care and inpatient nurses work is located in a state with a high percentage of Hospice stays of less than three days (Teno et al., 2013). Hospice use in this state increased over the last decade, along with increased intensive care unit utilization, more repeat hospitalizations, and later health care transitions. There are serious concerns regarding the high utilization of aggressive treatments in end of life and whether this care is consistent with what the client and family envisions for end of life (Teno et al., 2013). "Short Hospice lengths of stay raise concerns that Hospice is an "add-on" to a growing pattern of more utilization of intensive services at the end of life. Short hospice lengths of stay have increased, with 45.5% of late referrals to Hospice services coming from an acute care hospital where the referred patient has had a mean hospital length of stay of 7.7 days" (Teno et al., 2013, p. 475). The decrease in Hospice

lengths of stay and an increase in client acuity results in a decreased amount of time for the Hospice and Palliative care nurses to establish meaningful relationships with their clients and families. The health care and organizational structure within their state may not support an environment where Hospice and Palliative Care nurses are able and willing to engage in connecting with clients utilizing a philosophy of commitment. Work-related stress associated with decreased lengths of stay and increase client acuity, as well as depletion of their empathic comportment could explain why all the Hospice and Palliative care nurses in this study did not identify connecting with the client as a hope-inspiring strategy.

Fostering spirituality is a hope engendering nursing intervention that encourages clients to tap into their spiritual base, whether that is through established religious practices or through faith in self, family, others, a higher power or life after death (Buckley & Herth, 2004; Duggleby & Wright, 2004; Herth, 1995). The concept of faith is central to hope and individuals express their faith in unique ways. Hospice and Palliative Care nurses are charged with completing a spiritual assessment to determine their client and family's faith and identify ways that their faith can be integrated into end of life care. Spiritual practices contribute to hope inspiration and allow clients to find meaning in their illness and a purpose to living (Johnson, 2007). The nine Hospice and Palliative Care nurses who participated in this research study did not identify any nursing interventions related to fostering spirituality or supporting religious practices. These findings could be attributed to the home care and inpatient nurses' assumption that spirituality is embedded in other identified nursing interventions such as open communication, supporting clients and families, and setting the goal of a peaceful death.

Connecting with the client's spirituality may also be difficult with shorter Hospice lengths of stay. The Hospice and Palliative Care organization where the home care and inpatient nurses work has interdisciplinary team meetings where providers collaborate on developing, evaluating, and revising the plan of care for the client and family. A spiritual care provider is part of the interdisciplinary team. The Hospice and Palliative Care nurses may be referring spiritual needs to this provider, especially if their time with the client is limited or symptom management is a priority nursing intervention. Tuck, Pullen, and Wallace (2001) found that spiritual interventions provided by mental health nurses included praying with the client and referral to a minister, preacher or priest for spiritual guidance (Tuck et al., 2001). It may be difficult for Hospice and Palliative care nurses to engage in religious practices with the client and family if they do not value religion or are of a different religious persuasion than the client.

Summary

In summary, nine Hospice and Palliative care nurses completed the questionnaire utilized for data collection regarding perspectives on hope. The specific research questions that guided the data collection included:

1. How do Hospice and Palliative Care nurses describe the concept of hope?
2. In what ways do the nurses think that hope is helpful to clients?
3. What nursing interventions do nurses utilize to facilitate client's hopes?

Future orientation in a wish/desire/expectation of a positive outcome, enduring, dynamic primacy of relationships, and faith emerged as attributes of the concept of hope from the descriptions of the home care and inpatient nurses. Interconnectedness, future and goal-orientation, spirituality, and intrapersonal qualities are attributes consistent

with those described in the literature and contributed to the expansion of the original delineation of the critical attributes of hope.

The Hospice and Palliative Care nurses described a variety of ways that hope is helpful to clients. Accepting wishes as hopes, staying positive, staying in control, feeling a sense of safety, providing a purpose for living, and facilitating positive meaning making are ways in which hope is helpful to clients. These outcomes of having hope are also described in the literature, although wishing, sometimes described as “false hope” or unrealistic expectation, is controversial. Hospice and Palliative Care nurses may be more willing to accept wishing as hoping based on their commitment to preserving the human spirit in end of life. Feeling a sense of safety was described by the home care and inpatient nurses as a way in which hope is helpful to clients. A sense of safety has not been described specifically in the literature and may be linked to the concept of well being.

The Hospice and Palliative Care nurses described nursing interventions utilized to foster hope. Six areas emerged from these descriptions: open communication, use of humor, client and family education and support, comfort and symptom management, setting the goal of a peaceful death, and connecting with the client. These nursing strategies are consistent with strategies identified by Herth (1995), Turner and Stokes (2006), and Duggleby and Wright (2007).

Spirituality, interconnectedness, and positive meaning making were described by the home care and inpatient nurses as attributes of hope and how hope is helpful to clients. However, they did not emerge in the nurses’ descriptions of hope-inspiring strategies. Nursing interventions such as life review, facilitating spirituality, and

affirmation of worth contribute to positive meaning making in end of life (Herth, 1995; Turner & Stokes, 2006) were not described. Connecting with the client was described by two inpatient nurses and one home care nurse as a strategy to foster hope. Connecting with the client to foster hope in end of life care is a nursing intervention that should be identified by all Hospice and Palliative Care nurses in clinical practice. Hospice and Palliative Care nurses in this study may have interpreted use of humor, open communication, and providing client and family education and support as openness to connecting with the client, although this does not describe the level of personal engagement, willingness to journey with the client, and a philosophy of commitment that are foundational to genuine nurse-client connectedness and “grasping another person’s emotional and situational reality” (Richardson et al., 2012). Shorter hospice lengths of stay, increased client acuity, and availability of spiritual care providers may be mitigating factors that influenced the Hospice and Palliative Care nurses’ descriptions of hope-inspiring strategies.

Understanding intrapersonal, organizational, and health care system factors that impact the Hospice and Palliative Care nurse during the phases of deliberation and enactment can facilitate identification of mechanisms to minimize their negative effects on inspiring hope for clients at end of life.

Chapter V will review a summary of this dissertation research study describing the perspectives on hope of Hospice and Palliative Care nurses. Conclusions emerging from the descriptive data analysis and discussion of findings will be outlined.

Limitations of the study relating to methodology and trustworthiness will be described.

In summation, the implications for knowledge development, future research, nursing education and Hospice and Palliative Care nursing practice will be presented.

Chapter V

Summary, Conclusions and Implications

In Chapter V, a summary of this research study regarding the perspectives on hope of Hospice and Palliative Care nurses is presented. Conclusions from the data analysis are reviewed. Limitations related to research methodology and trustworthiness are discussed. Implications for knowledge development, future research, education and clinical practice in nursing are presented.

Summary

Hope has been identified as a fundamental component of professional nursing practice (Duggleby et al., 2007; Herth, 2001; Fitzgerald Miller, 2007). The importance of hope for clients experiencing the crisis of illness and end of life has been established in the nursing literature. Hospice and Palliative Care nursing practice is predicated on caring for patients at end of life. There is a limited repertoire of literature that describes the perspectives on hope held by Hospice and Palliative Care nurses and how these perspectives impact on their clinical practice and selection of strategies that foster hope. This gap in the literature on nurses' perspectives on the concept of hope, how hope is helpful to the client, and what particular nursing strategies they feel are effective in fostering hope provides the basis for further inquiry. The purpose of this research study was to describe the perspectives on hope of Hospice and Palliative Care nurses who work in one Hospice and Palliative Care organization. The specific research questions that guided this inquiry included:

1. How do Hospice and Palliative Care nurses describe the concept of hope?
2. In what ways do the nurses think that hope is helpful to clients?

3. What nursing interventions do nurses utilize to facilitate client's hopes?

A qualitative methodology utilizing a self-report questionnaire on hope was selected for data collection. Data were collected from Hospice and Palliative Care nurses who work in inpatient and home care settings. Manifest content analysis was utilized for analysis of the data from nine open-ended surveys returned by the nurses. The perspectives on hope of the Hospice and Palliative Care nurses contributed to expanding the critical attributes of hope to include spirituality and interconnectedness. Descriptions of nursing strategies that foster hope did not consistently demonstrate integration of the elements of connectedness and spirituality into the interventions.

Conclusions

Kim's (2010) practice domain delineates the nature of nursing practice and the aspects of the nurse as an engaged participant in practice. Decision making and action in practice requires the nurse to contextually integrate personal, theoretical, and experiential knowledge in client and health care circumstances. Deliberation and enactment in the provision of nursing care are grounded in the notion of addressing client needs within an external practice environment and through an internal environment that represents the nurse's unique perspectives and needs.

The Hospice and Palliative Care nurses who participated in this research study engaged in reflection on their nursing practice as it related to hope—inspiration and provided descriptions of the concept of hope, how hope is helpful to clients, and nursing strategies that foster hope. Caring for clients at end of life involves engaging with a client as they journey towards death while preserving the dignity and sanctity of their life, managing their symptoms, and mobilizing hope. This profound sense of

professional and personal commitment that exemplifies the practice of Hospice and Palliative Care nursing is not without its deterrents. The home care and inpatient nurses who participated in this research study provided limited descriptions of nursing interventions related to connectedness and no descriptions of nursing interventions related to spirituality, despite these strategies being identified as foundational to Hospice and Palliative Care nursing (Herth, 1995; Penz & Duggleby, 2010; Turner & Stokes, 2006).

Organizational issues, such a decrease in Hospice client lengths of stays, with a resulting increase in client acuity and conflicting end-of life-care plans may have been factors that impacted on these nurses' descriptions. Less time with sicker clients creates a practice environment where the priorities of making connections and supporting spirituality as components of hope inspiration are superseded by the need for symptom management and family support. It could be argued that many of these clients could be unconscious at the time the nurse is first caring for them. This can shift connecting with the client from a personal level to a physiological level. Turner and Stokes (2006) described a "hands-off" approach to hope facilitation in nurses who work in acute care settings (Turner & Stokes, 2006). It would seem that the practice environment systems issues with delayed referrals to Hospice and subsequent increased acuity of clients for the nurses in this study is creating circumstances that may mimic acute care environments. Additionally, Turner and Stokes (2006) suggested that "these [hands-off] strategies reflected the realities of providing nursing care in this [acute care sector] context, where short-term lengths of stay are the norm and the emphasis is often on

stretching resources and demonstrating cost savings, sometimes to the detriment of developing relationships with patients” (Turner & Stokes, 2006, p. 369).

Intrapersonal factors can impact on the nurse’s internal environment in deliberating and enacting care for clients at end of life. For the Hospice and Palliative Care nurses who participated in this research study, it is not known what individual factors may have influenced their perspectives on hope. Seven of the home care and inpatient nurses were more than 40 years old and six of the nurses had 16 years or greater of experience in clinical practice. All of these nurses identified Hospice care as their specialty. Age and years of experience in clinical practice may contribute to shaping the nurses’ perspectives on hope. Compassion fatigue is a phenomenon characterized by physical, emotional, and spiritual depletion associated with caring for patients in significant emotional pain and physical distress (Anewalt, 2009). Situational stress related to decreased lengths of stay and increased client acuity, as well as depletion of their empathic behaviors through constant use, could predispose these nurses to compassion fatigue. This rationale may offer some illumination on why all the Hospice and Palliative care nurses did not identify connecting with the client as a hope-inspiring strategy. Organizational and personal strategies have been suggested to decrease the risk of compassion fatigue, although it is not known whether these strategies were practiced or were available to the Hospice and Palliative Care nurses in this study.

The nurses’ state of hopefulness as individuals has been suggested to influence their ability to mobilize hope for clients at end of life. Duggleby and Wright (2007) explored the hope of professional caregivers and specifically discussed the hope of

nurses who cared for terminally ill clients (Duggleby & Wright, 2007). Seventy-six percent of their sample were nurses. Mean scores on the HHI for these nurses was 40.16, which indicated a high level of hopefulness. Palliative care professionals “described how their own hope helped them to foster positive relationships, communicate, provide comfort, and offer hope to palliative patients and their families...there seems to be a link between the hope of professional caregivers and the quality of care they provide” (Duggleby & Wright, 2007, p. 48). Mok et al. (2010) found similar results in their qualitative research exploring the meaning of hope to Chinese patients with advanced cancer from health care professionals’ perspective (Mok, et al., 2010). Fifty-six percent of their sample were nurses who worked on a palliative care unit in a hospital in Hong Kong. Participants described the need to remain hopeful to perceive and foster hope in the clients they cared for through affirmation of worth, relational connectedness, partnership, and religious support (Mok, et al., 2010). Exploring the state of hopefulness of the Hospice and Palliative Care nurses in this study may have contributed to understanding their perspectives on hope, especially their perspectives on the hope engendering nursing strategies of connecting with the client and fostering spirituality.

Limitations

There are several limitations in this research study regarding the perspectives on hope of Hospice and Palliative Care nurses. Establishment of trustworthiness in qualitative research requires evaluation of credibility, confirmability, dependability, and transferability. Transferability describes the extent to which the research findings can be transferred to other settings or groups (Graneheim & Lundman, 2004). Representativeness of the participants to the larger population is a significant variable in

evaluating transferability. In this research study, the sample size was nine, which is relatively small, and the response rate was 18%. This sample is not representative of the nurses who work at the Hospice and Palliative Care organization where data was collected, or of a general population of Hospice and Palliative Care nurses in the state or the United States. All nine nurses in the sample were White and female and predominantly older than 40 years old. Three of the nurses were 30–39 years old. The role that age and ethnicity may play in shaping the nurses' perspectives on hope is difficult to explore with a homogeneous sample. Cultural values and practices have been found to impact on individuals' perspectives on hope, as evidenced by the work from Holt (2000) exploring hope in the Dominican Republic and Miyazaki's (2004) descriptions of hope as situated in the Fijian culture. Expanding the sample size through vigorous recruitment and sampling in alternate geographic locations could improve the transferability of research findings.

The use of an open-ended questionnaire to collect data on Hospice and Palliative care nurses was intended to allow nurses the opportunity to reflect on their clinical practice and their perspectives on hope. Reflection-in-action describes what occurs when the nurse practices and it influences the decisions made and the care that is delivered. "It may be difficult for practitioners to articulate the knowledge they are using in action" (Atkins & Murphy, 1993, p. 1188) which can impact on their ability to describe this knowledge retrospectively. Several of the nurses at one of the long-term care meetings expressed their preference for being interviewed instead of completing a questionnaire. One nurse stated that she found it difficult to express herself in writing. Another nurse identified the lack of actual opportunities to use handwriting in their professional and

personal lives as a deterrent to completing an open-ended questionnaire. Incidentally, none of these nurses completed the hope questionnaire. Use of semi-structured interviews as a research methodology would provide the opportunity for the Hospice and Palliative Care nurses to express their perspectives verbally. This approach could have allowed this researcher to seek clarification on questions related to the concept of hope, how hope is helpful to clients, and nursing strategies that foster hope.

Implications

Knowledge development and future research.

This qualitative research study on Hospice and Palliative Care nurses' perspectives on hope has expanded on the limited available literature on nurses' perspectives on hope. Understanding how hope is defined, actualized, and utilized in Hospice and Palliative Care nursing practice, and the possible factors that may impact on fostering hope will provide opportunities for future nursing research. Semi-structured interviews, with questions regarding use of the word "hope" and the nursing strategies of connecting with the client and fostering spirituality, could provide for greater understanding of the challenges involved in Hospice and Palliative Care nursing practice. Interviews would allow for exploration of factors that impact on the nurses' perceptions of hope, such as their own hopefulness, work environment, job satisfaction, and compassion fatigue. Additional qualitative research studies should be conducted with a more diverse group of Hospice and Palliative Care nurses, including male nurses, younger nurses, and nurses from various cultural backgrounds, geographic locations, and Hospice and Palliative Care organizations. Field work and participant observation could provide rich insights into hope-inspiring strategies as actualized in Hospice and

Palliative Care clinical practice and perhaps shed some light on the nuances involved in connecting with clients that could not be appreciated in this research study.

Education.

It has been clearly established that hope is a fundamental concept in nursing practice and that inspiring hope is more than just a professional responsibility it is also a moral and ethical obligation that is the underpinning of care provision for all nurses. Nursing curriculums need to incorporate content on the concept of hope, hope assessment, and integrating hope-inspiring strategies into the client's plan of care. Clinical practicum experiences should integrate the theoretical knowledge on hope into the care of diverse client populations and focus on development of an empathetic comportment and making connections with clients. Nursing students need to develop a comfort level with using the word "hope" and asking clients what they hope for, and selecting "impaired hoping" as a nursing diagnosis. The proposed process model of hope outlined in this study could provide nursing students with a framework for hope assessment and selection of specific hope-inspiring nursing strategies dependent on the phase of hoping the client is experiencing.

Advanced practice nursing education should include a more comprehensive approach to engendering hope as a component of advanced nursing practice. Hope intervention programs, such as Herth's (2001) Hope Intervention Program and Duggleby et al.'s (2007) Living with Hope Program could be integrated into clinical practicums and program evaluation courses to evaluate appropriateness, utility, and effectiveness. Doctoral research on the phenomenon of hope could address the implications for future research and contribute to knowledge development and evidence for practice.

Clinical practice.

There are several implications for clinical practice that emerge from this research. Hospice and Palliative Care nurses have the opportunity to utilize reflection on their clinical practice as a means of identifying their perspectives on hope and how they integrate hope-inspiration into their professional practice. These insights could be critical in developing new or expanded perspectives on hope through description, self-awareness and analysis of feelings, critical analysis and synthesis, and evaluation (Atkins & Murphy, 1993). Peer debriefing, support groups, and writing and sharing of clinical exemplars regarding hope in Hospice and Palliative care nursing could facilitate use of hope language, sharing of how hope is helpful to clients, and discussion of strategies to inspire hope. Engaging in self-care activities to decrease the risk of compassion fatigue can help nurses mobilize the emotional energy to connect with clients and foster hope at end of life. Talking about one's concerns and feelings with an appropriate person can give support and hope to the caregiver and assist with the development of an action plan to address compassion fatigue (Lombardo & Eyre, 2011). Continuing education programs addressing spirituality, reminiscing, and life review could be important for nurses to develop comfort and competence in using these hope-inspiring strategies in their clinical practice.

There may be a role for incorporation of formal hope intervention programs into Hospice and Palliative Care nursing practice, especially in the home care and long-term care settings. Implementation of specific strategies to foster hope could be individualized to client circumstances and would provide opportunities to include family

and significant others in hope facilitation. The ability of prescriptive hope intervention programs to provide quality end of life care would require ongoing evaluation.

The systems issues with Hospice referrals in the state where the data from Hospice and Palliative Care nurses were collected requires serious attention. Decreased Hospice lengths of stay and higher client acuity when entering Hospice are detrimental to honoring client and family wishes in end of life and compromise the ability of nurses to form connecting relationships and to foster hope. Hospice and Palliative Care providers and administrators need to partner in assessing the factors that impact on Hospice referral mechanisms and implementing practice and systems changes to ameliorate the gaps in provision of Hospice and Palliative care services. Hospice and Palliative Care nurses deserve a practice environment that honors the sanctity of end of life care and allows hope inspiration to flourish.

Appendix A

Institutional Review Board Approval

THE
UNIVERSITY
OF RHODE ISLAND
DIVISION OF RESEARCH
AND ECONOMIC
DEVELOPMENT

OFFICE OF RESEARCH INTEGRITY
70 Lower College Road, Suite 2, Kingston, RI 02881 USA
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FWA: 00003132
IRB: 00000599
DATE: August 31, 2015

TO: Ginette Ferszt, PhD
FROM: University of Rhode Island IRB

STUDY TITLE: PERSPECTIVES ON HOPE OF HOSPICE AND PALLIATIVE CARE
NURSES FROM THE UNITED STATES

IRB REFERENCE #: 787363-2
LOCAL REFERENCE #: HU1516-013
SUBMISSION TYPE: Revision

ACTION: APPROVED
EFFECTIVE DATE: August 30, 2015
EXPIRATION DATE: August 29, 2016
REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # 7

Thank you for your submission of Revision materials for this research study. The University of Rhode Island IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation 45 CFR 46 and 21 CFR 50 & 56.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate **Appendix S - Event Reporting** for this procedure. All FDA and sponsor reporting requirements must be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office. Please note that all research records must be retained for a minimum of five years after the project ends.

Based on the risks, this project requires Continuing Review by this office by August 29, 2016. Please use the **CONTINUING REVIEW FORM** for this procedure.

If you have any general questions, please contact us by email at researchintegrity@etal.uri.edu. For study related questions, please contact us via **project mail through IRBNet**. Please include your study title and reference number in all correspondence with this office.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document unless the signature requirement has been waived by the IRB.



Matthew Delmonico, Ph.D., MPH
IRB Chair

Appendix B

Paquette Hope Questionnaire

Perspectives on Hope of Hospice and Palliative Care Nurses in the United States

We are interested in understanding the role of hope in hospice and palliative care nursing. Your participation will significantly contribute to a more global understanding of the phenomenon of hope that will help improve our professional nursing practice.

General information

Please complete the following information:

1. How many years of professional nursing practice have you had?
 - a. _____ < 5
 - b. _____ 5 – 10
 - c. _____ 11 – 15
 - d. _____ 16 – 20
 - e. _____ 21+
2. Age:
 - a. _____ < 30
 - b. _____ 30 – 39
 - c. _____ 40 – 49
 - d. _____ 50 – 59
 - e. _____ 60+
3. Gender:
 - a. _____ Male
 - b. _____ Female
4. What is your highest level of nursing education?
 - a. _____ Technical
 - b. _____ Diploma or University
 - c. _____ Master's
 - d. _____ Doctorate
5. Additional education: _____
6. Nursing Practice: (Check all that apply)
 - a. _____ Administration/management
 - b. _____ Direct patient care
 - c. _____ Education
 - d. _____ Research
 - e. _____ Supervision of direct patient care
7. Nursing work area: (Check all that apply)
 - a. _____ Home care
 - b. _____ Hospice
 - c. _____ Hospital
 - d. _____ Nursing home
 - e. _____ Other _____
8. What is your specialty in nursing?
 - a. _____ Hospice
 - b. _____ Medical surgical nursing
 - c. _____ Oncology
 - d. _____ Other _____

Please complete each question with as much detail as you can; feel free to use the back of the form if you need more space

1. As you think about the concept of hope, how would you describe it to a nursing student?

2. Briefly describe an experience where a patient has shared with you what he or she was hoping for.

3. In what ways do you think that hope is helpful to patients?

4. How do you think that hope helps patients to make sense of their circumstances or find meaning in their illness experiences? Please describe.

5. Please describe ways that you have helped patients and families find hope.

Thank you for your participation

Appendix C

Tables 1–6

Table 1

Critical attributes of hope in selected nursing literature

Critical attributes	Author(s)				
	Benzein & Berg, 2005	Lohne & Severinsson, 2006	Kim, Kim, Schwartz-Barcott, & Zucker, 2006	Rustøen, Howie, Eidsmo, & Moum, 2005	Davis, 2005
Multidimensional	X	X	X	X	X
Dynamic			X	X	X
Future oriented		X	X	X	X
Reality oriented				X	X
Central			X		
Contextual	X			X	
Possibilities		X	X		
Anticipation/optimism			X	X	
Provides meaning			X	X	
Action oriented		X			
Spiritual	X			X	
Interconnectedness	X		X		
Goal oriented		X	X		

Table 2

Summary of instruments to measure hope

Title/Description Discipline of origin	Conceptual basis/item generation	Populations	Reliability	Validity
Gottschalk Hope Scale (GHS) (Gottschalk, 1974) Verbal content Analysis Scale Psychological Hope Trait	Hope is defined as a measure of optimism that a favorable outcome is likely to occur	Psychiatric outpatients (N = 68), Normative adults (N = 109, 91)	Interrater reliability = .85	Concurrent: Hamilton Depression Scale, $r = -.38$; Behavioral Rating Scale, $r = -.61$
Hope Scale (HS) (Erickson, Post, & Paige, 1975) Future oriented goal statements, 30-item, 7-point scale of importance, 0-100% scale for probability of attainment	Based on Stotland's (1969) work that hope is future goal oriented	Undergraduate college students (N = 200) Hospitalized psychiatric population (N = 50)	Internal consistency: Cronbach alpha coefficient = .73 - .78 Stability: Test-retest = .79	Concurrent: Correlation with Taylor's Manifest Anxiety Scale, $r = -.28$
Hope Index Scale (HIS) (Obayuwana et al., 1982) 60 items, yes-no Possible range of score 0 – 500	Based on future expectations. Items generated from phone survey of 500. Cognitive, affective, motor component of 5 central themes (ego strength, religion, family support, education and economic assets)	Healthy adult and psychiatric adult populations (N = 486)	Internal consistency: KR - 20 = .61	Divergent: Correlation with Hopelessness Scale, $r = -.88$ (N = 486)
Hopefulness Scale (HFS) (Mercier, Fawcett, & Clark, 1984) 20 item, 5-point Likert scale Possible range of scores 0 – 100	Modification of the Hopelessness Scale (HS) by Beck et al. (1974)	Community-based healthy older adults	Internal consistency: Cronbach alpha coefficient = .87 - .93	Divergent: Correlation with Hopelessness Scale, $r = -.74$
Stoner Hope Scale (SHS) (Stoner, 1982) 30-item, 4-point Likert scale Importance and probability scores, total maximum score possible = 480 Three subscales: Intrapersonal, Interpersonal, Global	Stotland's (1969) theoretical constructs of hope Lynch (1965) and Marcel (1962) construct of hope as an inner sense requiring interaction with external resources	Cancer patients (N = 58) Community-based older adults	Internal consistency: Cronbach alpha coefficient = .93	Content: Experts in psychiatric and oncology nursing (3 members) Divergent: correlation with Hopelessness Scale, $r = -.47$

Table 2 (cont.)

Title/Description Discipline of origin	Conceptual basis/item generation	Populations	Reliability	Validity
State-Trait Hope Inventory (STHI) (Grimm, 1984) 40-item, 5-point Likert scale measuring state and trait dimensions of hope Possible range of scores 20 – 100 for each dimension	Items measure trait dimension of hope: the individual diff. in the hope personality characteristic that predisposes an individual to respond in a constant manner across a wide range of situations	Cancer patients (N = 60) Healthy adults and adults with severe psychiatric illness	Internal consistency: Cronbach alpha coefficients = .94 - .98 for healthy adults and .27 - .70 for adults with severe psychiatric illness	Construct: Concurrent: Spiritual Well-Being Scale, r = .60 state and .63 trait dimension Divergent: Correlation with Depression subscale of Brief Symptom Inventory, r = -.43
Miller Hope Scale (MHS) (Miller & Powers, 1988) 40-item, 5-point Likert scale Possible range of scores: 0 – 200 Three subscales: Satisfaction with Self, Others and Life; Avoidance of Hope Threats, Anticipation of a Future	Review of theological, philosophical, psychological, socio-anthropological, biological, and nursing perspectives on hope. Qualitative research on perspectives on hope in 59 persons who survived a critical illness Hope is a complex, multi-dimensional construct that is more than goal attainment and encompasses a state of being.	Well adult population (N = 522) Acute/ chronically ill adult populations	Internal consistency: Cronbach alpha coefficients = .83 - .93 Stability: Test-retest (2-week) = .82 - .85	Content: Expert panel on hope and measurement (6 members) Construct: Factor analysis: PCA with orthogonal rotation support three dimensions of hope Divergent: Correlation with Hopelessness Scale, r = -.47
Hope Index (HI) (Staats, 1989) 16 goal statements Extent of desire for goal and extent of expectation of reaching the goal 5-point Likert scale Possible range of scores: 0 - 400	Stotland's (1969) goal orientation and Beck et al.'s (1974) self-other-world depressive triad	Under-graduates (N = 234) and adults in the community (N = 303)	Internal consistency: Cronbach alpha coefficient = .86 Stability: Test-retest (3.5 to 9-week) = .60	Concurrent: correlation with Satisfaction With Life Scale, r = .41; with Life Optimism Scale, r = .37 and with EWBS, r = .24
Nowotny Hope Scale (NHS) (Nowotny, 1989) 47-item (initially), 4-point Likert scale (final version reduced to 29 items Six subscales: Active Involvement, Confidence, Relates to Others, Spiritual Beliefs, Comes from Within, Future is Possible	Review of qualitative literature and studies in psychology, psychiatry, theology, and nursing Hope is defined as a multi-dimensional, dynamic attribute of the individual	Well adults and adults with cancer (N = 302)	Internal consistency: Cronbach alpha coefficient for 47-item NHS with well and cancer patients = .89 Subscale reliabilities ranges from .51 to .75	Content: Expert panel on hope and measurement (6 members) Construct: Factor analysis: PCA with orthogonal rotation supported six dimensions of hope Divergent: Correlation with Hopelessness Scale, r = .47

Table 2 (cont.)

Title/Description Discipline of origin	Conceptual basis/item generation	Populations	Reliability	Validity
Herth Hope Scale (HHS) (Herth, 1991) 30-item, 4-point summated rating scale Possible score range 0 – 90 6 th grade reading level	Based on Dufault and Martocchio's (1985) definition of hope and Model of Hope	Cancer patients undergoing chemotherapy (N = 120) Acute and chronically ill adults, elder widow(er)s, and well adults	Internal consistency: Cronbach alpha coefficients = .75 - .97 Stability: Test-retest (2 week) = .89 - .91	Content: Two expert panels: 4 judges with expertise in hope and 3 experts in measurement Divergent: Correlation with Hopelessness Scale, $r = -.69$ Construct: FA with data from 3 studies (N = 300): 58% of the variance explained by three-factor solution
Herth Hope Index (HHI) (Herth, 1982) 12-item adapted version of the HHS Possible score range 12 – 48 Enlarged print to improved readability with ill and/or elderly patients	Adaptation of the HHS specifically for use in the clinical setting	Acute, chronic, and terminally ill adults (N = 172) Family caregivers of terminally ill	Internal consistency: Cronbach alpha coefficients = .75 - .97 Stability: Test-retest (2 week) = .87 - .91	Content: Two review panels: Experts in research/ measurement (4 members) and Client/Nurse Clinicians (12 members) Construct: FA: 41% of the variance explained by 3-factor solution
Hopefulness scale for adults (HSA) (Hinds & Gattuso, 1991) 24-item visual analog scale with open-ended question to document what is hoped for by the adolescent Possible score range 0 – 2,400	Based on qualitative study of adolescent hopefulness (well and ill) Measures the degree to which adolescents Possess a comforting or life-sustaining, reality-based belief that a positive future exists for self and others	Well and ill adolescents (N = 400)	Internal consistency: Cronbach alpha coefficients = .74 - .94	Content: Two independent panels, 3 adolescents and 3 nurses who care for adolescents Stated the HAS has construct validity and form equivalency, no specific findings presented

Table 2 (cont.)

Title/Description Discipline of origin	Conceptual basis/item generation	Populations	Reliability	Validity
Snyder Hope Scale (SNHS) (Snyder et al., 1991) 12-item, 4-point Likers scale Possible range of score 12 - 48	Hope is a cognitive set comprised of a reciprocally derived sense of successful agency and pathways	Healthy adults and adults with psychiatric illness (over 4 years) N = 2,753	Internal consistency: Cronbach alpha coefficients = .75 - .97 Stability: Test-retest 3-week = .85, 8-week = .73	Construct: Concurrent: Correlation with Rosenberg Self-Esteem Scale, r = .58; with Burger-Cooper Life Experience Survey, r = .54, with Life Orientation Test, r = .60 and with Generalized Expectancy for Success, r = .55 Divergent: Correlation with Hopelessness Scale, r = .51 Predictive: Predicted goal-setting behaviors.

Table 3

A selected review of quantitative literature on hope

Author(s)/ year	Population	Research Design	Measure of Hope	Additional Variables	Results
Rustøen & Wiklund (2000)	Newly diagnosed patients with cancer in Norway, N = 131	Descriptive correlational	Nowotny Hope Scale	Age Gender Living alone	Co-habitants had a significantly higher level of hope than those living alone (p=0.007)
Wang, Chang, Shih, Sun, & Jeng (2006)	Patients awaiting heart transplantation N = 45	Descriptive correlational	Herth Hope Index – Chinese version	Self-care behavior Social support Illness status Demo-graphic Variables	Social support best predictor of self-care behavior (29.4% of the variance) Social support, self-perceived health condition, religious beliefs and marital status significant predictors of hope (60.4% of the variance)
Wonghongkul, Tipaporn, Moore, Musil, Schneider, & Deimling (2000)	Women who survived breast cancer, lived without recurrence for at least 5 years	Cross- sectional descriptive	Herth Hope Index	Un-certainty Stress Appraisal	Uncertainty explained a significant amount of the variance in hope ([beta] = 0.349, p=0.001)
Kavradim, Özer, & Bozcuk (2012)	Patients diagnosed with cancer receiving chemotherapy N = 240	Exploratory Descriptive correlational	Herth Hope Scale	Socio-Demographic characteristics Disease process Chemotherapy symptoms	Net family income ([beta] = 0.17, p=0.007), level of knowledge about the disease ([beta] = 0.19, p=0.002), feeling of improvement ([beta] = -0.17, p=0.013), perception of satisfactory support ([beta] = -0.17, p=0.003), mouth ulcers ([beta] = -0.13, p=0.019), feeling anxious or worried ([beta] = -0.13, p=0.035) and and fear ([beta] = -0.14, p=0.028) were related to the total hope score

Table 3 (cont.)

Author(s)/ year	Population	Research Design	Measure of Hope	Additional Variables	Results
Bluvol & Ford-Gilboe (2004)	Families of stroke survivors with moderate to severe functional impairments and their spouses N = 40	Descriptive correlational	Herth Hope Index	Health work Quality of life	Positive relationships between hope and health work (r=0.52, r=0.39, p < 0.01) And between hope and quality of life (r=0.59, r=0.32, p<0.05)
Rustøen, Wahl, Hanestad, Gjengedal, & Moum (2004)	Norwegian adults with cystic fibrosis N = 87	Descriptive correlational	Herth Hope Index – Norwegian version	Demographic variables Health-specific variables	Married patients had higher hope than divorced/separated (P = .007, t = 2.8) Women had higher hope than men (P = .001, t = -.32) Oldest patient group had higher levels of hope than youngest group (P= .001, t = -.32) Group with > 4 years university education had higher hope than group with secondary education (P=.001, t=-.32) Higher FEV1% was associated with higher hope (r=0.37, P=.001)
Benzein & Borg (2005)	Patient with cancer in palliative care N = 40 Family members N = 45	Descriptive correlational	Herth Hope Index – Swedish version	Hopeless-ness Fatigue Age	Family members: Age and hope (r=-0.358, older family members had less hope) Fatigue and hope (r=-0.439) Hopelessness and hope (r=-0.723) Patients: Age and hopelessness (r=0.555) Hopelessness and hope (r=-0.580)

Table 3 (cont.)

Author(s)/ year	Population	Research Design	Measure of Hope	Additional Variables	Results
Rustøen, Howie, Eidsmo, & Moum (2005)	Older adults with heart failure N = 93	Descriptive correlational	Herth Hope Index – Norwegian version	Demographic variables Disease specific variables Self-assessed health status Satisfaction with life	Satisfaction with life and hope (r=0.54, P<.001) Comorbid diseases and hope (r=-0.27) Skin disease (r = 0.26) Psychiatric disease (r=0.25) Self –assessed health and hope (r=0.39) Self-assessed health and satisfaction with life were significant predictors of hope – 36% variance of total hope score
Davis (2005)	Older adults, primarily women N = 130	Cross-sectional correlational	Herth Hope Index	Spirituality Well-being State anxiety	Spirituality and hope (r=.25, p<.01) Well-being and hope (r=0.56, p<.01) Anxiety and hope (r=-.55, p<.01)
Duggleby, Cooper, & Penz (2009)	Personal care aides who provide direct care to older adults at home or in long-term care facilities N = 64	Descriptive correlational Concurrent triangulation mixed method design	Herth Hope Index Four question, open-ended survey on hope used for palliative care providers	Spiritual well-being Global job satisfaction Self-efficacy	Spiritual well-being and hope (r=-0.42, P<0.017) Global job satisfaction and hope (r=0.31, P<0.03) Self-efficacy and hope (r=0.47, P<0.017) Qualitative data supported findings, except for the negative relationship between hope and spiritual well-being
Wu (2011)	Family members of victims of man-made trauma N = 175	Descriptive correlational	Snyder Hope Scale	Quality of life PTSD symptoms Coping Resilience	Increased PTSD symptoms associated with lower hope (t=4.45.p<0.001) Hope had a significant impact on quality of life (B=0.17, p< 0.05) Resilience had the greatest impact on quality of life (B=.85) and hope (B=.25)

Table 3 (cont.)

Author(s)/ year	Population	Research Design	Measure of Hope	Additional Variables	Results
Michael & Snyder (2005)	Colleges students who experienced the death of a lover one within the latter half of their lives N = 158	Descriptive correlational	Snyder Hope Scale	Bereavement-related rumination Benefit finding Psychological well-being Self-esteem Posttraumatic growth	Hope was not related to rumination ($r = -.48, p = .547$) Hope was not significantly related to posttraumatic growth ($r = .11, p = .17$) or benefit finding ($r = .09, p = .28$) Hope was significantly related to all four variables of psychological well being (CESD: $r = -.22, p < .006$; STAI: $r = -.30, p < .001$; NA: $r = -.25, p < .002$; PA: $r = .45, p < .001$)
Lohne, Miaskowski, & Rustøen (2012)	Family caregivers of patients with advanced cancer	Descriptive correlational	Herth Hope Index – Norwegian version	Caregiver role strain	Family caregivers who lived with the patient had lower HHI scores than those who did not live with the patient. Lower levels of hope significantly correlated with increased caregiver role strain ($r = -.22, P = .02$)
Alberto & Joyner (2008)	Persons with chronic obstructive pulmonary disease who attend a community- based Better Breathers Support Group meetings N = 68	Descriptive correlational	Herth Hope Index	Optimism Self-care	Significant positive relationship between hope and self-care ($r = .39, p < .01$) and hope and optimism ($r = .59, p < .001$)
Pipe, Kelly, LeBrun, Schmidt, Atherton, & Robinson (2008)	Patients hospitalized in rehabilitation or subacute long-term recovery units. Data collected on admission, at discharge and six weeks post discharge N = 48	Descriptive correlational	Herth Hope Index	Spiritual well being Quality of life Orientation to life Activities of Daily living Acuity Psychosocial needs	On admission Orientation to life was significantly related to hope ($r = .459, p < .001$) Hope, spiritual well-being and quality of life were significantly and positively correlated at all three intervals of data collection (no statistics presented)

Table 4

A selected review of hope intervention literature from psychology and social work disciplines

Author / date	Program/ intervention	Study design	Sample/ Population of interest	Program implementation	Outcome variables	Results	Limitations
Fukai, Starino, Susana, Davidson, Cook, Rapp, & Gowdy (2011)	Wellness Recovery Action Plan (WRAP)	Quasi-experimental Experimental (n=58) and comparison (n=56) groups Data collected at first and last meeting and at a six month mailed follow-up	Adults with documented severe mental illness receiving community support services at five community mental health centers in Kansas Participants recruited from individuals who voluntarily joined WRAP groups where they were receiving mental health services	WRAP group program 1. Each group with four to 12 members 2. Eight to 12 weekly sessions, 1.5 to two hours each, eight week minimum commitment 3. Groups facilitated by WRAP certified staff, peer worker, cofacilitators included peer WRAP educators and a psychosocial rehabilitation group leader 5. Program aims to improve ability to take responsibility for wellness and stability, manage/reduce mental health symptoms and learn skills to reach out and use support	Modified Colorado Symptom Index (r= 0.93) State Hope Scale (r= 0.82) Recovery Markers Questionnaire (RMQ) (r= 0.69) -subscale of the Recovery Enhancing Environment Scale	No differences between groups regarding outcomes at pretest Statistically significant interaction effects for symptoms and hope with improvement in mean levels immediately after intervention and at six months in the experimental group (p<.001, d=0.4; p<0.013, d=0.4)	Lack of randomized control group No WRAP fidelity and research protocol existed Lack of systematic monitoring of the intervention Participants completed only 75% of the sessions Underpowered issue involved in repeated measures analysis design for RMQ outcome Participants may be using multiple mental health support services in addition to the WRAP program

Table 4 (cont.)

Author / date	Program/ intervention	Study design	Sample/ Population of interest	Program implementation	Outcome variables	Results	Limitations
Fung, Ho, Fung, Leung, Chow, Haan, & Barlaan (2011)	Mutual support group for caretakers of children with cerebral palsy (CP)	Pre/post intervention outcome study Data collected preintervention (time one), post intervention time two) and one month post intervention (time three)	Primary caretakers of CP patients attending a clinical at Duchess of Kent Children's Hospital in Hong Kong -CP child < 21 years old -no psychiatric illness	Parent support group in semi-structured format 1. Two groups with six subjects each 2. Sessions lasted 90 minutes 3. Four consecutive weekly sessions held 4. One booster session one month after the fourth session 5. Group led by Masters student in clinical psychology with two experienced clinical psychologists	Appraisal of Severity of Disability Parenting Stress Index-SF (r=0.9) Multidimensional Scale of Perceived Social Support (MSPSS) (r=0.9) Social Avoidance and Distress Scale (r=0.9) Hospital Anxiety and Depression Scale (HADS) (r=0.8, 0.9) Satisfaction with Life Scale (r=0.9) Subjective Happiness Scale (r=0.9) Rosenberg Self-Esteem Scale (RSES) (r=0.8) State Hope Scale (Snyder) Agency (r=0.5) and Pathways (r=0.9) subscales	50% or participants attended all sessions Hope was positively correlated with social support at times one and two (Kendall's tau-b = 0.7, p=0.04) Parenting stress, depression, social support and hope significantly improved at time two (p=0.03) Increased hope levels suggested caretakers felt more realistic about pursuing goals, their parenting role and enhanced ability to face their challenges	Absence of a control group Sampling bias High attrition rate Small sample size, limited generalizability

Table 4 (cont.)

Author / date	Program/ intervention	Study design	Sample/ Population of interest	Program implementation	Outcome variables	Results	Limitations
Meyers, Carducci, Loscalzo, Linder, Greasby, & Beckett (2011)	Simultaneous Care Educational Intervention using a problem solving intervention (COPE)	Prospective randomized trial Data collected at baseline and 30, 60, 90, 120 and 180 days after intervention	Intervention arm dyads: Patients simultaneously enrolled into phase 1, 2 or 3 cancer clinical trials for lymphoma and one caregiver Control group – usual care	Intervention dyads received the book <i>The Home Care Guide for Cancer</i> Chapters cover physical symptoms, psychological symptoms, issues related to resources, relationships, communication and support. Chapters follow a problem solving approach Three educational sessions offered by a trained educator COPE problem solving model used to identify dyad problems and facilitate problem solving	City of Hope Quality of Life - 41 item ordinal scale measures global QOL No validity/reliability cited Social Problem Solving Inventory Revised – 52 item multidimensional measure of social problem-solving ability	Moderately statistically significant improvement in QOL for caregivers Decline in patients problem-solving skills	Extended period of time for data collection Turnover with trainers Limited enrollment of ethnic minorities English language requirement
Kondrat & Teater (2010)	Solution focused therapy (SFT)	N/A	Persons presenting to the ED with suicidal ideations	SFT questioning strategies 1. goal question 2. exception questions 3. scaling questions 4. relationship questions 5. Intervention implemented by social worker	Increased hopefulness Reduction in self-reported level of suicidality	SFT may have a positive impact on level of hopelessness	No empirical evidence to support SFT effectiveness

Table 4 (cont.)

Author / date	Program/ intervention	Study design	Sample/ Population of interest	Program implementation	Outcome variables	Results	Limitations
Anbar & Murthy (2010)	Psychosocial support and goal setting	Case report	10 year old boy with cystic fibrosis awaiting lung transplantation Loss of hope and request for withdrawal of treatment	Physician encouraged expression of life goals and how his life might be improved. Patient empowered to have more control of daily symptoms Changes in his medical management to improve quality of life	Reestablishment of hope which allowed survival long enough to undergo successful lung transplantation	Meaning in life, goal setting and individualized management of symptoms can increase hopefulness	Individual experience not generalizable
Cook, Copeland, Corey, Buffington, Jonikas, Curtis, Grey, & Nichols (2010)	Wellness Recovery Action Plan (WRAP)	Cohort study Pre and post intervention comparison	Recruited consumers or survivors of psychiatric services – 381 participants at community mental health centers throughout urban, rural and suburban Vermont and Minnesota	Vermont – 40 hours of WRAP education delivered to groups of 15-20 individuals in 21 separate cycles over 2.5 years Minnesota – 16 hours delivered in eight two hour classes to groups of 4 – 15 individuals Two WRAP certified educators conducted classes	Survey instrument to assess three dimensions of self-management: 1) attitudes (hope for recovery 2). Knowledge (symptom triggers) 3. Skills (social support, wellness tools)	Significant positive changes in recovery attitudes observed in 76% of Vermont respondents and 85% of Minnesota respondents -increased hopefulness for their own recovery, awareness of early signs of decompensation, symptom management, use of a crisis plan Qualitative findings include participants' new view of wellness as an attainable, ongoing process	No control group Survey not psychometrically validated Study sample not random sample of individuals with severe mental illness Attrition and missing data No ID # on Minnesota surveys, couldn't be linked, no paired t-tests

Table 4 (cont.)

Author / date	Program/ intervention	Study design	Sample/ Population of interest	Program implementation	Outcome variables	Results	Limitations
Wilson, Marin, Bhardway, Lichlyter, Thurston, & Mohankumar (2010)	Four week Hope program including daily hope interventions involving positive messages and pictures as compared to a friendly weekday greeting	Quasi-experimental, intervention and control groups Data gathered at baseline and at the end of the four week Hope program	Nursing home residents over the age of 65, identified as depressed using the institution's Depression Rating Scale	First week – "hope card" delivered each weekday with an inspirational message Second week – Hope card and participants asked to share a time in the past when they experienced hope Third week – Hope pictures shown to each subject, hope message read, subject asked to set a goal for the day Fourth week – subjects asked to choose one picture that represented hope and explain why	Herth Hope Index (HHI)– 12 item shorter version of the Herth Hope Scale. Established construct validity, internal consistency and test-retest correlations Geriatric Depression Scale Short Form (GDSSF) – 15 item tool, established as valid and reliable	No difference between groups on HHI and GDSSF scores post intervention scores Intervention group had a statistically significant decrease in HHI scores post intervention Both groups had some decrease in GDSSF scores after four weeks	Hope intervention program might not be designed appropriately for depressed older adults Program length not sufficient enough to see changes in hope in this population

Table 4 (cont.)

Author / date	Program/ intervention	Study design	Sample/ Population of interest	Program implementation	Outcome variables	Results	Limitations
Barbic, Krupa, & Armstrong (2009)	Modified Recovery Workbook Program	Multicenter, prospective, single blind, randomized controlled trial at two outpatient mental health sites in Canada Intervention group received Recovery Workbook training, control group received treatment as usual Data collected pre and post intervention	Clients eligible if they used the services for more than six months, between ages of 18 and 60 and had schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder or bipolar disorder	Recovery Workbook Program - increases awareness of recovery, knowledge and control of illness, awareness of stressors, enhances personal meaning, builds personal support and develops goals and action plans 30 sessions recommended, 12 weekly two hour sessions done to accommodate participants Workbook content reviewed, discussed and practice exercises completed	Herth Hope Index (HHI) alpha = .97 The Empowerment Scale alpha = .85-.90 The Recovery Assessment Scale (RAS)– measures coping ability, sense of empowerment and quality of life alpha = .93 The Quality of Life Index, General Version – measures satisfaction with and importance of aspects of life alpha = .92	Statistical significant interactions between group and time found for Hope, empowerment, recovery and RAS subscales of personal confidence and hope, and goal and success orientation No differences between control and intervention groups on QOL scores	Original program was modified Small sample size n=33, not reflective of social and ethnic diversity of country, selection bias Excluded clients with comorbidity of substance abuse despite a high incidence

Table 4 (cont.)

Author / date	Program/ intervention	Study design	Sample/ Population of interest	Program implementation	Outcome variables	Results	Limitations
Berg, Snyder, & Hamilton (2008)	Four part Hope intervention to increase hope, thereby increasing pain tolerance and pain threshold	Intervention study Hope measured pre and post intervention	University students with low scores on the Trait Hope Scale, Revised	A cold pressor task was administered using an ice water bath Hope intervention included 1.guided imagery 2. dialogue 3.strategies instruction 4.worksheet	Trait Hope Scale-Revised alpha=.86 Positive and Negative Affect Schedule alpha=.88 Pain Catastrophizing Scale-Short Form alpha=.90	Hope scores increased among all female participants Increased pain tolerance for all participants	Small effect size Population and pain induction method have limited generalizability to a clinical population
Cantrell & Conte (2008)	Web based Hope Intervention Program (HIP)	Descriptive feasibility study	Six female young adults who were near-term (early) survivors of childhood cancer	Eight week program delivered by a nurse Weekly two hour sessions with specific focus, goals and activities related to hope based on Herth's hope inspiration program Delivered online, Web cameras and simultaneous voice, text and chat capabilities	Could the program be successfully delivered via the Internet? Would the subjects be receptive and interested in the aims of the HIP? Would an intimate and trusting relationship develop between the participants and the nurse? Would the participants perceive the time spent online as worthwhile and valuable?	Need access to an interventional technologist to troubleshoot problems in real time Participants felt a sense of community and connectedness Participants grateful for the opportunity to talk and that someone cared about them Participants identified the HIP as valuable, five thought the program was too short	Average two technological problems per session Personality characteristics and communication skills of the nurse Must be carefully assessed beforehand Audio versions of the sessions must be reviewed with text chats in order to comprehend content

Table 5

Hospice and Palliative Care Demographic Data: Nurses (n = 9), Frequencies, n (%)

	Home Care (n = 6)	Inpatient (n = 3)	Home care and Inpatient (n = 9)
Age			
30-39 years	2 (22.2)	1 (11.1)	3 (33.3)
40-49 years	1 (11.1)		1 (11.1)
50-59 years		2 (22.2)	2 (22.2)
60+ years	3 (33.3)		3 (33.3)
Gender			
Female	6 (66.6)	3 (33.3)	9 (100)
Ethnicity			
White	6 (66.6)	3 (33.3)	9 (100)
Highest level of nursing education			
Associate degree	3 (33.3)	3 (33.3)	6 (66.6)
Baccalaureate degree	3 (33.3) (1 DNP; 1 BA Psych)		3 (33.3)
Years of professional nursing practice			
< 5 years	2 (22.2)	1 (11.1)	3 (33.3)
16-20 years	1 (11.1)		1 (11.1)
21+ years	3 (33.3)	2 (22.2)	5 (55.5)
Type of nursing practice			
Administration/ Management	2 (22.2)	2 (22.2)	4 (44.4)
Direct patient care	6 (66.6)	2 (22.2)	8 (88.8)
Education	1 (11.1)	1 (11.1)	2 (22.2)
Research	1 (11.1)		1 (11.1)
Supervision of direct patient care	3 (33.3)		3 (33.3)
Area of clinical practice			
Home care	3 (33.3)	1 (11.1)	4 (44.4)
Hospice	6 (66.6)	3 (33.3)	9 (100)
Hospital	2 (22.2)	3 (33.3)	5 (55.5)
Nursing home	3 (33.3)	1 (11.1)	4 (44.4)
Other	1 (11.1) clinic	1 (11.1) MD office	2 (22.2)
Specialty in nursing			
Hospice	6 (66.6)	3 (33.3)	9 (100)
Medical/Surgical nursing	1 (11.1)		1 (11.1)

Table 6

Comparison of critical attributes of hope

Critical attributes	Benzein & Berg, 2005	Lohne & Severinsson, 2006	Kim et al., 2006	Rustøen et al., 2005	Davis, 2005	Johnson, 2007	Hospice and Palliative Care nurses (n = 9)
Multidimensional	X	X	X	X	X	X	
Dynamic			X	X	X	X	X
Future oriented		X	X	X	X	X	X
Reality oriented				X	X		
Central			X				
Contextual	X			X			
Possibilities		X	X			X	
Anticipation/optimism			X	X			
Provides meaning			X	X			
Action oriented		X					
Spiritual	X			X		X	X
Interconnectedness	X		X			X	X
Goal oriented		X	X				
Strength, determination, will to endure						X	X

Appendix D

Figure 1

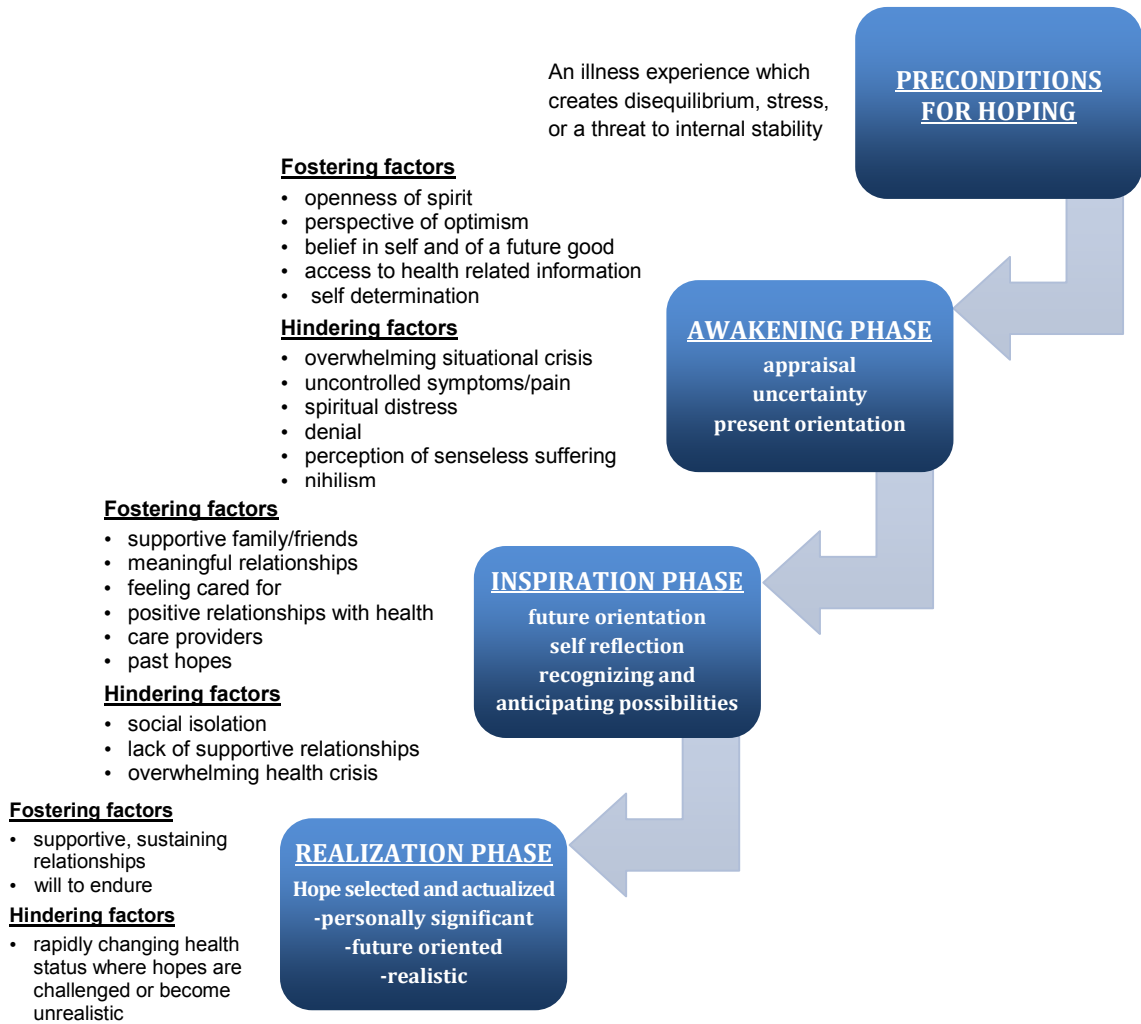


Figure 1

A preliminary model of the hoping process

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