HOPE AND THE ELDERLY INDIVIDUAL: CLINICAL ASSESSMENT AND HOPE FOSTERING STRATEGIES FOR THE ADVANCED PRACTICE NURSE IN PRIMARY CARE

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KATHRYN GRAY

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By

Kathryn Gray

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ABSTRACT

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Hope has been described as a basic human need essential for life. Hope as a concept specific to elderly individuals is unique from hope experienced by others since expectations for the future are less certain. Literature references the obligation of nurses to instill, maintain and restore hope to their patients. This responsibility requires that nurses understand the essence of hope, recognize the observable manifestations of hope and possess the resources to provide interventions to guide hope for the elderly individual.

Hope assessment used by the Advanced Practice Nurse in primary care is a means of evaluating quality of life of an elderly individual. Quality of life equates a maximized mind-body-spirit health potential for the elderly individual.

The APN will strengthen hope for the elderly individual by possessing knowledge of the multidimensional aspects of hope, by using formulated questions designed to assess for the presence of hope and by choosing strategies to facilitate that hope. The APN can then enable the elderly individual to mobilize hope for personally meaningful future fulfillment.

"Hope" is the thing with feathers
that perches in the soul
and sings the song
without the words
and never stops
at all.

E. Dickinson

ACKNOWLEDGMENTS

I would like to thank God for helping me to know hope. I would like to thank my family for helping me accept hope. I would like to thank my friends for fostering my hope. I would like to thank my committee for helping me to write of hope, especially Linda Keilman who always offered hope.

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"Hope springs eternal." "Where there is life, there is hope." Old proverbs, personal experience, philosophical and theological references and current research studies of the concept of hope lead one to believe that hope is a basic human response essential to life (Stephenson, 1991). Hope is associated with the meaning of life, "for we are saved by hope," Paul wrote in Romans 8:24, (Good News Bible [TEV]. 1976, p. 210).

Hope is an accepted component of nursing care. Obligations of the Advanced Practice Nurse (APN) are frequently outlined in terms of instilling, maintaining and restoring hope (McGee, 1984). Stephenson (1992) believes that fostering hope is one aspect of the professional nurse's role. Beginning with the writings of Florence Nightingale (1859), many references describe the importance of nurses understanding the concept of hope in their patients. Watson (1979) has identified hope as both a "curative and carative" force within the nursing process. Hope is considered to have therapeutic effects upon patient outcomes and nurses are said to positively effect the hope levels of their patients (Hinds, 1989).

The therapeutic value of hope has been implicated across a broad spectrum of health related issues as a factor in accepting illness-related infirmities such as cancer coping strategies and regaining health during recovery in spinal cord rehabilitation or substance abuse (McGee, 1984; Dufault & Martocchio, 1985). Unfortunately, very few authors have chosen to focus on the influence of hope for the elderly individual. Currently, most studies on the concept of hope have been based on adults of middle-age or the young (Herth, 1993).

Clinical observations and patient care experiences influence the belief that the concept of hope is an essential component in caring for older adults, but the empirical knowledge base about how to actually promote hope in elderly individuals remains elusive (Farran & Popovich, 1990). With the population of persons over 65 increasing dramatically, it is imperative that APNs, and other health care professionals, understand the concept of hope in order to assess an individual's hope status and to create an environment of hopefulness for the elderly. Quality of life is diminished when there is loss of hope combined with narrowing of goals and expectations for life (Herth, 1993).

Problem Statement

Hope is an ill-defined concept. At best it is a simple, universally understood human phenomenon. At worst, it is "soft" and abstract, ethereal and difficult to measure. The North American Nursing Diagnosis Association

(NANDA), (1992) delineates hopelessness as a nursing diagnosis, but not hope. Studies do not exist which agree on a definition of the concept of hope nor do studies reflect a broadly accepted criterion instrument measure of hope.

The APN may not consider hope as a quality of life parameter nor possess a baseline of knowledge to recognize the attributes of hope in the elderly individual. Recognizing the observable manifestations of hope and assessing for the presence of hopefulness is important for the APN to plan interventions for instilling, maintaining and restoring hope to the elderly individual. To avoid hopelessness, to promote successful aging and optimize quality of life for the elderly individual, the APN must be able to intervene with strategies to promote hope.

Many nurse clinicians and researchers respect the importance of hope in quality of life issues, yet a clinical basis for evaluating hope of the elderly individual is almost non-existent. Defining hope in relation to a future of goal achievement, personal success and control may be unrealistic to a generation of persons experiencing loss, health problems and a decreasing ability to care for themselves. Therefore, the problem of defining the concept of hope is further complicated by the perspective of age. Farran, Salloway and Clark (1990) suggest that for the older adult, hope has a different meaning than for those of a younger age strata. Older individuals may need to rely on

different methods and strategies for maintaining or regaining hope.

Because elderly individuals are unique in hope perspectives, the APN must possess a broad knowledge along the continuum from hope to hopelessness. The presence of hopelessness indicates that there is something awry perceptually; that needs or goals have not been met, that life or situations have become difficult or intolerable to the elderly individual (Farran & Popovich, 1990). Consequences of the absence of hope have been repeatedly demonstrated in psychiatric research, associating hopelessness with discouragement, despair, helplessness, depression and suicide (Farran & Popovich, 1990). The APN is challenged to recognize a negative expectancy of the future and to intervene in ways that assist the elderly individual to move through hopelessness toward hope.

The importance of quality of life health, inclusive of mind-body-spirit is embraced by nursing. Farran & Popovich (1990) suggest that hope can be maintained or regained for the elderly individual when physical, psychological and spiritual aspects of life are addressed. According to Watson (1988), instillation of faith and hope does facilitate the promotion of wholistic nursing care. The relationship between the APN and the elderly individual promotes hope through caring, a complex process with potential for maximizing quality of life through finding

meaning in one's own existence and discovering inner power and transcendence for self-healing (Watson, 1988).

The APN must appreciate the impact they themselves have upon the perception of hope of their elderly clients. During the patient-caregiver relationship, "the hopefulness or hopelessness of either the patient or the caregiver affects the other in the relationship," (Raleigh, 1992, p. 444). The therapeutic value of the APN as a source of hope is not usually emphasized, however family, friends, God and health care professionals are the most frequently identified sources of hope (Herth, 1993). "The reality for some isolated older persons is that professionals are the main source of social support," (Farran & Popovich, 1990. p.127). Recognition of this relationship component should heighten awareness for the APN of the responsibility inherent in nurturing the elderly individual's perception of hope.

Statistics compiled by the American Association of Retired Persons (AARP) reveal that the population of individuals 65 years of age and greater, numbered 33 million in 1994 and will more than double to 70.2 million by 2030 (Fowles, 1995). The older population itself is getting older. The 65-74 age group was eight times larger than in 1900, but the 75-84 group was 14 times larger and the 85 and older group was 28 times larger in 1994. Individuals live longer and healthier which in turn reflect collectively more life experiences, more intrusion of change, more potential

for loss and grief or more opportunity for growth through the hope of personally meaningful future fulfillment.

Statistically, individuals over age 65 represent 12% of the population and incurred 36% of the total health care expenditures equaling over $162 billion (Fowles, 1995). Less than 5% of the elderly are in nursing care facilities or other institutional settings (Eliopoulis, 1990). This means that the majority of older individuals will live out their lives in the community. Many of these persons have at least one and many have multiple medical conditions. Needs that may arise for the elderly individual will be in the areas of prevention, self-care education, support and restoration for chronic problems. The needs are all within the realm of the APN in primary care (Eliopoulis, 1990).

Elderly individuals striving for health of mind-body-spirit and APNs who strive to assist them achieve optimum quality of life need common parameters to appreciate the importance of hope as a carative and curative factor. It is essential that the concept of hope be understood and that strategies be recognized and encouraged which may help the older adult to maintain, instill or restore hope. If clinical indicators are outlined for the professional provider and hope fostering strategies are offered to the elderly individual which contribute to the optimism of hope, then the APN can utilize the opportunity to offer guidance towards attainment of health and well-being of an ever-growing, aging population.

"Nursing is accountable for managing the response to actual or potential health problems, and hope is one potential response," (McGee, 1984, p.43). Understanding the importance of hope to the quality of life of the elderly individual will enable the APN to identify specific intervention strategies to instill, maintain or restore hope. The APN can then act as a catalyst to create internal and external conditions which foster hope, to develop and promote hope resources and to minimize hope inhibitors.

Purpose

The purpose of this project is threefold: 1) to inform the Advanced Practice Nurse (APN) about the multidimensionality concept of hope as it applies to the elderly individual; 2) to offer specific hope-assessment questions to be used as guidelines during the psycho-social history interview with an elderly individual to determine the presence of hope during a primary care occasion; ad 3) to identify hope fostering strategies which assist the APN in selecting appropriate interventions to mobilize, support and enhance hope for the elderly individual.

Hope is a health care parameter which can serve as a basis for establishing quality of life dimensions. The more clearly the APN in primary care conceptualizes hope, the more definitive the applications for fostering hope in the care of the elderly individual. Assessment data on the individual's perception of hope serves as a foundation for estimating general well-being and optimum quality of life.

Interventions can then be designed to strengthen the hoping process without giving unrealistic reassurance.

Specifically, four (4) questions were developed to be asked of the elderly individual during the subjective psycho-social history interview by the APN in a primary care setting. These questions will be established as representative assessment indicators of hope in the elderly individual. These questions can serve as guidelines allowing the APN to evaluate the presence of hope in the elderly individual and, strengthened by guideline criterion, prepare the APN to offer viable strategies to instill, maintain and restore hope specific to the quality of life needs of the elderly individual.

The APN in primary care is in a unique position to positively impact quality of life for the elderly individual and to encompass the wholistic health approach of mind-body-spirit wellness. According to Watson, (1988), this reflects the true essence of nursing.

Definitions and Description of Terms

"Hope" is derived from the Latin root *speare*, meaning "to hope," (Webster, 1978). It is used as both a noun and a verb. As a noun, hope is defined as (1) a feeling that what one desires will happen; (2) the thing hoped for; (3) a cause of hope, a person or thing that gives hope to others or that others have hope in; (4) the ground for expecting something/promise," (Stephenson, 1991, p.1457). When used as a verb, hope is defined as "trust, reliance, desire

accompanied by expectation or belief in fulfillment, (Stephenson, 1991, p.1457).

Contextual usage of the word hope appears in literature from theology, philosophy, psychology, psychiatry and nursing. Hope is discussed as a theory, as a human dimension necessary for progressive development and as a source of meaning for existence. Implicit to the concept of hope are two conditions: 1) the desire for some good and, 2) the ability to look to the future with expectation (McGee, 1984).

Hope is considered an active process involving the interaction of a person's thoughts, feelings, actions and relationships. The cognitive component involves visualizing a future that does not yet exist and the calculation of outcome probabilities which provide grounding for the state of hope (Dufault & Martocchio, 1985). Emotions associated with hope reflect the state of feeling positive or feeling `good,' uplifted, inspired or nurtured. Hope is associated with the "feeling of confidence diluted by a degree of uncertainty," (Stephenson, 1991, p.1458).

The behavioral aspects of hope are reflected in the ability of hope to lead to self efficacy; the greater the perceived expectation of goal attainment, the more likely the individual is to achieve a goal (Stephenson, 1991). This implies that hope is a prerequisite to effective coping and adaptation behaviors. The resource relationship component of hope stresses the belief that help is available

to the individual from God, from other people or from other living entities (Dufault & Martocchio, 1985). Hope reflects an internal sense that assistance exists and allows the individual to move from a position of self-reliance toward that of support seeking from another source.

Dufault and Martocchio (1985), conceptualized hope as having two spheres of abstraction, the focus of hope being either a generalized or a particularized object or outcome. Generalized hope is the sense of a beneficial future, broad in perspective and not linked to any specific concrete goal. "Generalized hope protects against despair...and preserves the meaningfulness of life...like an intangible umbrella...that protects by casting a positive glow on life," (Dufault & Martocchio, 1985, p.380).

In contrast, particularized hope is directed toward a specific valued outcome or hope object. These objects of hope may be abstract or concrete, explicitly stated or merely implied (Dufault & Martocchio, 1985). Characteristics of particularized hope include the expectations that present circumstances can be improved upon, desired expectations are attainable; that desired circumstances will occur and what is currently valued in the present can also be part of the future. The person experiencing a particularized hope believes that unfavorable possibilities will not occur, (Dufault & Martocchio, 1985).

For the operationalization of this project, the definition of **hope** used was Stephenson's (1991): "Hope is a

process of anticipation that involves the interaction of thinking, acting, feeling and relating and is directed toward a future fulfillment that is personally meaningful," (Stephenson, 1991, p.1457). This conceptual definition of hope encompasses the attributes of hope for health of mind-body-spirit and is generalizable to the unique needs of the elderly individual for personal fulfillment without the particularized restriction of specific goal achievement or time orientation.

Quality of life is an attribute of health reflected by optimum wellness of mind, body and spirit and is considered in this project as distinct from quantity of life. Hope is positively correlated with quality of life (Frankl, 1959; Miller & Powers, 1988). Quality of life results in enhanced physical, mental, and spiritual functioning and is vital for promoting health and healing (Farran, Herth, & Popovich, 1985).

Elderly individuals are identified as those individuals over 65 years of age and cognitively oriented. For the purposes of this project, it is assumed that elderly individuals have experienced changes in their health, self-concepts or roles to render them susceptible to alterations in levels of hope (Herth, 1990).

Primary care is defined as care that a client receives when initially approaching the health care system and maintained throughout the continuum of care (Flynn & Heffron, 1988). Diagnosis and treatment of illnesses and

injuries, prevention of illness plus health promotion, maintenance and management of health are responsibilities of the APN. The APN as primary care provider functions as client advocate with an emphasis on wellness. The responsibilities of the APN in primary care include assessment, planning and evaluation of family and clients' abilities to cope, adjust and adapt (Given, 1996). APN responsibilities encompass the need to assess for the presence of hope, intervene to instill, maintain and restore hope and evaluate the outcome of these hope strategies.

Clinical indicators are considered those assessment guidelines by which an APN in primary care can find direction for making a judgment or decision toward a course of action during the assessment of hope. **Hope fostering strategies** are those plans and directions advantageous in facilitating the desired outcome of hope for the elderly client.

These definitions are utilized to show that hope is an essential quality of life parameter for the elderly individual. The APN in primary care possesses the ability to assess for the presence of hope in the elderly individual and can instill, maintain and restore hope through strategic interventions during a transpersonal caring occasion.

Conceptual Framework

Nurses care for persons inclusively of mind, body and spirit. The concept of hope is explored as it occurs during interactions in the primary care setting between the APN and

the elderly client. The importance of such a "caring occasion" is emphasized utilizing the theory framework of Jean Watson (1988).

Using the framework of Watson is helpful for the study of hope since the philosophy of Human Science and Human Care (1988) delineates hope as a nursing care guideline. Watson's metaphysical theory requires the professional nurse to work with persons in achieving a higher degree of harmony within the mind, body, and soul by offering hope through caring responsiveness to another's feelings and problems. Watson (1988) places emphasis on the importance of hope as caring component #2 within the ten `Carative Factor' guidelines:

1. Forming and acting from a humanistic-altruistic system of values
2. Enabling and sustaining faith-hope
3. Sensitivity to self and others
4. Helping-trusting human care relationship
5. Acceptance of expression of positive and negative feelings
6. Systematic, creative problem-solving caring process
7. Transpersonal teaching-learning
8. Provision for a supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment
9. Assistance with gratification of human needs
10. Allowing for existential-phenomenological and spiritual dimensions of caring and healing

These carative factors are actualized during any person-to-person contact as the APN participates with and cares for the elderly individual, regardless of the type or intensity of contact. The `transpersonal caring' model is the basic principle of Watson's philosophy. The caring-healing consciousness-experience between the APN and the patient is a phenomenological experience contained within a single caring moment when hope is maintained. Watson labels this moment, "the actual caring occasion," (Figure 1).

Watson (1988) states that the nurturing of faith and hope facilitates the promotion of wholistic nursing care through encouragement of an increased desire for wellness and through promotion of positive healthcare behaviors. The assumption follows that the APN can have a positive influence in the manifestation of hope of the elderly client during an actual caring occasion. The ultimate goal of the APN is to identify "an optimal or motivational level of hope," and to augment physical, mental and spiritual coping mechanisms (McGee, 1984, p.34).

This readily fits into the paradigm of Watson's theory framework. From the causal past, the APN brings personal experience of hope, knowledge of the concept of hope, experience in assessing the person's level of hope, and guidelines for instilling, maintaining and restoring hope to the primary care setting. The elderly individual brings his or her perceptions of the probability of achieving a given outcome, which may range from hopefulness to hopelessness to

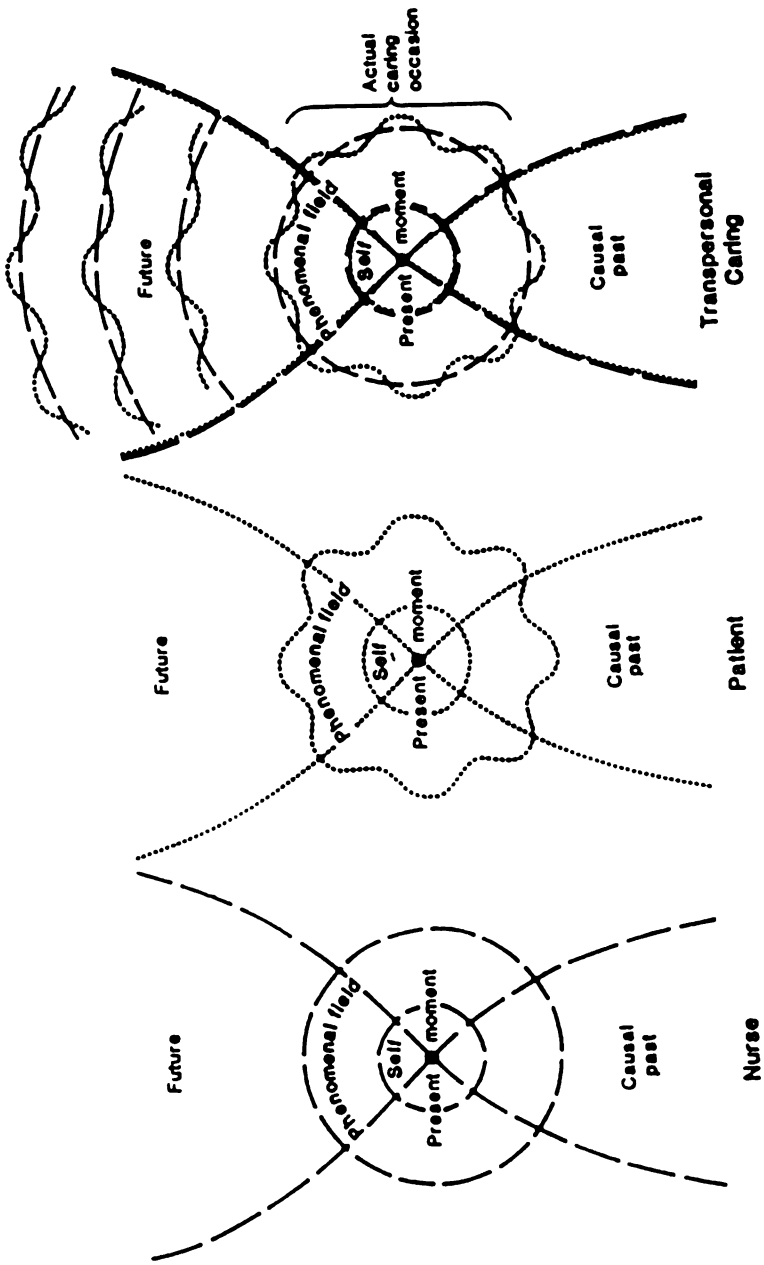

Figure 1. Watson's Model of Transpersonal Caring

the phenomenological field in the present moment. Then together, during the actual caring occasion, the `self' elderly individual and the `self' APN relate their individual phenomenological fields through a discussion of hope directed toward a future fulfillment that is personally meaningful (Figure 2).

To place the concept of hope within Watson's model inclusive of mind-body-spirit orientation, it is important to understand the multidimensionality of hope as described by such researchers as Dufault & Martocchio (1985). These dimensions include recognition of hope as having separate levels of cognitive and behavioral functioning, temporal perception and relational perspectives to self, to others, to the environment and to spirituality.

For the purposes of this project, the guiding framework for assessment of hope for the elderly individual is based upon the work of Farran, Herth, and Popovich, (1995) and will be synthesized into the design model of Watson (1988). This framework provides a helpful acronym, H-O-P-E. Each letter of the acronym incorporates one of four central attributes of hope synthesized from Dufault and Martocchio (1985), to encompass the multidimensionality of the concept.

H= Health (the experiential process)

O= Other (the relational process)

P= Purpose (the spiritual/ transcendence process)

E= Engaging Process (cognitive process)

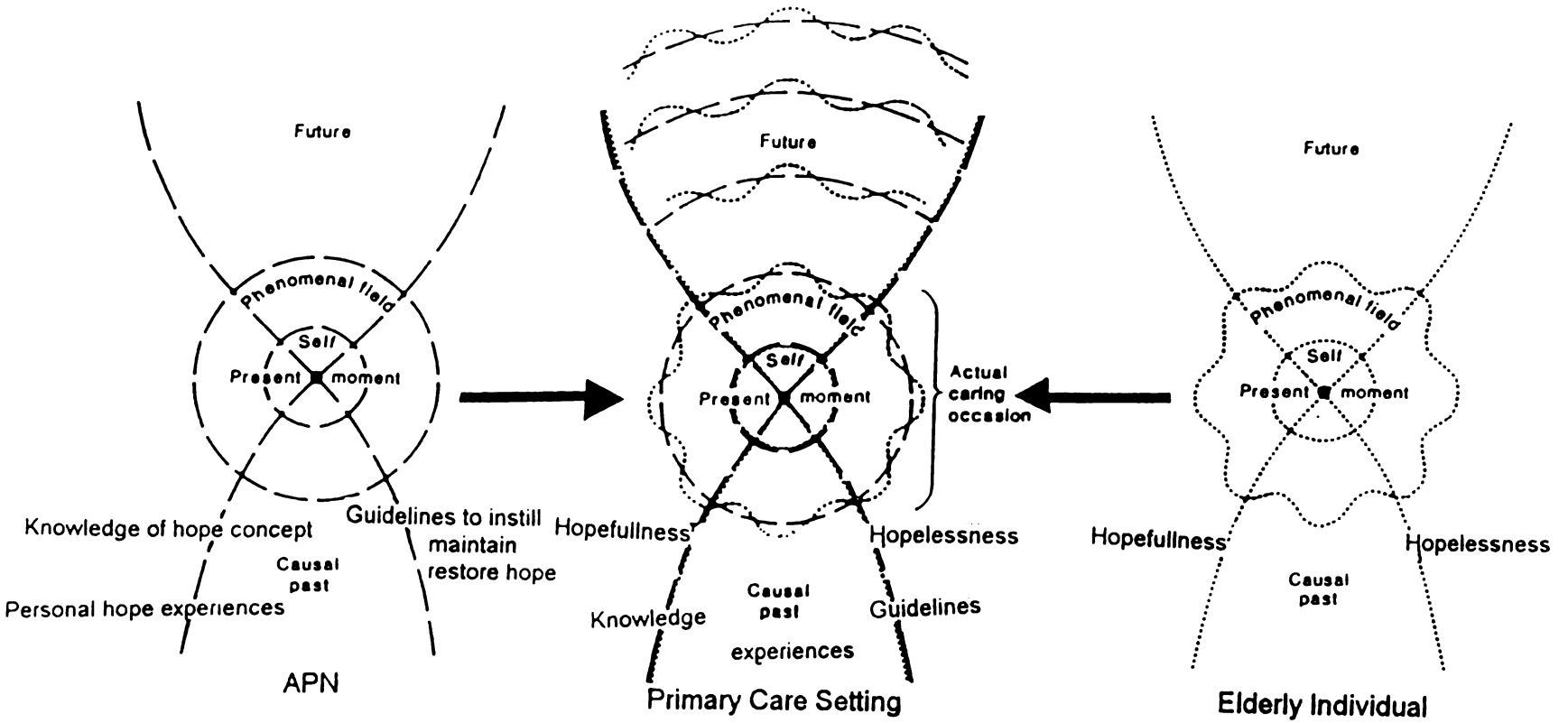

Figure 2. Adaptation of Watson's Model Showing the APN and the Elderly Individual in Primary Care

The "H" in the HOPE acronym represents health. During the caring occasion, the APN determines the older clients' general health, taking into account the chief complaint, the history of present illness and chronic conditions which affect their physical and mental health. It is also necessary to determine the patients' perceived state of health or wellness, since the elderly individuals' perception of health challenges their hope structures (Farran, Herth, & Popovich, 1995). In other words, the perceived state of the older clients' health will affect how the individual experiences hope. "H" representing health equates with the experiential component of the four attributes.

The "O" of the acronym framework represents others. The importance that others play in the maintenance of hope is well supported in the literature (Dufault & Martocchio, 1985; Herth, 1989; 1992; 1993; Hinds, 1984; Leetun, 1996; Miller, 1989; Raleigh, 1992; Stoner & Keampfer, 1985). It is important for the APN to determine the connectedness of the elderly individual to family, friends and community, and to determine if the relationships are positive. The actual and perceived state of the elderly individual's relationships will affect how they experience hope. The "O" representing others relates to the relational component of the four attributes.

The "P" from the acronym designates purpose (Farran, Herth, & Popovich, 1995). Meaning or purpose in life

relates to the transcendent aspects of spiritual or religious beliefs. Faith and/or meaning in life are regularly mentioned as sources of hope in research studies (Farran, Herth, & Popovich, 1995; Herth, 1990; 1991; 1993; Hinds, 1984; Miller, 1989). Assessment of purpose in life for the elderly individual involves recognizing their source of hope for spiritual reflection. Transcendent spiritual consciousness for elderly individuals involves getting to know parts of their lives that are unseen, delving inward amidst a deepening connectedness with nature, God or a Higher power (Leetun, 1996). The perceived state of the older clients' spirituality will affect how the individual experiences hope. The "P" of purpose represents the spiritual transcendence component of the four attributes.

"E" in the HOPE acronym represents engagement and the cognitive thought process (Farran, Herth, & Popovich, 1995). Rational thought processing involves goal formulation and outcome probability testing necessary for the elderly individual to maintain hope. It also encompasses the cognitive strategies such as affirmation, positive memory recall, and hopeful visualization. Lightheartedness and the use of humor are powerful cognitive strategies that can be utilized if hope should vacillate or falter, or if goals need to be refined or refocused (Gaskins & Forte, 1985; Herth, 1990; 1993; Leetun, 1996; Miller & Power, 1988). Goal perception and the use of these other cognitive engagement strategies must be evaluated by the APN while

assessing the cognitive engagement process of the four attributes (Figure 3).

The framework enables the APN to quickly assess the presence of hope in a clinical setting during an actual caring occasion. The HOPE acronym also allows the APN to differentiate between the dimensions of mind-body-spirit which may or may not be concurrent.

To facilitate the comprehensive assessment of the cognitive dimensions, Farran, Herth, and Popovich (1995) suggests a HOPE companion acronym: GRACT. This acronym helps the APN to remember assessment of the elements of the cognitive engagement process of HOPE, including the older individuals' perception of goals, his/her resources, action potential, and perception of control and of time.

G = Goal. Cognitive goal outcome or goal object identification and the probability of achievement of those goals includes priority setting among various goals, flexibility of those goals and establishing that goals are reality-based.

R = Resources. Both internal and external resources possessed by the elderly client must be assessed. Internal resources include personal attributes of courage, determination and optimism plus knowledge and use of cognitive strategies such as humor and positive self-talk. An internal resource necessary for assessment of the elderly is the level of energy and attention span. External resources to consider for assessment include the

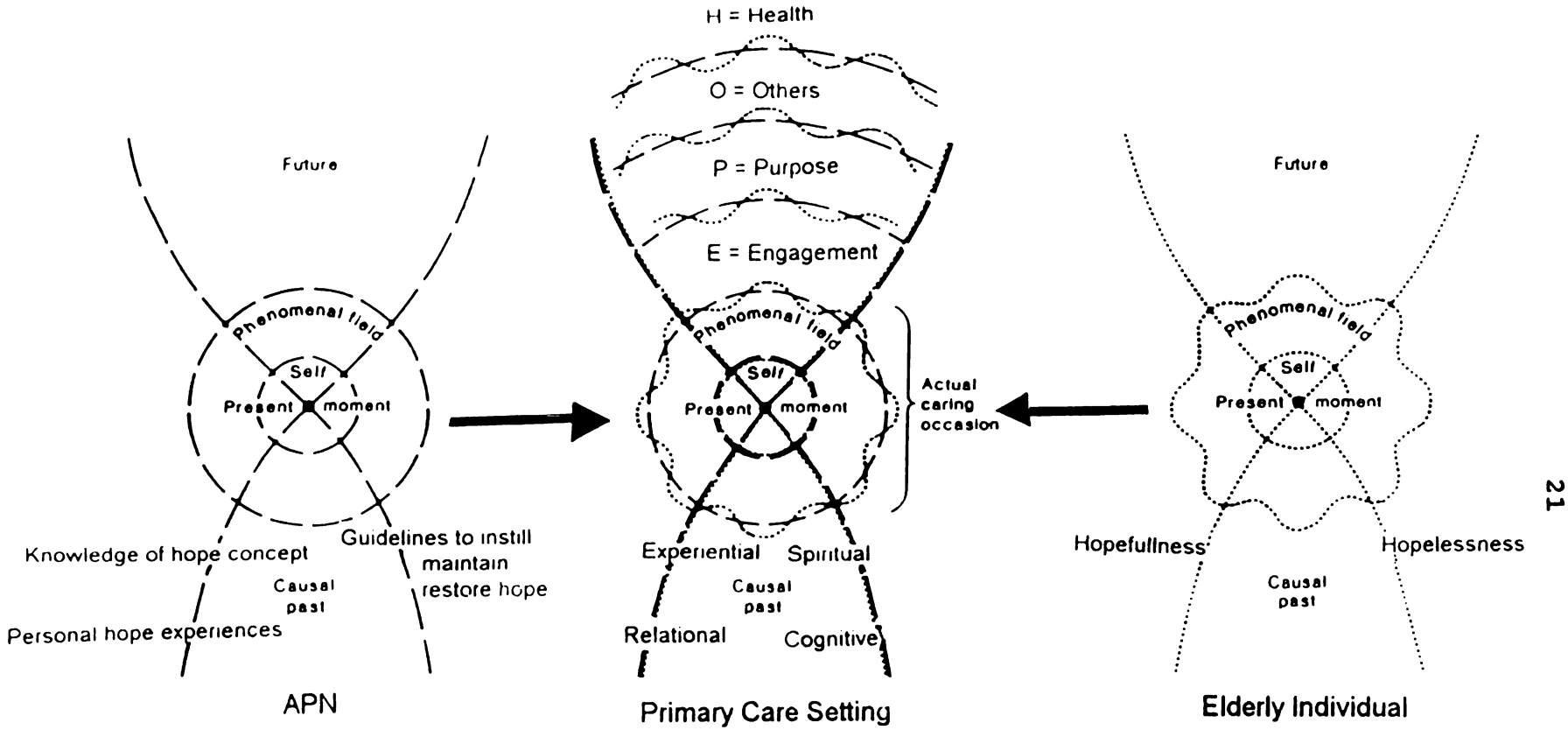

Figure 3. Adaptation of Watson's Model and the HOPE Framework.

availability and usefulness of support systems, both human and material. It is also important to determine the elder clients' willingness to utilize assistance that may be available.

A = Action. Hope involves action (Farran, Herth, & Popovich, 1995). This is in sharp contrast to hopelessness which by definition is absence of activity toward a goal (NANDA, 1992). It is important for the APN to assess the elderly clients' initiation of activity towards achieving the goal.

C = Control. The sense of control that the elderly individual perceives has been implicated by several authors as important to the maintenance of hope (Miller, 1988; Nowotny, 1989). During assessment of control, the APN must evaluate the individual's need for control, what specific areas of control are desired and whether that desire for control is realistic.

T = Time. Temporal orientation and the definition of time must be assessed to determine whether hope for the elderly individual is based on the past, present or future. Past experiences are suggested by researchers as the basis for confronting present and future experiences (Dufault & Martocchio, 1985; Farran, Herth, & Popovich, 1995; Herth, 1993; Miller, 1989). The APN must be aware that time passage to an aging individual is not necessarily minutes, days or years, but may be in relation to activities completed, events anticipated or the "eternal" future.

Using specific knowledge of the HOPE acronym for assessment presence of the four attributes of hope and remembering GRACT to more specifically assess cognitive hope, the APN will enter the actual caring occasion with the elderly individual in the primary care setting. From the causal past, the APN brings personal experience of hope, knowledge of the concept of hope, experience in assessing the person's level of hope, and guidelines for instilling, maintaining and restoring hope. The elderly individual brings his or her perceptions of hopefulness or hopelessness regarding a given outcome. Together, during the actual caring occasion transpersonal relationship, the elderly individual and the APN relate their individual phenomenological fields through a discussion of hope directed toward a future fulfillment that is personally meaningful (Figure 4).

Review of Literature

The objective of this literature review is to provide a synopsis of the research studying the concept of hope, the meaning and definition of hope, the assessment of hope and how assessment of hope relates to the elderly individual. The hope research described in Table 1 includes the population, the applications of hope for the particular study and identifies hope attributes described.

A thorough review of the literature reveals no studies relative to hope and the elderly individual in the primary

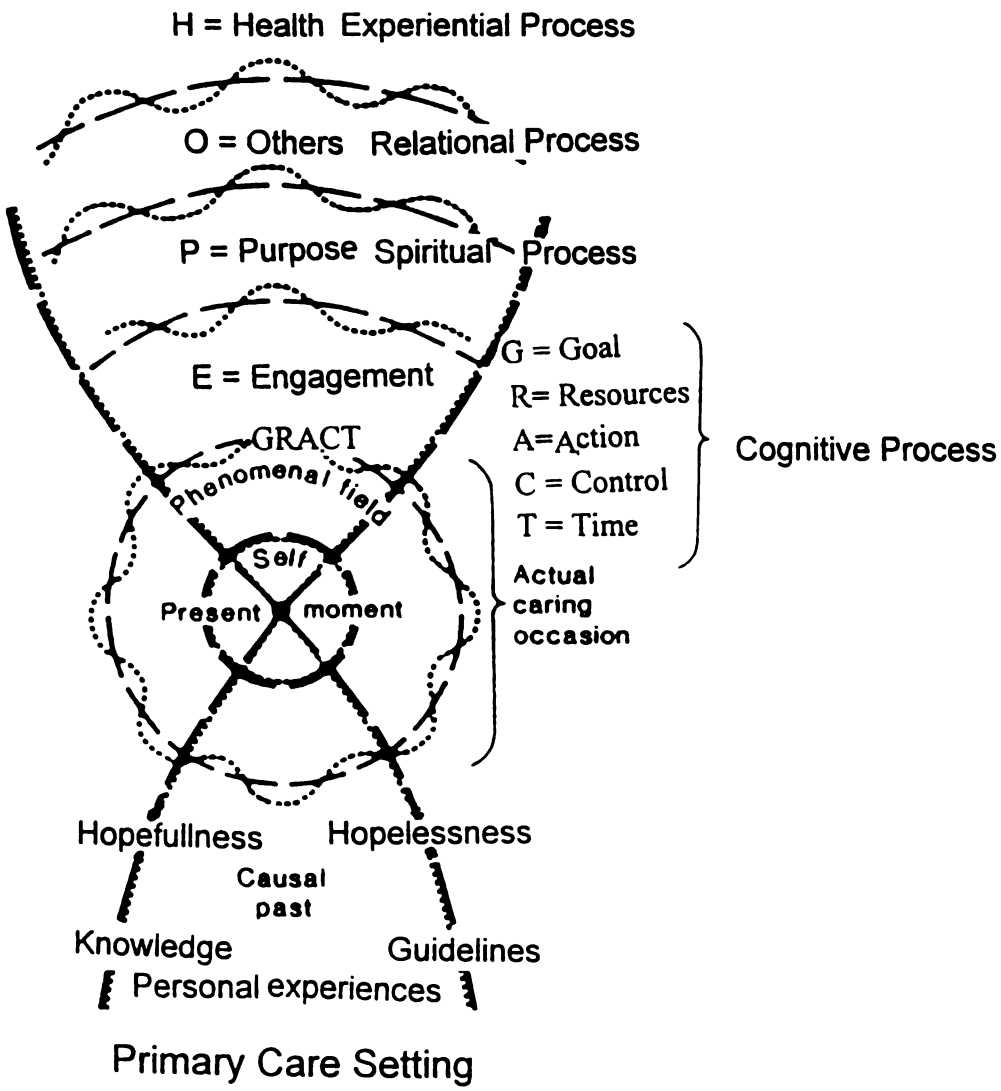

Figure 4. Adaptation of the Watson HOPE/GRACT framework.

Table 1.

Chronology of Hope Studies Showing Application and Attributes Used

Year	Investigator	Population	Hope Application	Hope Attributes Studied
1974	Beck, Weisman, Lester & Trexler	Hospitalized suicide attempts (N=294)	Hoplessness scale development ("Hopelessness Scale")	Negative future expectancies
1982	Stoner	Adult cancer patients (N=55)	Hope scale development ("Stoner Hope Scale")	Goal attainment probability of 20 "domains"
1984	Hinds	Hospitalized substance abuse adolescents (N=25)	Construct definitions	Hope continuum
1985	Dufault & Martocchio	Hospitalized elderly cancer patients (N=35)	Construct definition	Multidimensional conceptualization: "2 spheres/6 dimensions"
1988	Miller & Powers	Well adult students (N=522)	Hope scale development ("Miller Hope Scale")	Multidimensional: "6 factors" measured on continuum
1989	Nowotny	Adult cancer patients (N=150) Well adults (N=156)	Hope scale development ("Nowotny Hope Scale")	Multidimensional: "6 factors" measured on continuum
1989	Greene	Female psychiatric patients (N=60) (N=20)	Hopelessness without depression	Negative future expectancies/ relational connectedness
1989	Herth	Adult chemotherapy patients (N=120)	Hope scale development for clinical use ("Herth Hope Scale")	Multidimensional: "3 factors"

Year	Investigator	Population	Hope Application	Hope Attributes Studied
1990	Farran, Salloway & Clark (Farran & Popovich)	Community based elderly individuals (N=126)	Stressful life events, social supports, control, physical and mental health	Multidimensional: (Stoner's Hope Scale)
1991	Herth	Adult cancer pts. (N=180) Well adults (N=185) Well elderly (N=40) Elderly widowed (N=75)	Fatigue level, activities of living, coping, grief resolution	Multidimensional: ("Herth Hope Scale")
1992	Herth	Acutely ill adults (N=70) Chronically ill (N=71) Terminally ill (N=31)	Hope scale development for clinical use of frail ("Herth Hope Index")	Multidimensional: "3 factors"
1993	Herth	Elderly individuals (N=60)	Functional ability, perceived energy & health status place of residence	Multidimensional: ("Herth Hope Index")

care setting. Similarly, there is a lack of research regarding the assessment of hope by the APN. The literature does reveal unanimous concurrence that nurses can impact the concept of hope in their patients (Dufault & Martocchio, 1985; Farran, Herth, & Popovich, 1995; Gaskins & Forte, 1985; Herth, 1992; Raleigh, 1992; Stephenson, 1992; Watson, 1988;). Literature claims that the effects of hope positively impact patient outcomes (Hinds, 1984). The difficulty in substantiation of these assertions prior to 1985 was the lack of a therapeutic definition for hope. Until the concept of hope was defined, it was not possible to measure the presence of hope in a clinical setting.

For the purposes of this project, hope is defined as a process of anticipation involving the interaction of thinking, acting, feeling and relating directed toward a personally meaningful future fulfillment (Stephenson, 1991). This multidimensional definition assumes four central attributes of the concept: 1) that hope is an experiential process; 2) that hope is a rational thought process; 3) that hope is a relational process; and 4) that hope is a spiritual transcendent process (Farran, Herth, & Popovich, 1995). How the definition of hope developed as researchers probed the role that hope plays in affecting the human condition will be presented. A chronological progression of hope research branches into both qualitative and quantitative methods as multidimensional definitions of hope evolve. With inclusion of multidimensional attributes, hope

research more clearly embodied Watson's theory of mind-body-spirit wellness and became clinically more pertinent to the APN in primary care.

Hope research has been accomplished by sociologists, psychologists, physicians and nurses. Much of it has been conducted with psychiatric populations and focused on hopelessness (Ferran, Herth, & Popovich, 1995). Many standardized psychometric instruments have been developed to explore constructs using physical and psychological variables (Beck, Weisman, Lester, & Trexler, 1974; Farran & McCann, 1989; Farran & Popovich, 1990; Greene, 1989; Miller & Powers, 1988; Stoner & Keampfer, 1985). Qualitative exploration has been done almost exclusively by nursing (Farran, Herth, & Popovich, 1995), using a variety of clinical populations at varying stages of health, socioeconomic status and age and more often emphasized definitions or aspects of hope itself (Dufault & Martocchio, 1985; Gaskins & Forte, 1985; Herth, 1992; Raleigh, 1992; Stephenson, 1992).

Ironically, early studies of hope were invariably written in relation to potentially hopeless experiential situations of captivity, suffering and powerlessness (Farran, Herth, & Popovich, 1995). In a noted seminal work, Frankl (1959) equated hope with meaning and value of life. His first-person observations of victims in Holocaust concentration camps described how individuals who possessed hope were able to endure the most inexplicable and degrading

circumstances, while those without hope soon perished. Frankl came to equate hope with having "meaning" in life and lack of hope as having no meaning. Nardini (1952) described American prisoners of war in Japanese camps hopefully transcending their suffering despite the hopelessness of those surrounding them. Survivors relied upon having the will to live and having the perception of self-worth despite inescapable qualities of the environment.

Psychiatric populations are found to be the most frequently examined cohort (Farran, Herth, & Popovich, 1995). Studies of hospitalized suicide attempters (N=294) were studied and resulted in development of the Beck Hopelessness Scale (HS), (Beck, Weisman, Lester, & Trexler, 1974). Beck evaluated negative expectancies of future outcomes with hopeless individuals in a cross-sectional study. Correlations of suicidal intent and feelings of hopelessness prevailed. "Early studies frequently measured hopelessness using a single measure...[and] virtually all studies used the Hopelessness Scale" (Farran, Herth, & Popovich, 1995, p.123).

Theories developed which linked hopelessness as both a component and as a determinant of depression (Beck, Kovacs, & Weisman, 1975). Using 384 suicide attempters and the HS (Beck, Weisman, Lester, & Trexler, 1974), a correlational study related suicide and depression. This resulted in creation of the Beck Depression Inventory (BDI), still widely used today as a predictor of patients more likely to

commit suicide (Farran, Herth, & Popovich, 1995). Although items on the HS and the BDI were significantly correlated, ($r=0.69$, $p < .001$), Greene (1989) found that this did not account for a 50% variance in the responses to the two scales among severely depressed female patients (N=60). Women with high depression but low hopelessness patterns were more likely to have young children or to have had recent positive life events (Greene, 1989). Despite the small sample size, the findings suggest that, depending upon contributing conditions, individuals may be depressed but not hopeless. This finding corresponds to the relational attribute of hope and the process of connectedness, (Farran, Herth, & Popovich, 1995).

Defining the concept of hope was the nexus of many early studies. Twenty-five well and hospitalized adolescents in a substance abuse program participated in defining the concept of hope through semi-structured interviews (Hinds, 1984). Grounded theory methodology was used to achieve precise construct definitions. Beginning with open-ended data gathering, coding and analysis of the data identified increasingly structured characteristics or categories of hope. The subjects described a continuum of hope spanning four hierarchical levels of believing, from a state of "forced effort" to "anticipation of a personal future," implying that hope occurs in incremental amounts (Hinds, 1984, p.360).

Stotland (1969) was one of the first to propose a clinical theory of hope as a measurable and active process. Stotland (1969) defined hope as having a probability greater than zero of achieving a goal, consequently, hopefulness reflected high expectation and hopelessness a low expectation of success (Stotland, 1969). The narrow conceptualization of hope as a single dimension of goal achievement provided a necessary step in the direction of single element measurement. However it does not conform to the multidimensional construct of hope, and without acknowledgment of the mind-body-spirit domains of hope, Stotland's definition is too limited for the APN.

McGee (1984) studied hope as a factor influencing crises resolution and offered an early multidimensional definition of hope through synthesis of earlier concepts (Stotland, 1969; Lynch, 1974). McGee defined hope operationally by: 1) recognition that a stimulus for action exists, 2) that the response to the stimulus may include feelings, thoughts, expectancies or actions regarding a state of being that is desired but not presently experienced, and 3) that probability calculation for successful solutions to the need is influenced by situational variables. McGee stated that calculated hope probabilities are the product of four aspects of the personal being: cognitive, psychological, social and physiological" (McGee, 1984).

Gains in nursing research were next evident with the work of Dufault and Martocchio (1985). They described an expanded model of the hope concept as a dynamic and multidimensional construct (Dufault & Martocchio, 1985). Data was collected through interviews and participant observations from 35 elderly cancer patients in a longitudinal 2-year study. Re-analysis during a second longitudinal study with terminally ill persons (n=47) allowed the authors to conceptualize hope as an active process with two spheres; generalized hope and particularized hope. The two spheres were contained within six separate areas; the affective, cognitive, behavioral, affiliative, temporal and the contextual dimensions.

The affective dimension of hope was described as focusing on the broad emotions and sensations of the hoping process (Dufault & Martocchio, 1985). This involves the attraction of the individual to a desired outcome and the personal significance of that outcome to the individual. It also encompasses the feelings of confidence or the uncertainty about the outcome (Dufault & Martocchio, 1985). The cognitive dimension focuses on the thinking processes of hope including identification of the hope object or the goal and the assessment of reality in judging probabilities of the outcome as realistically possible (Dufault & Martocchio, 1985).

The behavioral dimension refers to action taken in relation to hope. The affiliative dimension focused on the

individual's involvement beyond the self to other-connectedness. This included components of social interaction, self-transcendence by relationships with other persons or with a Higher Power/God. The affiliative dimension is activated as the hoping person seeks help or is willing to receive help from others.

The temporal dimension involves the individual's perception of time, past, present and future (Dufault & Martocchio, 1985). Keeping non-specific time is a protective device guarding the individual from disappointment if hope cannot be realized within a known time frame or when there is a perceived precariousness of time in relation to a limited lifespan, illness or age. The contextual dimension is relative to the hoping person's surrounding life situation including physical and emotional well-being, functional abilities, relationships and the ability to fulfill role expectations.

Variations on these six dimensions have evolved from author to author, but later researchers allow for at least three of the dimensions (Farran et al., 1995; Herth, 1987; 1992; Miller & Powers, 1986; Nowotny, 1986; Stoner, 1982). Although the work of Dufault & Martocchio (1985) is admittedly a very limited study without any attempt to explain the collected `clinical data,' the construct of dynamic multidimensional attributes of hope persist to current theory. Dufault and Martocchio (1985) represent the

most commonly cited source of all early research on the concept of hope.

Once a nursing model was synthesized to the multiple dimensionality definition, instrument scales were developed to measure the concept of hope. The Miller Hope Scale (MHS), (Miller & Powers, 1988) was developed by nurse researchers to measure multidimensional aspects of hope in well adults (N=522). The MHS is a 40-item, 5-point Likert scale with high scores related to high hope based on "ten critical elements," which conceptually relate to the four central attributes of hope (Farran, Herth, & Popovich, 1995). Strong internal alpha consistency was reported and criterion-related construct validity was well established (Miller & Powers, 1988). The MHS detects high levels of hope in individuals screened to have no physical or mental health problems and to those who report future goal orientation (Miller & Powers, 1988) but is not generalizable to the frail, elderly client with deteriorating health or mental status (Farran et al., 1995).

Development of an instrument to measure hope in the elderly individual evolved slowly as recognition became apparent that aspects of hope differed with those persons having limited energy or functional resources. Cancer patients represented the next most studied cohort in the examination of hope (Farran, Herth, & Popovich, 1995). The complexity and intensity of nursing required to care for cancer patients stimulated the interest of nurse researchers

in examination of many variables including constructs of anxiety, pain, fatigue, coping, psycho-social adjustment and impact on family. Several hope instruments have been developed specifically for cancer patient populations. These include the Stoner Hope Scale (SHS) (Stoner, 1982); the Nowotny Hope Scale (NHS) (Nowotny, 1989); the Herth Hope Scale (HHS) (Herth, 1991), and the Herth Hope Index (HHI) (Herth, 1992).

Stoner (1988) based collected data from cancer patients upon the statistical theoretical formulations of Stotland (1969) for instrument development. The SHS measures the importance of 20-future-goal domains of intrapersonal, interpersonal and relational achievements measured on a 4-point Likert scale. Validity was established with a strong negative correlation to the Beck Hopelessness Scale and internal consistency was reported reliable in a small, cross-sectional study with adult cancer patients (N=55). Conceptually, the SHS best represents the central attribute of hope consistent to the relational process, but is limited by itemizing very specific goal achievement items (Farran, Herth, & Popovich, 1995). It is also of questionable value to the elder populations or the chronically ill since several items measure the need for control of health and the availability of family or friends, neither of which may be within the elderly individual's realm (Stoner, 1982). Scoring of the SHS is also fairly complex since the outcome

is designed to measure probability as well as the importance of hope (Farran et al., 1995).

Nowotny (1989) developed the only multidimensional scale to measure levels of hope designated by standard deviations; hopeful, moderately hopeful, low hope and hopeless. The NHS was administered with the Hopelessness Scale (HS) (Beck, Weisman, Lester, & Trexler, 1974) to well adults (n=156) and to adults with cancer (n=150). Correlations for the 29 items demonstrated an internal consistency of .90 and component analysis resulted in identifying six factors: confidence, relations to others, possibility of future, spiritual belief, activity and involvement and hope that comes from within, (Nowotny, 1989). A strength of the NHS in use with the elderly is the reference to transcendence of limitations, "I think I can learn to adapt to whatever limitations I may have," (Farran, Herth, & Popovich, 1995, p.62.), but there is no reference to health status.

The HHS, (Herth, 1989) was specifically developed to capture the multidimensionality of the hope concept in a clinical setting and to be useful with individuals in acute, chronic or terminal stages of illness. The Dufault and Martocchio model of hope (1985) was the conceptual framework used to create the HHS, a 30-item, Likert four-point scale questionnaire. Herth (1991) combined the dimensions of hope described by Dufault and Martocchio (1985) into a framework of three "factors" for generating items on the HHS: 1)

cognitive/temporal factor- the perception that a positive, desired outcome is realistically probable in the near or distant future, 2) affective/behavioral factor- the feeling of confidence with initiation of plans to affect the desired outcome, and 3) affiliative/contextual factor- the recognition of the interdependence and interconnectedness between self and others and between self and spirit (Herth, 1992).

The HHS (Herth, 1989) was originally tested in three populations of cancer patients: a convenience sample of adults (N=20), a pilot sample of inpatients and outpatients (N=40), and a sample of inpatients receiving chemotherapy (N=120). Data from these studies were combined to further evaluate the psychometric properties of the instrument. Construct validity was achieved through factor analysis of the three combined-dimension aspects of hope. Alpha coefficients were .89, .85, and .84 for the cognitive/ temporal, affective/behavioral and affiliative/contextual factors respectively (Herth, 1991).

Using the HHS (Herth, 1990), hope and grief resolution was studied in a mail survey (N=75) intended to examine the relationship of supportive networks, coping skills, past and concurrent losses and hope. Elderly subjects who had been widowed from 12-18 months were chosen through simple stratified random sampling to assure that an equal number of subjects were obtained according to three settings: hospital, hospice and nursing home. A high hope level

accounted for 79% of the effective grief resolution variance. Factors related to greater hope measurements included adequate present income, good health, fewer than two concurrent losses, a longer duration of spouse's illness, and frequent visits by family members. Subjects whose spouse had died in a hospice had significantly better grief resolution and higher levels of hope (Herth, 1990).

Utilization of any of the hope indices clinically requires reflection upon the amount of time, effort, and energy required of persons competing these instruments. Persons with potentially low hope levels such as the terminal cancer patient or the grieving elderly individual are necessarily persons with limited amounts of time and energy. Additionally, the effort and anxiety potential of the respondents confronting personal hope concepts and the discomfort of self-disclosure required suggests that researchers be cognizant of their subjects' vulnerability. The complexity and length of most existing instruments limit clinical utility for the frail elderly or for the client with diminished attention span.

For these reasons, the Herth Hope Index (HHI) was developed (Herth, 1992). The HHI is the adaptation that evolved from the Herth Hope Scale designed specifically for clinical use with individuals having limited resources of time, energy or effort (Herth, 1992). The objective of the tool is to capture the multidimensionality of hope represented by the HHS, but to reduce the number and

complexity of items and therefore render it more clinically useful. Twelve items were synthesized for the shortened instrument, paralleling the three dimensionality subscale factors of hope in the HHS. Larger than normal print type is used to improve readability for ill or elderly clients. The Likert-format items are scored on an ordinal scale from 1 to 4, where a score of 1 indicates "strongly disagree" and a score of 4 indicates "strongly agree" (Herth, 1992). Initially tested by a convenience sample (N=172) of ill adults, criterion-related validity was demonstrated by a high correlation with the original HHS (r=0.92), suggesting that the HHI is as comprehensive and reliable as the longer 30-item version. Further construct validity involved use of another comparison instrument, the Nowotny Hope Scale (Nowotny, 1989) and strong negative correlation with the Beck Hopelessness Scale (Beck, Weisman, Lester, & Trexler, 1974).

Support is given to the utility for clinical assessment of hope by the Herth Hope Index (HHI): "The potential usefulness [of the HHI] is great...and could potentially aid researchers or clinicians in the assessment of hope states within clients and in the evaluation of the effectiveness of hope-enhancing strategies," (Farran, Herth, & Popovich, 1995, p.63).

Because of its shortened length, multidimensionality construct and strong validity scoring, the HHI has been used repeatedly for hope assessment of elderly individuals.

Multiple studies of elderly populations accomplished in a variety of physical settings from long term care facilities to community based senior volunteers have been accomplished. The HHI has also been used with a variety of physical and mental capabilities of elderly individuals (Herth, 1992).

Older adults were studied to explore the meaning of hope and to identify strategies to foster hope (Herth, 1993). Sixty seniors were given the Herth Hope Index (Herth, 1992) and interviewed from three community living settings: private homes in urban areas, private homes from rural areas and residents from a senior citizen housing project. This study showed that the perceptions of hope were influenced by place of residence and energy level (Herth, 1993). With the exception of those experiencing severe fatigue or those residing in a long term care facility, these elderly individuals were found to experience high levels of hope despite age, functional ability or health status. Tukey HSD post hoc comparison procedure indicated that participants residing in long-term care facilities and experiencing high fatigue did have a significantly lower level of hope ($p > .05$) than those in any other category (Herth, 1993).

Herth (1992) believes that older persons rely on different methods of maintaining or regaining hope than younger persons and that "an inner power ...facilitates the transcendence of the present situation and enables a reality-based expectation of a brighter tomorrow for self

and/or for others," (Herth, 1993, p.151). This shift or refocusing of hopes was apparent in participants experiencing ill health or functional status decline. Whereas plans for a long future were abandoned, hope in the present was strong (Herth, 1992). Herth (1993) found that elders view hope as a process that "facilitates the transcendence of the present situation and enables a reality-based expectation" (Herth, 1993, p.151). Herth's findings suggest that hope is not dependent upon functional ability or health status since hopeful elderly individuals are able to "shift" or refocus hope to the present moment. In the process of overcoming stressful life events inevitable with aging, such as illness, infirmity, loss and grief, elderly individuals "choose to realize that meaning and purpose in life are possible despite the stripping process that accompan(ies) aging..." (Leetun, 1996, p.60).

Herth's study (1993) also suggests that caregivers extending hope fostering strategies can have positive impact on the level of hope experienced by older and frail adults (Farran et al., 1995). Herth elaborated eight categories of hope-fostering strategies derived from the four attributes: 1) inter-connectedness with self/others/the world, 2) purposeful activities, 3) uplifting memories, 4) cognitive strategies, 5) hope objects, 6) refocused time, 7) lightheartedness, and 8) spiritual beliefs/practices.

The concept of hope and elderly populations are used in several other studies (Farran, 1985; Farran & McCann, 1989;

Farran & Popovich, 1990; Farran, Salloway, & Clark, 1990). Using the Stoner Hope Scale (Stoner, 1982) and the Beck Hopelessness Scale (Beck, Weisman, Lester, & Trexler, 1974), Farran and McCann (1989) positively correlated physical and mental health with levels of hope in 126 community-based older adults. Individual factor analysis of the data from the specific instruments chosen revealed that different conceptual dimensions were reflected by each scale (Farran & Popovich, 1990). This underscores the importance of choosing the appropriate scale to evaluate conceptual dimensions (Farran & Popovich, 1990).

Farran and McCann (1989) proposed using hope as a function of all other variables including physical and mental health, social support, personal control, stressful life events, activities of daily living and religiosity. Farran used the same older adults longitudinally 2 years later despite a 43% attrition rate related to death, nursing home placement and illness (Farran & Salloway, 1990). Examination of variables from Time 1 and Time 2 revealed that interpersonal control, stressful life events and activities of daily living at Time 2 were the best indicators of physical health at Time 2. Furthermore, hope measured at Time 1 was the best indicator of mental health at Time 2. The best predictors of hope at Time 2 were mental health, religious beliefs and social supports at Time 2. This was felt to exemplify the complexity of the

relationships between hope and other physical and psychosocial variables (Farran, Herth, & Popovich, 1995).

A creative study using photo-assisted interviews identified sources of hope in older adults (Gaskin & Forte, 1995). A small convenience sample (N=12) of older adults living in their communities were given a 12-exposure camera with automatic flash and instructed to photograph anything that gave them hope. The photos were coded into groups representing specific themes. Spirituality was the theme most frequently identified, and often referred to when discussing pictures of nature. Although participants identified very personal sources of hope, the associated concepts represented consistency throughout the sample. A strength of this limited study was the development of hope fostering strategies developed from the theme clusters including flexible visiting hours and overnight visits with family members to Bible discussion groups and nature exploration (Gaskin & Forte, 1995).

The development of instruments to measure the elusive and intangible concept of hope is crucial to both the APN researcher and the APN in clinical practice. From the research perspective, the ability to assess the presence of hope in the elderly contributes to understanding how and when hope exists and the predictability of hope from individual to individual. From the clinical perspective, the ability to assess hope will guide planning and intervention of hope strategies to instill, maintain and

restore hope for the elderly individual. A brief hope assessment guideline would be useful for the APN to utilize during the subjective psycho-social interview. An assessment of the presence of hope can then be established during intake history, on initial visit, or during the history of present illness (HPI) at a repeat clinic visit and used as a repeated measure evaluation by the APN in primary care.

Hope Assessment and Strategic Interventions

Hope Assessment

This author has attempted to establish the importance of hope as a quality of life parameter for the elderly individual. Following, will be a method for assessing for the presence of hope using formulated questions to be asked during the history taking interview in a primary care setting.

Assessment of hope is difficult because of the elusiveness and complexity of the concept. The multidimensionality of hope as a concept transcending mind, body and spirit attests to its all-encompassing importance to an individual but its essence is nearly impossible to capture. Hope is dynamic; it fluctuates across time; it changes as goals and expectations change; it varies across the life span and from day to day. There are many factors to consider when attempting to assess hope in elderly individuals.

The APN in primary care accepts the variations which may affect the presence of hope and must also recognize the unique characteristics of the population. Variables of the elderly individuals themselves, such as decreased attention span, low energy levels due to illness or stress, or the diminished ability to communicate due to physical or mental impairment, affect hope assessment. Cultural orientation may influence the concept and reflection of hope. The elderly individual and the APN should be linguistically conversant or employ the assistance of a compatible translator to convey the abstract concept of hope. The acceptability of discussing hope is influenced by ethnic diversity.

Special characteristics of the clinical environment in primary care can also affect the assessment of hope. Time limitations in the practice setting to administer hope assessment instruments, or to score and record the outcomes necessitate a short, effective method. Privacy is a consideration for the elderly individual, especially in a busy clinical setting, when relatives or caregivers accompany the patient into the examination suite.

Successful assessment of hope is also contingent upon the skill and sensitivity of the APN. Combined with an understanding of the nature of the concepts and a rapport of trust and openness, an invitation to share personal experiences must be offered during a transpersonal caring occasion between the APN and the elderly client. The

"being" of the clinician is critical to the establishment of a caring environment and sense of trust (Watson, 1992). The APN is the instrument through which hope is assessed by using critical clinical observation skills and by intuition. The APN must actively listen for both the spoken and the unspoken signs of hope. Nonverbal cues, tone of voice, affect and body language can all be included in the charting and reporting for the presence or absence of hope in the elderly individual.

Being fully present in the moment by quieting inner thoughts and actively listening, the APN focuses with genuine caring in an accepting, nonjudgmental way. Active listening may clarify the message of hope and create a healing moment as the elderly individual is encouraged to tell their story, "because within their life experiences lies their hope," (Farran, Herth, & Popovich, 1995. p. 86). "Hope is not given with a pill or a needle and cannot be seen on the results of an X-ray or blood test, yet to meet anothers' eyes is often to know a great deal about the level of hope," (Jevne, 1991, p.149). Farran, Herth, and Popovich (1995) describe the effectiveness of combining the clinician's intuitive sense with the use of a hope inventory and of using interviews repeated over time in the assessment of clients' varying levels of hope.

A basic premise of Watson's theory of Human Caring and Humankind is the belief that the APN may have access to a person's mind, emotions and inner self provided that the

physical body is not perceived or treated as separate from the mind, body or soul (Watson, 1988). During the actual caring occasion in primary care, the APN embodies the ideal of nursing by utilizing the HOPE acronym to differentiate between the dimensions of mind-body-spirit, which may or may not be concurrent in the elderly individual. In the phenomenological shared moments of transpersonal caring, the APN and the elderly individual establish contact between persons; "one's mind-body-soul engages with another's mind-body-soul in a lived moment...[which] has the potential to transcend time and space and the physical, concrete world," (Watson, 1988, p.46). As the APN assesses the elderly individual for the presence of hope, both nurse and client bring their unique causal past experiences and knowledge of hope together. The present moment of transpersonal caring can then affect hopefulness of the future, for both the APN and the elder individual.

In summation, the elderly individual accesses the APN for primary care, thus initiating a caring occasion. The APN interviews the elderly individual to ascertain health status information during the subjective portion of the visit. Collected data includes the background and current psycho-social history. Using the four multidimensional attributes of hope through knowledge of the HOPE/GRACT framework (Farran, Herth, & Popovich, 1995), the APN is able to assess hope by incorporating questions into the psycho-

social history taking, which specifically evaluate the presence of hope.

Interpretive Questions For Assessment. Previous discussion of measurement tools to assess the concept of hope reveal that only one instrument, the Herth Hope Index (HHI) was specifically designed to accommodate the clinical setting (Herth, 1992). This abbreviated 12-item scale was created to screen hope status with regard to the decreased attention span and the fatiguability of the ill adult. These factors appropriately address the limitations of the elderly individuals seen in primary care. The HHI captures the multidimensionality of the four attributes of hope, allowing for the assessment framework of HOPE and GRACT to be utilized by the APN.

The APN in primary care is constrained by time and resources. To realistically evaluate the presence of hope for each elderly individual visit per day, the APN would necessarily need to administer the HHI to every client. It is possible to give the instrument to each elderly individual as they register at the intake desk, and even to have clerical staff score the results. The utility of incorporating hope assessment questions into the psycho-social history taking of every interview. Much the same way that clients are asked about mood, appetite and sleep patterns to evaluate depressive status, the APN can employ questions specific to hope evaluation for each elderly individual. It may be an effective strategy to measure hope

initially using the survey instrument and then follow-up with interview questions at subsequent visits or a specific follow-up visit to expand on the data. Observation must always be an ongoing process recorded at each visit. "The key, no matter what method or methods are used [of assessing hope] is the clinician's use of self," (Farran, Herth, & Popovich, 1995).

Four hope assessment questions are recommended by this author for use by the APN in primary care during the history taking interview of the elderly individual at each visit. These questions have been selected and synthesized from the Herth Hope Index (Herth, 1992) the Herth Hope Index (HHI). This instrument is representative of all four attributes of hope and is consistent with the framework acronym HOPE for assessing the concept. The four concepts represented by HOPE are reiterated as: H-health, an experiential process; O-others, a relational process; P-purpose, a spiritual transcendence process and E-an engagement/cognitive process (Farran, Herth, & Popovich, 1995).

The nature of the HHI "is such that the nurse is able to examine the response to each item and associate the individual's hope in relation to the particular area represented" by the central attributes (Herth, 1992, p.1257). All twelve items of the tool have significant loading on one of the attributes conceptualized, although the attributes were labeled as "Factors" by the author (Herth, 1992). Construct validity of the HHI factor loading

was established using maximum likelihood factor analysis with varimax rotation. Since each item is identified by factor loadings, it is possible to select items representative of the central attributes to incorporate into the transpersonal caring occasion of the history taking interview.

Item #4 of the HHI is, "I can see light in a tunnel" (Herth, 1992, p.1256). This is a commonly heard phrase of persons experiencing hope and positively reflects the experiential process according to the strong factor loading (0.81). Overcoming one's external circumstances of health (H, of HOPE), be it physical, psychological, social or spiritual health, requires overcoming the powerlessness of present situations to a future place of hope. The causal past-suffering brought to the caring occasion between the elderly individual and the APN, is potentially transformed in the phenomenological future by asking, "Do you see light at the end of the tunnel?"

Item #9 of the HHI states, "I am able to give and receive caring/love," (Herth, 1992). The ability to give and receive love and nurturing clearly reflects the relational process of the four attributes, O = others. A comparatively low value loading score (0.60) is reported by Herth, perhaps due to the semantics describing the relational process as the affiliative interconnectedness factor (Herth, 1992, p.1256). This description seems to muddy the relational borders of "self and others" with "self

and spirituality" and may account for the lower numerical value. No other items on the abbreviated HHI address relationship to others, although items on the Herth Hope Scale (HHS) do attend the relational component with, "I feel loved and needed," (Item # 24) (Herth, 1989, [from Farran, Herth & Popovich, 1995]). Ease of asking the elderly client, "Do you feel loved and needed" may be smoother than to ask "Are you able to give and receive love?" However, no factor loading value score is available to evaluate construct validity comparatively for this HHS item.

The ability of the elderly individual to give and receive love recognizes the value of role expectation and reflects a level self-worth, deserving of love despite aging or infirmity (Herth, 1992). Item #9 also reflects the caring of the APN during the actual caring occasion in the phenomenological present moment. "The reality for some isolated older persons is that professionals are the main source of social support," (Farran & Popovich, 1990, p.127).

Using Watson's (1988) model, the caring occasion can be extended into the future and expectations may manifest for potential change in experiential health. Physical health and psychological well-being may improve to affect hope in the future. Difficult relationships with significant others may alter through awareness, renewed communication, conflict resolution or self-forgiveness expanding through the present moment into the future of hope for the elderly individual.

Item #5 of the HHI reads, "I have a faith that gives me comfort" (Herth, 1992, p. 1256). This proposes that the elder adult experiences a transcendence of spirit which gives them hope. Theologians and philosophers both maintain that hope has no basis without faith and that faith cannot be sustained without hope (Farran, Herth, & Popovich, 1995). Asking the elderly client, "Does your faith comfort you?" the APN in essence asks, "Do you have `something' which gives you the ability to `rise above' difficult circumstances and which gives your life meaning?" The purpose and meaning in life, recognized above the limitations of aging, relate positively to the "P" of the HOPE acronym and describe the spiritual transcendence process which Watson believes is imperative to wholistic wellness (Watson, 1988). Deep faith brought from the causal past is enough to sustain hope in the present moment and secure hope for the future for some elderly individuals. For others, the experience of spiritual strengthening through interventions with the APN during the caring occasion may enrich contemplation of hopefulness for the future.

Despite the strong correlation noted above between hope and faith, this author experienced decisional conflict in using this question item. The word "faith" to some persons is clearly linked to a Judeo-Christian religious base (Farran, Herth, & Popovich, 1995). However, reliance upon God or a Higher Power is not uniformly accepted as the only

means of spiritual connectedness. Conceptually differing spiritual perspectives include Unity with Others, Nature, or the Universe (Haase, Britt, Coward, Leidy, & Penn, 1992). Factor loading for item #5 is relatively low (0.63), and may reflect this dichotomy. However, when establishing construct validity for the items selected for the HHI, Herth describes a numerical "value of >0.40 as the selected criterion for allowed variance," (Herth, 1992, p.1255). No other items on the HHI relating to the spiritual transcendency process were valued higher than item #5.

Item #1 of the HHI states "I have a positive outlook on life" (Herth, 1992, p.1256). This question is factor loaded (0.76) towards temporality and future orientation and therefore represents the attribute of Engagement through the cognitive process ("E" of HOPE and "T" of GRACT). It also reflects anticipation of a positive future fulfillment, a requirement by definition of the concept of hope (Stephenson, 1991). For these reasons, asking the elderly individual, "Do you have a positive outlook on life?" represents an appropriate question to evaluate the presence of hope. As a casual inquiry, the question can easily be asked in context with other psycho-social information during the history taking interview of a primary care visit.

A debatable second choice cognitive assessment question is Item #11 of the HHI: "I believe that each day has potential" (Herth, 1992, p.1256). It has relevance to the definition for future orientation and may be more

generalizable to a variety of non-specific conditions of the elderly including loss of control issues. Statistically, Herth (1992) found the question to have a lower factor loading value (0.54). The word "potential" may be confusing to cognitively challenged individuals or the word "each" ("...each day") may be too limiting. Perhaps changing the wording to "most days have promise" would be more positively factor loaded.

Four Questions for Assessing Hope. Therefore, there are four (4) questions which the APN can ask of the elderly individual during the actual caring occasion, to assess for the presence of hope. These questions encompass the central attributes of HOPE as an experiential, relational, spiritual and cognitive process while recognizing the unique qualities and specific limitations of the elderly individual. These questions are based on literature review, synthesized and reformulated for utility in a primary care setting:

1) Do you have a positive outlook on life?
2) Do you see a light at the end of the tunnel?
3) Are you able to give and receive love/care
4) Does your faith comfort you?

Hope Fostering Strategies. Obligations of the APN include fostering hope (McGee, 1984). If fostering hope is one aspect of the APNs role, then intervention strategies are necessary. This section proposes specific interventions to mobilize, support and enhance hope in the elderly

individual. Hope fostering strategies discussed here are those interventions which the APN in primary care would offer to the elderly individual to instill, maintain, or restore a hope using the HOPE framework (Farran, Herth, & Popovich, 1995) (Table 2).

Bulechek and McCloskey (1992) developed a classification system for nursing interventions which include the concept of hope. Several specific strategies were delineated to foster hope and prevent or diminish hopelessness. This system is recognized as the first attempt to classify potential strategies for nursing care related to hope (Farran, Herth, & Popovich, 1995).

H = Health, the Experiential Process. The APN asks of the elderly individual, "Do you see a light at the end of the tunnel?" to ascertain the presence of experiential hope and to determine whether the person's current health status is challenging their hope. The question is designed to create an atmosphere that allows the elderly individual to safely discuss hope, to express fears and to ask questions. Interventions may include providing physical and emotional support through the use of physical treatment plans, ordering appropriate prescriptives or implementation of medical durable goods (Farran, Herth, & Popovich, 1995). Restoration of healing (Leetun, 1996) may include collaboration with a multitude of other disciplines such as dietitians, opticians, physical therapists, counselors or physician specialists. Comfort measures may vary from

Table 2.

HOPE: Assessments and Interventions

	Question	Process Dimension	Intervention
H	Do you see a light at the end of the tunnel?	H=Health the experiential process (overcoming the circumstances of health)	-provide physical and emotional caring -encourage verbalization of hope significance -assist in review of physical, emotional and spiritual strengths -give permission to use former sources of comfort -assist to identify sources of hope -initiate referrals
O	Are you able to give and receive love?	O=Others the relational process (interconnectedness)	-establish open & caring environment -share information -promote relationships between family, friends, caregivers, pets & nature -encourage closeness & touch -suggest ways to give of themselves -expand introspective boundaries -involve significant others in care plan -encourage intergenerational involvement
P	Does your faith comfort you?	P=Purpose spiritual transcendence process	-facilitate caring environment conducive to sharing beliefs -acknowledge, respect and support belief system -facilitate spiritual resources -encourage reflection on meaning purpose of life and death -implement life awareness activities -advocate to S.O. the need for spiritual health -suggest gratitude/dream log -respect religious dietary needs

	Question	Process Dimension	Intervention
E	Do you have a positive outlook o life?	E=Engagement the cognitive process GRACT	**G-Goals** -discuss goals and their importance -assist in establishing achievable goals -assist to develop stepwise goals -guide to modify, redefine or refocus goals if needed -identify strengths; emphasize potentials -convey positive and hopeful attitude -encourage appreciation for values in the present
			R-Resources -assist to identify and nurture internal resources (determination, courage, optimism) -emphasize past strengths -encourage energizing strategies -limit unnecessary energy drains -teach, encourage, support cognitive reframing strategies -foster lightheartedness -identify external resources within community -encourage appropriate assistance
			A-Action -teach reality surveillance -define progress in small increments -use creativity to accomplish goals -focus on projects where progress can be seen -identify positive contributions -teach relaxation skills -encourage anticipation of simple joys -assist to identify hope objects

	Question	Process Dimension	Intervention
			C-Control -show respect for decisions made -give permission to hope -allow control whenever possible -offer choices -encourage significant others to allow control -validate that loss of control is not a weakness
			T-Time -identify hope as past, present or future orientation -recognize areas of past success -explore joys of past and present -share appreciation for joys of present -allow for time-event orientation

personal hygiene to play. Massage may allow for relaxation and a restful sleep. A lively game of cards may stimulate laughter or new friendships. The APN may foster hope by giving the elderly individual permission to return to former healthy pleasures such as music or gardening (Farran et al., 1995).

The APN can strengthen the hope of the elderly individual by sharing information about hope and the normal aging process, explaining that the concept changes with changes in life. Assisting the elderly individual to express feelings about hope and to identify areas of hope currently in their life helps them to accept the present (Herth, 1993). Emphasizing health potential rather than limitations allows the elderly individual to extend the self beyond the boundaries of the immediate situation, realize new perspectives and anticipate new experiences Leetun, 1996).

O = Others, the Relational Process. Strategic interventions to enhance an elderly individual in their relationships with others are initiated by establishing a positive relationship with the APN in an open caring environment (Farran, Herth & Popovich, 1995). Central to the instillation of hope is the establishment of a caring reciprocal relationship between the APN and the elderly individual (Herth, 1993). "Are you able to give and receive love or caring?" is the specific question which invites the elderly individual into a discussion of interconnectedness

and serves as a catalyst to create internal and external conditions that foster favorable relationships with family members, friends and other professional caregivers (Herth, 1993). The APN can create a vision of hope by actively listening, demonstrating a willingness to share professional expertise and relating personal experiences of the causal past which engender the equality of humanness. This enables the elderly individual to feel they are involved in a genuine caring relationship.

The APN should encourage positive relationships with family, friends, caregivers, pets and nature. Suggested ways for the elderly individual to give of themselves in supporting relationships with others include sharing a meal, bartering their talents or mentoring others. The APN can facilitate healing of relationships by embracing forgiveness and encouraging family to share perceptions of events so that distortions of events can be identified and countered with accurate information (Farran, Herth, & Popovich, 1995). The APNs verification of perceptions may allow the elderly individual to recognize limitations and find ways to reach out for assistance from others. Emphasizing personal strengths of courage, endurance and patience may help the elderly individual and their family accept an unfavorable diagnosis or an imminent death (Farran et al., 1995).

The APN can promote awareness of the world through discussion of current events, hobbies, or family events with the elderly individual. Encouragement should be given to

participate intergenerationally through storytelling, singing or reading to youngsters, helping with homework, teaching home economic skills such as baking or canning, becoming a school or church volunteer for youth, or letter writing to pen pals or politicians. The APN may support the idea of feeding the birds, growing houseplants or visiting nature. Pets are recognized as an important source of hope for the elderly individual as a means of comfort, communication, physical contact and unconditional love (Farran, Herth, & Popovich, 1995; Gaskin, 1995; Herth, 1993; Leetun, 1996).

Regular social contacts with nearby neighbors, clubs or organizations, telephone calling or computer e-mailing with acquaintances are strategies to stimulate conversation and external interest for the elderly individual by outwardly exhibiting concerns for the welfare of others. Many churches enlist members to visit persons unable to travel outside of their homes, encouraging the elderly individual to visit or call, or to be visited or called, strategy which increases social contact and broadens relationships with others (Leetun, 1996). Suggestions to write or dictate memoirs for future legacies enriches the past through reminiscence. Photo journaling with grandchildren or other young people allow the elderly individual to recount valuable lessons and colorful stories from the past while educating and entertaining for the future (Gaskin, 1995).

Connectedness for the elderly individual is encouraged by helping them to expand boundaries introspectively. By rediscovering and ultimately transforming the inner self, perceptions of the past and present can be integrated into hope for future fulfillment (Leetun, 1996).

P = Purpose, spiritual transcendence process. Spirituality is the theme representing hope identified most frequently by elderly individuals (Gaskins, 1995). "Does your faith comfort you?" is the question offered by the APN, leading to a discussion of hope through spiritual transcendence. After determining the elderly individual's source of hope, be it God, a Higher Power, Nature, self or others, the APN can create an environment conducive to expressing and practicing spiritual beliefs. This demands that the APN be self-aware of personal beliefs of spiritual transcendence and attain a comfort level in discussion of those beliefs.

Facilitation of spiritual resource availability is a strategic intervention to enhance hope through spiritual transcendence. Appointments with a chaplain, priest, pastor or rabbi, provisions for Bible study or readings of other inspirational books and listening to liturgical music are all methods which may renew the spiritual self (Farran, Herth, & Popovich, 1995). Advocating to family and friends the importance of the elderly individual's spiritual health will validate their spiritual needs and may help to encourage others to offer rides to church or synagogue or to

share prayer time or religious holiday observations. Maintaining religious artifacts and rituals are vital spiritual connections for many people. Religious dietary considerations should be respected by the APN and collaboration with the elderly individual to integrate these restrictions or necessities into their treatment plan should be attempted.

Advocating time alone for prayer, meditation or dream interpretation is valuable for the elderly individual to reflect upon the meaning and purpose of life and the meaning of death and dying. A spiritual gratitude log or dream journal keeping is a means some elderly individuals may use to reach spiritual transcendence. Strength and inner resources are developed through conscious introspection. These activities of the human spirit which allow surrender and spiritual connectedness beyond oneself should be encouraged (Leetun, 1996). The APN must allow permission for the elderly individual to achieve autonomy in selecting their own unique avenue for seeking value in self and the God of their personal understanding.

E = Engagement, the Cognitive Process and GRACT. The APN determines if the elderly individual has expectations for a positive future by asking, "Do you have a positive outlook on life?" If the answer is affirmative, then an open-ended question may follow to determine what goals and aspirations the individual holds for hope. This is designed to stimulate the cognitive process of short or long term

goal formulation and probability testing. This in turn reflects the first letter of the acronym GRACT, ("G" for goals) and assists the APN to recall that the cognitive process entails the consideration of goals, resources, action, control and time (Farran, Herth, & Popovich, 1995).

The APN should encourage the elderly individual to discuss anxieties and concerns, goals and hopes related to the future (Farran, Herth, & Popovich, 1995). Conveyance of a positive attitude is accomplished by identifying and supporting the strengths and positive potentials of the elderly individual to enhance their feelings of confidence and hope. The APN may find it necessary to guide and support the individual to modify, redefine or refocus goals. Helping to determine whether current goals can be met by the elderly individual or if modification or flexibility is necessary is an obligation of the APN, given the person's current abilities, past accomplishments, future capabilities and available support system (Farran et al., 1995).

Assisting the elderly individual to identify and value internal and external resources ("R"- resources of GRACT) is important for the APN to foster hope (Farran, Herth, & Popovich, 1995). Reinforcing physical abilities (sharp eyesight, good upper body strength) and emotional aptitudes (courage, loyalty, acceptance) plus reflection on past accomplishments may restore hope. Interventions to minimize unnecessary energy drain and noxious stimulation should be recognized. Priority setting of outside activities,

restricting unwanted distractions or implementing stress reduction techniques may be enough assistance to allow the elderly individual to restore hope. Likewise, increasing the positive flow of energy through a physical exercise program, nutritional management or encouraging playtime, music or other creative expression activities may promote optimism and increase hope (Leetun, 1996). Cognitive reframing through positive affirmation or mental imagery, positive self-talk, lightheartedness and humor are all strategies that the APN can utilize to bolster hope in the elderly individual (Farran et al., 1995).

Identifying available opportunity resources within the family and within the community may benefit the elderly individual and instill hope. The person's openness to receive assistance is important for the APN to ascertain while collaborating with the elderly individual and their family to identify, assess, select, mobilize and access external resources. Encouragement to avail themselves of support networks, counseling, volunteer assistance or social service plans may be the impetus needed to regain hope for the elderly individual and their family. Resource materials, books, videos, radio programs or public speaking engagement schedules can be offered as external sources of hope.

The APN will intervene to collaborate with the elderly individual to make plans and take action in ways that progress can be seen ("A"- action of GRACT), (Farran, Herth

& Popovich, 1995). Reality surveillance skills should be taught to help determine whether action is appropriate and congruent to meet goals. Helping the elderly individual to evaluate whether others are working effectively in their behalf is also a strategy to be employed by the APN (Farran et al., 1995).

Identification of small daily joys worthy of celebration, such as a sunset or the smell of fresh linens and the anticipation of enjoyable experiences such as the visit of a friend, a favorite meal or the first snowfall help to instill hope for the elderly individual. Object identification of possessions with significant meaning can stimulate actions of hopefulness such as the pasting of photographs in the family album or restitching the hem of a favorite heirloom quilt.

Control ("C" of GRACT) is important to hope fostering for the elderly individual even if the amount of control is minute (Farran, Herth, & Popovich, 1995). Creative ways for the APN to allow for control include discussion with the person and family about self-determination of time scheduling, the offering of food choices within a diet plan or decisions concerning which clothing to wear. Respect for the person's decision-making abilities and the APN's commitment to helping them maintain control through self actualization is essential. Assisting the elderly individual and their family to identify those problems which

they cannot solve is helpful to avoid frustration and defeat which may culminate in hopelessness (Farran et al., 1995).

The APN should be aware of the elderly individual's orientation to time ("T" of GRACT) and encourage their hope in relation to life events and to the temporal dimension as they perceive it (Farran, Herth, & Popovich, 1995). The continuity of time between past, present and future is altered with aging and frequently the APN must help the elderly individual determine whether their hope is based on past, present or future events (Farran et al., 1995). Encouraging identification of joyful life events of the past, recognition of pleasures of the present and anticipation of fulfilling future events may instill hope. Appreciation of each day as a gift to be celebrated is a useful strategy to the APN.

During a transpersonal caring occasion in primary care, the APN assesses for the presence of hope. Using the four hope questions to establish the presence of hope, the APN uses knowledge of the HOPE/GRACT acronyms to choose appropriate strategic interventions to maintain, instill or restore generalized hope to that elderly individual (Farran, Herth, & Popovich, 1995). According to Watson's theory (1985), the interaction of the APN with the elderly individual during the caring occasion can positively influence hope and therefore the quality of life for the future.

Conclusion

Hope is a vital ingredient for enhancing quality of life and for promoting health and healing (Farran, Herth, & Popovich, 1995; Miller & Powers, 1988). Obligations of the nursing profession and specifically the role of the Advanced Practice Nurse require hope-fostering (Dufault & Martocchio, 1985; Hinds, 1989; McGee, 1984; Stephenson, 1991). The population of elderly individuals is burgeoning (AARP, 1995; Eliopoulos 1995; Hess & Markson, 1995). Elderly individuals rely on primary care for their health maintenance (Eliopoulos, 1995; Flynn & Hefron, 1988). Elderly individuals are at risk for lowered hope levels due to the losses attributed to age (Farran, Salloway, & Clark, 1990; Herth, 1993). Therefore, the APN in primary care is professionally obligated to understand the concept of hope as it applies to the elderly individual and be prepared to intervene with strategies to maintain, instill and restore hope as a quality of life parameter.

Evaluation

Recognition that hope assessment is important as a quality of life parameter for the elderly individual is the first hurdle for the APN. If the APN in primary care is convinced that hope is a basic and essential life response, then hope assessment will be implemented into practice. Evaluation of assessment implementation will be difficult unless documentation of hope is initiated. Documentation is unlikely until standards of nursing care reflect hope as a

nursing diagnosis, perhaps as the opposing continuum of hopelessness (NANDA, 1986).

By asking the hope assessment questions, the APN invites the elderly individual to share feelings, beliefs and hopes in an actual caring occasion. This interaction itself can engender hope through the relational process ("O" others of HOPE) and therefore fulfills the intervention criterion of simply encouraging the elderly individual to interact with others. Evaluating this actual caring occasion as a hope fostering strategy can be done by noting the elderly individual as they respond; by the actual answers to these questions, by facial expression, by enthusiasm or reluctance to reveal their feelings, and by eye contact and body language. This should be documented in the objective data of the general survey. On repeated visits to the primary care setting, the elderly individual can be reassessed by the APN using the HOPE/GRACT framework questions and an improved quality of life can be established through discussion.

The interest shown by the APN concerning quality of life aspects of the elderly individual, should positively affect the evaluation of hope. The mind-body-spirit caring demonstrated by inquiring about the elderly individual's hope status, the sharing of strategies to instill, maintain and restore hope and the process of mutual goal setting directed toward future fulfillment, should help the elderly individual anticipate a personally meaningful sense of hope.

An important consideration of hope evaluation is the recognition that these hope questions are not designed to reflect a quantitative measure of hope. There are no "good" or "bad" amounts of hope. It may be necessary for the APN to allow an elderly individual unrealistic high hope so that they may cope with a particular situation. It is the presence of hope which determines quality of life.

Implications

Hope assessment of the elderly individual has several implications for the APN in clinical practice. Knowledge of the concept of hope specifically pertinent to the elderly individual should be introduced to all APN students in graduate curriculum and assessment of the presence of hope should be taught as an indicator of quality of life. Hope assessment questions should be included in the requirements of APN students during the psycho-social history data gathering format of a primary care visit. Hope assessment of the elderly individual should be repeated at each primary care visit by the APN in practice. Interventions which foster hope for the elderly individual should be taught to the student and presented to the practicing APN at clinical conferences. Strategies to maintain, instill and restore hope should be a consideration of the treatment plan at every primary care visit. Documentation should reflect hope fostering strategies offered to the elderly individual and their family by the APN. Hope goals expressed by the

elderly individual should be documented on the chart along with medical and nursing treatment goals.

Clinical studies are needed which utilize repeated measure assessments of hope of elderly individuals in the primary care setting. Reflection of hope as a measurable concept using an instrument such as the Herth Hope Index, (Herth, 1992), which is designed for clinical use and appropriate for the specific needs of the elderly would be helpful to evaluate the effectiveness of the strategic interventions listed in this project. Development of other tools which ask questions more conducive to the brevity and fluidity of the history taking interview would be beneficial. Further studies to measure the validity and reliability of those questions would be necessary.

Investigations of hope need to address the APN role specifically as they affect the enhancement of hope in relation to outcome-specifically wellness, response to treatment and quality of life for the elderly individual.

However, these specific hope assessment questions can be incorporated into data gathering by any health care professional. The enhancement of hope and offering of hope strengthening strategies are important for all health care providers.

Reflection

Norman Cousins (1989) believes that hope is the healing power of the human spirit, the strongest ally that health

care providers possess. He believes that hope is the hidden ingredient to any treatment and all prescription(s).

I believe that life is hope. Hope is the manna of strength which allows one foot to be placed in front of the other along the path. As APN's, it behooves us to be comfortable with this powerful treatment mode, to understand this human apothecary, to offer this bread of strength. We never know when the morsel of hope we offer during a caring moment will be the strength needed to carry on. Hope that is offered caringly is not lost to the APN, but reflected back by the elderly individual.

Jeunce (19845) has a vision of how caring should be. Where caregivers would touch patients gently - and not only physically. That every tough, every smile, every word, every fingerprint leaves a mark and makes a difference. Because caring makes a difference....caring gives hope.

Norman Cousins (1989) states that hope functions as a healing power of the human spirit. He maintains that hope is the strongest ally that health care workers have and that hope is the hidden ingredient in any treatment or prescription as the best human apothecary.

Hope is moving towards wholeness, considering all the offers; understanding that there will be meaning and despair, connectedness and separateness, commitment and freedom, head and heart, faith and doubt, life and death (Jevne, 1984).

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