

The nature of hope in hospitalized chronically ill patients

Dal Sook Kim^{a,*}, Hesook Suzie Kim^b, Donna Schwartz-Barcott^c, Donna Zucker^d

^a*Department of Nursing, College of Medicine, Chungnam National University, Moon-Hwa dong, Jung-gu, Daejeon City, Republic of Korea*

^b*Buskerud University College, Drammen, Norway*

^c*College of Nursing, University of Rhode Island, Kingston, RI 02881, USA*

^d*College of Nursing, University of Massachusetts at Amherst, Amherst, MA, USA*

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Abstract

Background: Hope as a universal human phenomenon has been studied from various perspectives often conceptualized as having a unified set of attributes. In this study however hope is viewed to be experienced by people in various patterns structured by different orientations and emphases depending upon their life circumstances. There is a paucity of studies in the literature examining patterns of hope experienced by people in chronic illness or in special life circumstances.

Objectives: The aim of this study was to discover patterns of hope in hospitalized chronically ill patients and to identify the major threads that structure various patterns of hope experienced by them.

Design: *Q*-methodology, which is an approach designed to discover patterns in various subjective experiences, was used as the method for data collection and theory generation. *Q*-methodology involves five steps in its approach, the first two as the first phase and the last three as the second phase. The study was carried out at a general acute-care, tertiary hospital in a New England state in the US. The study obtained data from a convenient sample of 12 chronically ill patients and 16 oncology nurses for the first phase, and a different convenient sample of 20 chronically ill patients for the second phase.

Results and conclusions: Five patterns of subjective experiences of hope emerged as: (a) externalism orientation, (b) pragmatism orientation, (c) reality orientation, (d) future orientation, and (e) internalism orientation. This means that chronically ill patients experience hope in various ways by focusing on different dimensions of meaning, suggesting the conceptualization of hope as a unitary construct may not reflect people's experiences of hope accurately. The major implication of the study is to rethink ways to assess patients' hope in terms of pattern differences rather than in terms of quantity.

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Keywords: Patterns of hope; *Q*-methodology; Chronically ill patients

What is already known about the topic

- Various philosophical and conceptual orientations regarding hope.
- Hope viewed and assessed as a human experience in a unified, general form varying in its degree (quantitatively) depending upon life circumstances.

*Corresponding author.

E-mail addresses: dskim@cnu.ac.kr (D.S. Kim), suziekim@regencydv.com (H.S. Kim), dsb@uri.edu (D. Schwartz-Barcott).

- Development of various tools for assessing the level of hope.

What this paper adds

- Hope revealed in five different patterns in chronically ill patients.
- Hope experienced subjectively by patients attributing different meanings to their life circumstances and emphasizing different orientations.

1. Introduction

Hope has been studied in nursing from various orientations as a subjective phenomenon in relation to illness experiences. It is often considered an essential state of mind that impacts on individuals' attitudes toward life and functioning. For example, Fryback (1991) identified hope as one of the three major themes in mental/emotional domain of health in persons with terminal disease. Since it is suggested that hope is present in nearly all people (Yates, 1993), it has to be assumed that hope also is present in chronically ill patients. However, the lives of chronically ill patients are often complicated by declining functioning, disability, persistent presence of unpleasant, troublesome symptoms, episodes of exacerbation of diseases, or a threat of death. Such circumstantial constraints associated with chronic illness may influence the ways chronically ill persons experience hope differently from how hope is experienced by healthy persons.

While the literature regarding hope is accumulating, experiences of hope and hope inspiration by people in different life-circumstances or culture remain under-researched and is consequently not well understood (Herth and Cutcliffe, 2002). Furthermore, most of the research on hope has held the assumption that hope is experienced as a unified general structure or process having a universal attribute rather than it being represented by dynamic patterns experienced differently by persons who are in different situations. It is possible to consider hope as a dynamic construct that may be affected by extraneous variables or changing conditions such as phases of illness (Farran et al., 1995).

The present study was based on two assumptions: (1) hope is an experience that is revealed in a dynamic pattern associated with an individual's life situation, and (2) chronically ill patients are likely to experience hope in different patterns than healthy persons. The specific purpose of this study was to discover the patterns of hope in chronically ill patients in an acute-care setting through *Q*-methodology. In this study the term, a chronically ill patient, was defined broadly as a patient who has a diagnosis requiring long-term medical care,

with possible exacerbations or related acute episodes that necessitate hospitalizations.

2. The literature review

In general hope is viewed as an essential and vital component in human life and health. However, there are many different orientations with which hope has been conceptualized by philosophers, psychologists, and nursing scholars. For example, hope is considered a component of caring (Mayeroff, 1972), is described as an inner force inherent in a person's will to live (Cousins, 1989), and is thought of as an element that is present in persons in the form of desire to function as an independent human being (El-Gamel, 1994). To existential philosophers such as Marcel (1978) and Fitzgerald (1979) hope is closely tied to the concept of human becoming and existence. Hope to Marcel (1978) is a process of human becoming through which one searches for meaning for oneself in intersubjective relationships. Marcel differentiates desire which is viewed as a specific "want" of objects from basic hope which exists as an orientation to future possibilities, transcending the limits of specific things or material. Aardema (1984) describes the kind of hope Marcel refers as transcendental hope.

In a different perspective than that espoused by Marcel, Schachtel (1959) distinguishes "realistic hope" from "magic hope" suggesting that realistic hope refers to a process of activity oriented to finding oneself or conditions of reality, while magic hope refers to wishful expectations that would be fulfilled by some persons or external forces such as God or fate. Magic hope is represented as "not active but passive in the present, and the present is empty" (Schachtel, 1959, p. 38). Stotland (1969) on the other hand considers hope as a condition of mind that results from a cognitive, evaluative process regarding goal attainment. These suggest that there are variations in the ways hope is conceptualized by philosophers and psychologists.

In nursing hope is often conceptualized or identified as a unified structure or a state of mind in a person, or as a static state that is experienced by a person with varying attributes or elements (for example, Hinds, 1984; Dufault and Martocchio, 1985; Herth 1990; Daly et al., 1999). Hinds (1984) identified hope in four categories—"forced efforts," "personal possibilities," "expectation of better tomorrow," and "anticipation of a personal future." Hinds (1988) added a category of "concern for and focus on other" in her later study. Nurse researchers have frequently utilized hope scales such as the Miller Hope Scale (Miller and Powers, 1988), Nowotny Hope Scale (Nowotny, 1989), and Herth Hope Scale (Herth, 1991), which consider hope as having universal attributes and general critical elements, within

structures of several dimensions. Herth and Cutcliffe (2002) in their review found that more than 15 different instruments for measuring hope are being utilized in nursing research and practice, all of which are based on the assumption of a unified structure represented by a set of universal attributes. Other models of hope undergirded by similar understandings are found in the model used by Bunston et al. (1995) that explains hope by causal factors, in the work of Penrod and Morse (1997) in which hope is viewed as a process in specific stages, and other explanatory models that include coping, spiritual well-being, fatigue, self-esteem, uncertainty, perceived health status, and other personal variables (Herth and Cutcliffe, 2002; Herth, 2004). In addition, hope strategies developed as nursing strategies (Rustøen et al., 1998; Herth, 2000) rely on the same idea that hope can be expressed by universal elements or attributes and that hope strategies are applicable as general approaches to all types of patients.

This is in contrast to a conceptualization of hope as a dynamic pattern or process. For example, hope is viewed as a part of human development, a process, or a source of meaning in life (Stephenson, 1991), or it is considered a force or energy that moves persons forward toward the future even when the future seems limited (Smith-Stoner and Frost, 1999). Wright and Shontz (1968) identified seven structures of hope that could emerge from a dialectical process involving “being encouragement,” “reality surveillance,” “worrying,” and “mourning”. Ersek (1992) found hope in a sample of 20 adult patients undergoing bone marrow transplantation as a dialectical process of reconciling in terms of keeping illness in its place by appraising illness as a threat or non-threat, and managing emotions and working through it in a way that fosters/sustains hope. It is also considered a dynamic pattern that results from changing nature of human feelings and experiences connected with individuals’ differing circumstances of living and experiencing (Morse and Doberneck, 1995). Morse and Doberneck discovered four unique patterns of hoping pathways exhibited by persons in four different situations: (a) hoping against hope in the breast cancer survived persons as they continually reformulated hope in response to each new barrier, (b) hoping for a chance in the patients undergoing heart transplant, (c) provisional hope in the breast feeding working mothers, and (d) incremental hope in the spinal cord injured mothers (Morse and Doberneck, 1995). These four patterns emerged as different responses to realistic assessment and tangible goal orientation. Kim (1992) also identified seven different structures of hope uniquely experienced by hospitalized chronically ill patients. From a multi-dimensional perspective Nekolaichuk and Bruera (1998) propose a hope model for palliative care that views the experience of hope as integration among personal spirit, risk, and authentic caring. Kylma and Vehviläinen-

Julkunen (1997) concluded from their meta-analysis of various studies of hope that hope is a subjective phenomenon and a dynamic process. In a similar view Parse (1999) from her existential phenomenological orientation considers hope as a universal human experience arising in personal uniqueness. These studies point to the notion that hope is a dynamic and dialectical process or a changing structure. However, the specific nature of the experience of hope for chronically ill patients is not known.

Hope processes may vary especially in patients with chronic illness who are likely to be in more complex situations of living related to uncertainty in comparison to healthy persons. Since there is an indication that the manner with which persons cope with the problem of uncertainty has implications for the process of hope, it seems critical to examine how the patterns of hope vary in the context of chronic illness.

3. The method

Q-methodology advanced by Stephenson (1953) was applied in this study in order to investigate the subjective experience of hope in chronically ill patients. *Q*-methodology is oriented to investigating subjectivity associated with behaviors, thoughts, and feelings by combining qualitative and quantitative techniques for data collection, data management, and analysis. Dennis (1986) suggested *Q*-methodology as a unique and totally different research tradition from the usual quantitative or qualitative approaches, which answers questions that seek to develop and understand different viewpoints of subjective phenomena in the nursing domain. *Q*-methodology adopts abduction as its logic of analysis, and specifies five steps for data collection and analysis (Stephenson, 1961). The empirical material for this study was collected from 1996 to 1998.

The study was carried out at a general acute-care hospital affiliated with a medical school in a metropolitan city in a New England state. The average number of beds in the hospital was around 230 during the study period. Most of the cancer patients were admitted to one specific unit designated as an oncology unit, while other patients with diagnoses of chronic diseases were admitted to three different medical units, of which total bed capacity was about 60 beds. Approvals from the University’s and the participating hospital’s Institutional Review Boards for human subjects were obtained for both phases of the study, and the participants signed the consent forms before the data collection began. The patient subjects for both phases of the study were those consenting to participate in the study among the patients with diagnosis of chronic illness admitted to these four units during the study period. The adult patients aged over 18 years who were able to read and write in English

or alert enough to engage in interviews were approached for participation. The medical records of all patients on these units were examined to identify those with the diagnosis of chronic illness, and the eligibility of participation in the study was determined for each patient with the aide of the head nurses especially in relation to the patient's alertness. This process was used to obtain the two patient samples. The nurse sample for the first phase of the study was obtained from those working on the oncology unit at the study hospital. All registered nurses on the unit consented to participate in the study and provided the data.

Step 1: Obtaining Q-population—a *Q*-population is a collection of items (statements) relevant to the study of a specific phenomenon obtained for a *Q*-study. Stephenson (1967) defined *Q*-population as “a collection of self-referent statements made by a person in a social situation.”(p.14). It is obtained by assembling a set of self-referent, descriptive statements made by subjects for a given experience. In this study, we obtained answers to eight open-ended questions regarding hope such as “Please tell me what you think *hope* is in your words” and “What kind of hope do you have at present?” from a convenient sample of 12 hospitalized chronically ill patients including some cancer patients and 16 staff nurses working in a cancer-care unit of the same hospital. The rationale for this sample constellation was the belief that both chronically ill patients and nurses who work with chronically ill patients would be able to give insightful statements regarding hope as experienced by chronically ill patients. The eight open-ended questions were formulated to elicit the study subjects' thoughts and ideas regarding hope comprehensively and in their own words as they have experienced it. The participants were encouraged through these questions to reflect on their lives and experiences to give answers to these questions so that they could think of hope from their own concrete life experiences. We obtained the answers to these questions as written statements from the subjects or through face-to-face interviews when the subjects (the patients) were unable to write them down. All statements from the subjects to these questions were transcribed, and read thoroughly. The statements expressed or emerged with different thoughts or meanings among the answers were edited and divided into single-idea statements by the researchers. In addition, the statements not in a self-referent form such as “I feel...” or “I believe...” were edited into these forms. A total of 118 self-referent statements each with a single idea regarding hope were assembled from the transcription of replies provided by the subjects. This set of 118 self-referent statements regarding the experience of hope became the *Q*-population for this study. Since these statements were directly derived from the data, except the conversion of some statements into self-referential

ones, there were many redundancies and similarities among them.

Step 2: Q-sampling—*Q*-sampling involves a process of selecting a set of statements (items) from a *Q*-population to be used as stimulus items in the later steps in the study. A *Q*-sample was extracted out by the researchers by examining the *Q*-population of 118 self-referent statements obtained for hope. These 118 statements were examined carefully by the researchers and were categorized into 37 types determined according to the similarities in ideas embedded in the statements. A set of 37 self-referent statements, each representing a type among the 118 items, was obtained by selecting the most representative statement for each category. The *Q*-sample for the study is listed in Table 1.

Step 3: P-sampling—*P*-sampling is sampling of subjects from a *P*-population, which is a population base available as subjects for the study. A *P*-sample consists of subjects who participate in the next phase of data collection. We obtained a convenient *P*-sample of 20 subjects from the hospitalized patients with diagnoses of chronic conditions in an acute care hospital in a New England State. *P*-sampling is anchored in the doctrine of small numbers because *Q*-methodology is oriented to investigating intra-individual significances rather than averages across the sample. The sample included patients with diagnoses of cancer but not in a terminal stage, COPD, arthritis with or without hip-replacement, cardiovascular diseases, stroke, peripheral vascular diseases, chronic renal disease, and addiction. The age of the subjects in the sample ranged from 33 to 84 with a mean of 64.

Step 4: Q-sorting—the purpose of *Q*-sorting is to get individual's impressions about the object being considered (Stephenson, 1967, p. 16). A *Q*-sort is a model of an individual's subjectivity (Brown, 1986). The *Q*-sorting following the forced nature of normal distribution *Q*-sort technique recommended in the literature (Brown, 1980) involves a two-step process. In preparation for this process, each of the 37 statements was typed on a 4 × 6 card singly as a *Q*-card. As the first step, the subjects in the *P*-sample were asked to sort each *Q*-card into an AGREE, NEUTRAL, or DISAGREE category. The second step involved re-sorting these statements that were placed in the three categories into a normal-curve structure ranging in the values of 1–9. The distribution of 37 statements into a normal curve means assignments of the total number of items (37) into nine ratings (values) with a consideration of the rating of 5 as the mean with the most items and a dispersion into the remaining two ends of “5”, that is, 1, 2, 3, 4 on one side and 6, 7, 8, and 9 on the other, as a bell curve. It was done with an aid of a pyramid figure of a normal curve in which the ratings of 1 and 9 would require two statements, the ratings of 2 and 8, three statements, the ratings of 3 and 7, four statements, the ratings of 4 and

6, six statements, and the rating of 5, seven statements. The subjects were asked to re-sort statements in the AGREE category first, by beginning the sorting into the rating of 9 with 2 statements first, then going down the rating scale until all of the statements in the AGREE category were re-sorted into the ratings. The re-sorting of the statements in the DISAGREE category was made next by classifying them into the ratings beginning with 2 statements for the rating of 1, 3 statements for the rating of 2, etc. The statements sorted into the NEUTRAL category were then re-sorted to complete the normal distribution for a total of 37 items. Although this procedure appears complicated, after an explanation and a demonstration by the researcher all subjects were able to complete the sorting without difficulty in less than 1 h. After the completion of sorting by each subject, he/she was interviewed regarding the reasons for selecting certain statements as the most strongly agree (the score of 9) and the most strongly disagree (the score of 1). These provided the data that were used to illustrate and characterize the descriptions of the patterns of hope emerged from the factor analysis.

Step 5: Determining Q-types by Q-factor analysis—the statements sorted by the subjects in the normal distribution structure of rating ranging from the score of 1–9 obtained in the previous step (*Q*-sorting) were subjected to *Q*-factor analysis using PC-QUANL program specifically developed for this method. This factor analysis using principal component factor analysis and varimax rotation is a method of person-typing (or mind-set typing) rather than an item-typing usually applied in *R*-factor analysis. *Q*-factor analysis defers in data input from the *R*-factor analysis by reversing the case and the item, because *Q*-factor analysis is a method of seeking operant combinations of “like” people, i.e., combinations of people who have sorted items in similar, correlated ways. Interpretation of *Q*-factor is a highly creative process in which the researcher arrives at an interpretation of factor-patterns by considering the information on (a) *Q*-factor arrays that show each person’s loading on the factor, (b) highly loaded items (more than +1.0 of Z-score) and lower loaded items (less than –1.0 of factor score) on the factor, (c) comments by the respondents on items scored at either extremes, and (d) the researcher’s understanding of the phenomenon. In this study, five distinctive patterns of hope were identified through the *Q*-factor analysis, using an Eigenvalue greater than 1.0 as the criterion for pattern determination.

4. The results

The five patterns of hope obtained from the results from the QUANL analysis of the data indicate various ways hope is experienced by different people in the

sample. Each pattern was represented by different individuals of the sample indicating that the persons experienced hope in one of these five patterns. Table 1 shows the Z-scores for the five patterns of hope for the 37 statements included in the *Q*-sampling for hope.

A specific label is given to each pattern to indicate the major representative characteristics of hope. However, there were two “consensus items” which either loaded highly or loaded very low (meaning neutral) on all factors, indicating that these items are common denominators agreed or thought irrelevant by everyone regardless of the pattern of hope they experienced. The highly-loaded consensus item was *I feel hope in my faith in God*, and the low-loaded consensus item was *I feel hope when I do the usual activities*. This means that people’s faith in God was thought to be an important aspect for experiencing hope to everyone, while being able to do usual activities was considered irrelevant to the experience of hope. In addition, the statement, *I feel hope when I think everything is in God’s hand*, was also loaded highly on four of the five factors, suggesting in general the importance of the faith in God in experiencing hope for these groups of people. Furthermore, as shown in Table 1, six statements were loaded insignificantly on all five patterns (that is, having the Z-scores between –1.0 and +1.0 on all factors), indicating that the ideas contained in these statements did not seem relevant to specifying the patterns of hope in these chronically ill patients regardless of the types.

In addition, because the subjects of this study were chronically ill patients, some with cancer, their outlook on illness in general was not positive, most of them expressing their resignation and acceptance of not getting better as a fact. Their hope tended to be framed within their realistic expectations regarding illness. Hence, although there were different degrees of emphasis on their resignation regarding illness among the five different patterns of hope, this theme of realistic acceptance was apparent in all of the patterns as an underlying characteristic that defined their hope.

Type I: externalism orientation. Six patients of the sample clustered on this type—a 76-year old man with small bowel obstruction and COPD, a 66-year old woman with breast cancer, an 84-year old man with laryngeal cancer, a 66-year old man with arthritis, and a 42-year old man and a 40-year old woman both with addiction. The sources of hope in persons of this type seemed to be others such as God and significant others rather than themselves. Their hope seemed to be based on their reliance on family, friends, or God as the most important things in their lives. What they thought of themselves or accomplished on their own seemed not to be important in giving them hope. The interviews with these subjects regarding their reasons for rating the specific items as the most strongly agreed ones revealed that they greatly relied on God’s power and grace as the

Table 1
Item descriptions and Z-scores for five types of hope identified through factor analysis

Item description	Type I	Type II	Type III	Type IV	Type V
1. I feel hope when I talk about my getting better.	0.4	0.7	<i>-1.1</i>	0.0	<i>-1.3</i>
2. I feel hope when I express my concerns and feelings.	<i>-0.7</i>	<i>-0.1</i>	<i>-0.9</i>	<i>-0.7</i>	0.7
3. I feel hope when I feel my family is happy, healthy, and safe.	1.6	1.6	0.7	1.3	<i>-1.3</i>
4. I feel hope when I am with my family and loved ones.	1.8	0.7	0.4	1.2	1.1
5. I feel hope when I find myself with support of family and friends.	1.4	1.1	0.5	0.9	1.2
6. I feel hope when I think everything is in God's hand.	1.5	0.5	2.0	2.2	1.9
7. I feel hope in my faith in God.	2.3	1.7	2.2	1.4	2.3
8. I feel hope when I see the people who are thinking, saying, or behaving in a humane manner.	<i>-0.2</i>	<i>-1.2</i>	0.7	<i>-1.4</i>	0.3
9. I feel hope when I use my sense of humor.	<i>-0.9</i>	<i>-0.8</i>	<i>-0.9</i>	<i>-0.2</i>	1.8
10. I feel hope when I do activities independently.	<i>-0.6</i>	<i>-1.4</i>	<i>-0.9</i>	<i>-0.7</i>	<i>-0.0</i>
11. I feel hope when I think I am still alive.	1.1	<i>-1.0</i>	<i>-0.2</i>	<i>-0.4</i>	<i>-0.0</i>
12. I feel hope when I am satisfied with the present looking forward to the future.	<i>-0.3</i>	<i>-0.0</i>	<i>-1.4</i>	0.2	<i>-0.6</i>
13. I feel hope because I think of my life as valuable even if I am faced with difficulties in life.	<i>-1.1</i>	<i>-0.0</i>	0.5	0.9	0.3
14. I feel hope when I get or do what I want.	<i>-1.3</i>	0.4	<i>-2.2</i>	<i>-1.2</i>	<i>-1.2</i>
15. I feel hope when I do the usual activities.	<i>-0.3</i>	<i>-0.2</i>	<i>-0.9</i>	<i>-0.1</i>	<i>-0.4</i>
16. I feel hope when I am quiet.	<i>-1.7</i>	<i>-0.5</i>	<i>-0.7</i>	<i>-2.0</i>	<i>-0.4</i>
17. Environmental stability brings me hope.	<i>-0.9</i>	<i>-0.5</i>	1.1	<i>-2.2</i>	<i>-0.4</i>
18. I feel hope when there are things that I can accomplish even if they are small things.	0.6	1.2	1.1	0.5	<i>-0.5</i>
19. I feel hope by accepting that life even with its negative side should be enjoyed.	<i>-0.5</i>	1.8	<i>-0.3</i>	0.1	0.6
20. I feel hope when I feel I am getting better.	1.1	0.3	0.5	0.5	0.9
21. I feel hope when I achieve goals.	0.3	<i>-1.5</i>	0.9	0.1	0.6
22. I feel hope when I think there is something to keep me alive and valuable in my life.	1.3	<i>-1.7</i>	<i>-1.7</i>	0.2	0.4
23. I feel hope when I look to the future with a positive attitude think that everything will turn out for the best.	<i>-1.5</i>	1.0	0.3	1.2	<i>-1.0</i>
24. I feel hope when the medical team (physicians and nurses) tells me about my progress.	0.2	0.6	<i>-0.4</i>	0.7	0.2
25. I feel hope when I get good care from nurses and staff.	<i>-0.1</i>	<i>-0.0</i>	0.7	<i>-0.4</i>	<i>-1.3</i>
26. I feel hope when I learn that medical progress will continue.	0.4	<i>-1.7</i>	0.3	<i>-0.7</i>	1.3
27. I feel hope when I talk with or see people who are in a worse situation than I am.	<i>-1.0</i>	0.2	1.4	<i>-2.0</i>	<i>-1.7</i>
28. I feel hope when I can help someone else or be useful.	<i>-0.8</i>	0.2	<i>-0.6</i>	0.7	0.2
29. I feel hope when I think new treatment will be available for me.	<i>-0.6</i>	0.5	0.5	0.6	0.1
30. I feel hope when I hear or see people who have overcome obstacles.	0.0	<i>-0.7</i>	0.5	0.0	<i>-0.2</i>
31. I feel hope when I listen to others' concerns and feelings in similar situations.	0.5	0.5	<i>-0.6</i>	<i>-1.5</i>	<i>-1.6</i>
32. I feel hope when I think every situation has a purpose and something to be learned.	<i>-0.7</i>	0.7	<i>-0.7</i>	0.4	<i>-1.5</i>
33. I feel hope because I think of my life as valuable even if I am faced with difficulties in life.	<i>-1.0</i>	0.0	1.3	<i>-0.4</i>	<i>-0.7</i>
34. I feel hope when I focus on living a full life with commitment.	0.6	<i>-1.9</i>	<i>-0.3</i>	<i>-0.5</i>	0.8
35. I feel hope when I challenge myself to meet my potential.	<i>-0.8</i>	<i>-1.9</i>	<i>-0.5</i>	0.4	0.6
36. I feel hope when I rationalize my situation.	<i>-0.7</i>	0.6	<i>-0.7</i>	<i>-0.9</i>	<i>-0.4</i>
37. I feel hope when I do anything to stay alive for my family.	0.6	0.7	<i>-1.3</i>	0.3	<i>-0.3</i>

Those above +1.0 indicating strongly agreed items and below -1.0 indicating strongly disagreed items identified in bold for each type. Positive z-scores are in the normal font, and negative scores are in italics.

source of hope, and they projected their hope through their families and friends as they considered their families "the most important thing in life." Their comments to the ratings for the most strongly disagreed

items revealed that they seemed to accept their own conditions as having no future for improvement, hence any hopeful thinking regarding their illness was rejected, instead hope was perceived in relation to family and

friends. This means that hope to them was not considered in relation to any positive prospects related to their own illness conditions.

Type II: pragmatism orientation. Four subjects of the sample clustered on this type—a 62 year-old woman with an end stage renal disease, a 73-year old woman with hip replacement for chronic osteoarthritis, a 71-year old woman with peripheral vascular diseases, and a 67-year old man with squamous cell carcinoma. Hope for this group of patients was not in grandiose things, or purposes that were thought to be unlikely to them. The source of their hope was in being able to do small things or enjoying things they can accomplish. In their interviews regarding the extremely rated items, they indicated that they did not believe in setting big goals with their lives as they did not believe in “them coming true.” They seemed to have accepted their illness conditions to be without the prospect of becoming better, thus seemed to rely on whatever they could get as the sources of their hope. In addition, they experienced hope by having positive attitudes regarding the future as well as the present.

Type III: reality orientation. Two subjects were identified in this type—a 76-year old woman with lymphoma and a 54-year old man with squamous cell carcinoma. This type of hope seemed to be experienced within the patients’ realistic perceptions about their situations, and was realized within the given frames. Their outlooks on future were well grounded in the reality of their illnesses. The patient with lymphoma stated that “Can’t always get what you want—must accept that too” in association with her strongly disagreed item, “I feel hope when I get or do what I want.” Similarly, the patient with squamous cell carcinoma also stated that “The way things are going and I am really ready for it to be over.” In addition to their realistic acceptance of their situations, their hope was also rooted in their perception of God as stable force in their lives, as indicated by the statement made by one patient that “Everything is in God’s hands—He has brought me through much...” They relied on God as being a stable force, but were different from the patients in Type I who had strong reliance on God as well as family and friends.

Type IV: future orientation. The patients grouped in this type of hope were a 58 year-old woman with melanoma, a 39 year-old woman with chronic headache and a history of CVA, 33 year-old man with recurrent rectal cancer, a 64 year-old man with small bowel obstruction who has survived colon cancer for 20 years, a 75 year-old woman with pancreatic cancer and a 69 year-old woman with total hip replacement and advanced arthritis. This type of hope was experienced through projections to the future that was viewed to have positive possibilities and strong dependence on God. A patient stated “everything happens for a reason,

regardless of your pleas,” and another stated, “as faith grows you have a more positive faith.” This position is close to what Marcel (1978) described as the non-acceptance of insolvency, as this type of hope seemed to be experienced in relation to an acceptance of possibilities in the future. In addition, the patients in this type of hope did not perceive hope in terms of what other people might do, as they seemed to be focused on their own situations actively. The patients expressed their orientations in themselves, future possibilities, and in God, rather than in others or the objective world.

Type V: internalism orientation. Two patients clustered on this pattern of hope—an 81 year-old woman with cardiovascular diseases, and a 64 year-old man with sigmoid resection for colon cancer. Their hope was self-oriented as hope seemed to be experienced through the use of humor, or when they learned about medical progress. This type of hope was based on the patients’ beliefs in whatever existed in present situations for them, thus was sustained through their own actions such as humor, their knowledge, and the presence of family and friends for them. As one of the patients stated, “hope is not in the nurse, but inside me,” their hope was from inside and in what they did. This type of hope was not experienced in relation to possibilities or to references to others. They seemed to believe that only they could solve their problems.

5. Discussions and conclusions

The results of this study indicate that hospitalized chronically ill patients view hope in five different patterns differentiated on two axes—(a) external and internal orientation, and (b) present and future orientation as shown in Fig. 1. As shown in Fig. 1, the five patterns revealed combinations of different orientations on these two axes. Thus, hope seems to be experienced by putting emphasis on future or present possibilities, or focusing on self or others as its sources. This suggests that hope is not experienced necessarily in terms of a specific set of conditions or attributes but by how individuals view possibilities in their life-circumstances (or lives) and what sources they see as the primary ones to draw their hope. This means that individuals perceive hope in different ways, emphasizing different orientations to life. The sources of hope are different from one individual to another, and chronically ill patients in an acute care setting were able to articulate the experiences of hope even within the given “hopeless” situations of their illnesses. While the subjects in this sample in general seemed to be resigned about the “hopeless” states of their illnesses, they were able to articulate the nature of hope for them. In addition, although we identified five different patterns of hope in these patients, faith in God was commonly held as an

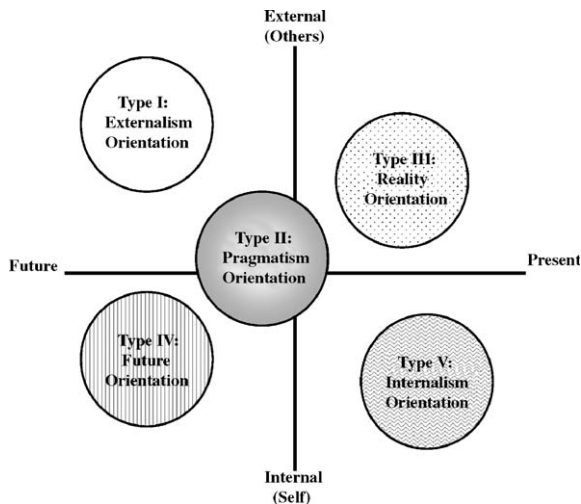


Fig. 1. Five patterns of hope for chronically ill patients.

important facet of hope by patients regardless of the pattern into which they were identified. God to these patients was not necessarily identified within a specific religious faith, but as an omnipotent and omniscient being that is capable of effecting changes in human condition and destiny. Since *Q*-methodology deals with operant subjectivity, these patients' orientations to God reside solely within the persons' meaning structures of hope. As stated by Brown, "there is no outside criterion for a person's point of view" (1980, p. 4).

Among the five patterns of hope, Type I (externalism orientation) and Type II (pragmatism orientation) were similar in their passive orientation to reality, but differed in projecting hope to different external entities. And, Type IV (future orientation) and Type V (internalism orientation) were similar in the sense that they were oriented to internal self. However, hope in Type IV (future orientation) seemed to be characteristic of fundamental hope specified by Marcel (1978) that emphasizes transcendental and intersubjective mutuality as the basis of hope. The patients in Type IV thus could have a trust in reality while being able to create future possibilities for themselves as the basis of hope. On the other hand, Type V (internalism orientation) seemed to emphasize achievement of autonomy or self-consciousness as the basis of hope. In a different way the patients in Type III (reality orientation) and Type V (internalism orientation) seemed to experience hope through perceiving evidences in reality or relying on cognitive causal processes accounting for such evidences. But they differed in finding such evidences externally (Type III) or internally (Type V). The five patterns of hope found in this American sample are similar to the seven patterns of hope found in a study using the same methodology with a Korean sample of chronically ill patients (Kim, 1992; Kim and Kim, 1997). The seven patterns in this

earlier study could also be located satisfactorily within the two-axial configuration, suggesting that the axis of internal–external orientation and the present–future orientation may be conceptual dimensions of hope for classifying individuals' experiences of hope. The difference found between the two studies is basically regarding the nature of external orientation, for which the American patients projected hope to God, while the Korean subjects' hope was projected to fate, indicating the different nature of beliefs regarding destiny and external control.

The conceptualization of hope adopted generally in nursing needs to be challenged on two accounts based on the findings of this study. The first point is related to the conceptualization of hope in which the structure of hope is identified to encompass goal orientation and realistic cognitive process (Wright and Shontz, 1968; Ersek, 1992; Morse and Doberneck, 1995) and the measurement of hope that includes goal orientation as an attribute (Farran et al., 1995). Contrary to such thinking, goal orientation as a key feature in structuring hope is not found in any of the patterns identified in this study. This may mean that hope in hospitalized patients with chronic illness is experienced differently, since "goal orientation" is often not a realistically possible notion given the uncertainty and limitations associated with chronic illnesses. Chronically ill patients may be inclined to seek hope not projecting to any specific goals but to other conditions and possibilities.

The second point of challenge is related to the conceptualization and measurement of hope that emphasizes a universal structure of hope. Since the result of this study suggests chronically ill patients experienced hope in different patterns, it may not be valid to "measure" the levels of hope based on a unified structure, as is the case with many of the available hope measurement tools. Many hope scales assume that hope is experienced in a similar pattern or structured about a set of universal attributes such as experiential, transcendental, rational, and relational components (Farran et al., 1995). Such instruments assume that hope is experienced universally in a same pattern regardless of people's life-circumstances, not differentiating the characteristic variations among patterns of hope. Since patterns of hope experienced by individuals seem to vary according to life-circumstances and individuals' orientations, and the patterns of hope in this study are found to be anchored on two axes, it may be more valid to consider hope assessment in terms of dynamic configurations differentiated according to axial anchoring and patterns, rather than as a measure of degree.

While the findings of this study and the literature suggest the value of conceptualizing hope as a qualitatively patterned experience, this study only gives a limited glimpse to understanding the phenomenon. There certainly is a need to gain further knowledge

regarding different patterns of hope that may be present in other life circumstances and in different population groups. Since the findings only pertain to this sample of American chronically ill patients, there also may be other patterns of hope that represent other chronically ill patients. Furthermore, in nursing there is a need to discover and identify patterns of hope individuals may experience in various life-circumstances, such as in acute or chronic illness, following life-threatening crises, with significant losses, during serious transitions in life, or in a terminal stage of illness. What it means is that further investigations are necessary to examine whether or not the two axes of differentiation identified in this study hold for the experience of hope in other life-circumstances. From such investigations it would be possible to develop a general theory of hope focusing on pattern differences, and to move toward developing hope inspiring strategies or nursing interventions that focus on individual patterns of hope experience under different life-circumstances. Furthermore, it would be possible to develop an assessment model for hope that can account for different patterns and characteristics of variations within different patterns.

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