HOPE IN THE ELDERLY: EXPLORING THE RELATIONSHIP BETWEEN PSYCHOSOCIAL DEVELOPMENTAL RESIDUAL AND HOPE

by

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HOPE IN THE ELDERLY: EXPLORING THE RELATIONSHIP BETWEEN PSYCHOSOCIAL DEVELOPMENTAL RESIDUAL AND HOPE
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DEDICATION

To my parents, Leonard and Dorothea Deges, who taught me the importance of learning.

To my husband, Donald Dewane Curl, who believes in me.
ACKNOWLEDGEMENTS

I wish to thank my committee: Dr. Helen Erickson, for outstanding support as Supervising Professor; Dr. Heather Becker, for assistance with quantitative methods; Dr. Ann Brooks, for guidance with qualitative methods; Dr. LaVerne Gallman, for insights into adult health; and Dr. Alexa Stuifbergen, for direction in using triangulation. Appreciation is also extended to: Dr. Cynthia Darling-Fisher, Dr. Nancy Kline Leidy, and Dr. Mary Nowotny, for permission to use their instruments; Dr. Carolyn Kinney, for reviewing human subjects materials; Dr. Sandra Meek, for conducting the inquiry audit; and May Dobal, for assisting with instrument coding.

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Finally, I want to especially thank: the elderly people, who so willing shared their time and life experiences with me; and my family, whose love and support sustained me.
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Hope has been postulated to be a motivational life force associated with psychosocial developmental residual from early stages of life (Erikson, 1963). This study explored the relationship between psychosocial developmental residual and hope, in order to test a mid-range theoretical model of hope. The hope model was retroductively derived from Modeling and Role-Modeling theory (Erickson, Tomlin, & Swain, 1988) and previous qualitative research (Dufault & Martocchio, 1985).

A correlational research design, with a qualitative component, was used to test the model. For the quantitative part of the study, 90 elderly subjects were selected from two community-based congregate housing vi
units in a small, rural midwestern city. Twenty-two of these subjects were also interviewed, with eight of the interviews purposively selected for the qualitative component of the study.

Psychosocial developmental residual was measured using the Modified Erikson Psychosocial Stage Inventory. The Nowotny Hope Scale was reconceptualized to measure two types of hope: generalized and particularized; which together measured the overall construct of hope.

Empirical findings indicated that subjects' overall developmental residual scores were significantly associated with their overall hope scores ($r = 0.58$, $p = .00$). Hierarchical regression analysis (based on sequentially entering residual from the eight developmental stages) found that 40% of the variance in subjects' overall hope scores was predicted by the eight developmental variables, with 22% of the variance being accounted for by residual from the first two developmental stages. Linear regression analysis discovered that trust-mistrust residual significantly predicted generalized hope ($r = .235$, $p = .03$), and autonomy-shame residual significantly predicted particularized hope ($r = .567$, $p = .00$).
Content analysis of the qualitative data delineated factors that promoted and diminished subjects' hope during difficult times, and identified subjects' attitudes toward the future. Triangulation of the findings indicated that the qualitative data supported the empirical results.

The findings provided evidence of support for the mid-range theoretical model of hope proposed in the study, and have implications for nursing practice, education, and research.
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CHAPTER I

INTRODUCTION

"Growing old" is a commonly joked about concept in American society. Such joking provides some comic relief for what is perceived by many adults as a very real threat, the threat of aging. In America, growing old is perceived as a negative experience by people of all ages, and is equated with increased physical and psychological struggles. This negative perception of aging is reinforced when elderly people describe their lives as hopeless.

Interestingly, society focuses on the "old" part of the phrase growing old, rather than on the concept of "growing"! The term growing means: to develop, to thrive, to come into being (Guralnik, 1977). Combining the term growing with the term old implies that aging is a positive, forward-moving process.

If more was known about hope in the elderly, nurses might be able to help people grow old gracefully and deal with stressors in a positive way. Being hopeful about the future is thought to be an important strategy for coping with stressors (Carpenito, 1992). Understanding the phenomena of hope in older adults is especially significant because many of the environmental changes and physical losses experienced by this population can not be controlled.

This chapter introduces a research study designed to empirically test selected theoretical relationships between psychosocial developmental residual and hope. The significance of the research is addressed in this
chapter, as well as the theoretical framework that guided the research. Also identified are the research questions, drawn from the theoretical framework, and definitions for the significant concepts. The chapter concludes with the assumptions, limitations and delimitations of the study.

**Purpose**

To gain an increased understanding of hope in older adults, this study examined the theoretical relationships between psychosocial developmental residual and hope in community-based elderly. The anticipated outcome of the study was to test and further develop a mid-range theoretical model of hope for an elderly population (see Figure 1).

The ultimate goal of this study was to provide information regarding possible sources of hope in older adults; in anticipation that information from this study could be used in the future to develop nursing intervention studies for elderly clients experiencing hopelessness.

**Significance of the Study**

As a discipline, nursing has had a long history of "fixing what's broken" in the human body, mind or
Figure 1. Proposed Theoretical Model of Hope
spirit; but if a human "part" did not need "repairing", little attention was given to that part. Recently, maintenance and promotion of the integrity of the human body has received more attention (Pender, 1987); but, the human mind and spirit are frequently not addressed until an impairment occurs.

While mental relaxation and imagery techniques are becoming accepted therapeutic modalities in nursing practice (Pender, 1987), the intended result is typically an improved physical condition rather than improved functioning of the mind or spirit. This lack of attention to the mind and spirit is incongruent with the nursing philosophy of viewing humans as integrated beings who need to be treated holistically (Erickson, Tomlin, & Swain, 1988; Travelbee, 1971; Watson, 1985).

Holistic health promotion from a community health nursing philosophy includes promoting the body, mind and spirit, although clinical practice seldom addresses all three aspects. However, as more is learned about controlling physical well-being with the power of the mind and spirit (Hickey, 1986; Engel, 1971; Rideout & Montemuro, 1986; Schneider, 1980), promotion of clients' holistic functioning may increase.
Hope is one aspect of mental and spiritual functioning that has been shown to be related to holistic health processes (Schmale & Iker, 1971). Theoretical and empirical sources suggest that hope influences people's health status and affects when people die (Brandt, 1987; Dubree & Vogelpohl, 1980; Engel, 1968, 1971). Changes and losses faced during the aging process make older adults at risk for experiencing hopelessness, which in turn increases the risk of sudden death or suicide (Engel, 1971; Hill, Gallagher, Thompson, & Ishida, 1988).

Hopelessness and suicide ideation in the elderly population drastically decreases the quality of life for a large segment of the elderly. With the growing population of elderly in the United States, the problem of hopelessness in older adults is a financial drain on the health care system. Health care following overt or covert suicide attempts is very expensive, as well as, the treatment of health problems exacerbated by feelings of hopelessness. In addition to the financial impact hopelessness has on society, there is a high emotional "cost" to the older adults experiencing hopelessness and to their loved ones.
As a practice discipline, the parameters of nursing practice are being defined by an evolving taxonomy of nursing diagnoses and related interventions. One of the nursing diagnoses accepted by the North American Nursing Diagnosis Association (NANDA) is hopelessness. Unfortunately, making an accurate diagnoses of hopelessness is difficult since the NANDA accepted defining characteristics for the diagnosis are similar to other diagnoses, e.g. powerlessness. Bruss' (1988) research on the appropriateness of NANDA's defining characteristics for hopelessness found that verbal cues, such as "I can't" or sighing, were the only critical defining characteristics for diagnosing hopelessness. Problems with diagnosing hopelessness in clients makes it difficult for nurses to know when hope promoting interventions are needed.

Four nursing diagnoses accepted by NANDA have interventions that include the promotion of hope in clients: 1) Grieving; 2) Hopelessness; 3) Ineffective Individual Coping; and 4) Potential for Self Harm (Carpenito, 1992). Many of the defining characteristics and nursing interventions for these diagnoses are based on unstructured clinical observations or on nurses' beliefs, rather than on research findings.
Obtaining more empirical data on what helps elderly people feel hopeful may increase the scientific basis for identifying interventions to promote hope. With additional research, health promotion activities could also be improved to help people of all ages possibly gain some behavioral and cognitive immunity (Seligman, 1975) against experiencing hopelessness.

In nursing, client care is based on the assumption that interventions should be congruent with clients' developmental stages. This assumption is commonly actualized in clinical practice by making interventions congruent with clients' chronological age, rather than focusing on the actual developmental stage where difficulty is being experienced. For clients experiencing hopelessness, this may be a hazardous or ineffective practice. "Since the developmental process is both time-related and dependent upon satisfying needs, it is possible that patients will experience stressors that are related to the chronological, age-related task at the same time that they experience stressors related to tasks from a much earlier developmental stage" (Erickson, 1988, p. 482).

For older adults, life stressors may be similar to those in previous developmental stages, even the first
stage of trust versus mistrust. For example, deaths of family members and friends may make elderly people question if they can trust their social support resources to fulfill their affiliation needs, and physical limitations may make them question if they can rely on their bodies to fulfill their individuation needs.

During stressful situations, people frequently draw on developmental residual from earlier stages to get their needs met. For many older adults, it is possible that they do not have favorable residual from early developmental stages to draw from during periods of change and loss. The lack of knowledge about parenting and child development during the early 1900s, and the large number of children in families of that era (all vying for limited resources like food and affection), may have set the stage for older adults to experience feelings of hopelessness when encountering repeated stressors in their life.

Hope is thought to be a virtue derived from healthy (favorable) psychosocial residual related to the trust versus mistrust task of the first stage of development (Erikson, 1963). According to Erikson's (1963) theory, psychosocial development is epigenetic in nature,
meaning that developmental residual from previous stages in life influences subsequent developmental tasks. This suggests that residual from earlier stages of development impacts on elderly people's level of hope, and that psychosocial experiences later in life impact on developmental residual from earlier stages (Erikson, 1963; Erickson et al., 1988). Consequently, hopelessness in an elderly person should be evaluated within the context of the actual developmental stressor being experienced, rather than assuming that the person is coping only with the ego integrity versus despair stage of development.

Little research has been done using Erikson's theory with older adults, because an adequate instrument to measure psychosocial developmental residual in this population has only recently been developed (Darling-Fisher & Kline Leidy, 1988). Within the metaparadigm of nursing, research in the area of hope is also in an early developmental stage.

Based on a synthesis of the literature presented in Chapter 2, nursing research is urgently needed in two areas. One area needing exploration is the relationship between residual from psychosocial developmental stages and hope in the elderly. The other area is
experimentally designed research to test the effectiveness of hope promoting strategies.

Research on the association between developmental residual and hope may provide the factor-relating aspect of theory development that is needed prior to testing interventions in the situation-relating and situation-producing phases of theory development (Dickoff & James, 1968). Thus, the study described in this report is an initial building block for developing knowledge about improving the life and health of older adults. Research findings in this area might ultimately be useful in developing public policy for services and programs targeted for older individuals.

Statement of the Problem

"Life is sustained by hope" (Menninger, 1967, p. 47) and hope is theorized to be a virtue contained in the psychosocial developmental residual derived from healthy resolution of the task related crisis of the first stage of life. Empirical testing of the theorized relationship between developmental residual and hope has not been conducted in an elderly population because instruments to measure both of these phenomena in this population have only recently been developed.
Understanding the relationship between these two phenomena, in an older population, could help guide nursing interventions for promoting, maintaining, and restoring hope in elderly people. Thus, the problem driving this research study was: What is the association between psychosocial developmental residual and hope in the elderly?

**Theoretical Framework**

The infrastructure of this study was a retroductively derived theoretical framework based on the nursing theory, Modeling and Role-Modeling (Erickson et al., 1988), and a conceptual model of hope (Dufault & Martocchio, 1985).

**Modeling and Role-Modeling**

A broad perspective of the concept hope and its relationships with other concepts is provided in the Modeling and Role-Modeling (MRM) theory and paradigm (Erickson et al., 1988). In this theory, hope is described as a futuristic perspective that is closely related to successful accomplishment of the trust versus mistrust stage of development and positive self-esteem. Research suggests that although hope is highly correlated with clients' sense of control and social
support, perceived control is the primary predictor of hope (Erickson, 1989).

Even though perceived control was found to be a stronger predictor of hope than social support, hope was observed to be indirectly affected by social support because support significantly predicted control (Erickson, 1989). These findings suggest that the first two stages of psychosocial development are highly interrelated, perhaps because both stages are contingent upon satisfaction of affiliation and individuation needs.

Erickson et al. (1988) consider hope to be "a projection of the 'self' into the future" (p.168). Along with a sense of the future, a sense of self-worth is thought to be critical for a person to have a positive orientation to life. Erickson et al. (1988) specifically note that a positive orientation to life can be experienced by people who are dying, as well as healthy individuals. Terminally ill individuals can "self-project" into the future by perceiving that a part of them will live on in the work they have accomplished or in the lives they have touched. Spiritual beliefs in an afterlife are also theorized as providing a future into which the dying can self-project.
Conceptual Model of Hope

Dufault and Martocchio's (1985) inductively developed conceptual model of hope is based on qualitative data from interviews with elderly cancer patients and with terminally ill persons, 14 years old and older. Analysis of the data formed the basis for Dufault and Martocchio's definition of hope as "a multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving a future good which, to the hoping person, is realistically possible and personally significant" (p.380). This perspective does not view hope and hopelessness as opposite ends of one continuum, nor is hopelessness seen as the absence of hope. Dufault and Martocchio believe that some dimension of hope is always present in a living person.

Rather than viewing hope as being on a continuum, qualitative data prompted Dufault and Martocchio (1985) to conceptualize hope as being composed of two spheres: generalized hope and particularized hope. Generalized hope is defined as a sense of some future beneficial, but indeterminate, development. This sphere of hope is perceived as giving life meaning and protecting against
despair. Particularized hope is concerned with an object of hope that may be concrete or abstract. This sphere encourages investment in and commitment to something that extends beyond the present moment. When hope for a particular object no longer seems realistic, generalized hope helps a person cope. Dufault and Martocchio conceptualize the two spheres of hope as each having six dimensions: affective, cognitive, behavioral, affiliative, temporal, and contextual.

Earlier writings by Rycroft (1979) theoretically support Dufault and Martocchio's (1985) premise that hope has a general and a particular form. Rycroft conjectures that the general form of hope is a social quality that is transmitted from person to person and generation to generation. Particular hope, according to Rycroft, focuses on a specific desire or goal that one wants to attain.

Theoretical Model of Hope

The mid-range theoretical model of hope, presented earlier in Figure 1 (p. 3), was developed by synthesizing propositions from Modeling and Role-Modeling theory (Erickson et al., 1988) and Dufault and Martocchio's (1985) conceptual model of hope. In the
theoretical model, residual from the first two stages of psychosocial development is theorized as affecting people's hope. Generalized hope is hypothesized as favorable residual from the trust versus mistrust stage of development, and particularized hope is viewed as a favorable outcome from the autonomy versus shame and doubt developmental stage. Hopefulness, a realistic high level of hope, is the combination of generalized hope and particularized hope. An outcome of hopefulness is a motivational involvement in living.

Hopelessness, a low level of hope, is the combination of isolated hope and learned helplessness. A person experiencing hopelessness is at risk for feeling despair (i.e., being devoid of hope), and dying or committing suicide.

This model depicts people who have anxious or insecure attachments, related to unfavorable developmental residual from the trust versus mistrust stage, as having fragile hope rather than generalized hope. Due to the epigenetic nature of Erikson's (1963) developmental stages, people who have had insecure attachments during the trust stage are likely to have insecure individuation during the autonomy stage. The
proposed model theorizes that attributes of shame and doubt emerging from the autonomy stage leads to learned help seeking behaviors rather than particularized hope. Learned help seeking behaviors, combined with fragile hope for the future, are thought to result in hope that is dependent on others or factors external to the person. Such individuals may be at risk for experiencing hopelessness when interpersonal, physical or environmental losses occur.

Research Questions

In order to test the theoretical model of hope, the study addressed the following questions regarding elderly persons living in community-based congregate housing.

1. What is the relationship between psychosocial developmental residual and level of hope?

2. Does trust versus mistrust developmental residual significantly predict generalized hope?

3. Does autonomy versus shame and doubt developmental residual significantly predict particularized hope?

4. How has hope been promoted or decreased during stressful or difficult times?

5. How is the future perceived?
Definitions

For this study, the following definitions were used.

COMMUNITY-BASED CONGREGATE HOUSING: is apartment-type housing for elderly individuals who can not or do not desire to maintain a private home, but who do not need the supervision or care provided in a nursing home.

DEPENDENT HOPE: is hope contingent on others or factors external to the person. Dependent hope results from the combination of fragile hope and learned help seeking behaviors.

DESPAIR: is being devoid of hope, and is likely to result in death by passively giving up on life or committing suicide.

ELDERLY: are people 62 years of age or older.

FRAGILE HOPE: is a tentative sense of the future for self but uncertainty about future affiliations with others, resulting from insecure attachments.

GENERALIZED HOPE: is a pervading sense of a positive future, including perceived affiliation with others and a sense of spirituality or transcendence; as measured by the generalized hope subscale of the Nowotny Hope Scale.
HOPEFULNESS: is a realistically based high level of hope that occurs when generalized hope and particularized hope are present in an individual; as measured by the Nowotny Hope Scale.

HOPELESSNESS: is a low level of hope resulting from the combination of isolated hope and learned helplessness; as measured by the Nowotny Hope Scale.

ISOLATED HOPE: is hope that is present oriented, because the person has a weak sense of the future, and is also emotionally individuated or detached from others.

LEARNED HELPLESSNESS: is a pervading sense of being unable to set present or future goals and the perceived inability to attain goals set by others, while still perceiving a sense of a future. Learned helplessness results from decreased autonomy and increased doubt due to repeated perceived inability to control voluntary responses.

LEARNED HELP SEEKING: is perceived goal attainment mainly through others, resulting in seeking others to help identify and meet one's goals.
PARTICULARIZED HOPE: is being able to identify valued future goals or desired outcomes, even during difficult situations, and perceived confidence in attaining the hoped for goals or outcomes in the immediate or distant future; as measured by the particularized hope subscale of the Nowotny Hope Scale.

PSYCHOSOCIAL DEVELOPMENTAL RESIDUAL: is the attributes (observable behaviors and attitudes) derived from each of the eight stages of Eriksonian development. These attributes reflect favorable and/or unfavorable feelings and perceptions of self and others; as measured by the Modified Erikson Psychosocial Stage Inventory (administered as the Personal Attitude Survey).

Assumptions

This study was based on the following assumptions:

1. Elderly people living in community-based congregate housing have experienced at least one physical, interpersonal or environmental change/loss that has challenged or threatened their individual perceptions of the future or attainment of goals.

2. Subjects gave honest responses to the questions, and the experiences of the subjects were "not
merely private, inner world [experiences]; but rather, inextricably bound with objective reality, and the basis from which scientific knowledge is derived" (Munhall & Oiler, 1986, p. xiv).

3. The transcripts of the interviews were parallel to the tapes of the interviews.

Limitations

The following limitations of this study are acknowledged:

1. Empirically based causal relationships can not be identified because of the exploratory, correlational design of the study.

2. Elderly people experiencing isolated hope, hopelessness, or despair may have been hesitant to participate in the study.

3. Generalizability of the findings is limited because the subjects were from a single geographic area and the sample was restricted to those who agreed to participate in the study.

Delimitations

Limiting the type of housing in which the participants lived provided some measure of control over variations in participants' health status and cognitive...
functioning, as well as the environmental factors experienced by the participants.

**Summary**

In this chapter, the research study was introduced and the purpose of the study was identified. The potential significance of the research was described, and the theoretical model of hope tested in the study was presented. The research questions addressed in the study were specified and definitions for significant concepts were identified. Limitations and delimitations of the study were also noted. The next chapter reviews the literature that provided the foundation for this study.
CHAPTER II
REVIEW OF LITERATURE

Expanding the science of nursing is a building process, with the building blocks being: systematic observation of clinical practice, qualitative and quantitative research, and literature from within and outside of the discipline. Literature important to the discipline includes information on: clinical data, theoretical models, qualitative inquiry and quantitative findings. Synthesizing the literature enables the researcher "to identify what is known and not known about a topic, to identify conceptual or theoretical traditions within bodies of literature, and to describe methods of inquiry used in the earlier work, including their successes and shortcomings" (Woods & Catanzaro, 1988, p. 46).

This chapter includes a synthesis of the psychosocial development literature and the literature on hope. For each of these two constructs, the review of literature begins with theoretical information, in order to provide a general understanding of the phenomenon, and is followed by research findings. Special emphasis is given to the literature on hope, including: (a) theoretical and research based characteristics of hope, (b) the impact of hope on health and illness, (c) theoretical models of hope, (d) measurement of hope, and (e) research on hope.
Psychosocial Development

Conceptual Background

Erik Erikson's (1963) theory of psychosocial development delineates eight developmental stages common to all humans. These eight stages are: (a) trust versus mistrust; (b) autonomy versus shame and doubt; (c) initiative versus guilt; (d) industry versus inferiority; (e) identity versus role confusion; (f) intimacy versus isolation; (g) generativity versus stagnation; and (h) ego integrity versus despair. These stages have been commonly misinterpreted as occurring only sequentially, according to chronological development; however, Erikson's theory actually specifies that these stages are epigenetic in nature.

Epigenetic means that all of the stages exist in some form throughout life, but "that psychosocial development proceeds by critical steps -- 'critical' being a characteristic of turning points, of moments of decision between progress and regression, integration and retardation" (Erikson, 1963, p. 170-171). This means that all of the stages exist and are integrated throughout life, but that psychosocial adaptation in life occurs by sequentially going through the critical steps (Erikson, 1963, 1982, 1984).
At each critical step, psychosocial adaptation occurs when a favorable ratio exists between the syntonic and dystonic aspects of the respective task. The syntonic quality should recurrently outweigh or at least be equal to the dystonic quality, but the dystonic quality should never be totally eliminated. For example, a favorable ratio of basic trust (syntonic quality) over basic mistrust (dystonic quality) is critical for the first step of psychosocial adaptation; but, a person needs some sense of mistrust as a healthy protection against dangerous people and situations. (Erikson, 1963, 1982, 1984).

Erikson (1963, 1982) notes that psychosocial adaptation at each critical step provides a type of ego strength and an attitude (virtue), both of which are essential resources for effective functioning (see Figure 2). Psychosocial attributes of a person are comprised of the basic ego strength and the virtue from each critical step. The strength is revealed in the observable behaviors of a person, and the virtue is reflected in the attitudes (conscious and unconscious inner states) of a person. The favorable or unfavorable attributes of each critical step is the psychosocial
Figure 2. Erikson's psychosocial developmental tasks with corresponding strengths and virtues, displayed with the first task on the bottom to show that it forms the base for other tasks. As with a house, a solid building starts with a strong foundation (Erickson et al., 1988, p. 62).
People who have a favorable ratio of psychosocial developmental residual from each of the critical steps preceding the step concurrent with their chronological age demonstrate effective, age-appropriate functioning. "Yet it is very possible to find 50-year-olds who are still 'working through' or completing . . . . a task of a much earlier stage in life (such as one involving the task of trust versus mistrust or autonomy versus shame and doubt)" (Erickson et al., 1988, p. 62). Even when favorable developmental residual has been derived from a critical step, the possibility that changing life conditions may erode the favorable residual remains (Erickson et al., 1988).

For clinical practice, the positive aspect of Erikson's theory is that people's psychosocial problems are not fixed, permanent situations, but critical steps yet to be favorably addressed. "This perspective provides a hopeful expectation for the individual's future since it connotes something still in progress" (Erickson, 1988, p. 63); and is an aspect of human functioning upon which nursing care can make an impact.
Overview of Erikson's Eight Stages of Psychosocial Development

Trust versus mistrust is the critical step that the infant confronts during the first year of life, especially during the first six months. Trust, as an ego strength, develops when an infant feels that his wants are frequently satisfied by familiar and reliable providers of care external to the infant. An additional factor that impacts on an infant's development of trust is a deep conviction on the part of the parents that there is meaning to what they are doing with the infant and in society. Parental faith and organized religion are important societal elements for establishing a sense of trust within the next generation (Erikson, 1963; Kaplan & Sadock, 1985).

Basic trust is the cornerstone or foundation upon which the other seven ego strengths depend. Erikson (1963) identifies that a general state of trust implies trust of others and trust of oneself. If basic trust is strong, the person will face life feeling hopeful, instead of feeling doom (Kaplan & Sadock, 1985). Hopefulness is the most basic and essential quality of development, because hope provides both a sense of an inviting future and a sense of being able to take
specific actions in the future. In adults, hope may mature into a sense of faith (Erikson, 1982, 1984).

When developmental residual from the first stage is mostly unfavorable, schizoid and habitual depressive states may occur. For a client who has an overriding sense of mistrust, it is especially critical that a sense of mutuality is established between client and nurse. The relationship must be one of equals, although the nurse uses clinical knowledge to direct the work with the client (Erikson, 1963; Kaplan & Sadock, 1985).

Autonomy versus shame and doubt is the second critical step of psychosocial development, and initially occurs during the second and third years of life. The toddler grapples with choosing between the social modes of holding on or letting go, by experimenting with walking and by controlling or letting go of bowel functions. The child struggles to master his whole self while contending with restraining forces like parental authority and the pull of gravity (Erikson, 1963, Kaplan & Sadock, 1985).

If the child is encouraged to rely on his own abilities, within a safe but permissive framework, he gains confidence in his autonomy and has faith that acting on his own does not jeopardize his existence
(Erikson, 1963; Kaplan & Sadock, 1985). An attitude of good will and pride is the favorable developmental residual derived from this critical step. "Autonomy and will, as well as industry and purpose [from the third and fourth critical steps], are oriented toward a future that will remain open, in play and in preparatory work" (Erikson, 1982, p. 79).

If the child is belittled or over-restrained, he is likely to become enraged at his impotence to control, with the resulting feelings of foolishness and shame causing doubt about himself. The rage and hostility may be turned inward, resulting in paranoiac fears and a compulsion for controlling minor things in life. Feelings of shame and doubt can also result in benign expectations and attitudes. This lack of confidence results from a perceived loss of inner control and feeling overly controlled by outside forces (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

The third critical task of development (initiative versus guilt) originally surfaces as a crisis in children 3 to 6 years of age. During this period a child has surplus energy, is eager and curious, and forgets failures quickly. "Initiative adds to autonomy the quality of undertaking, planning and 'attacking' a
task for the sake of being active and on the move" (Erikson, 1963, p. 255).

There is an ardent interest in the parent of the opposite sex during this stage, as well as emulation of parental role models. Emulation of adults who are recognized by their uniforms (e.g. fireman, nurses) also occurs. A child's visualization of himself in an adult uniform replaces envisioning himself in fairy tales (Erikson, 1963; Kaplan & Sadock, 1985).

During this stage, the child struggles between his own expanding desire to do what he wants and being told what to do by others. Favorable developmental residual occurs when the child integrates parental values into his actions, resulting in the child demonstrating self-obedience and self-guidance. In contrast, unfavorable residual from a lack of closeness to the parent promotes feelings of guilt and anxiety. When feelings of guilt result, there is often: (a) self-punishment in the form of psychosomatic disease, (b) overcompensation with showoff behaviors, or (c) repression of feelings demonstrated by inhibitions or impotence. As hopes and fantasies are repressed and inhibited, an inner rage occurs that is often submerged until later in life (Erikson, 1963; Kaplan & Sadock, 1985).
The industry versus inferiority stage coincides with the early school age years (6 to 11 years old), as the child learns to use the tools or technology of society. If the child becomes confident of his ability to produce things by receiving recognition for his efforts, then the child has accomplished a preliminary step to being a provider during his adult years (Erikson, 1963; Kaplan & Sadock, 1985).

Over use of work as a means for attaining a sense of being worthwhile during this stage can lead to being a conformist who is easily exploited by others. Conversely, the child who does not like to learn or use technology may conclude he is inferior and can not master things in the world. Inferiority is likely to result in inertia, which threatens the child's productivity and carries over into adulthood. This inertia is also closely related to the inhibition of play during the previous stage. Feelings of inferiority derived from this stage make the child more isolated from non-family associations (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

Adolescence (11 to 18 years of age) is a period when identity versus role confusion is a critical task. As childhood ends and youth begins, earlier stages are
again questioned to gain a sense of identity. Examining and identifying career options is interconnected with establishing an identity. The strength that emerges from establishing an identity is fidelity, which is closely related to basic trust from the first stage of development and to mature faith (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

An identity crisis occurs in adolescence when the budding teenager does not accept the role expected of him by society. The confusion and indecision that may occur while seeking an identity often causes adolescents to emotionally and physically cling together and to over identify with heroes. Adolescent love during this stage is not primarily a sexual matter but is mostly conversation. During conversation the adolescent's diffused ego image is projected onto another; seeing it reflected back by others helps to gradually clarify and identify one's identity (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

After a sense of identity has been attained during adolescence, the young adult is willing and eager to blend his identity with others during the sixth developmental stage. Intimacy versus isolation is the task that deals with commitment to affiliations, without
fear of ego loss. This is a difficult task because intimate, competitive and combative relationships may coexist with and against the same person. The mark of an adult is the ethical sense to differentiate between these relationships (Erikson, 1963; Kaplan & Sadock, 1985).

With true intimacy, there is a sense of mutuality that sustains long term relationships. Favorable outcomes of this stage are mutuality in sexual relations and the ability to bear a certain amount of frustration when sexual relations are not possible. Fear of ego loss during relationships interferes with mutuality and can lead to self-interest. If relationships are not maintained, due to self-interest or self-indulgence, a person's sense of isolation will increase (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

The critical step that emerges during middle age is generativity versus self-absorption and stagnation. Generativity includes productivity and creativity, with the primary concern of this stage being establishing and guiding the next generation or bettering society. A strong need to be needed surfaces during this stage, along with wanting guidance and encouragement from what has been produced (e.g. offspring, students, art).
Taking care of what has been produced is the virtue derived from this stage, but all of the strengths from the earlier stages (e.g. hope, will, purpose, love) are essential for caring for the next generation (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

Having children does not automatically guarantee favorable developmental residual during this stage, because negative residual from an adult's childhood impacts on how the adult deals with this critical step of middle age. For example, if there was a lack of basic trust from the first critical step, then the resulting lack of hope and faith in society may make being a parent an unwelcomed and unfulfilled role (Erikson, 1963; Kaplan & Sadock, 1985).

When generativity is low, there is regression to pseudo-intimacy with a pervading sense of stagnation and impoverishment. Adults, who feel impoverished, frequently become self-absorbed in meeting their own personal comforts and entertainment, and indulge themselves as if they were their own only child (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

Ego integrity versus despair is the last critical stage of development. Ego integrity is the "fruit" or emotional integration resulting from sufficient
development of ego qualities from the previous seven critical steps (Erikson, 1963, 1982; Kaplan & Sadock, 1985).

Ego integrity goes beyond narcissistic love, as it is a love of the human ego that conveys some world order and spiritual sense. An acceptance of one's life also occurs during this stage, with a readiness to defend the dignity of one's lifestyle against all physical and economic threats (Erikson, 1963). This even applies to older adults who are experiencing decreased physical autonomy because of natural changes with aging. Within these adults can "mature an active acceptance of appropriate limitations and a 'wise' choice of involvements in vital engagements of a kind not possible earlier in life -- and possibly (this we must find out) of potential value to a society of the future" (Erikson, 1984, p. 163).

Facing the prospect of death during later years can create feelings of despair, unless a strong sense of self and the perceived value of one's past life provides the ego integrity needed to feel satisfied with one's present life. Religious beliefs also seem helpful in gaining a sense of ego integrity, as many religions help older adults put life and death into perspective by
providing a sense of the future due to the prospect of heaven (Birren & Bengtson, 1988).

Without ego integrity there is a fear of death, and despair is experienced because time is too short to try to start another life. The observable characteristic of despair is sometimes disgust (Erikson, 1963; Kaplan & Sadock, 1985).

With ego integrity comes a sense of communion with society, a wisdom about the historical progression of society, and a sense of faith that takes the fear out of death. With ego integrity also comes a confident reliance on another's integrity, which is the meaning of trust (the first ego strength of development). Thus, there is a close connection between adult integrity and infantile trust. Erikson (1963) paraphrases this connection by noting that "healthy children will not fear life if their elders have integrity enough not to fear death" (p. 269).

Even when earlier critical developmental crises have resulted in favorable developmental residual, changes with aging threaten the emergence of ego integrity. With aging, radically limited choices in activities and living arrangements can make people's power of will weak, initiative and purpose seem
uncertain, competence and meaning in work rare, identity restricted to what one has been, and love and care limited. Such conflicts, as one faces death, can propagate feelings of dread not explainable by present theories of anxiety, a sense of evil not connected with classical feelings of guilt, and a lack of existential identity (or sense of "I") that identity theories cannot discern. Erikson (1984) identifies these as "problems of Being [unmet needs], the open or disguised presence of which we must learn to discern in the everyday involvements of old people" (p. 163).

Research Related to Psychosocial Development in Older Adults

A dearth of empirical research exits in the literature on Erikson's developmental theory as related to older adults; probably due to the lack, until recently, of valid and reliable instruments to measure psychosocial development in the aged (Darling-Fisher & Kline Leidy, 1988; Domino & Hannah, 1989). However, findings from the studies that do exist provide useful information in building knowledge about psychosocial development in older adults and indicate that psychosocial development is associated with health and illness.
In 1987, MacLean surveyed current and retired employees (N = 156; 24 to 80 years old) of a large university to study the relationship between development and healthy lifestyle practices. Developmental residual was found to be a stronger predictor of health behaviors than life stressors or the presence of health problems. This finding suggests that "persons with high levels of developmental resources may have sufficient capabilities to practice healthy behaviors in spite of the exposure to stressful life events" (MacLean, 1987/1988, p. 72).

Intriguingly, the data from MacLean's (1987/1988) study identifies that of the eight developmental stages, the stage of intimacy contributed the most to variance in health behavior subscales. Residual from the stage of intimacy and the presence of health problems accounted for 18% of the variance in subjects' overall health behavior scores. Recent stressors and developmental residual from the stage of intimacy were noted as the strongest predictors of healthy nutritional behaviors, accounting for 11% of the variance in nutritional behaviors. Developmental residual from the stages of trust and intimacy were found to account for 30% of the variance in relaxation behaviors.
A study by Domino and Hannah (1989) also correlated developmental residual with healthy functioning, but operationalized healthy or effective functioning from a psychological, rather than physical, perspective. In 143 Elderhostel participants, an association was found between effective functioning and seven of the developmental stages. Residual from the generativity stage was the one stage not significantly correlated with effective functioning.

Of interest in Domino and Hannah's (1989) study was the difference in developmental predictors of effective functioning found between men and women. Using stepwise regression analysis, trust was the highest predictor of effective functioning in men and accounted for 21% of the variance in this variable. For women, residual from the identity stage was the highest predictor of effective functioning, accounting for 13% of the variance in functioning. Residual from the industry stage was the second highest predictor of effective functioning for both men and women. These findings imply that differences in self-reported effective functioning of elderly people may be reflective of gender differences within the American culture.
Rather than focusing on health, two studies by nurses have examined aspects of the association between psychosocial development and illness. Research by Finch (1987) discovered a correlation between subjects' developmental residual and length of hospital stay following an elective surgery (N=25, ages 20 to 81). Determination of subjects' developmental residual was made by using a nursing assessment tool originated by Finch (1987).

A positive correlation was obtained between subjects' mistrust developmental residual and their length of hospital stay ($r = .51, p < .01$). Likewise, a positive correlation was noted between subjects' shame/doubt developmental residual and their length of hospital stay ($r = .43, p < .05$). In contrast, length of hospital stay was not significantly correlated with trust or autonomy residual. Due to the epigenetic nature of psychosocial development theory (Erikson, 1963), it is not surprising that only mistrust, and not shame and doubt, entered a stepwise multiple regression analysis of length of hospital stay (Finch, 1987).

Finch's (1987) study provides valuable information for nurses, as the findings support the importance of clients perceiving that they have a trusting
relationship with staff. Clients who have high mistrust development residual are likely to exhibit detached, pessimistic, and sometimes aggressive and paranoid behaviors; but rather than being alienated by these behaviors, nurses need to encourage clients' affiliation with the staff (Finch, 1987). Nursing interventions that promote affiliation may significantly lower health care costs, if length of hospitalization could be decreased by these interventions.

Kline Leidy (1990) also investigated the association between psychosocial development and illness by examining the correlation between developmental attributes and the symptomatic experience of people with chronic obstructive pulmonary disease \((N = 109; \text{ages } 40 \text{ to } 84)\). Psychosocial attribute strength was found to be a significant predictor of basic need satisfaction for both men and women. In turn, basic need satisfaction was observed to be a significant predictor of perceived stress and the intensity of the symptomatic experience. Thus, psychosocial attribute strength was not directly associated with the intensity of the symptoms experienced by subjects, but was indirectly related because attribute strength predicted basic need satisfaction. These findings suggest that nursing
interventions which strengthen psychosocial attributes may help meet basic needs and indirectly minimize physiologic symptoms (Kline Leidy, 1990).

Gratton (1973) researched the phenomenon of interpersonal trust by asking subjects \( N = 16 \) to describe their experiences in this area. Subjects described three different types of interpersonal trust: (a) physical relaxation with another, where there is a feeling of comfort with another; (b) being able to count on others to respond in a consistent manner; and (c) trusting despite the inability to predict what will happen (Knowles, 1977). These findings provide evidence of support for Erikson's (1963) theory, as the first two types of interpersonal trust appear to describe the tasks of the trust versus mistrust stage of development, and the third type seems to describe the virtue hope that is derived from favorable residual of the first stage.

As explained in the overview of Erikson's (1963) eight stages of development, the last stage of development is thought to be closely interrelated with the first stage. Research findings obtained by Viney (1987) in Australia and America support this connection \( N = 813; \) ages 6 to 86). Based on content analysis of
interviews, physically healthy subjects in the ego integrity versus despair stage often used words that represented the construct trust, rather than mistrust, when they talked about their present life.

Conversely, data about the interrelationship of the first and last stages of development in an unhealthy subject is provided in a case study by Liptzin (1985). This case study details the life of an elderly woman with chronic psychological problems, who found no meaning or purpose in life and had frequently contemplated suicide. Lack of trust from being rejected by her mother during infancy and childhood was connected with the psychological problems that the client experienced during her later years. By using an Eriksonian framework for psychotherapy, Liptzin (1985) was able to increase the client's sense of trust, which gradually improved her psychosocial functioning in the area of ego integrity.

In a study by Goebel and Boeck (1987), older adults (N = 51, ages 70-90) with high ego integrity had less fear of death than subjects with low ego integrity. Chronological age was not found to be correlated with fear of death or ego integrity. However, fear of death was significantly related to place of residence for
subjects with low ego integrity scores, as institutionalized subjects had higher fear of death scores than older adults who lived independently. For elderly persons with high ego integrity scores, place of residence did not significantly correlate with fear of death scores.

Goebel and Boeck (1987) interpreted these findings as indicating that lack of control over an event that one expects to be able to control (e.g., selecting one's place of residence) makes a person with low integrity feel more hopeless and helpless, than lack of control over an event one expects to have little control over (e.g., one's death). For elderly people with low ego integrity, the inescapable confirmation of the imminence of death in an institutional environment may make favorable resolution of the ego integrity versus despair stage more difficult.

Rosel (1988) used qualitative research methods to explore ego integrity versus despair by examining two women's lives, and writings about a third subject (a female fictional literary character). The purpose of Rosel's research was to determine whether the terms Erikson (1963) used to describe the strengths and weaknesses of the eighth stage of development accurately
described the stage. Rosel's (1988) findings support Erikson's (1963) choice of terms, that is, ego integrity, despair, and wisdom. In addition, Erikson's (1963) original terms were conceptually clarified by Rosel's qualitative data.

From the data, ego integrity was further elucidated using the words clarity and intensity. Clarity implies an order or neatness that provides structure in the environment and in thinking. Intensity, as related to ego integrity, means physical and emotional vitality during special occasions, like visits from friends or trips to church. The original term despair was clarified by the following words and phrases: mourning, self-pity, closely related to loneliness, disappointment in humanity, and sheer exhaustion from using up one's "fixed" amount of energy (Rosel, 1988).

The third term studied from Erikson's (1963) theory was wisdom, the eighth virtue emerging from favorable developmental residual. From Rosel's (1988) study, wisdom was depicted as "conserving precious energy and then lavishing it on specially chosen events, .... understanding of life based on one's past experience" (p. 21), folk wit, and being "in possession of one's own
mental stamina, some of one's physical stamina and of one's immortal soul in the face of death" (p. 22).

A noteworthy finding of Rosel's (1988) study was that elderly people who reach a favorable balance between integrity and despair in their 60s or 70s, may in their 80s reach a developmental task beyond Erikson's (1963) eighth stage. In the study, octogenarians were absorbed in daily routine and social rituals rather than contemplating the meaning and purpose of life. "Continued development for them entail[ed] coping with age on a day to day basis" (Rosel, 1988, p. 20).

Synthesizing the research studies in this section with the theoretical information described in previous sections suggests that early stages of psychosocial development (e.g., trust versus mistrust and autonomy versus shame and doubt) may be associated with physical and psychological functioning in older adults. However, relatively little empirical data have been ascertained to explain and understand this possible association; thus, additional research is needed in this area.

Hope

As noted in Chapter 1, the genesis of hope is thought to derive from favorable residual from the first stage of psychosocial development (Erikson, 1963).
Thus, theoretically a person who experiences more trust than mistrust during the first year of life learns to hope. Conversely, if a person does not successfully adapt to this stage, an excessively cautious attitude about life is assumed and withdrawal from the world may occur (Stevens, 1983). This implies that one’s basic level of hope is determined early in life and can not be substantially increased during later years unless the need for trust is first fulfilled.

Conceptual Definitions and Characteristics of Hope

Philosophers frequently describe hope as a prospective emotion related to an attitude about the future (Rycroft, 1979). Presumably persons who experience hope desire the attainment of something not yet acquired, and believe that what is desired can be obtained. According to Ladd (1915), hoping is viewed as mainly an activity or function of the unconsciousness. Combining Ladd’s view with Erikson’s (1963) developmental theory suggests that favorable residual from the first stage of development gives one a general, intrinsic and covert sense of hope. One’s sense of hope then may only become conscious and overt when there is
a hoped for "object", resulting from experiencing suffering or life struggles.

In the nursing literature, Schneider (1980) notes that hope is not normally present in a person's consciousness, but is an underlying sensation and belief that functions as a foundation for dealing with the process of living. Schneider indicates that feelings of hopelessness occur when people feel helpless, due to having lost control over matters that are important to them. Thus, Schneider indirectly proposes that powerlessness leads to learned helplessness, which in turn causes feelings of hopelessness.

Fromm's (1968) belief that hopelessness is precipitated by loss suggests that hopelessness can occur instantaneously and does not always result from powerlessness or learned helplessness. However, similar behaviors are exhibited by persons experiencing hopelessness and those experiencing powerlessness or learned helplessness, that is, lack of expression, withdrawal from contact with others, and inability to plan (Fromm, 1968).

Although the antithesis of hope may be hopelessness or fear, Ladd (1915) identifies it as despair. Ladd reveals that despondency results when the promise hope
provides is absent. In these early writings, Ladd describes the promise hope provides as an attitude and affective sense of a future good. This sense of a positive future results from three affective factors (i.e., desire, expectation, an attitude of trust) and at least a minimal amount of knowledge, as "the absolutely and completely unknown cannot be the object of hope" (Ladd, p. 27).

This postulated connection between hoping and knowing is significant, as this suggests that hope is not only an emotional state but a cognitive process. If hope is partially dependent on knowledge about the future, then falsely reassuring clients may not prompt them to be hopeful, and informing clients that they have only a limited time to live may eliminate their hope. Ladd (1915) eloquently describes this by stating "If nothing were doubtful, we should not hope; if everything were doubtful, we could not hope" (p.30).

Lynch's (1965) definition of hope "as the fundamental knowledge and feeling that there is a way out of difficulty" (p. 32) concurs with Ladd's (1915) views. According to Lynch, hope gives one the perception that there are solutions to handling problems, even the problems of illness. Korner (1970)
also agrees with Ladd's perception that hope and despair are inversely associated. Korner identifies the purpose of hope as being a defense against despair and that hopelessness can occur without depression.

Hopelessness in mentally ill people is defined by Lynch (1965) "as a sense of the impossible" (p. 48), as well as a feeling that the world is too much to handle and that it is futile to try. According to Lynch, mentally ill people become apathetic and unable to look to the future.

Korner (1970) differentiates between behaviors of depression and hopelessness by identifying that depressed people show their discomfort physically, while people experiencing hopelessness almost become invisible because they do not interact with the environment. Perhaps what Korner is describing are degrees of hopelessness, rather than a difference between depression and hopelessness. In either case, relating these behaviors to a society where "the squeaky wheel gets the grease" suggests that people who are feeling hopeless may rarely be attended to by the current health care system.

Interestingly, Lynch (1965) argues that hopelessness is not entirely a negative condition. He
states that some degree of hopelessness in people helps them to realize they are human and not omnipotent. The weakness in Lynch's argument is that a person who feels hopeless often does not feel important as a human being, so feelings of hopeless may make a person feel less human rather than more human.

Wishing is differentiated from hoping by many psychologists and nurses (Korner, 1970; McGee, 1984; Stotland, 1969; Wright & Shontz, 1968). Wishing is postulated as having mainly an emotional focus, while hoping also has a cognitive focus. Thus, hoping is more reality-based than wishing.

The nursing literature is divided as to whether or not hope is determined by one's personality trait. McGee (1984) identifies hope as being determined in part by one's predisposition, and Grimm (1991) conceptualizes hope as being both a trait and a state. Conversely, Dufault and Martocchio (1985) purport that hope is not trait-oriented. Vaillot (1970) also states that hope is not a personality trait, specifically, not the trait of optimism. Vaillot describes optimism as being a self-centered and superficial trait, while hope springs from the depths of one's being.
Lynch (1965), Korner (1970) and McGee (1984) view hope as a coping mechanism that fortifies people. Hope is defined by McGee as a stimulus for action, with the chosen response being based on: (a) the perceived importance of the goal, (b) perceived solutions, and (c) perceived probability of success in goal attainment. According to McGee, one's perceived probability of success is influenced by: (a) the situation, perceived personal control of the outcome, and (c) coping mechanisms.

McGee's (1984) conceptual model of hope (see Figure 3) depicts hopefulness and hopelessness as polar opposites, with discrete underlying categories. On one end of the continuum are the unrealistically hopeful, who may be immobilized during crisis situations because their hopefulness is not focused on reality. Usually these people only seek treatment when "forced" to do so by significant others.

On the opposite end of the continuum are the unjustifiably hopeless, who give up during crisis because they have no hope. Denial is the only thing that makes the situation bearable for these people. Health professionals may falsely perceive the passive behavior of these people as indicating that all of their
Figure 3. Schematic of McGee's (1984) model of hope
needs are met. People in the chronically fearful category experience an alarm or arousal reaction with the slightest change, since they have experienced many failures in life. Health providers and families find these people burdensome, as they require a high level of energy and patience from caregivers and family members (McGee, 1984). It may be possible that these two groups are actually experiencing learned helplessness, with the unjustifiably hopeless group using depression to cope with the learned helplessness.

The fragile copers vacillate between hope and despair, while requiring continual support from external sources (McGee, 1984). Correlating these behaviors with Erikson's developmental stages and Modeling and Role-Modeling theory (Erickson et al., 1988) may indicate that the fragile copers have anxious, rather than secure, attachments to their support systems, due to unfavorable residual from the trust versus mistrust stage of development.

McGee (1984) considers the realistic copers as the "mentally healthy". This group has a positive outlook on life and accepts periods of hopelessness in life while still maintaining a predominately hopeful status during crisis situations. Due to this group's positive
orientation to problems, McGee purports that caregivers are often the recipients of care from the realistic copers. This may be the group of people nurses describe as a joy to care for, because this group fulfills nurses' unmet needs.

Similarly to Grimm (1991), McGee (1984) states that one's level of hopefulness at any point in time is determined by a trait variable (optimistic or pessimistic personality), and by state variables. Examples of state variables are: (a) perceived probability of goal achievement, (b) perceived internal and external resources of support, and (c) importance of the goal (McGee, 1984).

Although hope is typically defined as a positive factor, the concept of hopefulness is rarely addressed in the nursing literature. Perhaps nurses' lack of concern about hopefulness exemplifies the valuing of clients' problems, rather than clients' strengths, and the priority given to "fixing" health problems rather than preventing problems.

Within the discipline of nursing, McGee (1984) and Hinds (1984, 1988) are two authors who have specifically defined hopefulness in their writings. As explained earlier, McGee states that people who are extremely
hopeful are unrealistic and will become immobilized in crisis situations. A premise of McGee's (1984) model is that "the medical ideology of cure fosters unrealistic hopefulness" (p. 42) in patients.

Hinds' (1984, 1988) insights into hopefulness come from a grounded theory generated definition of hopefulness from well and ill adolescents. Hopefulness is defined by Hinds as "the degree to which an adolescent possesses a comforting or life-sustaining, reality-based belief that a positive future exists for self or others" (1988, p. 85). Hinds (1988) hypothesizes that hopefulness is "both a biological and psychological response modifier, thereby influencing both tumor progress and sense of well-being in cancer patients" (p. 79).

The absence of the concepts hope and hopefulness in medical, psychological and philosophical references is a notable point (Corsini, 1984; Edwards, 1967; Glanze, 1986; Goldenson, 1984; Kamenetz, 1983; Miller & Keane, 1987; Pearce, 1983). One might conjecture that because hopefulness is not perceived as a problem or impairment, it has not become a part of the mainstream of these disciplines.
Theological encyclopedic references address the concept of hope at length, but do not specifically define hopefulness or distinguish it from hope (Eliade, 1987; Metford, 1983). Hope, from a theological perspective, is "the supernatural, infused, theological virtue that makes it possible for the Christian to expect with confidence to attain to eternal life" (New Catholic, 1967, p. 133). Biblical and theological references identify hope as a virtue (in conjunction with faith and charity), as an act (the act of hope) and as an impetus for religious renewal (Eliade, 1987; Metford, 1983; New Catholic, 1967). Most of the theological attention given to hope has occurred since World War II, possibly due to the tragedy of the war (New Catholic, 1967).

Rather than discussing hopefulness, the concept of hopelessness is more commonly addressed in the nursing literature (Campbell, 1987; Isani, 1963; & Schneider 1980). While no systematic definition of hopelessness is found in the literature, commonly described characteristics of the concept are: (a) negative expectations for the future; (b) loss of control over future outcomes; (c) passive acceptance of the futility of planning to achieve goals; and (d) emotional
negativism as expressed in despair, despondency, and/or desperation (Campbell, 1987).

According to Isani (1963), people experience hopelessness when they anticipate improving their situation by achieving a goal, but then fail to achieve the goal. This failure is compounded by unfavorable comparisons of the present situation with past anticipations of success. When a person fails to modify the goal or the route for achieving the goal, the goal remains unattainable and the person loses faith in himself and others. This results in a "giving up" attitude and increases feelings of hopelessness. Thus, Isani perceives hopelessness as being manifested by: (a) actions which lack effort towards goal attainment, (b) thoughts which reinforce the inability to achieve the goal, and (c) feelings of powerlessness. Although Isani describes these behaviors as being elements of hopelessness, the behaviors seem more descriptive of Seligman's (1975) concept of learned helplessness.

Research Based Definitions and Characteristics of Hope

In the late 1960s, a small group of psychologists began to study hope as an affective and cognitive process, rather than viewing hope as only an emotional
state or personality trait (Stotland, 1969; Wright & Shontz, 1968). Wright and Shontz's study of hope in handicapped children and adults found that the cognitive process of hope goes through developmental stages. In young children, primitive hopes are "equivalent to desires that are neither time- nor reality-dependent" (Wright & Shontz, 1968, p. 324). As children mature, hope becomes future-oriented but not reality based; until, as young adults, they begin to take charge of their lives. Mature adults realize that hope must be reality based and requires some action on their part (McGee, 1984; Wright & Shontz).

According to qualitative data analyzed by Miller and Powers (1988), hope is "a state of being characterized by an anticipation for a continued good state, an improved state, or a release from a perceived entrapment" (p. 6). Factors that seem to strongly influence hope are: "mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, and a sense of the possible" (Miller & Powers, p. 6).

McGee (1984) and Owen (1989) are two of the few writers to note that hoping requires energy. Based on qualitative data Owen (1989) collected from six oncology
clinical nurse specialists, hope is thought to be preserved or lost due to exchanging, transforming or moving energy. Synthesizing Owen's findings with Modeling and Role-Modeling theory (Erickson et al., 1988) suggests that people in a state of impoverishment may not have the energy needed to be hopeful, without assistance from others; and hoping may deplete the energy of those in a state of arousal.

Research by Hinds (1988) found four dimensions of hopefulness in adolescents. Similar to the unrealistic hopefuls identified by McGee (1984), Hinds found the least hopeful adolescents to be those who artificiality take on a more positive view of life, whereas adolescents who believed they would have a second chance at life were more hopeful. The next highest degree of hopefulness was exhibited in adolescents with positive expectations about the future in general; and the highest degree of hopefulness was found in those with specific, positive, future possibilities for themselves or others.

Based on a qualitative study of hope in cancer patients, Stoner and Kempfer (1985) conceptualized three spheres of hope: (1) intrapersonal, (2) interpersonal, and (3) global. Cancer patients are
thought to have varying levels of hope in these three spheres, but the levels were not specified.

Spheres of hope were also identified by Dufault and Martocchio (1985), based on their qualitative study of hope in older adults. Because Dufault and Martocchio's findings were specifically derived from an elderly population, the generalized and particularized spheres of hope elucidated in their work provided part of the theoretical framework for this research study. The theoretical framework, including an in-depth description of generalized hope and particularized hope, can be found in Chapter 1 (see p. 13-16).

**Impact of Hope on Illness and Death**

During the late 1960s and early 1970s, a small number of nurses, physicians and psychologists began to examine the relationship between psychological functioning and physical illness or death in order to explore why people become ill or die at specific times in their lives (Engel, 1968; Jourard, 1970; Travelbee, 1971; Vaillot, 1970). Exploring the possible existence of a connection between the mind and body was in opposition to the mechanistic paradigm espoused at that time; because historically, disease had been investigated from
a reductionistic perspective that excluded examining possible psychosocial etiologies (Engel, 1968).

In 1970, Jourard described illness as an existential phenomenon. He argued that people live only as long as they experience meaning and value in their lives, that is, only as long as they have something meaningful that invites them into the future, and provides new insights about living and dying. "As soon as meaning, value, and hope vanish from a person's experience he begins to stop living; he begins to die" (Jourard, 1970, p. 273).

A premise of Jourard's (1970) beliefs is that self-destructive mechanisms are always present in people's physical being, but that these destructive mechanisms are held in check as long as the individuals experience meaning and hope in their lives. When meaning and hope in life are diminished, the self-destructive mechanisms are able to function free of mental controls. According to Jourard (1970), mental and physical illnesses are evidence that a person has outgrown his/her lifestyle, and that illness is a time "to stop, reflect and meditate, dream, and invent a new self" (p. 274).

Engel's (1968) research findings regarding the life situations in which patients become ill or die give
empirical credence to Jourard's (1970) ideas. Using retrospective methods, Engel identified life situations which seemed conducive to illness and death, and labeled these phenomena the "giving-up--given-up complex". The five characteristics of the complex are: (a) a giving up component resulting from helplessness or hopelessness; (b) a self image of no longer being competent or in control; (c) feelings of less gratification or support in interpersonal relationships or roles in life; (d) feeling a disruption in the sense of continuity between past, present, and future; and (e) reactivation of memories of earlier periods of giving-up. Using current terminology to describe the characteristics of the complex results in the following labels: (a) situational powerlessness and/or learned helplessness; (b) low self-esteem; (c) lack of affiliation; (d) loss of hope or future orientation; and (e) prior unresolved developmental stages and/or unfilled needs.

According to Engel (1968), the mind constantly seeks solutions to conflicts or stress by examining past and present coping strategies. When the mind can not find a solution or coping strategy, it alternates between giving up and struggling to find a solution.
Engel's (1968, 1971) research findings support Jourard's (1970) idea that disease occurs during periods of psychic disequilibrium, when the body's ability to fight off certain potentially pathogenic processes is reduced. Engel (1968) suggests that in order for a specific organic disease to develop, a genetic predisposition to the disease must already exist or the person will become mentally ill but not physically ill. Thus, the giving-up--given-up complex contributes to the emergence of disease but does not cause a specific physical disease; nor is the occurrence of a specific disease solely contingent upon the complex.

Engel's (1968) theory has been supported by several physiological studies (Engel, 1971; Greene, Goldstein, & Moss, 1972; Schmale & Iker, 1966, 1971). Kiecolt-Glaser and Glaser (1986) found that heightened and sustained periods of emotional distress or disequilibrium increased transient immunosuppression, especially in the elderly. Hopelessness is one type of psychic disequilibrium that has been correlated with the occurrence of cervical cancer (Schmale & Iker, 1966, 1971), cardiac arrests, and cardiovascular accidents (Engel, 1971; Greene et al., 1972). As knowledge about the connection between hopelessness and occurrence of
disease has increased, the medical community has begun to recognize the provision of hope as a powerful treatment (Cousins, 1989).

Recognition of the connection between hope and health is not a new idea. The impact feelings of hope and hopelessness have on health and illness was described in the early 1970s by Vaillot (1970) and Travelbee (1971). Publications by these two nurses are "classics" in the nursing literature on hope. As with these publications, much of the hope literature in nursing has been based on data obtained from general clinical observations or case studies, rather than from quantitative research (Hickey, 1986; Lange, 1978; Limandri & Boyle 1978; Miller, 1985; & Schneider, 1980).

A case study that exemplifies the impact feelings of hope and hopelessness have on clients is Dubree & Vogelpohl's (1980) description of Barney, an intensive care unit patient Vogelpohl worked with as part of a graduate nursing course. Barney had been labeled by the staff as depressed, and a "problem" patient. By becoming Barney's sounding board, Vogelpohl learned that Barney had entered the hospital with an unrealistically hopeful attitude that someone could change his situation without him having to do anything. When this
Vogelpohl's nursing interventions focused on giving Barney a sense of the possible, by setting specific goals and demonstrating that help was available from others. As a result, Barney made dramatic progress in his physical and overt emotional status.

To help Barney prepare for the separation process, Vogelpohl intermittently reminded Barney that they would have to terminate their relationship at the end of Vogelpohl's three month clinical experience. Although Barney seemed to be in satisfactory physical condition when Vogelpohl made her last scheduled clinical contact, he died less than thirty hours later. Dubree and Vogelpohl (1980) attribute Barney's death to his overwhelming sense of hopelessness following Vogelpohl's termination of their relationship.

Similar case studies in the literature suggest that hope is a very powerful force, that depends on the attitude of those around the client and the client's perceived availability of help from others (Stotland, 1969; Travelbee, 1971). Nurses need to be aware of the power of hope, and that "the decision to use realistic hope as a nursing intervention involves making a conscious choice to use oneself in an ongoing
relationship" (Dubree & Vogelpohl, 1980, p. 2049). The involvement and commitment implied in this type of relationship is a connectedness and mutuality with clients that is beyond what many nurses consider to be a "professional" nurse-client relationship.

In order to use "realistic hope" as a nursing intervention, nurses need to have an accurate theoretical model of hope, including factors that facilitate individuals' perceptions of hope. Thus, theories of hope are discussed next.

Theories of Hope

Nurses interested in deductively building knowledge in the area of hope need to base their research on a theoretical framework. Theoretical models of hope have been purposed by Stotland (1969), Travelbee (1971) and Miller (1983). Also, as described in Chapter 1, the nursing theory Modeling and Role-Modeling (Erickson, et al., 1988) provides a theoretical framework for understanding hope within a broader context.

Stotland (1969), a psychologist, was one of the earliest hope theorists. By conducting post hoc analyses on case studies of people who attempted or committed suicide in a mental hospital in England, he inductively developed a theory of hope that addressed
suicidal behavior (Kobler & Stotland, 1964). Stotland's work was a turning point in the study of hope, as prior to his book, The Psychology of Hope, (1969) hope had not been recognized as a "legitimate" construct in psychology.

In his writings, Stotland (1969) defines hope as "an expectation greater than zero of achieving a goal" (p. 2); and hopelessness as a negative expectancy concerning oneself and one's future. His main premise is that many people are mentally ill due to feeling hopeless; and thus, can not independently help themselves to improve. As a result, mentally ill individuals indirectly ask others to help them, often using indirect verbal messages as initial pleas for help. If people do not respond to these messages, the hopeless person might attempt suicide as another plea for help. Actual suicide though is not the intention, as the individuals expect to be rescued. Stotland claims that what the mentally ill really want is to change their situation; but because they do not know how, they look to those around them to find direction for their actions.

According to Stotland (1969), therapy needs to focus on giving hopeful cues to patients. Jourard
(1970) also believes that environmental cues are important, and states that cues from one's culture invites a person to die at a certain age. In addition, Stotland suggests using goal setting as a therapy in order to: (a) change the aspects of people's environmental situations that initially caused their mental illness, and (b) decrease anxiety experienced from feeling hopeless. Decreasing anxiety is thought to indirectly increase hope, because less anxiety increases motivation for achieving goals, which in turn leads to hopefulness.

Although Stotland's (1969) theory provides direction for working with elderly clients who are already experiencing feelings of hopelessness, it does have limitations. The theory is limited in scope because: (a) it does not address the interrelationship between hopelessness and coping with multiple physical limitations, (b) many elderly are not able to change their environmental circumstances due to financial or physical reasons, and (c) prevention of mental illness is not adequately addressed. Primary prevention of hopelessness is an important factor when working with community-based elderly.
Another theoretical framework of hope is one proposed by Travelbee. In her book, *Interpersonal Aspects of Nursing* (1971), hope is defined "as a mental state characterized by the desire to gain an end or accomplish a goal combined with some degree of expectation that what is desired or sought is attainable" (p. 77). In contrast, hopelessness is defined as "being devoid of hope" (p. 81). Travelbee's theory is based on two assumptions: (a) it is the role of the professional nurse to assist the ill person to experience hope, in order to cope with the stress of illness and suffering; and (b) in all life experiences, human beings are motivated by a search for meaning.

A major theme of Travelbee's (1971) theory is the relationship between hope and dependence on others. Travelbee's view of hope is congruent with Vaillot's (1970), who states that hope begins when one has exhausted his/her own resources and needs to draw on the strength of others. According to Travelbee, hope emanates from the knowledge that help is available in times of need and distress. Assistance or help from others, especially when one's inner resources are not sufficient, builds trust in humans. Thus, Travelbee
suggests that social support enables a person to be more hopeful, which in turn improves coping abilities.

In Travelbee's (1971) theory, hope is also related to perseverance, choices, and courage. Travelbee proposes that when people are hopeful they can cope with suffering and find meaning in the suffering, which in turn enhances coping and hopefulness. When a person experiences prolonged suffering without support or assistance, Travelbee believes that the person begins to lose hope and feels despair. If the suffering continues without support, the person experiences apathetic indifference, resulting in an "interpersonal emergency".

The generalizability of Travelbee's (1971) theory to acute care settings is limited, because most hospital stays are short. In many situations, it would be difficult to accomplish the five phases of the human-to-human relationship Travelbee deems necessary in order to establish rapport with clients. Accordingly, her theory may be more appropriate for long term care or public health settings. Also, Travelbee's assumption that people search for meaning in life experiences may not be applicable for some cultures, and for clients who have major basic need deficits (e.g., low socioeconomic status, chronic pain).
Miller's (1983) theory of the powerlessness - hopelessness cycle provides guidance in working with older adults, as the theory was specifically developed to explain phenomena experienced by elderly who feel threatened by chronic illness or hospitalization. The theory is based on: the adaptation paradigm, Engel's (1968) giving-up--given-up complex, and qualitative data. Miller proposes that the powerlessness-hopelessness cycle starts in older adults when chronic illness or hospitalization produces situational powerlessness. Normally, elderly people are able to adapt when changes occur gradually. However, when older adults experience continual losses they are vulnerable to powerlessness, and chronic pathologic conditions or hospitalization may result in impaired adapting.

Miller's (1983) model depicts powerlessness as causing low self-esteem and depression, which in turn leads to hopelessness. When hopelessness is reached, the person is immobilized and gives up trying, which causes an increased sense of powerlessness. The cycle continues until the level of hopelessness becomes so severe that it leads to isolation, loneliness, and death.
This model (Miller, 1983) has utility as a theoretical framework for understanding hope in elderly people living in community and institutional settings. However, a clear distinction between powerlessness and learned helplessness is lacking; and an explanation of why some elderly become hopeless and some do not, when experiencing the same stressors, is not adequately addressed.

Learned Helplessness as a Related Theory

A phenomenon related to hopelessness is learned helplessness. Seligman's (1975) theory of learned helplessness is based on the premise that people learn when outcomes are independent of voluntary responses. Over time, the inability to control outcomes through voluntary responses results in: (a) behavior changes, exemplified by low motivation to respond to stimuli; (b) cognitive changes, demonstrated by lack of ability to learn and perceive success; and (c) emotional disturbances, such as depression.

An assumption of Seligman's (1975) theory is that people are born generalizers. Consequently, when a person learns that voluntary responses are independent of outcomes in one situation, the feelings are generalized to other situations. This learned behavior
is deeply entrenched when lack of control (powerlessness) is experienced repeatedly within a 72 hour time period. Changing this learned behavior is more difficult than learning new behavior, which makes "quick fixes" for this learned process ineffective.

The younger a person is when perceived lack of control over the environment is experienced, the more tenacious the learned helplessness characteristics. This is especially true for situations where gratification, nurturance, or relief from suffering was desired. Repeated powerlessness in these situations stimulates feelings of fear. To cope, people frequently become depressed as a way to inhibit future fear and keep the present fear within tolerable limits (Seligman, 1975).

People's perceptions of the reasons (or attributes) for the lack of control are critical in determining the extent to which people experience learned helplessness (Robertson, 1986; Stoner, 1985). Theoretically, the strongest feelings of helplessness are experienced by those who perceive the lack of control as: (a) due to their own inadequacies (internal vs. external attributes); (b) pervading their whole life (global vs.
specific attributes); and (c) having long term negative consequences (stable vs. unstable attributes).

LeSage, Slimmer, Lopez, and Ellor's (1989) research on the relationship among these variables showed that in nursing home residents negative attributions were significantly correlated with learned helplessness. Unfortunately, many of the residents who were identified by the staff as exhibiting learned helplessness behaviors refused to participate in the study. The passive and withdrawn nature of this type of client may make it difficult to do clinical research in this area.

Based on the study by LeSage et al. (1989), it is important to note that nursing staff frequently become angry with clients exhibiting learned helplessness behaviors. This is a change from earlier research by Taylor (1979), that identified the "good" patient as one who is frequently passive or helpless. This change in staff's perceptions of clients' behaviors may have been influenced by the self-care movement in society, and the limited number of staff in many health care settings.

Nurses' frustrations with dependent, helpless clients seem likely to bias the care nurses provide these clients. As a result, nurses may be slow to respond to these clients' requests, begrudgingly provide
care, and overcompensate by treating the clients as helpless children. Such behaviors by nurses may add to clients' learned helplessness, because induced dependence from extensive assistance in completing a task can increase helplessness (Avorn & Langer, 1982).

A weakness of Seligman's (1975) theory is the absence of a clear differentiation between learned helplessness and hopelessness. Specific interventions to decrease learned helplessness in clinical practice are also lacking in the theory, although a general orientation for helping those experiencing learned helplessness is provided.

**Measurements of Hope**

Before theories related to hope can be tested, researchers need instruments to measure how variables affect hope and how hope affects other variables. Stotland's (1969) theory of hope has been a significant precursor to the development of such instruments. Prior to the publication of his theory, most psychologists viewed hope as a "diffuse feeling state and consequently too vague and amorphous for quantification and systematic study" (Beck, Weissman, Lester & Trexler, 1974).
One of the first instruments developed to measure an aspect of hope was Beck's twenty item Hopelessness Scale (Beck et al., 1974). This widely used scale is based on Stotland's conceptual definition of hope and has good reliability (alpha = .93). However, the validity of the Hopelessness Scale for measuring the complete dimensions of hope has been questioned, because the scale does not measure extreme hopefulness (Greene, 1981; McGee, 1984).

A scale that measures the broad dimensions of hope, as defined by Stotland (1969), is Gottschalk's Hope Scale (1974). This scale uses content analysis to evaluate clients' verbalizations during a five minute taped period. Gottschalk's scale has been effectively used in nursing research (Erickson & Swain, 1982).

Erickson, Post and Paige (1975) also developed a scale based on Stotland's (1969) definition of hope. This twenty item Hope Scale is reliable (alpha = .79) and covers the broad dimensions of hope. However, when the scale was pilot tested on cancer patients it was found to be confusing and some of the items were not applicable for older adults (Stoner & Keampfer, 1985).

In contrast, the Stoner Hope Scale (Stoner & Keampfer, 1985) is applicable for both older adults and
ill individuals. This scale measures three types of hope: (1) global, (2) intrapersonal, and (3) interpersonal. A difficulty with this scale is that some of the items related to global hope (e.g., access to cultural facilities like symphonies) may not be appropriate for individuals of various socioeconomic levels and for people living in rural geographic areas. A more appropriate scale for use with a diverse population is the Hope Index Scale (Obayuwana, Collins, Carter, Rao, Mathura & Wilson, 1982).

Hope has been measured in a community-based older population by modifying Beck's Hopelessness Scale and the Stoner Hope Scale. The resulting instrument is called the Hopefulness Scale (Farran, Salloway, & Clark, 1990). For the purposes of this study, a concern about the instrument was whether it measures global (generalized) hope, as reported in the literature, or whether it actually measures particularized hope.

Several nurses have developed hope scales based on qualitative studies. Miller (1986/1987) studied 59 persons who survived a critical illness to develop the Miller Hope Scale for adults (Miller & Powers, 1988), and Hinds (1984) studied 25 adolescents to develop the Hopefulness Scale for Adolescents. Plummer (1988) used
qualitative data, clinical experience and a review of the literature to develop an 18 item, forced choice, Indices of Hope Questionnaire that was tested on institutionalized elderly.

Nowotny's (1989) Hope Scale was developed based on a conceptual framework derived from a review of the literature. The scale has been successfully tested on a large number of well adults and adults with cancer ($N = 306$; Cronbach alpha = .90). Interestingly, the cancer patient's scores were similar to those of the well adults.

The number of instruments recently developed to measure hope in a variety of populations attests to the significance of this construct.

Research Related to Hope

Much of the research literature on hope is based on Beck's Hopelessness Scale, case studies, or descriptive data; because, as already noted, instruments to measure hope from a multidimensional focus have only recently been developed. As previously identified, hopelessness has been correlated with the development of cancer (Schmale & Iker, 1966, 1971), and sudden death (Engel, 1968, 1971; Greene et al., 1972). Negative attitudes about the future have also been significantly correlated
with decreased survival in "terminally" ill nursing home cancer patients (Stein, Linn, & Stein, 1989).

Intriguingly, Greene, O'Mahony, and Rungasamy (1982) found that hopelessness scores of people who were chronically ill did not differ from scores of those who were acutely ill. When this finding is interpreted in relationship to Miller's (1983) theory of the powerlessness-hopelessness cycle, one might speculate that the health care delivery system affects people's feelings of hopelessness more than length of illness.

Research findings examining the correlation between hopelessness and locus of control have had mixed results. Prociuk, Breen, and Lussier (1976) found hopelessness to be related to increased external locus of control and depression. Similarly, Farran (1985) observed that in community-based elderly internal locus of control was significantly correlated with higher levels of hope. However, Larisey (1983) and Brandt (1987) found no statistically significant relationship between hopelessness and locus of control.

Brandt (1987) studied women receiving chemotherapy for breast cancer and learned that most of the women (29 out of 31) reported not feeling hopeless, even though the majority had an external locus of control. Similar
findings were uncovered in Rideout and Montemuro's (1986) study of patients with chronic heart failure. Also of interest was the finding that adaptability in these patients related more to their positive future orientation than to the severity of their disease.

Brockopp, Hayko, Davenport and Winscott (1989) found a significant ($r = .34; p = .01$) relationship between interpersonal control and hope. In Rothlis' (1984) study, the use of self-help groups decreased feelings of hopelessness and loss of control (i.e., helplessness).

In Brandt's (1987) and Rideout and Montemuro's (1986) studies on hope, an association between hope and social support was noted, although the relationship was not statistically significant. Farran and McCann (1989) found that social support was a predictor of hope in community-based elderly over a two year period of time. These findings suggest that the relationship between social support and hope is more stable over time than the relationship between control and hope.

Research studies by Mays (1982/1984) and Daboub (1988/1989) specifically examined hope in the elderly. Mays' study investigated the relationships among self-esteem, life satisfaction and hope in 54 well-oriented
ambulatory people, 60 years of age and older. A significant positive relationship was found between hope and life satisfaction ($r = .42$), and a significant relationship was observed between hope and self-esteem ($r = -.37; p < .05$ [low scores on the instrument measuring self-esteem reflect high self-esteem]). However, generalizability of these findings is limited because subjects were not randomly selected for the study.

Daboub's (1988/1989) study investigated the relationship between purpose in life and hope in 65 elderly adults, 60 years of age and older. A strong positive relationship was discovered between purpose in life and hope ($r = .63, p = .00$). Interestingly, a gender difference was observed for the variable hope; as the female subjects were more hopeful than the male subjects. This finding suggests that assessing older men's levels of hope is especially important, particularly since hope is related to mental and physical health in community-based elderly (Farran, 1985).

The literature also indicates that spiritual beliefs and hope are significantly correlated (Farran, 1985; Herth, 1989). During illness situations,
hopelessness was found to be inversely correlated with perceived helpfulness of religious beliefs (Brandt, 1987).

Evidence supporting Stotland's (1969) theory that environmental cues influence people's levels of hope has been obtained by several researchers (Buehler, 1975; Seligman, Macmillan, & Carroll, 1971; Sobel, 1969). Of note is Herth's (1989) finding that clients who receive chemotherapy in inpatient or outpatient settings are significantly more hopeful than those receiving treatments at home. Herth interpreted this finding as indicating that the difference may have been due to the hopeful attitude of the staff.

O'Malley and Menke (1988) tested clients within a week of having a myocardial infarction and obtained unexpectedly high hope scores. It is possible that these findings are indicative of clients' denial of the affect the infarct would have on their lives, rather than depicting their actual level of hope.

Cancer patients in Young-Brockopp's study (1982) rated the need for hope as the number one priority. This need for hope was not only hope for a cure, but hope for some pleasurable feeling or event. Artinian's (1984) descriptive study on fostering hope in children
having bone marrow transplants suggests that goal setting is an important intervention for increasing one's level of hope.

A study by Wendland (1985) delineates several hope promoting factors, as identified by 25 community-based elderly subjects. Based on interviews, factors frequently cited as facilitating hope were: (a) family (children, spouse, grandchildren); (b) spiritual aspects of life (attending church, relationship with God, and scripture/prayer); (c) physical health; and (d) a positive or determined attitude. Family factors identified as facilitating hope were mutual support and being part of each other. Grandchildren were thought to facilitate hope through newness and stimulation (e.g. being curious about the future).

In Wendland's study (1985), friends and spiritually were identified as facilitating hope by providing support and personal growth. A sense of spiritually also aided hope by providing enjoyment, peace and purpose in life. Good health and a positive attitude were mentioned as facilitating hope by providing motivation or energy and freedom or independence. These findings provide beginning insights regarding hope in community-based elderly people, and information about
factors that may possibly promote hope in this population (Wendland, 1985). However, because quantitative methods were used to analyze the interview data, the contextual meaning of these findings is lacking.

The actual affect nursing interventions have on clients' hope is difficult to determine, as few experimentally designed research studies are found in the literature. Smith (1982) used a quasi-experimental design to study hope and the effect of teaching college students imagery techniques. No statistically significant relationship was observed between teaching students imagery techniques and their hopelessness, but the research design had severe limitations.

Another intervention study found in the literature used a strong experimental design to study hopelessness in females. The findings suggest that a 14 week (2 hours/week) cognitive-behavioral therapy group session significantly decreased subjects' hopelessness scores for a three year period (Gordon, Matwychuk, Sachs, & Canedy, 1988).

Hope promoting nursing strategies have been identified in two qualitative research studies (Miller, 1989; Hinds, Martin, & Vogel, 1987). These studies
provide helpful preliminary data for correlational and experimental research in this area.

In Miller's study (1989), nine hope-inspiring themes were identified from interviews with clients \((N = 60)\) following discharge from a critical care unit. The hope-inspiring themes were: (a) cognitive strategies, (b) mental attitude of determinism, (c) philosophy of life, (d) spiritual strategies, (e) relationships with caregivers, (f) family bond, (g) sense of being in control, (h) goal accomplishment, and (i) miscellaneous strategies, like humor and distraction. The study by Hinds et al. (1987) used grounded theory methods to identify the hope process adolescents with cancer go through. Based on the data, humor was the only strategy directly linked to promoting hopefulness. Cognitive distracters were noted as preceding a state of hopefulness, but a trusting nurse-client relationship was identified as being a prerequisite for any hope promoting strategies.

**Summary**

In the discipline of nursing, empirically based interventions for promoting hope are lacking; as most hope related interventions found in the literature are
based on unstructured clinical observations or nurses' beliefs. In addition to the gap in research based interventions to promote hope, the nursing literature lacks research data on the relationship between developmental residual and hope in elderly people. Although it is theorized that hope originates from psychosocial developmental residual, a better understanding of the relationships among developmental residual, particularized hope, and generalized hope is needed to assist nurses in identifying hope promoting nursing interventions.

As presented in this chapter, an analysis and synthesis of the literature on psychosocial development and hope indicates that an adequate theoretical model for describing hope is lacking. Drawing from the literature, a model of hope based on developmental residual from early stages of life is needed and should be empirically tested in an elderly population. This is an area of research that awaits exploration, and is needed for clinical practice. The research study overviewed in Chapter 1, and detailed in the next chapter, serves as an initial step for building knowledge in this area.
CHAPTER III

METHODOLOGY

Over the centuries, scholars' fascination with "what", "how" and "why" questions has stimulated the development of quantitative and qualitative research methods. Quantitative methods are useful for addressing many "what" questions, but "how" and "why" questions are difficult to answer using such methods. This is especially true when asking why or how humans respond or interact as they do in specific situations. Qualitative research methods provide a framework for answering these types of questions about humans. Research using qualitative methods attempts to capture the complex interrelationships of situations, whereas quantitative methods try to precisely examine isolated categories (McCracken, 1988). Both quantitative and qualitative methods were used in this study due to the nature of the research questions of interest.

The research design of the study is described in this chapter, including an overview of the triangulation process. Following the design section, selection of the sample is discussed and a detailed description of the data collection process is provided. Next, protection of subjects' rights is addressed. The chapter concludes with an explanation of the instruments used in the study.
Research Design

A correlational design (including association and prediction), with a descriptive component, was used to address the research questions identified in Chapter 1. Correlational designs, also called exploratory correlational surveys (Woods & Catanzaro, 1988), are "appropriate when discovering associations or relationships between or among certain variables" (Phillips, 1986, p. 205). Associations among variables, rather than causality, is the focus of research when the variables under study can not be experimentally controlled or manipulated.

A correlational design was appropriate for this study because experimental manipulation of psychosocial development and hope in an older population was not ethically or scientifically sound without first doing this correlational study.

Correlational designs are also fitting when descriptive data about the variables of interest have already been obtained by studying the variables independently. Findings from such descriptive studies provide information for the researcher to ask questions about the associations among variables studied together for the first time (Brink & Wood, 1983). Thus, previous
research findings are synthesized to develop a theoretical framework that is tested by the correlational design.

As noted in Chapter 1, previous descriptive studies on hope in the elderly (Dufault & Martocchio, 1985; Farran, Salloway, & Clark, 1990; Wendland, 1985) were synthesized with Modeling and Role-Modeling theory (Erickson et al., 1988) to develop the theoretical framework tested in this study.

Using a correlational design for a study affords the researcher several benefits. When correlational studies build on previous descriptive studies, finding significant associations among variables often results in the generation of hypotheses that can be tested in future studies (Woods & Catanzaro, 1988). Another benefit of a correlational design is the examination of the degree of association among variables, rather than noting the association as only "all or nothing". In addition, correlational designs can be used in realistic settings to study several variables simultaneously.

Limitations of a correlational design include: (a) caution in identifying cause-and-effect relationships, because control over extraneous variables is limited; and (b) the risk of identifying spurious or arbitrary
relational patterns that have little validity or reliability (Isaac & Michael, 1981). To minimize possible limitations, care was taken to address these issues in the design of the study (see next section).

Controls in Correlational Research Designs

For quantitative research, the ability to generalize findings to situations similar to the one being researched is of great interest to clinicians and researchers. With correlational survey designs, generalizability (external validity) is enhanced by using random sampling procedures to select a representative sample of the population of interest (Woods & Catanzaro, 1988). To improve the generalizability of the quantitative component of this study, random sampling procedures were used to identify which apartment residents were invited to participate in the study.

The homogeneity of a sampling frame provides a degree of control over extraneous variables, as does limiting the time span during which data are collected. The sampling frame for this study was moderately homogeneous because subjects' place of residence was similar, that is, community-based congregate housing. The timeframe for collecting data for the study was
limited as much as possible, with data being collected between February, 1991 to April, 1991.

Accurate measurement of variables is another critical factor affecting the internal validity of a correlational design (Brink & Wood, 1983). Reliability and validity of the instruments used to measure the variables is addressed later in this chapter.

An additional method for supporting the internal validity of findings is triangulation; as triangulation uses independent measures of the phenomena of interest to come to agreement regarding the findings, or at least to note that contradictions in the findings do not exist (Miles & Huberman, 1984). Because a correlational design is subject to identifying spurious or arbitrary relational patterns, the correlational data in this study was triangulated with a descriptive design using qualitative methods.

**Triangulation**

In research, triangulation is a general term implying the use of multiple or different data sources, research methods, investigators, or theories (Duffy, 1987; Lincoln & Guba, 1985). Triangulation of research methods is called between-methods triangulation because
both qualitative and quantitative methods are used (Duffy, 1987). Between-methods triangulation is frequently employed in nursing research because the discipline is interested in the holistic human experience (Duffy, 1987; Murphy, 1989). This type of triangulation helps to assimilate the qualitative-quantitative dichotomy in nursing research by "conducting research from the perspective of a human science and within the context of the everyday practices of nurses." (Porter, 1989, p. 101).

McCracken (1988) encourages researchers to use between-methods triangulation to take advantage of the positive aspects of both research methods. Quantitative methods are useful in identifying the existence of relationships among variables, while qualitative research is useful in understanding the social and cultural context of the relationships among the variables (McCracken, 1988). Thus, a research study that triangulates a quantitative design with a qualitative method has two benefits:

1. The validity of findings derived from correlational methods can be "double checked" against descriptive findings.
2. Qualitative data can provide "additional explanatory power to quantitative outcomes" (Hinds, 1989, p. 442-443).

The first three research questions of this study were addressed using quantitative methods within a correlational design:

Question 1. What is the relationship between psychosocial developmental residual and level of hope?

Question 2. Does trust versus mistrust developmental residual significantly predict generalized hope?

Question 3. Does autonomy versus shame and doubt developmental residual significantly predict particularized hope?

Psychosocial developmental residual, the predictor variable in these questions, was operationalized using the Modified Erikson Psychosocial Stage Inventory (Darling-Fisher & Kline Leidy, 1988). The criterion variables (levels of hope, particularized hope, and generalized hope) were operationalized using the Nowotny Hope Scale (Nowotny, 1989).
A descriptive research design employing qualitative methods was used to address the remaining two research questions:

Question 4. How has hope been promoted or decreased during stressful or difficult times in elderly people's lives?
Question 5. How is the future perceived by the elderly?

Data on these two questions were obtained from interviews with subjects. According to Van Maanen (1979), obtaining this type of qualitative data helps uncover the meaning, rather than only the frequency, of naturally occurring phenomena in the social world.

Qualitative Component of the Study

As a professional discipline, the ultimate goals of nursing research are the improvement of patient care and the enhancement of the health care system. Qualitative methods help meet both of these goals by exploring the interrelationship between troubles (e.g., health needs) people experience in their personal lives and public responses (e.g., health care policies) to those troubles (Denzin, 1989).
Meeting people's needs requires understanding how people interpret the interactions that occur in their world, and especially how interactions have altered how they define themselves and their relations with others. Denzin (1989) calls these significant interactional moments "epiphanies", because these experiences are often turning points in people's lives.

The qualitative component of this study examined elderly people's epiphanies in order to gain an understanding of how hope has been promoted or decreased during significant moments in their lives. How elderly people view the future after experiencing turning points in their lives was also explored.

Although the people in this study experienced individual epiphanies, "no individual is ever just an individual. He or she must be studied as a single instance of more universal social experiences and social processes" (Denzin, 1989, p. 19). The qualitative component of this study attempted "to uncover this complex interrelationship between the universal and the singular, between private troubles and public issues in a person's life" (Denzin, 1989, p. 19).

Elucidating the connection between private troubles and public issues requires understanding the contextual
background of each subject's self-story. Thus, for this study subjects were interviewed regarding their epiphanies, hope, and sense of the future.

**Rigor in Qualitative Research**

The *credibility* of qualitative research is analogous to the internal validity of quantitative research. The qualitative researcher must show that the multiple constructed realities of a situation are accurately reflected in the findings, resulting in a true and full picture of the data (Duffy, 1987). Strategies to enhance the credibility of qualitative research include: (a) prolonged engagement in the situation being studied, (b) triangulation of sources or methods, (c) negative case analysis, and (d) member checks (Lincoln & Guba, 1985; Porter, 1989). For this study, triangulation of data sources and member checks at the end of each interview were used to address the credibility of the findings.

Consistency in research findings is of utmost importance in both qualitative and quantitative research projects. Within the quantitative research framework, consistency is evaluated in reference to the reliability of the data collection instruments. One of the basic
beliefs of the natural paradigm is that reality is changed by studying it (Lincoln & Guba, 1985). Therefore, qualitative research methods are concerned with dependability rather than reliability.

Dependability in qualitative findings can not exist unless credibility in the research is first present (Porter, 1989). This means that the strategies used to assure credibility will also enhance the dependability of the research. Additional strategies to maximize dependability are coding formats, keeping detailed field notes, audit trails and inquiry audits (Miles & Huberman, 1984; Sandelowski, 1986; Kirk & Miller, 1986).

An inquiry audit involves a detailed examination of the research process by someone outside of the research team (Lincoln & Guba, 1985). For this study, a nurse researcher external to the study conducted an inquiry audit of the qualitative findings, using coding formats and summary sheets (including field notes) as part of the audit trail. In addition, interrater reliability between the investigator's coding of data and the external nurse researcher's coding was determined (Woods & Catanzaro, 1988).

Inquiry audits also provide information about the confirmability of qualitative research, as well as the
dependability of the research. Confirmability addresses the conventional concept of objectivity or neutrality in research (Lincoln & Guba, 1985). Even though the natural paradigm views inquiry as value-bound, qualitative data must be factual and confirmable. An inquiry audit examines the decisions in the audit trail to determine if the research findings, interpretations and recommendations are internally coherent (Lincoln & Guba, 1985; Porter, 1989).

Sample Selection

The target population for this study included elderly individuals living in community-based congregate housing units in a small (population < 20,000), rural, midwestern city of the United States. A list of the elderly residents of two community-based congregate housing units in this city served as the sampling frame. The list of names was obtained from the managers of the housing units. Simple probability sampling was used to select subjects from the sampling frame.

In order to be included in the study, subjects met the following criteria:

(a) sixty-two years of age or older;

(b) ability to speak and read English;
(c) residing in a community-based congregate housing unit; and
(d) ability to give written consent to participate in the study.

The managers of the congregate housing units determined if apartment residents met these criteria before residents' names were included in the sampling frame.

The sample size for the quantitative part of the study was 90. This sample size was determined by using the multiple regression option of the Sample Calc computer program (Anderson, 1982). By setting the significance level at $p = .05$ and the power level at $.80$ (20% chance of making a beta error), Sample Calc identified that 88 subjects were needed for the sample when a moderate (.44) potential effect size among the variables was projected and up to eight predictor variables were used. The sample size was based on eight predictor variables due to the eight subscale scores on the Modified Erikson Psychosocial Stage Inventory.

In order to obtain 90 subjects for the study, 128 randomly selected apartment residents were invited to participate. Thus, the participation rate was 70%.

Of the 90 subjects completing the quantitative instruments, simple probability sampling was used to
initially select 20 subjects who were also interviewed as potential subjects for the qualitative component of the study. Although qualitative research characteristically uses purposive sampling to increase the likelihood of obtaining data from the existing multiple realities (Lincoln & Guba, 1985), random sampling was done initially to facilitate collecting interview data and quantitative data during only one personal visit to subjects.

After collecting data from the 90 subjects, interviews with the subset of 20 subjects were placed into one of four groups according to subjects' scores on the trust-mistrust and autonomy-shame subscales of the Modified Erikson Psychosocial Stage Inventory (see Figure 4). Criteria established by the investigator prior to data collection specified that before purposively selecting interviews for data analysis there would be a minimum of four interviews in each group.

After computing subjects' psychosocial developmental scores, it was found that randomly selecting subjects to be interviewed attained an adequate representation of subjects in three of the four groups, with the exception being those with high trust-mistrust scores and low autonomy-shame scores.
Figure 4. Placement of interviews into one of four groups, based on subjects' subscale scores for trust and autonomy on the Modified Erikson Psychosocial Stage Inventory.

<table>
<thead>
<tr>
<th>Development</th>
<th>trust</th>
<th>mistrust</th>
</tr>
</thead>
<tbody>
<tr>
<td>autonomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group A:</td>
<td>trust = 4 or &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>autonomy = 4 or &gt;</td>
<td></td>
</tr>
<tr>
<td>Group B:</td>
<td>trust = 3 or &lt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>autonomy = 4 or &gt;</td>
<td></td>
</tr>
<tr>
<td>shame/doubt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group C:</td>
<td>trust = 4 or &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>autonomy = 3 or &lt;</td>
<td></td>
</tr>
<tr>
<td>Group D:</td>
<td>trust = 3 or &lt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>autonomy = 3 or &lt;</td>
<td></td>
</tr>
</tbody>
</table>
Consequently, from the overall group of 90 subjects, additional interviews were conducted with two subjects purposively selected to represent the high trust-mistrust and low autonomy-shame category.

McCracken (1988) states that for qualitative research a sample of eight respondents is adequate for capturing the existing multiple realities of a phenomenon, if the subjects are purposively selected. Therefore, from the 22 interviews conducted, eight interviews of subjects with varying developmental residual scores were purposively selected for data analysis. Two interviews from each of the four groups were selected based on the following criteria:

(a) **Group A** (high trust-mistrust and high autonomy-shame group): combined highest scores on the two subscales;

(b) **Group B** (low trust-mistrust and high autonomy-shame group): largest difference between the two subscale scores;

(c) **Group C** (high trust-mistrust and low autonomy-shame group): largest difference between the two subscale scores; and
(d) **Group D** (low trust-mistrust and low autonomy-shame group): combined lowest scores on the two subscales.

**Procedures for Data Collection**

After randomly selecting the sample from the sampling frame, a letter describing the study and explaining how individuals were selected for inclusion in the study was sent to each potential subject (see Appendix A). Within a few days of receiving the information letter, a follow-up telephone call was made to each potential subject to further explain the study, and to ask if the person was interested in participating in the study. If the individual verbally agreed to participate, an appointment was made for the investigator to personally visit with the subject in his or her apartment (or other location within the apartment complex). During this personal visit, written permission (see Appendixes B & C) for inclusion in the study was obtained and data were collected.

During the data collection process, the investigator read the directions of the instruments to the subjects, and asked for questions or areas needing clarification. Subjects frequently requested help with
the negatively worded items on the Modified Erikson Psychosocial Stage Inventory.

For subjects who preferred additional help, the investigator read the items on the instruments to/with the subjects. The investigator maintained an even tone of voice while explaining the directions and items, so as not to influence subjects' responses. None of the subjects preferred to complete the instruments in private, although this was offered and explained when the consent form was reviewed.

Those subjects who were randomly selected to be interviewed, in addition to completing the questionnaires, were asked to complete the instruments before the interviews were conducted. After the instruments were completed, subjects' energy levels for participating in the interviews were determined by asking them if they would like to be interviewed at that time or at a later time during the next few days. None of the subjects desired to have the interviews done at a later date. All of the interviews were audio-taped and conducted by the investigator.

As a benefit to the subjects, the investigator offered to review subjects' medications and provide health education information about their medications.
The investigator also offered to take subjects' blood pressure. Of the 90 subjects, 37 (41%) desired information about their medications and 9 (10%) wanted their blood pressure taken. Information about community resources (e.g., cholesterol screening at the health department) or referrals for follow-up care (e.g., dental or medical care) were also provided for 17 (19%) of the 90 subjects.

Pilot Study

Prior to conducting the main research study, a pilot study was completed with a convenience sample of four elderly individuals living in community-based low income apartments. Informed consent to participate in the pilot study was obtained. The data collection process for the quantitative component of the study was pilot tested on all four of the individuals, and two of the four were interviewed to pilot test the qualitative component.

Seven potential subjects were contacted in order to solicit four people willing to participate in the study. People were hesitant to participate because they found the detailed information letter and consent form, which were mailed to them, to be confusing. Consequently, in the main study only a brief information letter (see
Appendix A) was sent to potential subjects; and rather than mailing the consent form, it was given to subjects at the beginning of each personal visit so that the investigator could explain the information.

Based on the pilot study experience and findings, the following additional modifications were made when the main study was conducted:

1. Questions 15 and 16 on the Demographic Questionnaire were reworded to be clearer.

2. Subjects were verbally instructed to complete the Nowotny Hope Scale based on their feelings regarding a recent change/stress in their life, as the written instructions frequently prompted subjects to think of difficult events from many years past. Subjects had trouble consistently answering questions about events in the distant past.

3. Subjects were verbally instructed to complete the Modified Erikson Psychosocial Stage Inventory (Personal Attitude Survey) according to how they viewed themselves overall during their life. This was done because assessment of subjects' developmental residual from their overall lifespan was the concept of interest, and for some items (e.g. #2 I'm a hard worker) subjects
frequently commented that aspects of their life had changed since retirement.

4. Wording on the interview schedule was clarified, and an item on motivation for living was added (i.e., What keeps you going on a day to day basis?).

5. The investigator signed a copy of the consent form and gave it to each subject prior to asking subjects to sign the form. This seemed to increase subjects' comfort level when signing the form, and gave them written and signed assurance that all information would be confidential.

6. Information was posted in each apartment complex explaining that some residents would be receiving a letter inviting them to participate in a research study. A picture of the investigator was included on the poster.

7. The age criteria for including subjects in the study was lowered from 65 to 62 years of age, to be consistent with the age requirements for admission to the housing units.

Protection of Human Rights

Protecting the rights of research subjects is an important ethical and legal issue, especially when human
subjects are involved. As part of the human subjects review process at The University of Texas at Austin, approval of this study was obtained from the School of Nursing Departmental Review Committee. Also, written endorsement to conduct the study in two community-based congregate housing units was obtained from the respective managers.

Prior to calling potential subjects, a letter explaining the voluntary nature of the study and the protection of confidentiality was sent to each subject (see Appendix A). Within a week of sending the information letter, the investigator telephoned potential subjects. Questions regarding the study were addressed during the telephone contact and individuals were invited to participate in the study.

For those persons indicating a desire to be included in the study, written consent (see Appendixes B & C) was obtained by personally visiting the subjects in their apartments or in a private meeting area within the apartment complex. Most of the congregate housing residents had the cognitive ability to be able to give written consent to participate in the study because the housing units were comprised of independent-living apartments. However, as a safeguard mechanism, the
housing managers were asked to delete from the sampling frame names of residents who would not be able to give an informed consent.

Confidentiality was maintained for the data contained on the instruments and for information disclosed on the audio-tapes. In place of subjects' names, code numbers were used on the data collection instruments and on transcripts of the audio-taped interviews. A listing of the subjects represented by the code numbers were kept in a locked cabinet accessible only to the investigator. The signed consent forms were also kept in a locked cabinet because respective code numbers were on the consent forms.

The interviews were transcribed by the investigator, in a private setting. No one other than the investigator heard the tapes. When the research study was completed, the tapes recordings were erased.

Instrumentation

To answer the research questions, three data collection instruments were used with 90 subjects, and a semi-structured interview schedule was used with 22 of the 90 subjects. The Modified Erikson Psychosocial Stage Inventory (Darling-Fisher & Kline Leidy, 1988) and
the Nowotny Hope Scale (Nowotny, 1989) were selected for use in this study because these instruments were conceptually appropriate for the study, and had been tested using an elderly population. In addition, both instruments were developed by nurses and measure the phenomena from a nursing perspective.

To aid in the administration of these instruments to an elderly population with possible diminished visual acuity, the size of the printing was enlarged when reproducing the instruments.

**Demographic Questionnaire**

The Demographic Questionnaire (DQ) was developed by the investigator, to collect quantitative data about the sample (see Appendix D). Collecting demographic information about subjects helps with generalizing findings, as knowledge about basic characteristics of a sample indicates if a sample is similar to the general elderly population.

Standard demographic questions were included in the questionnaire, for example, date of birth, gender and marital status. Also included were questions theoretically related to the study. Questions on frequency of spiritual activities, contact with family, and social and community support were used to examine
the construct validity of the generalized hope subscale of the Nowotny Hope Scale. Questions on the DQ relating to level of education and "getting what is desired in life" were used to examine construct validity of the particularized hope subscale of the Nowotny Hope Scale.

To promote subjects' interest in completing the instrument, the form was personalized by writing it in a first person format. Subjects took approximately five to ten minutes to complete the DQ, which was administered to subjects at the end of the quantitative data collection session.

Prior to analyzing data, items 6, 10, 11, 12, and 13 on the DQ were recoded so that larger code numbers reflected a higher quantity of an item (e.g., Q10 - response 1 "I am financially comfortable" was recoded to 3, and response 3 "I do not have enough money for basic expense" was recoded to 1).

Modified Erikson Psychosocial Stage Inventory

For this study, the Modified Erikson Psychosocial Stage Inventory (see Appendix E) was used to measure the predictor variables, that is, subjects' psychosocial developmental residual. The Modified Erikson Psychosocial Stage Inventory (MEPSI) was selected as the
instrument of choice because it measures psychosocial attributes in adult populations, within the context of Eriksonian developmental theory. The MEPSI was developed because of the scarcity of an easily administered survey instrument that was also reliable and valid for adult populations. As recommended by the developers of the instrument, when the inventory was administered to subjects it was entitled the Personal Attitude Survey (see Appendix F) (Darling-Fisher & Kline Leidy, 1988).

The MEPSI is a Likert-type scale comprised of eighty items (scored 1 to 5), with ten items for each subscale, corresponding to Erikson's eight stages of development. Residual derived from resolution of each of the eight stages is addressed using five positive and five negative items. Each subscale score is obtained by reversing the values of the negatively worded items and calculating a subscale mean for any subject answering at least three of the five positive items and three of the five negative items of the subscale. Thus, missing data are not a factor if three of the five positive and negative items have been answered (Darling-Fisher & Kline Leidy, 1988).
A predominance of negative developmental residual or attributes is reflected by a low score (i.e., 1 to 2), and a predominance of positive attributes is reflected by a high score (i.e., 4 to 5). Thus, the higher the score the stronger the positive attributes. To dichotomize scores into low or high categories, the data are cut at 3, with scores less than or equal to 3 being considered low scores and scores equal to or greater than 4 being considered high scores (see Figure 4, p. 102). An aggregate score that reflects one's psychosocial attribute strength across stages is obtained by summing the means of the eight subscale scores and computing an average for the aggregate mean (Darling-Fisher & Kline Leidy, 1988).

Reliability of the MEPSI has been determined by evaluating the internal consistency of the instrument. The stability of the instrument over a period of time has not been evaluated (e.g., with test-retest procedures); however, theoretically the construct (psychosocial developmental residual) measured by the instrument should not vary significantly over a period of several weeks or months.

The internal consistency of the MEPSI has been evaluated using a population of 168 adults ranging in
ages from 19 to 86 years old. Approximately 32% of the subjects had some form of chronic illness. Cronbach's alpha (coefficient alpha) for the aggregate score of the entire scale was .97, suggesting that a unidimensional construct (i.e., general strength of psychosocial attributes) is measured by the instrument. Coefficient alpha scores for the subscales corresponding to the eight stages of development were: trust .82, autonomy .84, initiative .78, industry .88, identity .85, intimacy .78, generativity .75, and ego integrity .80 (Darling-Fisher & Kline Leidy, 1988).

When the MEPSI was used with a population comprised of older adults (N = 109; mean age 65.21 years, SD = 8.46) with chronic obstructive pulmonary disease, high internal consistency (alpha = .94) was noted for the overall scale. Coefficient alphas for the subscales ranged from .67, for the generativity-absorption and ego integrity-despair subscales, to .78 for the autonomy-shame subscale (Kline Leidy, 1990). Kline Leidy's study of healthy older adults (N = 100, mean age = 72.97 years, SD = 13.7) also found the internal consistency of the overall scale (alpha = .94) to be high, with subscale alphas ranging from .54 (ego integrity-despair) to .78 (industry-inferiority). For these two older
populations, lower reliability levels for the latter developmental stage subscales support the validity of the instrument; because instability in the stage related to one's chronological age is expected, according psychosocial developmental theory (C. Darling-Fisher & N. Kline Leidy, personal communication, July 17, 1990).

For this study, based on the 84 subjects who answered all of the items on the MEPSI, the overall Cronbach's alpha was high (.91). Six other subjects completed enough items for scoring purposes (i.e., 3 out of 5 negative and positive items per subscale) but were not included in the reliability analysis because they omitted some items. Coefficient alphas for the subscales ranged from .47 for intimacy-isolation to .74 for industry-inferiority (see Table 1).

The lower than expected coefficient alphas for some of the subscales may be a reflection of factors other than the actual reliability of the subscales. The sample size (N = 84) may have been one factor. A sample of at least 100 subjects may have more accurately reflected the reliability of the 10 item subscales.

Another factor that may have impinged on the coefficient alphas of the subscales is the possible dual dimensionality of the subscales, because each subscale
Table 1

**Cronbach's Alpha (Coefficient Alpha) for MEPSI**

<table>
<thead>
<tr>
<th></th>
<th>Total Sample&lt;sup&gt;a&lt;/sup&gt; (N = 84)</th>
<th>Housing Unit A (n = 45)</th>
<th>Housing Unit B (n = 39)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Scale:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Development</td>
<td>.91</td>
<td>.89</td>
<td>.93</td>
</tr>
<tr>
<td><strong>Subscales:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust-Mistrust</td>
<td>.57</td>
<td>.55</td>
<td>.60</td>
</tr>
<tr>
<td>Autonomy-Shame/Doubt</td>
<td>.68</td>
<td>.67</td>
<td>.71</td>
</tr>
<tr>
<td>Initiative-Guilt</td>
<td>.69</td>
<td>.53</td>
<td>.78</td>
</tr>
<tr>
<td>Industry-Inferiority</td>
<td>.74</td>
<td>.70</td>
<td>.75</td>
</tr>
<tr>
<td>Identity-Role Confusion</td>
<td>.67</td>
<td>.70</td>
<td>.64</td>
</tr>
<tr>
<td>Intimacy-Isolation</td>
<td>.47</td>
<td>.41</td>
<td>.55</td>
</tr>
<tr>
<td>Generativity-Absorption</td>
<td>.69</td>
<td>.61</td>
<td>.74</td>
</tr>
<tr>
<td>Ego Integrity-Despair</td>
<td>.66</td>
<td>.57</td>
<td>.75</td>
</tr>
</tbody>
</table>

<sup>a</sup>Reliability analysis was based on 84 of the 90 questionnaires; 6 questionnaires were not completely answered.
addresses both favorable and unfavorable developmental residual (e.g., trust and mistrust). Zeller and Carmines (1980) state that:

From a practical estimation standpoint, . . . alpha does not provide an optimal estimate of reliability when the items that make up the composite are heterogeneous in their relation to one another (and when N is small). In these conditions, Cronbach's alpha is smaller than the internal consistency of the composite (p. 60).

Response style is another factor that may have lowered the subscale coefficient alphas. When subjects were grouped according to their respective congregate housing units, and Cronbach's alpha procedure was run separately on the two data sets, seven of the eight subscale alphas for housing unit A were lower than those for housing unit B (see Table 1). Interestingly, while completing the MEPSI, several of the subjects in housing unit A commented that they did not want to brag about themselves and thus did not mark the extreme ends of the scale.

Subjects in housing unit A also frequently commented that it was best not to share much personal information with others in the housing unit, as the information would often be misinterpreted and inaccurately passed on to other people. These feelings were commonly expressed when completing items 26 and 39
of the MEPSI (see Appendix E), both of which are in the intimacy-isolation subscale.

For the total sample, the low coefficient alpha (.47) for the intimacy-isolation subscale may have been a manifestation of some subjects' difficulty in dealing with this developmental stage, rather than being an indicator of subscale reliability. The logic of this possibility is supported by the fact that 64% of the sample were widowed and 10% were divorced.

Cronbach's alpha (.57) for the trust-mistrust subscale may have also been affected by some subjects' difficulty in dealing with intimacy-isolation issues. Because of the epigenetic nature of psychosocial development, difficulty in later stages of development can affect earlier stages, especially stages with similar developmental issues (Erikson, 1963; Erickson et. al., 1988). Developmental issues in the intimacy-isolation stage are similar to the trust-mistrust stage.

Due to the various factors that may have artificially lowered some of the subscale coefficient alphas, the lower than expected alpha findings were not considered to have jeopardized the reliability of the results of this study, especially considering the high alpha for the overall scale.
Content validity of the instrument has been assessed by six experts in Eriksonian developmental psychology. Construct validity of the inventory has been evidenced by significant relationships between chronological age and the total score on the MEPSI, and by the strong correlations found among theoretically related subscales (Darling-Fisher & Kline Leidy, 1988).

Nowotny Hope Scale

For medical studies on hope, a frequently used instrument is Beck's Hopelessness Scale (Beck et al., 1974). Some nursing research studies have also used the Beck Hopelessness Scale (Rideout & Montemuro, 1986; Brandt, 1987); however, Beck's scale measures only a narrow purview of a person's level of hope. The validity of using Beck's Hopelessness Scale to measure the complete dimensions of hope has been questioned; because the scale focuses on hopelessness, and does not measure extreme hopefulness (McGee, 1984). Greene (1981) also noted this weakness in the scale when it was used to measure hopelessness in the general population.

For this study, the Nowotny Hope Scale (Nowotny, 1989) (see Appendix G) was used to measure the criterion variable (overall level of hope) in research question 1, because the scale conceptually addresses
multidimensional dynamic attributes of hope. The scale was developed to measure hope following a stressful event and has been tested on patients with cancer, in addition to well adults, including elderly. Another noteworthy aspect of the Nowotny Hope Scale (NHS) is the parsimony of the instrument. The NHS consists of only 29 self-report items, takes just 10 minutes to complete, and has good reliability and validity (Nowotny, 1989).

Reliability of the NHS has been demonstrated by the high degree of internal consistency of the instrument (alpha = .90, N = 306). In Nowotny's (1989) testing of the instrument, Cronbach's alpha for the six subscales ranged from .64 to .90. Content validity of the NHS has been determined by a panel of six experts on hope; and the construct validity of the instrument has been supported by factor analysis (Nowotny, 1989).

Items on the NHS are scored on a 1 to 4 point scale, with strongly agree responses receiving four points. The total score on the scale is attained by reversing the numbered response for negatively worded items, and then summing the scores for all of the items. Cut-off scores for four different levels of hopefulness are provided for the scale. Scores depicting the four different levels of hope were determined by Nowotny.
(1989) based on the standard deviation for the mean score (see Appendix H).

To make the response options of the NHS more compatible with the Modified Erikson Psychosocial Stage Inventory (MEPSI) (see Appendix E), approval from Nowotny was obtained to reverse the Likert response anchors for the NHS. Thus, the modified NHS had the "strongly agree" response on the right side of the instrument, as was the "almost always true" response on the MEPSI (M. Nowotny, personal communication, August 13, 1990).

Approval was also acquired to include number values under the response categories of the NHS, rather than using an open response area as in the original NHS (M. Nowotny, personal communication, August 13, 1990). The first page of the NHS (as used with the subjects), with the modified response section, is included in Appendix I.

Measurement of generalized hope (for research question 2) and particularized hope (for research question 3) was accomplished using selected items from the NHS which were conceptually congruent with the definitions of these two types of hope (see Appendix J). Scores on the generalized and particularized subscales
were calculated by reversing the response scores on negatively worded items, and summing the scores for each item within a subscale. A summative score for each subscale was obtained.

Content validity of the items selected to measure the newly conceptualized generalized hope and particularized hope subscales was evaluated by the developer of the NHS (M. Nowotny, personal communication, August 13, 1990). Dr. Nowotny and the investigator similarly categorized 28 of the 29 NHS items under either the generalized hope subscale or the particularized hope subscale, for an interrater agreement of .94 using the conservative Kappa's Cohen formula, correcting for chance agreement.

Construct validity of the generalized hope and particularized hope subscales was evaluated by examining relationships between subscale scores and selected variables on the Demographic Questionnaire (DQ). As expected, for this study (N = 90) significant Pearson Product Moment correlation coefficients were found between generalized hope subscale scores and frequency of spiritual activities (r = .59, p = .00), frequency of contact with family or relatives (r = .35, p = .00), and number of support systems (r = .37, p = .00).
Interestingly, a small significant correlation between generalized hope scores and level of education ($r = .21$, $p = .04$) was also obtained; whereas, the correlation between particularized hope scores and level of education was not significant ($r = .13$, $p = .24$). This finding may be more reflective of past social norms regarding education rather than indicating a weakness in the subscales; because, when female subjects completed the education question they frequently stated they were not allowed to attend high school because their fathers thought education was important only for boys.

Although the correlation of particularized hope and generalized hope with level of education were both fairly small, the significant correlation between generalized hope and education may reflect the psychosocial strength (i.e., drive) derived from favorable residual related to the first stage of life. Individuals who have a strong sense of psychosocial drive may pursue more formal education than those who do not have this strong drive.

Regarding the particularized hope subscale, a significant Pearson Product Moment correlation coefficient was found between particularized hope subscale scores and frequency with which one got what
was wanted out of life (r = .33, p = .00). Thus, convergence between subscale scores and selected demographic variables supported the construct validity of both subscales.

Construct validity of the two subscales was also supported by additional correlational findings (see Table 2). The correlation between generalized hope and trust-mistrust was higher (r = .24, p = .03) than the correlation between generalized hope and autonomy-shame (r = .19, p = .07). Also, the correlation between particularized hope and autonomy-shame was moderate (r = .57, p = .00), while the correlation between particularized hope and trust-mistrust was weak (r = .29, p = .01). Interpreting these findings within the epigenetic framework of psychosocial development suggests that the two types of hope differ in some aspect; but that particularized hope seems to build on generalized hope, much as autonomy-shame residual builds on residual from the trust-mistrust stage of development.

To further assess whether the two subscales differed, subjects' generalized hope scores were compared with their particularized hope scores. Because
Table 2

Correlation Matrix of Generalized Hope, Particularized Hope and Selected Developmental Residual Variables

<table>
<thead>
<tr>
<th></th>
<th>Overall Hope</th>
<th>Generalized Hope</th>
<th>Particularized Hope</th>
<th>Overall Development</th>
<th>Trust-Mistrust</th>
<th>Autonomy-Shame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Hope</td>
<td>1.00</td>
<td>.87 (p&lt;.00)</td>
<td>.91 (p&lt;.00)</td>
<td>.58 (p&lt;.00)</td>
<td>.30 (p&lt;.00)</td>
<td>.45 (p&lt;.00)</td>
</tr>
<tr>
<td>Generalized Hope</td>
<td>1.00</td>
<td>.58 (p&lt;.00)</td>
<td>.39 (p&lt;.00)</td>
<td>.24 (p&lt;.00)</td>
<td>.19 (p&lt;.00)</td>
<td></td>
</tr>
<tr>
<td>Particularized Hope</td>
<td>1.00</td>
<td>.62 (p&lt;.00)</td>
<td>.29 (p&lt;.00)</td>
<td>.57 (p&lt;.00)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Development</td>
<td>1.00</td>
<td>.68 (p&lt;.00)</td>
<td>.78 (p&lt;.00)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust-Mistrust</td>
<td>1.00</td>
<td>.38 (p&lt;.00)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy-Shame</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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subjects varied in their developmental residual, it was important to compare individual subjects' generalized hope scores with their respective particularized hope scores, rather than comparing total group scores. A paired t test was performed pairing individual mean particularized hope scores with individual mean generalized hope scores. The statistically significant finding ($t = 3.77, df = 89, N = 90$) suggests that the two subscales differ in some dimension of hope, and provides some evidence of support for the discriminability between the two subscales.

Reliability of both subscales was observed to be high, when evaluated for internal consistency using Cronbach's alpha ($N = 90$). For the generalized hope subscale the Cronbach coefficient alpha was .83, and for the particularized hope subscale the alpha was .85. Coefficient alpha for the overall hope scale was .89, which compared favorably with Nowotny's original finding for the overall scale ($N = 306$, coefficient alpha = .897) (M. Nowotny, personal communication, August 13, 1990).

**Interview Schedule**

Interviewing as a research technique is actually conversation with a purpose. Lincoln and Guba (1985)
identify five purposes for doing interviews: (a) obtaining data about here-and-now constructions of reality; (b) obtaining reconstructions of realities in the past; (c) obtaining projections of expected realities in the future; (d) extending information gained from other sources, that is triangulation; and (e) verifying the investigator's interpretation of previously collected data. All of these purposes applied to this research study.

These five purposes can be accomplished through structured or unstructured interviews. Structured interviews are typically used when the investigator knows exactly what information is being sought; and thus, knows how to frame questions appropriately. Unstructured interviews are "the mode of choice when the interviewer does not know what he or she doesn't know" (Lincoln & Guba, 1985, p. 269).

The interview schedule (see Appendix K) used in this study was semi-structured because there were specific research questions to address, but the entire realm of the area of interest was unknown. Probes, directed cues for eliciting more information, were also included in the interview schedule for specific questions (Woods & Catanzaro, 1988). Subjects
(informants) had an opportunity to become comfortable with the investigator prior to the interview because the interview questions were asked after the quantitative data were collected.

"Pacing" the interview was important in order to keep the interview productive. Pacing was done by keeping the interview focused on the informant and by using probes. Interviews were done overtly, with informants knowing that they are being interviewed and audio-taped.

Although an interview schedule was used to guide the data collection, in qualitative research the investigator is the primary data-gathering instrument. The human investigator is able to understand the data as they are being collected, and can adapt the data collection process as necessary to obtain a richness of information not possible with predetermined paper-and-pencil instruments. During data collection, the investigator used tacit or intuitive knowledge to obtain data about the nuances of situations and relationships (Lincoln & Guba, 1985; McCracken, 1988).

Within the framework of qualitative data collection, the goal of an interview is to obtain a thick description of the lived experience. A thick
description "goes beyond mere fact and surface appearances, it presents detail, context, emotion, and the webs of social relationships that join persons to one another" (Denzin, 1989, p. 83).

Obtaining a thick description of a significant interactional experience (epiphany) mandates that the meanings, actions, and feelings present during an experience are captured in the interview. Capturing a thick description of an epiphany requires framing questions with a "how". The focus is not on why the problems occurred, but on how the experiences occurred (Denzin, 1989). The interview schedule for this study used how questions whenever possible.

When the interview reached a "natural" end (e.g., the investigator had no more questions and the informant had no more comments related to the interview questions), the investigator gained closure by summarizing what she believed the informant had said. By summarizing each interview and asking informants for validation, the member checking technique for establishing the credibility of the qualitative data was addressed.

Immediately after each interview the investigator completed a summary sheet about the interview (see
Appendix L). The summary sheet "allow[ed] the investigator to capture thoughtful impressions and reflections and consolidate ideas for further investigation or analysis" (Woods & Catanzaro, 1988). The summary sheet also included field notes about observations made during the interview, for example, non-verbal behavior and environmental conditions (Lincoln & Guba, 1985; Lofland & Lofland, 1984).

Summary

This chapter detailed the use of quantitative and qualitative methods to address the research questions. The research design was presented, followed by procedures for selecting the sample and strategies for protecting the rights of the subjects. The data collection process and instruments, including the interview schedule, were explained. The results of the data collection process are delineated in the next chapter.
CHAPTER IV
DATA ANALYSIS AND FINDINGS

Seek the Truth,
for the Truth
Will Set You Free

This chapter describes the analysis of the quantitative and qualitative data which were collected using the methodology described in Chapter 3. The research questions for the study serve as the organizing framework for explaining the data analysis process, and the resulting findings. Interpretation of the findings is addressed in Chapter 5.

Quantitative Analyses and Findings

Statistical analysis of the quantitative data was conducted using programs from the Statistical Package for the Social Sciences (SPSS-X) (SPSS-X, 1988). An alpha level of .05 was used to determine statistically significant findings.

Sample Characteristics

Ninety randomly selected older adults, from two community-based congregate housing units in a rural community, served as the sample for this study. Sample
characteristics for selected variables on the Demographic Questionnaire were explicated using descriptive statistics (see Table 3)

The majority (80%) of the subjects were female, and the ethnicity of all subjects was Caucasian. Subjects' ages ranged from 63 to 92, with a mean age of 78. Based on the demographic characteristics of the sample, a profile of the "typical" subject would be: a grade school educated, 78 year old Catholic, Caucasian widow, with two self-report health problems (arthritis and hypertension), who has lived in an apartment complex for over five years, has weekly contact with her family, and describes her financial status as adequate to cover basic expenses.

Three of the subjects' spouses had died within the previous year, while none of the subjects were divorced during the previous year. The average number of children per subject was three, while the average family of origin was much larger (M = 7). The largest family of origin had 23 children, with 28% of the subjects being reared in families with 10 or more children. This was an important characteristic since the study focused on exploring psychosocial developmental from early stages of life.
Table 3  
**Demographic Characteristics of the Sample (N = 90)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>18</td>
<td>20.0%</td>
</tr>
<tr>
<td>Females</td>
<td>72</td>
<td>80.0%</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63-69</td>
<td>17</td>
<td>18.9%</td>
</tr>
<tr>
<td>70-74</td>
<td>14</td>
<td>15.5%</td>
</tr>
<tr>
<td>75-79</td>
<td>23</td>
<td>25.5%</td>
</tr>
<tr>
<td>80-84</td>
<td>16</td>
<td>17.8%</td>
</tr>
<tr>
<td>85-89</td>
<td>18</td>
<td>20.0%</td>
</tr>
<tr>
<td>90-92</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>90</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Married</td>
<td>9</td>
<td>10.0%</td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>14.4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>58</td>
<td>64.4%</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Divorced</td>
<td>9</td>
<td>10.0%</td>
</tr>
<tr>
<td><strong>Highest Level of Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-8 years of grade school</td>
<td>38</td>
<td>42.2%</td>
</tr>
<tr>
<td>1-4 years of high school</td>
<td>27</td>
<td>30.0%</td>
</tr>
<tr>
<td>Vocational Training</td>
<td>9</td>
<td>10.0%</td>
</tr>
<tr>
<td>1-4 years of college</td>
<td>11</td>
<td>12.2%</td>
</tr>
<tr>
<td>Graduate classes or higher</td>
<td>5</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Length of Residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in Apartment Complex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>12</td>
<td>13.3%</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>23</td>
<td>25.6%</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>49</td>
<td>54.4%</td>
</tr>
</tbody>
</table>
Table 3 (Continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious Affiliation</td>
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<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>49</td>
<td>54.4%</td>
</tr>
<tr>
<td>Protestant</td>
<td>35</td>
<td>38.9%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Financial Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfortable</td>
<td>42</td>
<td>46.7%</td>
</tr>
<tr>
<td>Enough for Basics</td>
<td>44</td>
<td>48.9%</td>
</tr>
<tr>
<td>Not Enough for Basics</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Number of Self-reported Health Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>One</td>
<td>14</td>
<td>15.6%</td>
</tr>
<tr>
<td>Two</td>
<td>28</td>
<td>31.1%</td>
</tr>
<tr>
<td>Three</td>
<td>17</td>
<td>18.9%</td>
</tr>
<tr>
<td>Four</td>
<td>15</td>
<td>16.7%</td>
</tr>
<tr>
<td>Five</td>
<td>12</td>
<td>13.3%</td>
</tr>
<tr>
<td>Types of Reported Health Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer (past or present)</td>
<td>17</td>
<td>18.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12</td>
<td>13.3%</td>
</tr>
<tr>
<td>Cardiac dysfunction</td>
<td>33</td>
<td>36.7%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>38</td>
<td>42.2%</td>
</tr>
<tr>
<td>Stroke</td>
<td>11</td>
<td>12.2%</td>
</tr>
<tr>
<td>Respiratory dysfunction</td>
<td>16</td>
<td>17.8%</td>
</tr>
<tr>
<td>Depression</td>
<td>18</td>
<td>20.0%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>65</td>
<td>72.2%</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>34.4%</td>
</tr>
<tr>
<td>Verbal or Personal Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Family/Relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>39</td>
<td>43.3%</td>
</tr>
<tr>
<td>Weekly</td>
<td>40</td>
<td>44.4%</td>
</tr>
<tr>
<td>Monthly</td>
<td>7</td>
<td>7.8%</td>
</tr>
<tr>
<td>Yearly</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
<td>2.2%</td>
</tr>
</tbody>
</table>
Table 3 (Continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Types of Support Systems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td>3</td>
<td>3.3%</td>
</tr>
<tr>
<td>Two</td>
<td>10</td>
<td>11.1%</td>
</tr>
<tr>
<td>One</td>
<td>71</td>
<td>78.9%</td>
</tr>
<tr>
<td>None</td>
<td>6</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Types of Support Systems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/Relatives</td>
<td>81</td>
<td>90.0%</td>
</tr>
<tr>
<td>Friend/Neighbor</td>
<td>12</td>
<td>13.3%</td>
</tr>
<tr>
<td>Community (e.g. minister, nurse)</td>
<td>6</td>
<td>6.7%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>None</td>
<td>6</td>
<td>6.7%</td>
</tr>
</tbody>
</table>
Subjects' daily participation in spiritual activities, like praying, was extremely high (88%). Only 6% of the subjects never participated in spiritual activities. Additional data (e.g., age, developmental residual scores and hope scores) about the total sample and subsamples are included in Appendix M.

In relation to demographic variables, the subsample \( (n = 8) \) used in the qualitative analysis component of the study was similar to the total sample. The mean age of the subsample was 76 years old \( (SD = 6.19) \). All of the subjects were female, most were widowed \( (n = 6, 75\%) \) and had a grade school education \( (n = 5, 62\%) \).

Research Question 1

Research question 1 (What is the relationship between psychosocial developmental residual and level of hope?) was analyzed using the Pearson Product Moment Correlation to compare subjects' aggregate score on the Modified Erikson Psychosocial Stage Inventory (MEPSI) with their total score on the Nowotny Hope Scale (NHS). A statistically significant, moderate correlation between subjects' overall developmental residual scores and overall hope scores was obtained \( (r = 0.58, p = .00, N = 90) \). This finding suggests that 34\% \( (r^2 = .34) \) of the variance in subjects' overall level of hope was
shared with the variance in subjects' psychosocial developmental residual.

Question 1 was also examined using hierarchical regression to determine the amount of variance in hope accounted for by the eight psychosocial developmental predictor variables (i.e., the mean scores on the eight subscales of the MEPSI). With hierarchical regression, the sequence in which predictor variables are entered into a model are theoretically determined (Woods & Catanzaro, 1988). For this study, the sequence in which the predictor variables were entered into the model was based on Erikson's eight stages of development (1963). Thus, due to the epigenetic nature of the theory, the subscale score for trust-mistrust on the MEPSI was entered into the model first, followed by the subscale score for the second stage, autonomy-shame/doubt, etc.

Table 4 delineates the results of the hierarchical regression of the eight psychosocial developmental predictor variables on the criterion variable, overall level of hope. At each step, the regression equation was statistically significant ($F$ ranged between 6.87 to 12.12, $p = .00$). However, entry of each predictor variable did not statistically improve the predictability of the regression equation.
Table 4

Hierarchical Multiple Regression of Psychosocial Developmental Residual on Overall Level of Hope (N = 90)

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>Multiple R</th>
<th>R²</th>
<th>Adjusted R²</th>
<th>F</th>
<th>Sig F</th>
<th>Betas In</th>
<th>R² Change</th>
<th>F Change</th>
<th>Sig Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust - Mistrust</td>
<td>.299</td>
<td>.089</td>
<td>.079</td>
<td>8.69</td>
<td>.00</td>
<td>.299</td>
<td>.089</td>
<td>8.69</td>
<td>.00</td>
</tr>
<tr>
<td>Autonomy - Shame</td>
<td>.466</td>
<td>.218</td>
<td>.200</td>
<td>12.12</td>
<td>.00</td>
<td>.386</td>
<td>.128</td>
<td>14.24</td>
<td>.00</td>
</tr>
<tr>
<td>Initiative - Guilt</td>
<td>.489</td>
<td>.239</td>
<td>.213</td>
<td>9.04</td>
<td>.00</td>
<td>.221</td>
<td>.021</td>
<td>2.47</td>
<td>.11</td>
</tr>
<tr>
<td>Industry - Inferiority</td>
<td>.522</td>
<td>.272</td>
<td>.238</td>
<td>7.97</td>
<td>.00</td>
<td>.225</td>
<td>.033</td>
<td>3.86</td>
<td>.05</td>
</tr>
<tr>
<td>Identity - Confusion</td>
<td>.546</td>
<td>.298</td>
<td>.256</td>
<td>7.14</td>
<td>.00</td>
<td>.226</td>
<td>.025</td>
<td>3.04</td>
<td>.08</td>
</tr>
<tr>
<td>Intimacy - Isolation</td>
<td>.589</td>
<td>.347</td>
<td>.300</td>
<td>7.36</td>
<td>.00</td>
<td>.250</td>
<td>.049</td>
<td>6.25</td>
<td>.01</td>
</tr>
<tr>
<td>Generativity - Stagnation</td>
<td>.635</td>
<td>.403</td>
<td>.352</td>
<td>7.91</td>
<td>.00</td>
<td>.349</td>
<td>.055</td>
<td>7.67</td>
<td>.00</td>
</tr>
<tr>
<td>Ego Integrity - Despair</td>
<td>.636</td>
<td>.404</td>
<td>.345</td>
<td>6.87</td>
<td>.00</td>
<td>-.048</td>
<td>.001</td>
<td>.16</td>
<td>.68</td>
</tr>
</tbody>
</table>

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The prediction capabilities of the regression equation was significantly changed with the entry of the second variable, autonomy-shame/doubt ($R^2$ change = .13, $F$ change = 14.24, $p = .00$). Other predictor variables that significantly improved the ability to predict subjects' overall level of hope were: industry-inferiority, intimacy-isolation, and generativity-stagnation. With all eight of the predictor variables in the equation, 40% of the variance in subjects' overall hope scores was predicted by the psychosocial developmental variables ($R^2 = .40$).

The psychosocial developmental stage congruent with most subjects' chronological age was the only predictor variable (i.e., ego integrity-despair) to have a negative beta weight. This finding is congruent with the theory of psychosocial development, because instability in individuals' adaptation to the critical task of their age-related stage is expected.

**Research Question 2**

Simple linear regression analysis was used to address research question 2 (Does trust versus mistrust developmental residual significantly predict generalized hope?). Table 5 displays the regression of trust-
Table 5

Linear Regression of Trust-Mistrust Psychosocial Developmental Residual on Generalized Hope (N = 90)

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>98.76</td>
<td>1</td>
<td>98.76</td>
<td>5.17</td>
<td>.03</td>
</tr>
<tr>
<td>Residual</td>
<td>1678.83</td>
<td>88</td>
<td>19.07</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results of Linear Regression

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>r</th>
<th>r²</th>
<th>Adjusted r²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust-Mistrust</td>
<td>.235</td>
<td>.055</td>
<td>.044</td>
</tr>
</tbody>
</table>
mistrust subscale scores of the MEPSI on generalized hope subscale scores of the NHS. Although the coefficient was small, the findings revealed that trust-mistrust developmental residual scores significantly predicted generalized hope scores ($r = .24$, $F = 5.17$, $p = .03$). The variance in generalized hope scores accounted for by the trust-mistrust scores was 6% ($r^2 = .06$).

Research Question 3

The third research question (Does autonomy versus shame and doubt developmental residual significantly predict particularized hope?) was also addressed using simple linear regression analysis. Table 6 displays the regression of autonomy-shame/doubt subscale scores of the MEPSI on particularized hope subscale scores of the NHS. Autonomy-shame/doubt developmental residual was found to be a statistically significant predictor of particularized hope ($r = .57$, $F = 41.79$, $p = .00$). The amount of variance in particularized hope scores accounted for by autonomy-shame/doubt developmental residual was 32% ($r^2 = .32$).
Table 6

Linear Regression of Autonomy-Shame/Doubt Psychosocial Developmental Residual on Particularized Hope (N = 90)

Analysis of Variance Table for Significance of $r^2$

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>800.94</td>
<td>1</td>
<td>800.94</td>
<td>41.79</td>
<td>.00</td>
</tr>
<tr>
<td>Residual</td>
<td>1686.60</td>
<td>88</td>
<td>19.16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results of Linear Regression

Criterion Variable: Particularized Hope

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>r</th>
<th>$r^2$</th>
<th>Adjusted $r^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy-Shame/Doubt</td>
<td>.567</td>
<td>.321</td>
<td>.314</td>
</tr>
</tbody>
</table>
Qualitative Analyses and Findings

Interview data were analyzed to address research question 4 (How has hope been promoted or decreased during stressful or difficult times?) and research question 5 (How is the future perceived?).

Data collected using qualitative methods are typically analyzed for themes, categories, or clusters (Miles & Huberman, 1984). Woods and Catanzaro (1988) recommend that the first reduction of data occur by placing the data into broad categories based on the conceptual framework. "These broad categories may be thought of as 'baskets' labeled for the variables or processes that are the focus of the study" (Woods & Catanzaro, 1988, p. 439).

For this study, the initial data reduction process was completed using categories deductively determined from the research questions and the review of literature (see Figure 5).

Following initial data reduction, content analysis was done on the data within each of the broad categories. Phrases or statements within each broad category were analyzed to inductively search for themes. Common themes were then grouped into categories or subcategories.
Research Question 4:
A. Epiphany
   A1. Overt Problem Creating the Epiphany
   A2. Experiential Aspect of the Epiphany
   A3. Sense of control
B. Long Term Life Changes or Outcomes Resulting from the Epiphany
C. Promoters of Hope
D. Diminishers of Hope

Research Question 5:
A. Attitude Towards the Future
B. Timeframe of the Future
C. Sense of an Afterlife
D. Sense of Future for Others
E. Motivators for Day-to-Day Living
F. Goals or Plans for the Future
   F1. Actions for Goal Attainment
   F2. Confidence in Goal Attainment

Figure 5. Broad categories used for qualitative data reduction.
Analysis of qualitative data requires investigators to use their creative abilities and insights, along with their conceptual abilities (Ammon-Gaberson & Piantanida, 1988). To evaluate the trustworthiness of the investigator's analysis of the data, an inquiry audit was conducted by a nurse researcher with experience in qualitative methodology. Materials used in the audit trail included: four interview transcripts, four summary sheets (field notes) of the interviews, and data from eight interviews sorted (color coded) into categories and subcategories, with related thematic coding formats. Since the auditor was able to follow the decisions noted in the audit trail, the dependability of the study was supported (see Appendix N).

Credibility (internal validity) of the findings was also evaluated by the auditor. The primary concern when evaluating credibility is whether the findings accurately portray the context of the overall situation (Lincoln & Guba, 1985). Modifications in the thematic codes were made by the investigator until consensus between the auditor and investigator was reached.

To determine the confirmability of the categories used by the investigator, and to further assess the
dependability of the study, the auditor evaluated the appropriateness of data in randomly selected categories. Interrater reliability between the auditor's and investigator's categorization of data was calculated by dividing the number of agreements by the number of agreements plus disagreements (Polit & Hungler, 1987). For the randomly assessed categories, interrater reliability ranged from .90 to 1.00 (see Appendix N). These findings supported the confirmability and dependability of the qualitative analysis.

**Research Question 4**

In order to address research question 4 (How has hope been promoted or decreased during stressful or difficult times?), four broad baskets/categories of interview data were analyzed. The first broad category included: (a) the overt problems creating major turning points (epiphanies) in subjects' lives, (b) the experiential aspect of the epiphanies, and (c) subjects' sense of control. Long term life changes or outcomes resulting from the epiphanies was the second broad category; while the third category was promoters of hope, and the fourth category was diminishers of hope. Each of these four broad categories are addressed separately.
Epiphanies

Overt problems creating subjects' epiphanies frequently involved separation from, or the death of, a loved one. Three of the epiphanies included separation from a familiar geographic area, as well as separation from loved ones. The common theme for all of the epiphanies was a loss of attachment object. Objects of attachment ranged from spouses and children, to home (geographic) environments. One subject said, "well after my husband died . . . I just felt lost, really lost". Loss of attachment to one's home environment was illustrated by a female's comments:

I had never been to Florida before and ah some of the people that where there said you mean you've never been down here before, how can you stand it and I'd get wet you know all around my waist and ah it seemed that ah the sun is different even from what it is here in Kansas, ah it would just seem, it seemed to me it would just reach clear into my bones.

Themes depicting the experiential aspects of the epiphanies encompassed feelings of shock, anger, loss, abandonment, aloneness, instability, inability to go on with life, threatened self-image, and feeling as if one's sanity was threatened. Data exemplifying these themes are found in Table 7.
<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shock</td>
<td>Oh, he died so fast, it was, I was just in shock I guess (c1306)</td>
</tr>
<tr>
<td></td>
<td>when he died it was just such a shock (c1507)</td>
</tr>
<tr>
<td></td>
<td>the shock took me to my knees (c5713)</td>
</tr>
<tr>
<td>Anger</td>
<td>well at first I was angry . . . very angry . . . I was angry at God . . . I thought all my friends' husbands came back and mine didn't (c4611)</td>
</tr>
<tr>
<td></td>
<td>when I came home you know, his mother was there but she was, wasn't helping along a lot, . . . she left it up to us, you know, to do things, . . . whatever I could I stumbled up and did myself . . . I was suppose to stay in bed you know (c5915)</td>
</tr>
<tr>
<td>Loss</td>
<td>I just felt lost, really lost (c0101)</td>
</tr>
<tr>
<td></td>
<td>I lost three, ah, I lost a really six, I had six miscarriages. Three were well in the early stages, and then the other three you you could tell what the babies were (c1306)</td>
</tr>
<tr>
<td>Abandonment</td>
<td>I waited for 3 weeks again and didn't hear nothing, I had the two little ones, had no way, no way of knowing if he was going to come back and no income, no nothing (c5122)</td>
</tr>
<tr>
<td>Themes</td>
<td>Examples of Supporting Data (with case numbers)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Threatened</td>
<td>they would bring you in the office and say ah do you think that you are real good at teaching . . . and then he would bring you in another time and say have you improved . . . a teacher was sent in to observe our teaching and to mark us . . . I was just so full of work in my teaching and planning and everything that I didn't get it done early enough and I really hate that, I just hated it terrible (c7720)</td>
</tr>
<tr>
<td>Self-image</td>
<td></td>
</tr>
<tr>
<td>Instability</td>
<td>that was the last I heard of him for a couple of months, and then I really didn't know what to make of it, he didn't send no letter or anything, ah then in a couple of months he came back or he showed up quick, he didn't write or nothing (c5122)</td>
</tr>
<tr>
<td></td>
<td>this one time they came they took him to jail because it was some bill pass due, was not long after that I thought this was the beginning of something very unbalanced again (c5122)</td>
</tr>
<tr>
<td>Feeling</td>
<td>except for being by myself, that's the hardest part (c0101)</td>
</tr>
<tr>
<td>Alone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>when you're around someone . . . you didn't feel like you were so terribly alone, which is not a good feeling to feel so, you know, just like you were the only person left I guess (c4611)</td>
</tr>
<tr>
<td></td>
<td>I was alone you know, that was something that bothered me (c5915)</td>
</tr>
<tr>
<td>Themes</td>
<td>Examples of Supporting Data (with case numbers)</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Sanity Threatened</td>
<td>I really I almost went off my mind, I'm quite sure that I did (c7720)</td>
</tr>
<tr>
<td></td>
<td>It was just the feeling that I might lose out you know, getting down there to half before zero, you just feel oh boy am I going over the brink (c7720)</td>
</tr>
<tr>
<td>Can't Go On</td>
<td>I didn't think I could live another day (c1507)</td>
</tr>
<tr>
<td></td>
<td>well, I know that I didn't feel like Christmas, he was run over on New Years Day and I didn't feel like Christmas for about 5 years, I just couldn't see Christmas come (c1507)</td>
</tr>
</tbody>
</table>
An intriguing finding was one subject who had a strong positive spiritual experience during the epiphany, along with the negative. Her description of finding her husband's body was that

... the shock took me to my knees ... I had to crawl up the stairs then in getting to get some help, but in crawling up the stairs I felt a presence I never felt any stronger, it was like some THING put their arms around me and it was almost like I heard a voice 'you'll be ok [subject's name]' and ... I have been, I have been ok, so that was one of the most profound spiritual experiences of my life.

Subjects' feelings of control over how the epiphany turned out, or control over how they coped with the epiphany fit into dichotomized categories. Four subjects felt a sense of control and four did not feel a sense of control. One subject stated:

Well, I think I controlled it pretty good. I made it. Did pretty well, when I think back. I didn't go to pieces; I did when, till the funeral was over, this was when I came out of my shock or whatever it was, and then after it all I felt I did pretty good.

Another subject described her lack of control:

I don't know it seems like I never really had ah had any control, I ah it never seemed like it was never up to me, whatever was done was just done.
Life Changes or Outcomes

Three subjects identified only negative long term changes due to their epiphanies, three indicated only positive outcomes, and two subjects described both positive and negative changes. Changes in daily living, like cooking for one and lack of transportation, were viewed as negative outcomes; as well as experiencing emotional distress, like sadness, loneliness, prolonged anger, and a prolonged sense of loss (see Table 8).

Increased spirituality was a positive outcome of some epiphanies, resulting in acceptance of God's will and a sense of faith in God. Feeling closer to one's family, and being more empathic and supportive of people were also identified as positive outcomes. Increased personal strength was another common outcome, including a sense of survival, determination and assertiveness (see Table 8). One subject stated:

I think as long as he was living I depended a lot on him for decisions and this and that. And after that why I knew I had to decide what to do, what I'm goin' to do and it made me get stronger in doing what I'm goin' to do, I'm going to do it. I'm more determined now that I'm going, in the early days I didn't, I relied on him a lot.

Although several subjects reported becoming emotionally stronger after losing their spouse, one subject demonstrated a negative case for this theme when asked
<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. NEGATIVE CHANGES</td>
<td></td>
</tr>
<tr>
<td>A. Emotional Distress</td>
<td></td>
</tr>
<tr>
<td>1. Sadness</td>
<td>you don't feel happy anymore (c5915)</td>
</tr>
<tr>
<td></td>
<td>just sad that he left you know (c5915)</td>
</tr>
<tr>
<td>2. Loneliness</td>
<td>I guess I feel like I always did, except for being by myself, that's the hardest part (c0101)</td>
</tr>
<tr>
<td></td>
<td>I have to be here by myself but then I'm not the only one you know but it hurts anyway (c5915)</td>
</tr>
<tr>
<td>3. Prolonged Anger</td>
<td>I think I still have bad feelings about the way they treated us (c7720)</td>
</tr>
<tr>
<td></td>
<td>I was very angry . . . I was angry at God, I guess that's the way a cancer patient feels . . . eventually [I got over it] . . . I don't really know how long it took but as time went on why it just got easier (c4611)</td>
</tr>
<tr>
<td>4. Prolonged Sense of Loss</td>
<td>since he's gone, well I don't know, the only thing I miss seeing him (c0101)</td>
</tr>
<tr>
<td></td>
<td>only that I missed him so . . . I wasn't angry at God, but I just couldn't forget it (c1507)</td>
</tr>
</tbody>
</table>
Table 8 (continued)

<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Changes in Daily Living</td>
<td>he was my transportation and I always depend[ed] on him, he took me whenever I had to go someplace (c0101)</td>
</tr>
<tr>
<td></td>
<td>making meals and everything like that, its hard for one to cook (c0101)</td>
</tr>
</tbody>
</table>

II. POSITIVE CHANGES

A. Increased Spirituality

1. Acceptance of God's Will

   I kind ah give up more of that control and allowed God to be in control of things (c5713)

   I just thought well that's God's will. . . . that's the way it's suppose to be, that's the way it's going to be. . . . that's God's will, and that's it. (c1306)

   I did question why did it have to be him. Why did he have to? But which a person does I think when you're in that first, but after that I thought well, that's the way God's will . . . God took those three children from me too. . . . That was God's will too. And their better off I guess than what the ones that are living (c1306)

2. Faith in God

   I realized that the Lord was still there and that I could depend on him because I did get through it . . . it made my faith stronger (c7720)
### Table 8 (continued)

<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. (continued)</td>
<td>I got closer and I got a desire to go to church and I wanted to live the right way . . . this was really a life sort of a Godless one, I went to church on Sunday even but it didn't mean much you know . . . that's when I realized that there is a God, that it doesn't all come from humans whatever happens to us (c5122)</td>
</tr>
<tr>
<td>B. Increased Personal Strength</td>
<td></td>
</tr>
</tbody>
</table>
| 1. Assertive | I just stood my ground, with other people. (c1306)  
After he was gone I just made up my mind that I'm going to fight back if someone says something I don't like I just tell'em about [it]. And I'm still that way. I just don't ah, I'm a lot stronger than I use to be, let's put it that way (c1306)  
maybe I did not depend so much on others, maybe I started to have more courage than I use to . . . I was stronger, I did things and I was not afraid to go for any challenge you know like I had I had before (c5122) |
| 2. Sense of Survival | I survived and I still survive and I hope, how long I don't know (c0101) |
Table 8 (continued)

<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. More Determined</td>
<td>I just had to do it! I just had to. That's what my kids say. I never saw anybody so head strong as you are. Well, I think I got that way when I had to do it, do it my way, there's nobody there to do it for me, I just took the bull by the horns I guess, and just went on. (c1306)</td>
</tr>
<tr>
<td>C. Closer to Family</td>
<td>I was closer to my family, I never would of have been that way to my sisters . . . they were closer to my kids than they would have been, very much so, my sisters and my mom too (c5122)</td>
</tr>
<tr>
<td>D. Empathy and Support for Others</td>
<td>I think well they [other people] might be getting into that same shoe . . . I talk to them, tell them what I experienced and what they would go through, what their going to go through after their husband passed away . . . you have to encourage them a little, help them (c0101)</td>
</tr>
</tbody>
</table>
if she was more independent after her husband’s death:

I don’t know, he did a lot of things where he was the leader of everything . . . and I don’t like that I have to do it now.

Promoters of Hope

Factors that promoted or increased hope during or after the epiphanies were grouped into five main categories: (a) adequate finances, (b) time to heal, (c) assistance from agencies, (d) actions of people, and (e) subjects’ activities and thoughts. In regards to finances being a promoter of hope, one subject said:

I knew I had enough money you know, so I could come here [apartment complex], . . . that's what we all both saved money for, he said if I die you’ll have enough . . . so I'm lucky there.

Time to heal was identified as a promoter of hope by two subjects. One stated:

I sorta waited for time, it seems like time does the healing.

Four of the eight subjects indicated that agencies or community services increased their feelings of hope. Two subjects found comfort in living in community-based congregate housing and having catered meals at the apartment complex. One subject commented:

I was glad that I lived here yet . . . I don't know what I would of done if I'd been out by myself . . . its the people that helped, the people around in the building here. . . . Its hard for one to cook,
course it makes it nice now see they cater in one meal a day for five days a week, that makes it if you don't eat at home you can make your reservations, go out there [in the community room of the complex] and eat.

Other agencies noted as helping increase subjects' hope during their epiphanies were: (a) welfare services, (b) county attorney's office, (c) mortuary, and (d) Alcoholics Anonymous. No health care agencies were mentioned.

Family members were the most frequently cited group of people to increase subjects' hope, with the second most noted group being friends and neighbors. Only one subject identified being helped by other people (i.e., a priest, a nurse who was a neighbor, and a physician who was a family friend).

Specific actions by people that promoted subjects' hope ranged from being physically present, to acting as an advocate and sharing responsibilities, to giving financial and emotional support (see Table 9). People demonstrated emotional support by showing sympathy, caring (sense of "being there"), being willing to talk/listen, sharing feelings from a similar epiphany, and giving trusted advice (see Table 9).

Many of the hope promoting strategies described by subjects focused on activities subjects did themselves.
Table 9

**Themes and Data Describing Hope Promoting Actions of Other People**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Presence</td>
<td>What helped, the kids [son and wife] was next door and the little ones [grandchildren] run back and forth. When I was home then they were over, and that helped. (c1306)</td>
</tr>
<tr>
<td></td>
<td>My neighbor . . . she'd come over and she sit with me (c1507)</td>
</tr>
<tr>
<td></td>
<td>when you're around someone like that you didn't feel like you were so terribly alone (c4611)</td>
</tr>
<tr>
<td>Financial Support</td>
<td>I had 3 sisters that had a home . . . so I moved in with them, . . . they provided you know while I stayed home with the kids (c5122)</td>
</tr>
<tr>
<td></td>
<td>I was living in a basement apartment and a wall washed out so I went to stay with my folks (c5122)</td>
</tr>
<tr>
<td>Acting as an Advocate</td>
<td>[my] sister went . . . to the doctor, and she said . . . I wish they'd take [admit subject's husband] to the hospital [due to his illness] 'cause [subject] is waiting to go to the hospital [to have a baby, but has no one to take care of her husband] (c5122)</td>
</tr>
<tr>
<td>Sharing Responsibilities</td>
<td>I had a lot of help . . . the folks in the summer time they'd take the two oldest ones as they grew up and were harder to watch . . . and try and teach them or help them and help me in the mean time too (c5122)</td>
</tr>
</tbody>
</table>
Table 9 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(continued)</td>
<td>my niece you know helped me a lot, move in here you know, they always try to help me whatever I want to do</td>
</tr>
<tr>
<td></td>
<td>(c5915)</td>
</tr>
<tr>
<td></td>
<td>our son would be right there and he'd say I'll go up to the [service station], you just park right here</td>
</tr>
<tr>
<td></td>
<td>Horn and I'll tell the man what you need (c7720)</td>
</tr>
<tr>
<td></td>
<td>they come around and they had pity on me . . . and kind of helped me along, kind of felt sorry for me (c0101)</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>just knowing I think that they cared and loved you . . . that's probably what helped the most (c4611)</td>
</tr>
<tr>
<td>1. Sympathized</td>
<td>people wanted to help me I knew, . . . they were always there saying if you need help we're right here . . .</td>
</tr>
<tr>
<td></td>
<td>I got the idea that I was not alone (5122)</td>
</tr>
<tr>
<td></td>
<td>[they] were just there if I wanted to [talk] fine, if I didn't want to fine, they were just there for me (c5713)</td>
</tr>
<tr>
<td>2. There for You - Cared</td>
<td>Yeah, they would [let me talk]. I talked about a lot (c1306)</td>
</tr>
<tr>
<td></td>
<td>You couldn't help but not talk about it (c4611)</td>
</tr>
<tr>
<td></td>
<td>I'd go see Father [priest]. . . and he'd talk. . . to me (c5122)</td>
</tr>
</tbody>
</table>
### Table 9 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Shared Similar Epiphany</strong></td>
<td>She'd say I've lost so many children and I've forgotten about 'em, and she told me about someone who lost a child and they sat by the window and looked out the window and she could not forget her child (c1507) anytime that I got a chance . . . I would run to the other teachers . . . and say how are you doing this, how are you coping with this and they would give me some reason . . . that really helped me when I realized there were other teachers there going through the same thing that I was (c7720)</td>
</tr>
<tr>
<td><strong>5. Gave Trusted Advice</strong></td>
<td>[someone who shared a similar epiphany said] don't sit, you work and that helps you (c1507)</td>
</tr>
</tbody>
</table>
These activities involved: staying busy with a job or other work, praying and meditating, socializing, helping others and trying to learn more. Internalizing positive thoughts was another hope promoting strategy subjects used. Subjects' thoughts encompassed encouragement via self-talk, focusing on problem solving, facing life on a day to day basis, being determined to go on, and having an internal sense of spiritual support (see Table 10).

**Diminishers of Hope**

During difficult times in subjects' lives, hope was decreased or diminished by several factors. People diminished subjects' hope by leaving them out of social activities and through people's negative interactions with subjects. Interactions were viewed as negative: (a) when subjects were told by others that they knew how it felt, (b) when others tried to make subjects feel better by pointing out positive aspects of the epiphany, (c) when others expected subjects to forget the problem and go on, (d) when people implanted negative ideas in subjects' minds, and (e) when subjects were dominated by (had to give in to) others (see Table 11).

The one community service identified as being a diminisher of hope was the transportation system. Even though transportation services for the elderly and
Table 10

Categories, Themes and Data Describing Hope Promoting Strategies Used by Subjects

<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. ACTIVITIES</strong></td>
<td></td>
</tr>
<tr>
<td>A. Staying Busy/Work</td>
<td>what helped a lot was my job at school . . . I worked at school, and I guess I just went on from there . . . if I'd just been home in the house and wouldn't been doing something, it would of been a lot harder (c1306)</td>
</tr>
<tr>
<td></td>
<td>I just did not give myself an awful lot of time to really feel bad . . . there was always something to keep me busy and going (c5122)</td>
</tr>
<tr>
<td>B. Praying/Meditating</td>
<td>I always prayed the rosary (c5915)</td>
</tr>
<tr>
<td></td>
<td>I believed in prayer a lot (c5122)</td>
</tr>
<tr>
<td></td>
<td>pray and meditation on a daily basis (c5713)</td>
</tr>
<tr>
<td>C. Socializing/Being With People</td>
<td>you work with people all day, and that kind of helps (c1306)</td>
</tr>
<tr>
<td></td>
<td>that activity that's going on in here [apartment complex] that was helpful, that was really helpful . . . we go to the Community Room, we can get together over there and play cards and everything, there is plenty of activity around here, keeps you going (c0101)</td>
</tr>
<tr>
<td></td>
<td>then you start well going out, I started dating again (c4611)</td>
</tr>
<tr>
<td>Categories and Themes</td>
<td>Examples of Supporting Data (with case numbers)</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>D. Helping Others</td>
<td>trying to help others . . . I have done consistently since that time (c5713)</td>
</tr>
<tr>
<td>E. Learn More</td>
<td>I think . . . trying to learn more . . . ah attending [AA] meetings (c5713)</td>
</tr>
<tr>
<td>II. THOUGHTS</td>
<td></td>
</tr>
<tr>
<td>A. Self-Talk/ Encouragement</td>
<td>I just made up my mind I was going to go forward. Well, a person can tell'em, but you got to come to it on your own. You just got to make up your mind you're goin' to and that's it. (c1306)</td>
</tr>
<tr>
<td></td>
<td>you just go along and try to make the best of, you know, the best of it I guess (c4611)</td>
</tr>
<tr>
<td></td>
<td>there was some comfort in knowing that I did everything that I knew I could do, so that I didn't have to suffer with the guilt. . . of saying well maybe there was something else (c5713)</td>
</tr>
<tr>
<td></td>
<td>and I said to myself I am not going to end up there (c7720)</td>
</tr>
<tr>
<td>B. Focusing on Problem Solving</td>
<td>I was just thinking how will I make, and just so my finances can make it, keep up, thinking about who I can go to church with, transportation (c0101)</td>
</tr>
<tr>
<td>C. Live Day to Day</td>
<td>I just went along with life (c5915)</td>
</tr>
<tr>
<td></td>
<td>[I] didn't look forward to a long time or days, just from day to day at times (c5122)</td>
</tr>
</tbody>
</table>
### Table 10 (continued)

<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D. Had to Go On/Determination</strong></td>
<td>And I finally just realized that I just had to go on. I figured I was just going to have to keep a goin'. Couldn't bring him back. I knew I had to [go on], that was all there was to it. There was no choice. (c0101)</td>
</tr>
<tr>
<td></td>
<td>I had to go on yes, cause I knew he wouldn't be ever come back, wouldn't ever be coming back anymore (c4611)</td>
</tr>
<tr>
<td></td>
<td>determination I guess, that comes in the category of stubbornness . . . I do have strong determination (c5713)</td>
</tr>
<tr>
<td><strong>E. Internal Spiritual Support</strong></td>
<td>I always think our Lord never sends anything, any cross that's bigger then we can bear so you know I could of stood more if I had to I guess (c5122)</td>
</tr>
<tr>
<td></td>
<td>I think it was a process of my surrender my stubbornness and my self will to God's will . . . and it was with that surrender and willingness that I think when I needed the most, the God of my understanding was there (c5713)</td>
</tr>
<tr>
<td></td>
<td>I would say Lord I can't do this day, I just can't do it, it's just too much for any person to do, now you take over Lord and help me, and he would and before I knew it the day was gone and ah I had done it, so I have always depended on the Lord to ah get me through anything no matter what it was (c7720)</td>
</tr>
</tbody>
</table>
handicapped existed, one subject thought the
inconvenience of the system negated it as a workable
method of transportation. Perhaps the most significant
findings regarding community agencies were: (a) the
dearth of community services to help subjects during
their epiphanies, and (b) that only half of the subjects
sought out and used existing services.

In addition to external forces, subjects' level of
hope was diminished by their own thoughts, feelings and
actions (see Table 11). Cognitive factors decreasing
hope mainly involved having negative expectations.
Another negative cognitive factor was focusing on the
physical, rather than spiritual, remains of loved ones.
One subject said

The hardest thing for me was to accept the fact
that he was in that cold, cold ground. I just, that
was the hardest thing for me to accept.

Even though this subject believed in a spiritual
afterlife, her thoughts focused on the physical remains
of her husband rather than on his spirit or soul.

Affective factors that diminished hope were: (a)
feeling alone, (b) feeling as if there was nothing to
look forward to, (c) feeling like a social misfit, and
(d) feeling distrustful of one's social network.
Activities that decreased subjects' sense of hope
Table 11

**Themes and Data Portraying Diminishers of Hope**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Left Out of Social Activities / Discarded</strong></td>
<td>And another thing that happens, not only me, but other people too, once one of 'em is gone you're left out, you're just not . . . included in so many things that goes on. It's just like they discard you, ah, you're just left out. I'm not the only one. There's a lot of widows that say that. (c1306)</td>
</tr>
<tr>
<td></td>
<td>they never included you like they did before, in social things (c1306)</td>
</tr>
<tr>
<td><strong>Negative Interactions</strong></td>
<td></td>
</tr>
<tr>
<td>1. Told &quot;Know How It Feels&quot;</td>
<td>a lot of people came to the house and they, some of them told me, that never lost a child but they feel [for] me, but I just couldn't see it, I just could not see it</td>
</tr>
<tr>
<td>2. Pointed Out &quot;Positives&quot;</td>
<td>one grandma walked home from church with me one day and she said I hear you are grieving over your son, she said I'm an old woman and I haven't had a loss in the family, you've got a baby in heaven . . . , and she said God is taking care of that baby, I said I was taking care of him too, (c1507)</td>
</tr>
<tr>
<td></td>
<td>county attorney said I hope he just stays lost because I know what happens almost every time, he said guys like that they come and go and the families get larger and ah the need for assistance gets bigger while they just shed their responsibilities</td>
</tr>
</tbody>
</table>
Table 11 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. (continued)</td>
<td>and they are gone, he said I hope he never comes back, and I still didn't want to give in to that feeling (c5122)</td>
</tr>
<tr>
<td>3. Expected to Forget /Go On</td>
<td>one lady came and she said in a year you'll have forgotten him, but I did not forget him in a year (c1507)</td>
</tr>
<tr>
<td></td>
<td>well you couldn't help but not talk about it but then after so long you, people expect you to go on with your life (c4611)</td>
</tr>
<tr>
<td></td>
<td>he (county attorney) said I guess the best thing for you to do is to make up your mind you're going to do it or just let him run, you can't possibly chase him down . . . it's better for you to just leave him go, but that was pretty hard for me to take, be free of him (c5122)</td>
</tr>
<tr>
<td>4. Implanted Negative Ideas</td>
<td>[when] we first got down there they took us as teachers on a tour . . . to show us where things were . . . and they said here is the insane asylum and this is where most of the teachers end up, that's what they told me on the first week that I was there, don't you think that wasn't in the back of my mind all the time, all the time I was there (c7720)</td>
</tr>
<tr>
<td>5. Dominated / Had to Give In</td>
<td>I guess what bothered me there was ah too because we lived in with the in-laws you know and had to give in to a lot of things, that part you know, course that's always in life, you couldn't do anything for yourself, you had to give in (c5915)</td>
</tr>
</tbody>
</table>
Table 11 (continued)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Convenient Transportation</td>
<td>as I say he was my transportation . . . you have to depend on each other, . . . the transportation I had, the lady moved, [the ACCESS van] boy you have to wait so long, boy you have to wait long (c0101) I didn't drive a car, I didn't have a car, I had the two kids and no way of getting around (c5122)</td>
</tr>
<tr>
<td>Negative Cognitive Factors</td>
<td></td>
</tr>
<tr>
<td>1. Negative Expectations</td>
<td>but I was sorta of always waiting to see if there was a phone call you know, I waited for a phone call to tell me that he's in jail, that he wrote more checks than he had money in the bank (c5122) I remember when I was correcting these tests, these intelligence tests and things, that I did cry at that time, I felt the day when I said I can't do this (c7720)</td>
</tr>
<tr>
<td>2. Thinking of Physical Remains</td>
<td>The hardest thing for me was to accept the fact that he was in that cold, cold ground. I just, that was the hardest thing for me to accept. I couldn't know why a person, to do that, but that's the way they are. Life is. (c1306)</td>
</tr>
<tr>
<td>Negative Affective Factors</td>
<td></td>
</tr>
<tr>
<td>1. Feeling Alone</td>
<td>I think the worse part is you're all alone (c1306)</td>
</tr>
<tr>
<td>Themes</td>
<td>Examples of Supporting Data (with case numbers)</td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>1. (continued) feel like you were so terribly alone, which is not a good feeling to feel so you know, just like you were the only person left I guess (c4611)</td>
<td>but I was alone you know, that was something that bothered me (c5915) and so he left . . . and left me down there with those four children and that's when my hope went down to one half below zero, I do not know how I got through that (c7720)</td>
</tr>
<tr>
<td>2. Nothing to Look Forward To</td>
<td>there's nothing nothing to -- well, maybe nothing to look forward to (c1306)</td>
</tr>
</tbody>
</table>
| 3. Felt Like a Social Misfit    | you couldn't go no place because you was a fifth wheel wherever you went, . . . you're out-of-place wherever you go (c1306) and then to stumble around all this time without a husband and having a baby you know, that's not the nicest, it was hard (c5122) they [sons] were in Scouts, and they would leave to go to camps or so and everybody was there with their mama and their dad and they had their dad help and here I was, I was helpless, . . . the kids enjoyed it just the same, but I felt terrible cause I couldn't spend a weekend (c5122)
<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Distrustful of Social Network</strong></td>
<td>that's something that kind of worries me, you know, I keep thinking maybe she's [niece] after my money. . . . I guess, the good Lord will take care of it, but you get thoughts you know sometimes, of course we all aren't perfect (c5915)</td>
</tr>
<tr>
<td><strong>Negative Activities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1. Dealing with Conflict</strong></td>
<td>when it was time to go to PTA meeting or those little teacher's meeting or one of those when you hear what the kids have done you know, you have to go and make things right or talk with somebody, that's when it was really harder for me than any other time (c5122)</td>
</tr>
<tr>
<td><strong>2. Dealing with Financial Difficulties</strong></td>
<td>I couldn't afford a babysitter to go to work (c5122) the only thing I had a concern about was getting it all paid for (c5713) we had to go to a lending place . . . to get a little money . . . to leave Florida because I told [my husband] I just couldn't I just couldn't take that any longer (c7720)</td>
</tr>
</tbody>
</table>
included dealing with conflict and financial difficulties (see Table 11).

**Research Question 5**

Data related to subjects' perceptions of the future were grouped into six broad categories in order to address research question five (How is the future perceived?). The six categories were: (a) attitude towards the future, (b) timeframe of the future, (c) sense of an afterlife, (d) sense of future for others, (e) motivators for day-to-day living, and (f) goals or plans for the future. The last category included actions for goal attainment and confidence in goal achievement. Each of these six broad categories are addressed separately.

**Attitude Towards the Future**

Two overriding themes evident in subjects' comments about their future were: (a) living life one day at a time, and (b) acquiescence to an uncertain future. One subject's description of living life one day at a time was

I just take it day to day. I'm here today, maybe gone tomorrow, maybe sick tomorrow. You never know. I just, I just never even think much about it [the future], I just go day to day.
Acquiescence to the uncertainty of the future was exhibited in comments by several subjects:

what comes you take;

whatever happens is goin' happen, there's just nothin' you can do about it;

accept the things I can not change, it's a simple way of living that's been more than satisfactory for me.

When subjects' responses were analyzed for their general orientation or view of the future, three subjects expressed a positive sense of the future, three spoke of a negative or limited future, and two subjects had mixed or uncertain feelings about the future. One of the subjects with a positive orientation to the future said:

Yeah, I look forward. I look forward to my health, try to keep on doin' what I'm doin'. That's what I, that's what I look forward to. I never think . . . that I'm goin' go down and can't do this what I'm doin'. I don't know why;

and another subject stated:

I look forward to the future . . . I like to be as up as I can be most of the time.

Subjects' uncertain or mixed feelings about the future were exemplified by comments like

well I don't know what's goin' [to] happen in the future, . . . I just hope everything goes all right and ah nothing bad happens here with me or something like that but you never can tell; and
I feel very uncertain about the future, like I might not be around so much you know, . . . as far as planning for next year or two years from now I don't because I think God willing I'll be here and I'll be grateful, I don't want to die but ah I'm sort of ready to die, I went to the cemetery the other day to see the graves of my family you know and ah I get quite homesick for them . . . my kids always say well mom we're still here you know you can wait your turn, and which I'm going to as far as that goes.

Subjects with a negative or limited sense of the future commented:

I don't think I have any thoughts about the future . . . I've bought my casket and I'm ready . . . sometimes I think I'm goin' die during the night, with you know diabetes, my mother died suddenly, she had diabetes and my son has it, but other than that I just don't care;

I really haven't gotten like, well if you don't have children or grandchildren so you know you don't have all that to look forward;

I don't think I have to look forward to anything.

**Timeframe of the Future**

When subjects were asked how far ahead they really thought about or planned for, responses ranged from the next day, to a month, to a couple of years, to many years in the future. The majority of the responses (n = 4) were in the next day category. One of these subjects stated "I get through the day and that's all that matters."
One of the two subjects who planned up to a month ahead said

usually its just from month to month, we get our bills paid with our Social Security check and then we look forward to the next check.

The subject who talked about the future in terms of many years ahead commented

the other day I said I hope to be a 100 and doin' what I'm doin'. But if I'm goin' get real sick I wouldn't want to be a 100 years old.

Sense of an Afterlife

Subjects' responses describing their general feelings about an afterlife were divided between skepticism and concordance. Skeptical belief in an afterlife was evident in responses by three subjects. One subject's skepticism was apparent when she said

It would be nice if somebody would come back and tell you oh it's nice there and there or you better be prepared for something like this or that, but they never come back to tell you, so we have to believe what we get taught or something.

Another subject remarked:

well God doesn't want us to go in too deep you know, but we wonder you know, what's in the next world, but it's something we can't understand cause of all the people from when the world was made you know, from the 1900s you think will they have room for us up there, but guess God almighty, he has his plans.

Five subjects' views were in concordance with an afterlife. Their peaceful acceptance of an afterlife
was exhibited in their comments:

Well, I think about an afterlife. I think it's better than what we have here, that's what I think.

I think that [cemetery] would be a lovely place you know to be, but it really doesn't make any difference to me where that part goes cause I'm going to be around for a long time, my spirits going to be around.

**Sense of Future for Others**

Subjects' general feelings about the future of others, e.g. their children or grandchildren, were evenly divided between positive and negative responses. Four subjects seemed apprehensive and viewed the future of others as possibly negative, while the other four subjects trusted in a positive future for others.

Apprehension was noted in comments like:

Ah, that's one thing I worry about, their future. For some reason or other I think these kids has got to have a hard going. Grandchildren, great-grandchildren is going to be worse yet I think.

I feel like there is really not too much of a decent future, . . . I really don't know ah how much time we have or I think that the earth is sort of corrupting itself you know to where human life has not got too much of a chance, I don't know I might be mistaken I'm no scientist but what you hear I take that to heart seriously and I think I feel for the, not really for the coming generation, but for those beyond that.

In contrast, subjects who exhibited a more trusting belief in the future of others said:
well I just hope and pray that they can live on, have a good life, no sickness or anything, which they pretty well [are] healthy all of them;

I just hope that it's as good of world as its been for me, for the children to come, it's been a wonderful world to me. . . I think America is so great that it can't fail for our children.

Motivators for Daily Living

Data in this category addressed factors that motivated subjects to go on living from day to day (see Table 12). Motivators of a more specific nature were: (a) everyday activities, and (b) work to be done. More general motivators that gave subjects a sense of purpose included: (a) spirituality, (b) beneficence, (c) self-evolvement, and (d) love of life.

One subject had difficulty identifying a motivator. Her main approach to daily living was just to get through or survive each day. She stated

I'm just glad that I can get through the day you know . . . I'm glad when the evening comes, my favorite thing is to sit in this chair and watch TV and thats by then I'm usually tired, you know real tired.

Goals and Plans for the Future

Subjects' goals for the future included: (a) maintaining one's health, (b) having a good death, (c) being with God, (d) enjoying retirement, (e) improving
Table 12

Categories, Themes and Data Illustrating Motivators for Day-to-day Living

<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. SPECIFIC MOTIVATORS</strong></td>
<td></td>
</tr>
<tr>
<td>A. Everyday Activities</td>
<td>well [I] think about what I'm going to do during the day and keep my activities up, whatever I want to do, go to town, or go to Alco when it's nice and go visiting (c0101) puzzles and cooking, love to cook (c5122)</td>
</tr>
<tr>
<td>B. Work to be Done</td>
<td>I always have something to do (c0101) Work! Got to get this done and got to get that done. And I gotta be ready to go to work by noon, and I'm always, well, once in a while I like [to] sleep in a little bit. But I'm always up on the go. (c1306)</td>
</tr>
<tr>
<td><strong>II. GENERAL MOTIVATORS</strong></td>
<td></td>
</tr>
<tr>
<td>A. Spirituality</td>
<td>I get up in the morning and I sit here and I pray until noon . . . I pray a lot . . . I think that's why he [God] has me here (c1507) saving [my] soul, that's the purpose now (c4611)</td>
</tr>
<tr>
<td>B. Beneficence</td>
<td>be of help to as many as I can is my purpose here (c5713)</td>
</tr>
<tr>
<td>C. Self-evolution</td>
<td>I think to learn as much as I can . . . I know there's more to learn (c5713)</td>
</tr>
</tbody>
</table>
Table 12 (continued)

<table>
<thead>
<tr>
<th>Categories and Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. (continued)</td>
<td>I think that elderly people should have several different talents, everybody has several talents if they will develop them, and they should have several different things that they like to do (c7720)</td>
</tr>
<tr>
<td>D. Love of Life</td>
<td>Life [keeps me going] (c5713)</td>
</tr>
<tr>
<td></td>
<td>I just love life, I just love living (c7720)</td>
</tr>
</tbody>
</table>
one's finances, and (f) improving one's self (see Table 13). Actions taken to attain the desired goals encompassed: (a) health promotion activities, like eating right and exercising; (b) religious activities, such as, praying for special favors, going to church and using holy water; (c) decreasing outside commitments in order to relax and stay home; (d) seeking buyers for work produced in order to improve finances; and (e) self-help activities, like reading, listening to self-help tapes, and attending support groups.

When subjects were asked how confident they were that they would attain their goals, none of the subjects expressed a strong sense of confidence. In regards to goal achievement, most (n = 5) of the subjects' comments reflected cautious optimism. As one subject explained,

I hope for it, I don't know whether I get it or not as I say, if God will answer you, ah answer you sooner or later, you don't know when, your prays will be answered they say.

The other three subjects portrayed a sense of acquiescence about attaining their goals. One subject stated:

well that's not in my hand anyhow, . . . that's in God's hands . . . whatever's going to happen will happen;
### Table 13

**Goals for the Future**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Examples of Supporting Data (with case numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain Health</td>
<td>no plans, hope for the future, well I hope to stay healthy and walking (c0101)</td>
</tr>
<tr>
<td></td>
<td>just to stay healthy so I can take care of myself (c5122)</td>
</tr>
<tr>
<td></td>
<td>I hope that my eyes stay good and my fingers that don't get too bad that I can do this kind of work (1306)</td>
</tr>
<tr>
<td>Good Death</td>
<td>I hope I don't have to suffer so long . . . good death, easy death</td>
</tr>
<tr>
<td>Being With God</td>
<td>there's no plans except to pray and hope that God will take me home</td>
</tr>
<tr>
<td>Enjoy Retirement</td>
<td>I'm just kind of glad to retire . . . so I don't have that responsibility anymore and ah my goal is just to live happily here in this apartment (c7720)</td>
</tr>
<tr>
<td>Improve Finances</td>
<td>I have made a genealogy chart . . . and I have been trying to get it published . . . that's my future goal . . . what I really did it for was to help us with extra money for retirement (c7720)</td>
</tr>
<tr>
<td>Self-improvement</td>
<td>I haven't given up on the idea of going back to school and learning all that I can, I do read a lot as you can see, I tape a lot, . . . I know there's more to learn . . . some of the discoveries that he [self-help author] has made, I can learn from those people (c5713)</td>
</tr>
</tbody>
</table>
and another one said:

    I leave it up to the Lord, if he doesn't want it to be published that's fine with me, whatever he wants.

Only two subjects identified specific plans they hoped to fulfill in the future. One subject wanted to attend two family reunions, and the other subject planned to make quilts for her grandchildren.

Several subjects seemed to shy away from making specific plans, with two subjects specifically talking about the inherent potential for disappointment when one makes plans. One subject explained:

    if you think to the future then it wouldn't happen then you feel worse yet . . . if you have plans for the future and they don't come true that's worse than not having any plans at all . . . you can't plan ahead anymore . . . if you plan ahead in the future, it never will turn out, most of the time anyhow, cause I found that out already, making plans and they didn't come true and then you feel bad about it.

Another subject shared similar feelings:

    I sometimes tentatively plan you know, like a trip, but not totally and certainly not the outcome of how it's going to be . . . I'll let it happen, if it works out it works out and if it doesn't, see if I plan and have these expectations I set myself up for disappointment and I don't like to feel that.

Additional Quantitative Analyses and Findings

In an effort to more fully explore the findings of this study, additional analyses were conducted on the
quantitative data. Findings reported in this section were obtained using parametric statistics, except for cases where group variances were significantly different; in those cases nonparametric procedures were used. Thus, in the following sections, when parametric results are reported for unequally sized groups it means the homogeneity of variance assumption was tested and was not violated.

Using hope scores (overall hope, generalized hope, and particularized hope) as the criterion or dependent variables, additional exploratory analyses found significant results for three predictor variables: (a) psychosocial developmental residual, (b) gender, and (c) health problems. Specific findings for each of these variables are presented in the following three sections.

Differences Based on Psychosocial Developmental Residual

Analyses were conducted to determine if subjects with varying developmental residual scores had statistically different hope scores. This area of analysis was of interest because findings for research questions 1, 2, and 3 suggested an association between developmental residual and hope. Due to those findings, a logical question to ask was: Is there a statistically significant difference in hope scores for subjects with
high developmental residual and those with low developmental residual?

To address this question, subjects were first divided into four groups (see figure 4, p. 102), according to their trust-mistrust and autonomy-shame subscale scores for the Modified Erikson Psychosocial Stage Inventory (see Appendix M, Table M-2). The four groups were:

Group A: subjects' with trust-mistrust and autonomy-shame scores of 3.5 or higher, n = 56;

Group B: subjects' with trust-mistrust scores of 3.4 or lower and autonomy-shame scores of 3.5 or higher, n = 13;

Group C: subjects' with trust-mistrust scores of 3.5 or higher and autonomy-shame scores of 3.4 or lower, n = 12;

Group D: subjects' with trust-mistrust scores of 3.4 or lower and autonomy-shame scores of 3.4 or lower, n = 9.

Using the one-way analysis of variance (ANOVA) procedure, with developmental residual as the independent variable, significant differences in overall hope scores (F [3,86] = 3.28, p = .03) were found. Duncan's procedure (p < .05) noted a significant difference between Group A (high trust-mistrust and high autonomy-shame scores) and Group D (low trust-mistrust and low autonomy-shame scores). The one-way ANOVA

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procedure with developmental residual and generalized hope scores obtained non-significant findings, $F (3, 86) = .78, p = .51$.

Developmental residual groups and particularized hope scores were analyzed using the Kruskal Wallis oneway ANOVA of ranks procedure. Significant results were obtained, when corrected for ties, chi-square $(3, N = 90) = 18.89, p = .00$. Duncan's procedure noted significant differences between four pairs of groups: A and C; A and D; B and C; and, B and D. The deciding factor was a difference in autonomy-shame scores within each of the four pairs. In the same way, no significant differences were noted between Groups A and B, nor between Groups C and D; perhaps because both A and B groups have high autonomy-shame scores, and both C and D groups have low autonomy-shame scores.

**Gender Based Differences**

Differences in developmental residual and hope were also analyzed with gender as the independent variable. One way ANOVA procedures noted that men had significantly higher autonomy-shame scores than women, $F (1, 88) = 6.50, p = .01$. This difference between men and women did not carry over to particularized hope scores, as a
oneway ANOVA between gender and particularized hope was non-significant, $F(1,88) = 0.04, p = .84$. Conversely, the Kruskal Wallis oneway ANOVA of ranks procedure found females' generalized hope scores to be significantly higher than the males. The mean rank for females was 48.30, while the mean rank for males was 34.31; resulting in a significant chi-square (corrected for ties = 4.15, $p = .04$). Although a gender difference in generalized hope scores was noted, when gender differences in trust-mistrust scores were analyzed using oneway ANOVA procedures, non-significant findings were obtained, $F(1,88) = 0.19, p = .66$.

Health Problems

Pearson Product Moment Correlation analysis revealed a significant, although small, inverse correlation between particularized hope scores and subjects' number of self reported health problems ($r = -.22, p = .04, N = 90$). A similar inverse relationship was found between autonomy-shame scores and number of self reported health problems ($r = -.26, p = .02, N = 90$). Thus, subjects with lower particularized hope scores and those with lower autonomy-shame scores reported experiencing more health problems. No significant correlations were obtained between
generalized hope scores and number of health problems, or between trust-mistrust scores and number of health problems.

Exploratory analyses of different types of self-reported health problems uncovered several statistically significant relationships (see Table 14):

1. Subjects' with arthritis (n = 65) had lower overall developmental residual scores (M = 3.79, SD = .40) than subjects (n = 25) without arthritis (M = 3.98, SD = .29), t(88) = 2.20, p = .03.

2. Subjects' with arthritis had lower particularized hope scores (M = 53.45, n = 5.00) than subjects without arthritis (M = 56.24, SD = 5.59), t(88) = 2.30, p = .02.

3. Subjects' with respiratory problems (n = 16) had lower overall developmental residual scores (M = 3.65, SD = .37) than subjects (n = 74) without respiratory problems (M = 3.88, SD = .38), t(88) = 2.21, p = .03.

4. Subjects' with respiratory problems had lower overall hope scores (M = 84.38, SD = 8.32) than subjects without respiratory problems (M = 89.78, SD = 8.51), t(88) = 2.31, p = .02.

5. Subjects' with respiratory problems had lower generalized hope scores (M = 32.31, SD = 5.20) than
Table 14

Overview of Significant Findings For Subjects with Various Types of Self Reported Health Problems

<table>
<thead>
<tr>
<th>Health Problems</th>
<th>Overall Trust-Develop.</th>
<th>Autor.-mistr.</th>
<th>Overall Hope</th>
<th>Gen. Hope</th>
<th>Part. Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>L</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Dysfunction</td>
<td>L</td>
<td></td>
<td>L</td>
<td>L</td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H</td>
</tr>
<tr>
<td>Depression</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td></td>
</tr>
</tbody>
</table>

Note.  L = lower scores; H = higher scores; blank areas indicate non-significant findings.
subjects without respiratory problems ($M = 35.09$, $SD = 4.17$), $t (88) = 2.31$, $p = .02$.

6. Subjects' with high blood pressure ($n = 38$) had higher generalized hope scores ($M = 35.71$, $SD = 3.62$) than subjects ($n = 52$) without high blood pressure ($M = 33.79$, $SD = 4.87$), $t (88) = 2.05$, $p = .04$.

7. Subjects' reporting problems with depression had lower scores on (a) overall hope, (b) particularized hope, (c) overall developmental residual, and (d) autonomy-shame residual, compared to subjects reporting no problems with depression (see Table 15).

**Triangulation of Quantitative and Qualitative Findings**

As stated in chapter 3, one of the weaknesses of correlational survey designs is the possible detection of spurious or arbitrary relational patterns (Isaac & Michael, 1981). To help evaluate the clinical relevance of correlational patterns detected in this study, quantitative and qualitative data were triangulated. Triangulation was performed only after completing data analysis for all five research questions, in order to prevent contaminating the findings related to the individual research questions.
Table 15

**Significant Differences Between Subjects Reporting a Problem with Depression and Subjects Not Reporting a Problem with Depression (N = 90)**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Problem with Depression (n = 18)</th>
<th>No Problem with Depression (n = 72)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Hope</td>
<td>83.50 (8.67)</td>
<td>90.15 (8.22)</td>
<td>3.04</td>
<td>.00</td>
</tr>
<tr>
<td>Particularized Hope</td>
<td>50.55 (5.02)</td>
<td>55.13 (4.97)</td>
<td>3.49</td>
<td>.00</td>
</tr>
<tr>
<td>Overall Development</td>
<td>3.54 (.40)</td>
<td>3.91 (.35)</td>
<td>3.93</td>
<td>.00</td>
</tr>
<tr>
<td>Autonomy-shame</td>
<td>3.46 (.47)</td>
<td>3.94 (.47)</td>
<td>3.86</td>
<td>.00</td>
</tr>
</tbody>
</table>
The triangulation process involved placing each interview into one of four groups, according to subjects' scores on the Modified Erikson Psychosocial Stage Inventory (see Figure 4, p. 102). Whereas previously the interviews selected from the four developmental categories were analyzed as one group, for the triangulation process the interviews were re-analyzed as four separate groups. The purpose of the second analysis was to detect similarities and differences in the qualitative responses, between the four different quantitative groups.

The premise underlying the triangulation process was: if actual relationships existed between psychosocial developmental residual and hope, then subjects with differing developmental residual should give somewhat different responses to the qualitative research questions on hope (i.e., questions 4 and 5). Thus, if different response patterns between the four groups of interviews were obtained, the validity and reliability of the correlational findings of the study would be supported. If differing response patterns in the qualitative data were not noted, then a spurious or arbitrary relational pattern in the quantitative data may have been obtained.
To guard against bias in the analysis, new thematic codes were not identified for the qualitative data. Instead, thematic codes derived during the data analysis process for research questions four and five were used.

Table 16 displays a comparison of the four quantitatively divided groups, for selected qualitative categories. The most striking difference in the groups was found when Group A was compared with the other three groups. Group A subjects projected an overall positive perspective in regards to changes resulting from epiphanies, sense of control, orientation to the future, sense of an afterlife, and a sense of future for others.

Factors motivating Group A to go on living were general in nature, that is, love of live, self-evolvement, and beneficence. Another interesting difference was that Group A subjects were chronologically in later developmental stages at the time of their epiphanies than subjects in the other groups, except for case 0101.

A comparison of the high trust-mistrust groups (A and C) with the low trust-mistrust groups (B and D) showed that the views of all four subjects in Groups A
Table 16

Comparison of Different Psychosocial Developmental Residual Groups
for Selected Qualitative Categories

<table>
<thead>
<tr>
<th>Psychosocial Developmental Residual Group (with case #)</th>
<th>Psychosocial Development at Time of Epiphany</th>
<th>Changes due to Epiphany</th>
<th>Sense of Orientation to Epiphany</th>
<th>Epiphany to Afterlife</th>
<th>Future Skepticism</th>
<th>Future Others</th>
<th>Motivator for Living</th>
<th>G (general)</th>
<th>S (specific)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Trust-mistrust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Autonomy-shame (Group A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c5713</td>
<td>Generativity</td>
<td>2 +, 0 -</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>c7720</td>
<td>Generativity</td>
<td>1 +, 1 -</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Low Trust-mistrust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Autonomy-shame (Group C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c1507</td>
<td>Intimacy</td>
<td>0 +, 1 -</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>c5122</td>
<td>Intimacy</td>
<td>3 +, 0 -</td>
<td>+/-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>Low Trust-mistrust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Autonomy-shame (Group B)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c1306</td>
<td>Intimacy</td>
<td>2 +, 0 -</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>c5915</td>
<td>Intimacy</td>
<td>0 +, 1 -</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>S/G</td>
<td></td>
</tr>
<tr>
<td>Low Trust-mistrust</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Autonomy-shame (Group D)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c0101</td>
<td>Ego Integrity</td>
<td>2 +, 3 -</td>
<td>+/-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c4611</td>
<td>Intimacy</td>
<td>0 +, 1 -</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>G⁸</td>
<td></td>
</tr>
</tbody>
</table>

* Subject had difficulty identifying a motivation for living.
and C were in concordance with an afterlife, while only one subject out of Groups B and D shared this perspective. Also, three out of the four subjects in Groups A and C viewed the future of others as positive, whereas only one subject in the low trust-mistrust groups had this view.

Differences between the high autonomy-shame groups (A and B) and the low autonomy-shame groups (C and D) were noted for two categories: sense of control during/after the epiphany, and orientation to the future. Three out of the four high autonomy-shame cases felt a sense of control in dealing with their epiphanies; in contrast, for the low autonomy-shame groups, control was perceived by only one subject. For the orientation to the future category, three of the high autonomy-shame cases had a positive outlook but none of the low autonomy-shame cases did (i.e., 2 negative, 2 mixed).

In conclusion, differences were found in the qualitative data for the four development groups. The differing patterns of responses among these groups provide evidence of support for the quantitative findings.
Validity Issues

Prior to interpreting findings from any research study, the external and internal validity of the study needs to be addressed. These two issues are discussed in this section, as a prologue to the interpretation of the findings presented in Chapter 5.

External Validity

The use of random sampling procedures to identify which apartment residents were invited to participate in the study enhanced the external validity of the findings. However, generalizability of the empirical findings remains limited due to the singular ethnicity of the subjects, and the sole geographic location of the sampling frame. Due to the nature of qualitative research, the qualitative findings from this study are not generalizable beyond the sample.

Internal Validity

The occurrence of the Persian Gulf War during part of the data collection period for this study necessitates that findings be interpreted with caution. The war between the United States and Iraq began on January 16, 1991 and ended on February 28, 1991. Data for this study were collected between February 11 and
April 23, 1991. Because part of the data were collected while the United States was at war, a possible threat to the internal validity of the study needs to be considered.

To evaluate the possible affect the war may have had on subjects' overall hope, generalized hope, and particularized hope scores, t tests were conducted comparing data (n = 24) collected during the war with data (n = 66) obtained after the war ended. For the three hope variables, no significant differences between the two groups of data were found.

To evaluate if the hope of the entire sample might have been lowered because of the war, the mean hope score in Nowotny's (1989) original study was compared to the mean overall hope score for this study. The mean hope score for this study was found to be higher (M = 88.82, SD = 8.7) than the mean hope score for Nowotny's study (M = 82.7, SD = 9.8), which included well adults and patients with cancer.

In conclusion, these findings suggest that the Persian Gulf War did not hinder the internal validity of the study.
Summary

In this chapter, data analysis procedures and findings were detailed. Triangulation of the quantitative and qualitative findings was also described. As a prelude to the next chapter, validity issues were discussed.
CHAPTER V

INTERPRETATION, CONCLUSIONS AND IMPLICATIONS

The Little Boy and the Old Man

Said the little boy, "Sometimes I drop my spoon."
Said the little old man, "I do that too."
The little boy whispered, "I wet my pants."
"I do that too," laughed the little old man.
Said the little boy, "I often cry."
The old man nodded, "So do I."
"But worst of all," said the boy, "it seems
Grown-ups don't pay attention to me."
And he felt the warmth of a wrinkled old hand.
"I know what you mean," said the little old man.
(Silverstein, 1981, p. 95)

For this study, the relationship between psychosocial developmental residual and hope in older adults was explored using a correlational design, with a descriptive (qualitative) component. The sampling frame for the study was elderly subjects, 62 years of age or older, who lived in community-based congregate housing units in a small, rural midwestern city of the United States. Random sampling procedures were used to select 90 subjects for the quantitative part of the study. From the sample of 90, 22 subjects were interviewed, with 8 of the interviews purposively selected for the qualitative component of the study.
The overriding purpose of this study was to test a mid-range theoretical model of hope in the elderly (see Figure 1, p.3). Due to the concepts and constructs in the model, the variables of interest for the study were: (a) trust-mistrust developmental residual, (b) autonomy-shame developmental residual, (c) generalized hope, and (d) particularized hope. The Nowotny Hope Scale (Nowotny, 1989) was reconceptualized to measure two types of hope: generalized and particularized; which together measured the overall construct of hope.

In order to test the theoretical model of hope (see Figure 1), quantitative methods were used to explore the variables of interest. Specifically examined was the utility of using psychosocial developmental residual from the first year of life (trust-mistrust) to predict generalized hope in an elderly population, and residual from the second year of life (autonomy-shame) to predict particularized hope.

Findings from the study are interpreted in this chapter, and the major conclusions related to the findings are presented. Based on the findings, implications for theory development, practice, education and research are delineated.
Interpretation of Findings

Findings related to the first three research questions indicated that subjects' overall developmental residual scores were significantly associated with their overall hope. For research question one, hierarchical regression analysis (based on sequentially entering residual from the eight developmental stages) found that 40% of the variance in subjects' overall hope scores was predicted by the eight developmental variables, with 22% of the variance being accounted for by residual from the first two developmental stages. Simple linear regression analysis discovered that for research question two, trust-mistrust scores significantly predicted generalized hope scores; and for research question three, autonomy-shame scores significantly predicted particularized hope scores.

These findings suggest that hope in older adults is associated with psychosocial developmental residual, especially residual from the first two stages of life. Synthesizing these findings with the construct validity analysis of the two hope subscales (see Chapter 3, pp. 122-127) suggests that generalized hope and particularized hope measure different dimensions of hope; although particularized hope seems to build on...
generalized hope, much as autonomy-shame residual builds on residual from the trust-mistrust stage of development.

Qualitative findings associated with research questions four and five added a contextual dimension to the study. Data showed that epiphanies (difficult times) in subjects' lives related to the loss of significant attachment objects. The "objects" of attachment included loved ones and geographic environments. During difficult times, hope was both promoted and diminished by other people's actions, and by activities and thoughts of the subjects.

Hope was diminished when other people said they knew how the subjects felt, and when people tried to "fix" or improve subjects' feelings by pointing out the positive aspects of the epiphanies. Expecting subjects to forget and go on with their lives, and ignoring or not including subjects in social activities also decreased hope. In contrast, hope was promoted when people gave subjects emotional support as they worked through their situation. Emotional support involved being sympathetic, caring (physically being with subjects or offering assistance), and allowing subjects to talk about their situation. Subjects were most
trusting of advice from people who had shared a similar epiphany.

Subjects' activities that promoted hope were staying busy, praying, and socializing; whereas activities that diminished hope were dealing with conflict and coping with financial difficulties. The major cognitive factor decreasing hope was having negative expectations (a lack of trust) about the outcome of the epiphany. Conversely, some subjects increased their hope by thinking encouraging thoughts (self-talk). Other hope promoting factors were: being determined, living day to day (i.e., not thinking too far into the future), and having a sense of internal spiritual support.

Subjects' thoughts of the future mainly focused on living one day at a time. Motivation for living ranged from everyday activities to loving life. Most of the subjects strongly believed in a harmonious afterlife; however, subjects were not as positive about the possible future of younger generations.

Few subjects reported making specific plans for the future, due to the inherent potential for disappointment associated with planning. Subjects' perceived lack of control over the future was also reflected in subjects'
low level of confidence about attaining desired goals. The most common goal for the future was maintaining one's health, in order to care for oneself.

Triangulation of the qualitative data, from research questions four and five, with the quantitative results for the first three questions found that the qualitative data supported the empirical findings. Qualitative analysis of the interview data found that subjects with favorable trust-mistrust and autonomy-shame developmental residual had a stronger sense of control and more hope for the future than those with unfavorable developmental residual. These findings were congruent with the quantitative results. Because similar findings were obtained through the use of different methodologies, the likelihood of the correlational findings being arbitrary, or due to rival hypotheses, is less.

Additional exploratory analysis of the data revealed several significant findings. However, these findings need to be interpreted cautiously due to the potential for a Type IV error whenever numerous post-hoc analyses are conducted.

A significant difference in overall hope scores was found between subjects with high trust-mistrust and
high autonomy-shame scores, and those with low trust-mistrust and low autonomy-shame scores. Also, a significant difference in particularized hope scores was discovered between developmental groups (see Figure 4, p. 102), with the determining factor being autonomy-shame developmental residual.

Further exploration of the data uncovered gender based differences in the findings. Male subjects had significantly higher autonomy-shame residual scores than female subjects, and females had higher generalized hope scores than males. The gender related differences noted in the hope scores are similar to Daboub's (1988/1989) finding that females were more hopeful than males.

While scrutinizing the data, significant findings related to subjects' self reported health problems were also discovered. Subjects with low autonomy-shame/doubt residual scores, and those with low particularized hope scores had significantly more health problems than other subjects. These results are indirectly supported by MacLean's (1987/1988) study that found developmental residual to be a strong predictor of health behaviors. Results from Finch's (1987) study provides additional support, as a significant moderate ($r = .43, p < .05$)
correlation between unfavorable shame/doubt residual and length of hospital stay was observed.

When subjects with specific types of health problems were compared with subjects not experiencing the health problems, several significant findings surfaced. Subjects with respiratory dysfunction and those with arthritis had significantly lower overall developmental residual scores and lower particularized hope scores. Subjects reporting problems with depression had significantly lower scores in the areas of overall development, autonomy-shame, overall hope and particularized hope. These results are inversely similar to Domino and Hannah's (1989) findings that developmental residual was associated with healthy psychological functioning.

An intriguing finding was obtained for subjects with high blood pressure, as these subjects had significantly higher generalized hope scores than subjects without high blood pressure. This may indicate that people with high blood pressure cope differently than people with other health problems, or that these individuals have unfavorable residual from developmental stages beyond the trust-mistrust stage.
Major Conclusions

Based on the interpretation of the data, conclusions related to the following three areas were drawn: (a) theoretical model of hope in the elderly, (b) Erikson's epigenetic theory of psychosocial development, and (c) Modeling and Role-Modeling theory. Although conclusions are presented, due the limitations of correlational research designs and the validity issues discussed in the previous chapter, the tentativeness of these conclusions is acknowledged.

Theoretical Model of Hope

As stated earlier, the overriding purpose of this study was to test a mid-range theoretical model of hope in an elderly population (see Figure 1, p. 3). The results of the study provided evidence of support for the portion of the model depicted in Figure 6.

Evidence supporting the conceptualization of hope as a multidimensional construct, comprised of the concepts generalized hope and particularized hope, was obtained. Also, favorable psychosocial developmental residual from the first stage of life was found to be a weak, but significant predictor of generalized hope; and favorable residual from the second stage was a
Figure 6. Portion of Theoretical Model of Hope Supported by Research Findings
significant, moderate predictor of particularized hope. Thus, for this study, psychosocial developmental traits from early stages of life were discovered to affect the level (states) of hope in older adults.

The qualitative findings furnished support for the relationship between hopefulness and motivational involvement in living. Two subjects who were interviewed, both with high trust-mistrust and high autonomy-shame scores, stated that their reason for living was a love of life. This finding was congruent with Dufault and Martocchio's (1985) qualitative description of hope as a dynamic life force.

The relationship between low autonomy-shame residual and hopelessness, depicted in Figure 1 (see p. 3), was indirectly supported by the research findings. Subjects who reported having problems with depression also had low autonomy-shame scores and low particularized hope scores. This may suggest that "functional" depression (as opposed to debilitating depression) is a clinical manifestation of learned helplessness.

Conclusions about low generalized hope could not be drawn because the empirical data indicated that subjects' generalized hope scores were relatively high.
This was not a surprising finding. As stated in Chapter 1, one of the recognized limitations of this study was the potential difficulty in getting subjects experiencing low generalized hope (isolated hope) to participate. Another factor that may have restricted the range of variance in generalized hope scores was the predominance of strong religious affiliations within the overall group of subjects.

Qualitative data from subjects with low trust-mistrust scores and those with low autonomy-shame scores provided some evidence of support for the relationship between hopelessness and despair depicted in Figure 1 (see p. 3). Several of these subjects commented that they had no future; and one subject, with low trust-mistrust scores and low autonomy-shame scores, had a difficult time thinking of any purpose or motivation for living. This subject's life primarily evolved around trying to just get through or survive each day, and trying to save her soul.

**Erikson's Theory of Psychosocial Development**

The findings of this study provide supporting evidence for the epigenetic nature of Erikson's (1963, 1982) theory of psychosocial development. Erikson's
theory proposes that hope is the virtue derived from a favorable balance of trust versus mistrust, during the first stage of life. This suggests that a person's sense of hope is related to developmental residual from the first stage of life, no matter what the chronological age of the person.

Empirical findings for this study showed that in the elderly population sampled, trust-mistrust residual significantly predicted overall level of hope and generalized hope. Possible epigenetic dynamics between the first two stages of life may explain why a person's overall hope has both generalized and particularized components.

The hierarchical regression findings of this study also supported the epigenetic nature of Erikson's (1963, 1982) theory. All but three of the eight developmental stages significantly improved the capability of the regression equation to predict overall hope. Only one of these three stages, that is, ego integrity-despair, had a negative beta weight. This is congruent with the theory because some instability is anticipated in individuals' adaptation to the critical task of their age-related stage of development. The other two stages that did not significantly improve the regression
equation (i.e., initiative-guilt, and identity-confusion) are closely related to the autonomy-shame stage. It is likely that the contribution from these two stages was not significant because residual from the autonomy-shame stage was entered into the equation first.

A finding that was inconsistent with Erikson's (1963, 1982) theory was the identification of 13 subjects who had low trust-mistrust scores but high autonomy-shame scores. According to Erikson, developmental stages sequentially build on one another, suggesting that a later stage would have a lower score than an earlier stage, if the favorable residual from the earlier stage was weak.

This finding needs to be explored further using instruments that measure favorable and unfavorable residual from each stage separately (e.g., trust separately from mistrust).

Modeling and Role-Modeling Theory

The grand theory, Modeling and Role-Modeling (MRM), proposes that people's utilization of self-care resources and self-care knowledge results in self-care actions that impact on their health status (Erickson et al., 1988). Hope is specifically identified in the
theory as a possible internal self-care resource. Evidence supporting this theorized linkage between hope and health status was obtained from the study. Empirical findings detected a small but significant inverse (\( \tau = -.22, p = .04 \)) relationship between subjects' hope and their number of health problems, as well as the types of health problems they experienced.

Another proposition of MRM theory that was tentatively supported was the nexus between autonomy (perceived control) and hope. Although Erikson's developmental theory has identified hope as mainly being connected to trust, MRM theory has suggested that hope is related to control, as well as trust. MRM theory postulates that promoting "in people a sense of their own power to bring about some significant change also promotes hope and future expectations" (Erickson et al., 1988, p. 188). This proposition was tentatively supported because a significant, positive, moderate relationship (\( \tau = .57, p = .00 \)) between autonomy-shame residual and particularized hope was observed.

Qualitative findings from this study lend support for the MRM interventions aimed at promoting client's positive orientation. "Promoting positive orientation has two aspects: The first aspect is to promote self-
worth, the second is to promote hope for the future" (Erickson et al., 1988, p. 186). Table 17 depicts qualitative findings from this study that lend support for specific MRM interventions aimed at promoting clients' positive orientation.

In addition, qualitative findings (i.e., factors that diminished hope) indirectly provided support for two additional MRM interventions. In this study, it was found that other people decreased subjects' hope by implanting negative ideas in subjects' thought processes (see Table 11, p. 169). Conversely, MRM theory identifies giving clients positive embedded verbal commands as a hope promoting intervention.

The other MRM intervention indirectly supported by this study related to teaching clients "how to project themselves positively into the future" (Erickson et al., 1988, p. 191) using imagery and dreaming about hopes for the future. MRM theory notes that some clients' hopes or dreams frequently result in disappointments because the clients' expectations are too great. The theory recommends that nurses help these clients dream about less ambitious or more realistic hopes. In this study, the importance of this intervention was corroborated by
Table 17

**Qualitative Findings that Lend Support for Specific Nursing Interventions Used to Promote a Positive Orientation**

<table>
<thead>
<tr>
<th>Nursing Interventions Based on Modeling and Role-Modeling Theory</th>
<th>Qualitative Findings (see Tables 9 and 10 in Chapter 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Projecting a sense of future for the client by sharing positive expectations (e.g. life is worth living)</td>
<td>1. Self-talk / Encouragement</td>
</tr>
<tr>
<td>2. Scheduling visits/time to be with clients.</td>
<td>2. Physical Presence</td>
</tr>
<tr>
<td>3. Encouraging clients to take things in small steps.</td>
<td>3. Live Day to Day (during a crises)</td>
</tr>
<tr>
<td>4. Focusing on goals and promoting client's control (clients need to be supported to be autonomous)</td>
<td>4. Focus on Problem Solving; and Being There for You / Caring</td>
</tr>
<tr>
<td>5. Role-modeling hope within the context of client's reality</td>
<td>5. Shared Similar Epiphany</td>
</tr>
</tbody>
</table>
subjects' refusal to make specific plans for the future due to their belief that planning brought with it inherent disappointment.

Implications

Findings and conclusions from this study have implications for the discipline of nursing. To show the connecting links between this study and the discipline of nursing, implications are addressed as they relate to theory development and expansion, practice, education, and research. The implications identified for nursing practice and education are preliminary in nature, as additional research is needed to confirm the results of this study.

Implications for Theory Development and Expansion

1. The relationships among generalized hope, particularized hope, and affiliated-individuation need be explored. Modeling and Role-Modeling (MRM) theory purposes that the state of affiliated-individuation "comes only on the heels of a real sense of Eriksonian trust and autonomy" (Erickson et al., 1988, p. 174). Likewise, generalized and particularized hope are also related to these two developmental stages. The possibility that affiliated-individuation is a mediating
factor between developmental residual (i.e., trust and autonomy) and the two types of hope needs to be examined.

2. The possible relationships among the concepts and constructs presented in Figure 1 (p. 3) need additional study. For example, investigating the possible relationship between particularized hope and learned helplessness could further develop the mid-range theory of hope.

3. Gender related differences in psychosocial developmental residual need to be explored. The finding that females had significantly higher generalized hope scores than males is of special interest because hope is thought to be a dynamic life force. Possible connections between generalized hope and perceived enactment of autonomy (PEA) should be pursued, as Hertz (1991) found males had significantly lower PEA than females.

4. The relationship between psychosocial developmental residual and hope in older adults needs to be explored using an instrument that measures favorable and unfavorable residual separately for each developmental stage (e.g., measures both trust and mistrust residual). Findings from such a study may identify if hope is determined by the balance between favorable and
unfavorable residual, or by either favorable or unfavorable residual.

5. The possible relationship between generalized hope and high blood pressure needs to be explored.

Implications for Nursing Practice

1. Community agencies may want to develop casefinding procedures that effectively identify people needing help, because people who are experiencing epiphanies (difficult times) may not independently seek out community services.

2. Individual emotional support services, rather than support groups, may be more helpful for people with low hope. If support groups are the only type of assistance available, someone who has a trusting relationship with the client may want to initially attend the support group with the client.

3. Clients' need for assistance with transportation or finances should be considered when identifying important nursing assessment factors, because the lack of either of these factors may diminish hope.

4. When working with elderly clients, nurses may want to discuss health promotion activities with these clients, as many of them may be highly motivated to live healthy lifestyles in order to continue to take care of themselves.
5. Nurses might want to focus on helping elderly clients set process goals, rather than outcome goals; because clients usually have more control over achieving process goals. An example of a process goal would be: the client will eat 3 fruits or vegetables daily for the next week; while an outcome goal would be: the client will lose one pound during the next week.

6. For older adults, short term client goals may be more helpful than long term goals, because elderly clients may have difficulty projecting into the future farther than a few days to a few weeks.

7. Before planning interventions, nurses may want to assess clients' developmental residual, generalized hope and particularized hope. For elderly clients lacking generalized hope, nurses might need to focus on establishing supportive and trusting relationships with these clients, before other psychosocial interventions will be effective. Clients lacking particularized hope may need encouragement and support to determine: (a) in which areas they want to be autonomous, and (b) in which areas they chose to be dependent.

Implications for Nursing Education

1. Students may need help in realizing that elderly people who are independent and seem to be functioning
well may still need assistance in identifying and/or using community resources.

2. The significance of the interrelationships among the human mind, body and spirit should be considered for inclusion in nursing curricula. For example, students could benefit from knowing that psychosocial developmental residual might be associated with specific types of health problems.

3. Qualitative data from this study might help young adult nursing students to better understand how some elderly people view the world.

Implications for Nursing Research

1. With an elderly population group, data collection may be enhanced if the investigator collects data in person, and signs a copy of the consent form prior to asking elderly subjects to sign the form.

2. This study needs to be replicated using more diverse populations, especially populations diverse in ethnicity and spiritual beliefs.

3. To evaluate the effectiveness of the hope promoting factors identified in this study, situation relating research studies need to be conducted using an experimental or quasi-experimental design.
Summary

This study explored the relationship between psychosocial developmental residual and hope in a community-based elderly population. The empirical and qualitative findings obtained lend support for the theoretical model of hope described in Chapter 1, and have implications for nursing practice, education, and research.
Appendix A

Letter to Potential Subjects

Dear (Subject's Name):

I teach nursing at Fort Hays State University and am interested in learning about the ideas and concerns of older adults, such as yourself. As an older adult, I would like to visit with you about a study I am doing on hope.

________, the manger of _________, has given me permission to contact you, since you live in _________. I will telephone you sometime during the next few days to make an appointment to visit you. During our visit, I will explain my study on hope and invite you to be a part of the study. People who wish to be included in the study will be asked to sign a consent form that protects their rights and assures that all the information I obtain will be kept confidential.

If you chose to be included in this study, you will be helping nurses improve the lives of older adults in the future. Also, in return for your help, I will be happy to take your blood pressure, review your medications and share health information with you.

I look forward to meeting you.

Sincerely,

Eileen Deges Curl, R.N., M.S.
Ph.D. Candidate, and
Associate Professor of Nursing
Appendix B

Consent Form 1 for Subjects Participating in the Quantitative Component

Consent Form 1

Hope in the Elderly:
Exploring the Relationship Between Personal Attitudes and Hope

You are invited to participate in a study of hope and related factors in adults who are 65 years of age or older. I am a graduate student at The University of Texas at Austin in the School of Nursing, and this study is my doctoral dissertation. I anticipate learning how attitudes of older adults relate to their level of hope. You were selected as a possible participant in this study because you live in (housing unit name). You will be one of 70 persons chosen to participate in this part of the study. With your help, other nurses and myself will learn important information about how to help older adults enjoy life more.

If you decide to participate, I will ask you to complete three questionnaires. One of the questionnaires asks for background information about you, for example, your date of birth. The other two questionnaires will look at how you view yourself now and what you think of the future. The questionnaires require very little writing. If you need help reading them or assistance in writing, I will be available to help you. The three questionnaires will take 45 to 50 minutes to complete. If you choose to participate, you will also need to sign this consent form.

There should be no risks to you as a volunteer in this study. The only inconvenience for you will be spending the time to complete the questionnaires. Sometimes answering questions about one's life can bring up feelings. If that should happen, I will be happy to refer you to an appropriate professional, at your expense.

The benefits to you include possibly gaining some insight into your feelings by completing the
questionnaires and receiving a brief summary of the results. You may also enjoy having me visit with you in your home and feel good that your participation in this study may help nurses improve the lives of older adults in the future. If you choose, I will also review your medications and write down helpful information about your medications while I wait for you to complete the questionnaires. There is no monetary compensation or cost for participating in the study.

Any information from this study that can be identified with you will remain completely confidential. Your name will not appear on the questionnaires, instead a code number will be used. Your questionnaires will be put in an envelope and then placed in a locked file. Also, information as to your specific code number will be kept in the locked file until the end of the project, then the code list will be destroyed.

Your decision whether or not to participate in this study will not prejudice your future relations with The University of Texas at Austin, Fort Hays State University, or (housing unit name). If you decide to participate, you are free to discontinue participation at any time without prejudice.

If you have any questions, please contact me at my home address, [address], or by telephone at [phone number]. If you would like to talk with the professor supervising this study, please call Dr. Helen Erickson, Ph.D., R.N. at The University of Texas at Austin [phone number].

You will be offered a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time without prejudice after signing this form, should you choose to discontinue participation in the study.

Signature of Participant __________________________ Date ____________

Signature of Researcher __________________________ Date ____________
Appendix C

Consent Form 2 for Subjects
Participating in the Quantitative and Qualitative Components

Consent Form 2
Hope in the Elderly:
Exploring the Relationship Between
Personal Attitudes and Hope

You are invited to participate in a study on hope and related factors in adults who are 65 years of age or older. I am a graduate student at The University of Texas at Austin in the School of Nursing, and this study is my doctoral dissertation. I anticipate learning how attitudes of older adults relate to their level of hope. You were selected as a possible participant in this study because you live in (housing unit name). You will be one of 20 persons chosen to participate in this part of the study. With your help, other nurses and myself will learn important information about how to help older adults enjoy life more.

If you decide to participate, I will ask you to complete three questionnaires. One of the questionnaires asks for background information about you, for example, your date of birth. The other two questionnaires will look at how you view yourself now and what you think of the future. The questionnaires require very little writing. If you need help reading the questionnaires or assistance in writing, I will be available to help you. The three questionnaires will take 45 to 50 minutes to complete.

As part of the study, you will be interviewed by me about what has increased or decreased your feelings of hope during stressful or difficult times in the past and what you think of the future. If you are tired after completing the questionnaires, we can schedule the interview for a short time later. The interview will be about 30 to 60 minutes long and will be audio taped with a tape recorder. If you choose to participate, you will also need to sign this consent form.

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Any information from this study that can be identified with you will remain completely confidential. Your name will not appear on the questionnaires, instead a code number will be used. Your questionnaires will be put in an envelope and then placed in a locked file. Also, information as to your specific code number will be kept in a locked file until the end of the project, then the code list will be destroyed.

The tapes will be coded so that no identifying information is on the cassette and the tapes will be kept in a locked file. The tapes will be heard only by me and possibly my supervising professor, Dr. Helen Erickson, Ph.D., R.N. The tapes will be transcribed using only the code numbers. No names or personally identifying information will appear on the transcriptions. Tapes will be kept under lock and key at all other times. When this research project is completed, the tape recordings will be erased.

There should be no risks to you as a volunteer in this study. The only inconvenience for you will be spending the time to complete the questionnaires and participate in the interview. Sometimes answering questions about one's life can bring up feelings. If that should happen, I will be happy to refer you to an appropriate professional, at your expense.

The benefits to you include possibly gaining some insight into your feelings by completing the questionnaires and receiving a brief summary of the results. You may also enjoy having me visit with you in your home and feel good that your participation in this study may help nurses improve the lives of older adults in the future. If you choose, I will also review your medications and write down helpful information about your medications while I wait for you to complete the questionnaires. There is no monetary compensation or cost for participating in the study.

Your decision whether or not to participate in this study will not prejudice your future relations with The University of Texas at Austin, Fort Hays State University, or (housing unit name). If you decide to participate, you are free to discontinue participation at any time without prejudice.
If you have any questions, please contact me at my home address, or by telephone. If you would like to talk with the professor supervising this study, please call Dr. Helen Erickson at The University of Texas at Austin.

You will be offered a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time without prejudice after signing this form, should you choose to discontinue participation in the study.

Signature of Participant

Date

Signature of Researcher

Date
Appendix D

Demographic Questionnaire
(DQ)

Please answer each of the following questions, so I can learn about you and your life.
Please fill in the blanks.

1. What is your date of birth?
   (Month) _____ (Day) _____ (Year) _____

2. Gender
   (1) Male _____
   (2) Female _____

3. Race/Ethnic Group
   (1) White _____
   (2) Black _____
   (3) Hispanic _____
   (4) Asian _____
   (5) American Indian _____
   (6) Other (please specify) __________________

4. Marital Status
   (1) Single (never married) _____
   (2) Married _____
   (3) Separated _____
   (4) Divorced _____
   (5) Widowed _____

5. Has your marital status changed within the last year?
   (1) No _____
   (2) Yes _____
      If your response was yes, please describe the change
      (Example: remarried) __________________

      If you have ever been widowed, what year did this occur? _____
      If you have ever been divorced, what year did this occur? _____
6. Faith
   (1) Catholic _____
   (2) Protestant _____
   (3) Jewish _____
   (4) None _____
   (5) Other (please specify) ________________

7. How much schooling have you completed?
   Check the highest level you completed.
   (1) No formal schooling _____
   (2) Part of grade school _____
   (3) Finished grade school _____
   (4) Part of high school _____
   (5) Finished high school _____
   (6) Vocational Training _____
   (7) College (1 to 2 years) _____
   (8) College (3 to 4 years) _____
   (9) Graduate Classes _____

8. Present Medical Problems:
   Check all that apply to you now.
   (01) No health problems _____
   (02) Cancer
       (Where is the cancer?) ________________
   (03) Diabetes _____
   (04) Heart disease/problems _____
   (05) High blood pressure _____
   (06) Stroke _____
   (07) Respiratory problems _____
   (08) Depression _____
   (09) Arthritis _____
   (10) Please write in any other medical problems:
        ___________________________________________________________________

9. How long have you lived in the apartment complex?
   (1) less than six months _____
   (2) six months to 1 year _____
   (3) 1 to 2 years _____
   (4) 3 to 5 years _____
   (5) more than 5 years _____
10. Which best describes your financial status?
   (1) I am financially comfortable. _____
   (2) I have enough money for basic expenses but not for extra things. _____
   (3) I do not have enough money for basic expenses. _____

11. How often do you pray, talk to God, or participate in spiritual activities?
   (1) Daily _____
   (2) Weekly _____
   (3) Monthly _____
   (4) Yearly _____
   (5) Never _____

12. How often do you see or talk to your family or relatives?
   (1) Daily _____
   (2) Weekly _____
   (3) Monthly _____
   (4) Yearly _____
   (5) Never _____

13. During most of your life, how often did you feel you could get what you wanted out of life?
   (1) All of the time _____
   (2) Most of the time _____
   (3) About half of the time _____
   (4) Only a few times _____
   (5) Never _____

These questions will help me to know a little more about your background.

Please fill in the blanks.

14. How many children were in the family you grew up in?
   (Include yourself in the number you give.) _____

15. If your mother is dead, how old (in years) were you when she died? ________
16. If your father is dead, how old (in years) were you when he died? _________

17. How many children did you have? _________________
   How many of your children are still living? _____

18. List the people you count on the most when you need help?
   (Example: daughter, friend, neighbor, minister)
   __________________________________________
   __________________________________________
   __________________________________________

Thank you very much for answering these questions.
We would like to know a little about you and how you view your situation. Here are some thoughts that most people have about themselves at one time or another. Please read each sentence and CIRCLE the number, on the scale of 1 (HARDLY EVER TRUE) to 5 (ALMOST ALWAYS TRUE), which shows how often the sentence is true of you. Don't spend a lot of time thinking about your response. There are no right or wrong answers. Please do not omit any answers.

<table>
<thead>
<tr>
<th>How often is this true of you?</th>
<th>Hardly Ever True</th>
<th>Occasionally True</th>
<th>About Half The Time</th>
<th>Usually True</th>
<th>Almost Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am able to take things as they come...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I'm a hard worker....</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I get embarrassed when someone begins to tell me personal things...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I'm warm and friendly.........</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I really believe in myself...............</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I change my opinion of myself a lot......</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I like to assume responsibility for things...............</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I've got a clear idea of what I want to be.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>How often is this true of you?</td>
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<td>Usually True</td>
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<tr>
<td>Almost Always True</td>
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<tr>
<td>9. I feel mixed up...... 1 2 3 4 5</td>
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<tr>
<td>10. I find the world a very confusing place. 1 2 3 4 5</td>
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<tr>
<td>11. I feel guilty about many things........... 1 2 3 4 5</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>12. I know when to please myself and when to please other........... 1 2 3 4 5</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>13. The important things in life are clear to me................... 1 2 3 4 5</td>
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<tr>
<td>14. I don't seem to be able to achieve my ambitions........... 1 2 3 4 5</td>
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<tr>
<td>15. I don't seem to have the ability that most others have........... 1 2 3 4 5</td>
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<tr>
<td>16. I've got it together. 1 2 3 4 5</td>
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<tr>
<td>17. I know what kind of person I am........... 1 2 3 4 5</td>
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<tr>
<td>18. I worry about losing control of my feelings........... 1 2 3 4 5</td>
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<tr>
<td>19. As I look over my life, I feel the need to make up for lost time................... 1 2 3 4 5</td>
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<td>20. I feel that I have the wisdom and experience to be of help to others........... 1 2 3 4 5</td>
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</tbody>
</table>

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<tbody>
<tr>
<td>21. I feel that I have left my mark on the world through my children/work...........</td>
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<td>22. I rely on other people to give me ideas.....</td>
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<td>2</td>
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<tr>
<td>23. I think I must be basically bad...........</td>
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<td>24. Other people understand me...........</td>
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<td>25. I can't decide what I want to do with my life...........</td>
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<td>26. It's important to me to be completely open with my friends......</td>
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<td>27. I spend a great deal of time thinking about myself...........</td>
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<td>28. I find that good things never last long...............</td>
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<tr>
<td>29. I feel I am a useful person to have around...............</td>
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<td>30. I keep what I really think and feel to myself...............</td>
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<tr>
<td>31. I have many regrets about what I might have become...........</td>
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<tr>
<td>How often is this true of you?</td>
<td>Hardly True</td>
<td>Occasionally True</td>
<td>About Half The Time</td>
<td>Usually True</td>
<td>Almost Always True</td>
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<td>32. I'm an energetic person who does lots of things........... 1</td>
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<tr>
<td>33. I'm trying hard to achieve my goals..... 1</td>
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<tr>
<td>34. Things and people usually turn out well for me........... 1</td>
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<td>35. I am afraid of growing old........... 1</td>
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<tr>
<td>36. I think the world and people in it are basically good........... 1</td>
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<tr>
<td>37. I am ashamed of myself.................. 1</td>
<td>2</td>
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<tr>
<td>38. I'm good at my work.. 1</td>
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<tr>
<td>39. I think it's crazy to get too involved with people.................. 1</td>
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<tr>
<td>40. People try to take advantage of me...... 1</td>
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<tr>
<td>41. I like myself and am proud of what I stand for.................. 1</td>
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<tr>
<td>42. I have a sense that there is purpose in my life.................. 1</td>
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<tr>
<td>43. I feel inadequate in my interactions with others.................. 1</td>
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<td>How often is this true of you?</td>
<td>Hardly True</td>
<td>Ever True</td>
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<td>44. I find myself expecting the worst to happen.............</td>
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<tr>
<td>45. I care deeply for others.........................</td>
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<tr>
<td>46. My achievements and failures are largely a consequence of my own actions........</td>
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<td>47. I find I have to keep up a front when I'm with people........</td>
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<td>48. I don't really feel involved......................</td>
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<td>49. I can't make sense of my life....................</td>
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<td>50. It is important to me to feel that I have made a contribution in life........</td>
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<tr>
<td>51. There's a lot about my life I'm sorry about........</td>
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<td>52. I waste a lot of my time.........................</td>
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<td>53. I'm as good as other people......................</td>
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<td>54. I like to make my own choices....................</td>
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<td>55. I am disgusted by other people...............</td>
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<td>How often is this true of you?</td>
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<td>56. I feel at peace with my life............ 1</td>
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<td>57. I don't feel confident of my judgment....... 1</td>
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<td>58. I'm basically a loner 1</td>
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<td>59. I cope very well..... 1</td>
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<td>60. I have difficulty relating to people different from me.... 1</td>
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<td>61. I'm not much good at things that need brains or skill...... 1</td>
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<td>62. I have (have had) a close physical and emotional relationship with another person.. 1</td>
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<td>63. I have discovered no mission or purpose in life.......... 1</td>
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<td>64. I stick with things until they're finished............. 1</td>
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<td>65. I'm a follower rather than a leader........... 1</td>
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<td>66. I find it hard to make up my mind...... 1</td>
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<td>67. I trust people....... 1</td>
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<td>68. I like to take risks. 1</td>
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<tr>
<td>How often is this true of you?</td>
<td>Hardly True</td>
<td>Occasionally True</td>
<td>About Half True</td>
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<td>69. I worry about how others perceive me...</td>
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<tr>
<td>70. It is more important to work on behalf of those I care about than to work just for myself...</td>
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<td>71. I like new adventures</td>
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<td>72. I prefer not to show too much of myself to others...</td>
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<td>73. If I could live my life over, there is little I would change</td>
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<td>74. I don't get things finished...</td>
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<td>75. I like finding out about new things or places...</td>
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<td>76. I don't get much done</td>
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<td>77. I find it easy to make close friends...</td>
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<td>78. I can't make up my own mind about things</td>
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<td>79. As I look back over my life, I realize my parents did the best they could for me...</td>
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<td>80. I am proud of what I have accomplished in my life...</td>
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Appendix F

Example of the First Page of the Modified Erikson Psychosocial Stage Inventory as Administered to Subjects Using the Title Personal Attitude Survey
PERSONAL ATTITUDE SURVEY

We would like to know a little about you and how you view your situation. Here are some thoughts that most people have about themselves at one time or another. Please read each sentence and CIRCLE the number, on the scale of 1 (HARDLY EVER TRUE) to 5 (ALMOST ALWAYS TRUE), which shows how often the sentence is true of you. Don't spend a lot of time thinking about your response. There are no right or wrong answers. Please do not omit any answers.

<table>
<thead>
<tr>
<th>How often is this true of you?</th>
<th>HARDLY EVER TRUE</th>
<th>OCCASIONALLY TRUE</th>
<th>ABOUT HALF THE TIME</th>
<th>USULLY TRUE</th>
<th>ALMOST ALWAYS TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I am able to take things as they come.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>2) I'm a hard worker.</td>
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Appendix G

Nowotny Hope Scale®

The purpose of this questionnaire is to study your feelings after a stressful event. Please think of a significant event or situation where you felt stressed or pressured because of the necessary changes in your life. Imagine the event occurring right now. Place a check mark under the response that best reflects your feelings. There are no right or wrong answers to the statements.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Strongly Agree</th>
<th>Disagree</th>
</tr>
</thead>
</table>

1. In the future I plan to accomplish many things.

2. I can take whatever happens and make the best of it.

3. I have difficulty in setting goals.

4. My family (or significant other) is always available to help me when I need them.

5. I feel confident about the outcome of this event/situation.

6. I know I can make changes in my life.
7. I think I can learn (or I have learned) to adapt to whatever limitations I have (or might have).

8. I am ready to meet each new challenge.

9. I feel the decisions I make get me what I expect.

10. My religious beliefs help me most when I feel discouraged.

11. I feel confident in those who want to help me.

12. Sometimes I feel I am all alone.

13. I see a light at the end of the tunnel.

14. I share important decision making with my family (or significant other).
15. I use prayer to give me strength.

16. I like to sit and wait for things to happen.

17. I like to make my own decisions.

18. I want to maintain control over my life and my body.

19. I expect to be successful in those tasks that concern me most.

20. I use scripture to give me strength.

21. When faced with a challenge, I am ready to take action.

22. I have confidence in my own ability.

23. I know I can go to my family or friends for help.
<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

24. I look forward to the future.

25. I like to do things rather than sit and wait for things to happen.

26. I lack confidence in my ability.

27. I have important goals I want to achieve within the next 10-15 years.

28. I know I can accomplish this task.

29. I have a positive outlook.
Appendix H

Scoring for

Nowotny Hope Scale

All items are scored:

- Strongly Agree = 4
- Agree = 3
- Disagree = 2
- Strongly Disagree = 1

except items 3, 12, 16, and 26. These are negative items and are scored:

- Strongly Agree = 1
- Agree = 2
- Disagree = 3
- Strongly Disagree = 4

LEVELS OF HOPE (cut-off scores)*:

- Hopeful 116-95
- Moderately Hopeful 94-73
- Low Hope 72-51
- Hopelessness 50-29

* determined by using standard deviation of scores, mean = 82.7, SD = 9.8 (Nowotny, 1989)
Appendix I

First Page of the
Novotny Hope Scale
as Administered to Subjects
Using Modified Response Section
Nowotny Hope Scale

The purpose of this questionnaire is to study your feelings after a stressful event. Please think of a significant event or situation where you felt stressed or pressured because of the necessary changes in your life. Imagine the event occurring right now. Please circle the response that best reflects your feelings. There are no right or wrong answers to the statements.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) In the future I plan to accomplish many things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2) I can take whatever happens and make the best of it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>3) I have difficulty in setting goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>4) My family (or significant other) is always available to help me when I need them.</td>
<td>1</td>
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Appendix J

Items from the Novotny Hope Scale
Used to Create Subscales for
Generalized Hope and Particularized Hope

New Generalized Hope Subscale

Original Subscale: Relates to Others

Q 4. My family (or significant other is always available to help me when I need them.

Q11. I feel confident in those who want to help me.

Q12. Sometimes I feel I am all alone.

Q14. I share important decision making with my family (or significant other).

Q23. I know I can go to my family or friends for help.

Original Subscale: Religious Faith

Q10. My religious beliefs help me most when I feel discouraged.

Q15. I use prayer to give me strength.

Q20. I use scripture to give me strength.

Selected Items from Original Subscale:
Future is Possible

Q 1. In the future I plan to accomplish many things.

Q13. I see a light at the end of the tunnel.

Q24. I look forward to the future.
New Particularised Hope Subscale

Original Subscale: Confidence

Q 2. I can take whatever happens and make the best of it.
Q 6. I know I can make changes in my life.
Q 7. I think I can learn (or I have learned) to adapt to whatever limitations I have (or might have).
Q 8. I am ready to meet each new challenge.
Q 9. I feel the decisions I make get me what I expect.
Q 21. When faced with a challenge, I am ready to take action.
Q 22. I have confidence in my own ability.
Q 29. I have a positive outlook.

Original Subscale: Active Involvement

Q 3. I have difficulty in setting goals.
Q 16. I like to sit and wait for things to happen.
Q 25. I like to do things rather than sit and wait for things to happen.
Q 26. I lack confidence in my ability.
Q 27. I have important goals I want to achieve within the next 10-15 years.
Original Subscale: Comes From Within

Q17. I like to make my own decisions.

Q18. I want to maintain control over my life and my body.

Q19. I expect to be successful in those tasks that concern me most.

Selected Items from Original Subscale: Future is Possible

Q 5. I feel confident about the outcome of this event/situation.

Q28. I know I can accomplish this task.
Appendix K
Interview Schedule

Section A: Epiphany
When you completed one of the questionnaires, you were asked to think of a significant time in your life when you felt especially stressed because of changes in your life.

A1. What stressful or difficult time in your life did you think about?

   Was this experience a significant turning point in your life? If not, what has been a problem time in your life that seemed like a turning point or changed you in some way?

A2. How was that experience for you?

   Probe: How did other things in your life at that time affect what was happening?

Section B: Affecters of Hope
I'm interested in learning about how hopeful you were during this stressful or difficult experience. By hopeful, I do not mean happy, I mean if you felt or thought that you would make it through the experience and that it would work out somehow.

B1. What seemed to increase or encourage your hope?

   Probes: Was it helpful to talk about it?

   How did other people increase your hope?

   How did agencies or services in the community increase your hope?

   How did activities or thoughts you had increase your hope?
B2. What seemed to decrease or lower your hope?

Probes: How did other people decrease your hope?
How did agencies or services in the community decrease your hope?
How did activities or thoughts you had decrease your hope?

B3. How much control did you feel you had over how the situation turned out?

How did this affect your hope?

Section C: Outcomes or Changes from the Epiphany

Stressful or difficult experiences in life sometimes affect our life after the experience.

C1. How did that point in your life change your life since then?

C2. How do you feel about other people since then?

C3. How do you feel about yourself since then?

C4. How do you feel about God or a supreme being since then?

C5. Did anything positive (good or beneficial) come out of the changes resulting from that experience? If yes, what.

Section D: Perceptions of the Future

We've discussed some aspects of your past, now I would like to learn about your view of the future.

D1. How do you feel about the future?

Probe: Are you looking forward to the future, not looking forward to it, or do you have mixed feelings about the future?
D2. When you think of the future, how far ahead do you think about?

Probe: Do you think about tomorrow, next week, next month, in six months, next year, or what?

How far ahead do you plan?

Do you think of only this life, or do you also think about after this life?

D3. What keeps you going on a day to day basis (what motivates you to get up in the morning)?

D4. Do you have any goals (plans) or hopes for the future? If so, what?

D5. Do you think you will get what you want in the future? (Do you think you will achieve your goals or plans?)

D6. Are you doing anything special so you can fulfill your goals for the future? What?

D7. How do you feel about the future of others?

Section E: Conclusion

E1. Is there anything else you would like to talk about?

E2. Summarize responses given during the interview and validate summary with respondent.

Thank informant.
Appendix L

Summary Sheet for Interviews

Date: ___________  Code ______

Time of visit: ________ (Length of visit ________)

Context of Environment: ____________________________________________________________

Observations about the Respondent: ________________________________________________

Epiphany: _______________________________________________________________________

Promoters of Hope: _________________________________________________________________

Disparages of Hope: _________________________________________________________________

Outcome of Epiphany: __________________________________________________________________

Generalized Hope: high____, moderate____, low____

Sense of a Future: ___________________________________________________________________

Motivation for Living: __________________________________________________________________

Particularized Hope: high____, moderate____, low____

Goals (realistic?): ___________________________________________________________________

What new theoretical meanings or insights were gained (any surprising findings)?

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

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Medications reviewed: declined______; # reviewed_____

Other pertinent data from interview or responses to questionnaires:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Follow-up requested (e.g. requests for information about community services)

________________________________________________________________________

________________________________________________________________________
Appendix M

Additional Sample and Subsample Findings
Table H-1

Age, Psychosocial Developmental Residual Scores and Hope Scores for Total Sample and Selected Subsamples

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (N = 90)</th>
<th>Subsample Interviewed (n = 22)</th>
<th>Subsample for Qualitative Analysis (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (M)</td>
<td>77.60</td>
<td>76.64</td>
<td>76.00</td>
</tr>
<tr>
<td>Standard Deviation (SD)</td>
<td>6.98</td>
<td>6.64</td>
<td>6.19</td>
</tr>
<tr>
<td><strong>Overall Developmental Residual</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (M)</td>
<td>3.84</td>
<td>3.69</td>
<td>3.66</td>
</tr>
<tr>
<td>Standard Deviation (SD)</td>
<td>.39</td>
<td>.46</td>
<td>.70</td>
</tr>
<tr>
<td><strong>Trust-Mistrust</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (M)</td>
<td>3.81</td>
<td>3.60</td>
<td>3.54</td>
</tr>
<tr>
<td>Standard Deviation (SD)</td>
<td>.49</td>
<td>.67</td>
<td>.95</td>
</tr>
<tr>
<td><strong>Autonomy-Shame</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (M)</td>
<td>3.85</td>
<td>3.67</td>
<td>3.52</td>
</tr>
<tr>
<td>Standard Deviation (SD)</td>
<td>.50</td>
<td>.58</td>
<td>.78</td>
</tr>
<tr>
<td><strong>Overall Hope</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (M)</td>
<td>88.82</td>
<td>86.64</td>
<td>91.38</td>
</tr>
<tr>
<td>Standard Deviation (SD)</td>
<td>8.69</td>
<td>10.94</td>
<td>14.22</td>
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<tr>
<td><strong>Generalized Hope</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (M)</td>
<td>34.60</td>
<td>33.23</td>
<td>37.13</td>
</tr>
<tr>
<td>Standard Deviation (SD)</td>
<td>4.47</td>
<td>5.66</td>
<td>4.76</td>
</tr>
<tr>
<td><strong>Particularized Hope</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (M)</td>
<td>54.22</td>
<td>53.41</td>
<td>54.25</td>
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<tr>
<td>Standard Deviation (SD)</td>
<td>5.29</td>
<td>6.86</td>
<td>9.62</td>
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</tbody>
</table>

*This subsample was purposively selected to reflect the multiple realities in the data, (i.e., representative of favorable and unfavorable developmental residual from the trust-mistrust and autonomy-shame stages). See pages 103-104.*
Table H-2  
Psychosocial Developmental Residual Scores and Hope Scores for Total Sample and Qualitative Subsample Developmental Groupings

<table>
<thead>
<tr>
<th></th>
<th>Developmental Groups</th>
<th>Developmental Groups</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>A (p=56)</td>
<td>B (p=13)</td>
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<tr>
<td>Overall Developmental Residual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>4.03</td>
<td>3.59</td>
</tr>
<tr>
<td>SD</td>
<td>.31</td>
<td>.30</td>
</tr>
<tr>
<td>Trust-Mistrust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>4.03</td>
<td>3.21</td>
</tr>
<tr>
<td>SD</td>
<td>.33</td>
<td>.25</td>
</tr>
<tr>
<td>Autonomy-Shame</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>4.10</td>
<td>3.87</td>
</tr>
<tr>
<td>SD</td>
<td>.35</td>
<td>.26</td>
</tr>
<tr>
<td>Overall Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>90.57</td>
<td>89.23</td>
</tr>
<tr>
<td>SD</td>
<td>8.82</td>
<td>8.33</td>
</tr>
<tr>
<td>Generalized Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>35.09</td>
<td>34.46</td>
</tr>
<tr>
<td>SD</td>
<td>4.76</td>
<td>4.58</td>
</tr>
<tr>
<td>Particularized Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>55.48</td>
<td>54.77</td>
</tr>
<tr>
<td>SD</td>
<td>5.00</td>
<td>4.44</td>
</tr>
</tbody>
</table>

Note. Developmental Groups refer to Figure 4, page 102.

*This subsample was purposively selected to reflect the multiple realities in the data, (i.e., representative of favorable and unfavorable developmental residual from the trust-mistrust and autonomy-shame stages). See pages 103-104.
Appendix N

Audit of Qualitative Findings
September 23, 1991

Eileen Degas Curl
Hays, KS 67601

Dear Eileen,

This letter presents the report of a critical examination of the qualitative portion of your dissertation as part of your doctoral study at the University of Texas. This in-depth review was done at your request as support for the quality of your work, particularly the trustworthiness of your qualitative data analysis.

First I will address my background which qualifies me as a reviewer in qualitative research; then I will address my review of your research process. My background includes an earned doctorate in Adult Health Nursing from the University of Texas at Austin. I completed course work in qualitative research in nursing as part of my program of studies. My dissertation was done using a triangulation of qualitative and quantitative methodologies.

I. Credibility

Your materials gave evidence of activities which increase the probability that credible findings were produced. These activities included triangulation of data collection methods and negative case analysis. Further evidence of member checking was apparent in the transcripts of the original interviews when you summarized what you heard in the interview and invited reaction from your informants.

II. Transferability

Lincoln and Guba maintain that it is the qualitative investigator's responsibility to provide the data base that makes transferability judgments possible on the part of potential appliers. They specify that thick description makes this possible. In searching your materials, there was ample evidence of thick descriptions in which detail, context, emotion, webs of social relationships, feelings, actions, and meanings were apparent. An example of this was the interview transcript in case 1306.

III. Dependability

In my examination of your work I found no evidence of methodological shifts. In study of your raw data, I found no evidence that the researcher brought closure to informants' statements or led the informants in the direction of the researcher's a priori constructs. The researcher endeavored to find negative as well as positive data. In your categorization process, all data were accounted for and all areas were explored. It was possible for me to follow what you as the researcher did in deciding about how to categorize your data.
It is my opinion that the dependability of your qualitative analysis is supported.

IV. Confirmability

I read the raw data, the field notes, and the categorizations presented to me. I systematically reviewed your materials to ascertain whether the findings are grounded in the data and found that they were. As examples:

1. Case 1306, Lines 34 and 35: He died so fast, it was, I was just in shock I guess.

Case 5713, Lines 46 and 47: The shock took me to my knees; I had to crawl up the stairs.

Category: Experiential aspect of the Epiphany - Shock

2. Case 5127, Lines 584 and 585: There was always something to keep me busy and going.

Case 1306, Line 118: I think my job helped me the most.

Category: Promoters of hope - Activities that the Informants did that increased hope, subcategory: Job/Work/Busy

I concur that your categorizations were appropriate to the presented raw data, which indicated that you followed logical inferencing in your analysis. Your categories were clear and did fit with the raw data. The categories contained explanatory power as they were grounded in the data. Grounding categories in the data reduces to a minimum the researcher’s bias and imposition of a prior theoretical idea.
Negative evidence was taken into account. As an example Case 5713, Lines 38 to 53 in the raw data reports the informant identified a comforting profound spiritual incident as a part of the experiential aspect of an epiphany. This datum was contrary to your other cases. I noted your accommodation of this negative case.

I repeated the review process of comparing your raw data and categories throughout your materials. From such detailed review, I believe identification of categories and subcategories and your category labeling are grounded in the data and not in your personal constructs.

You asked me to address intercoder reliability. I used Polit and Hungler’s procedure for computing interrater reliability [Polit, D.F., & Hungler, B.P. (1987). Nursing research: Principles and Methods (3rd ed.). Philadelphia: J.B. Lippincott, p.321]. One subcategory was selected from each of your major categories and the interrater reliability was calculated for that subcategory:

1. Category: Experiential Aspect of the Epiphany
   Subcategory: Felt alone
   Interrater reliability = 1.00

2. Category: Outcomes of the Epiphany
   Subcategory: Stronger
   Interrater reliability = .90

3. Category: Promoters of Hope
   Subcategory: Actions of people that promoted hope - Physical presence
   Interrater reliability = 1.00
4. Category: Diminishers of Hope  
   Subcategory: Left out of Social Activities  
   Interrater reliability = 1.00

5. Category: Control over how the epiphany worked out  
   Subcategory: No sense of control  
   Interrater reliability = 1.00

6. Category: Future  
   Subcategory: Sense of Future for Others  
   Interrater reliability = 1.00

In summary, I attest to the carefully planned analysis process in this study. It meets Lincoln and Guba's criteria for establishing trustworthiness. The study is a scholarly document with a well documented data collection and process of analysis. I believe it will contribute to the knowledge base of the discipline of nursing.

Sincerely,

[Redacted]

Sister Sandra Meek, Ph.D., R.N.  
Associate Professor

SSM:cn
References


VITA

Eileen Marie Deges Curl was born in [redacted] Kansas, on September 28, [redacted] the daughter of Dorothea Anna (Engel) Deges and Leonard August Deges. After graduating from Wheatland High School, Grainfield, Kansas, in 1972, she entered Marymount College of Kansas in Salina. She received the degree of Bachelor of Science in Nursing from Marymount College in 1976, graduating summa cum laude. In 1977, she received the degree of Master of Science, with a major in Community Health Nursing and a minor in Health Administration, from the University of Colorado Health Science Center in Denver.

During the following years she was employed as a faculty member at Marymount College of Kansas, and as a community health consultant for the Kansas Department of Health and Environment. In 1981 she joined the faculty at Fort Hays State University, Hays, Kansas, where she is currently an associate professor.

She has co-authored several articles, including: "The 'Forgotten' Setting of Ethical Dilemmas: Long Term Care" (1985), "Openness to Change" (1987), and "Nursing Centers: Urban to Rural" (1990) in The Kansas Nurse;

During the summer of 1987, she entered the Graduate School of The University of Texas at Austin. She received the degree of Doctor of Philosophy in May 1992.

Permanent address: [Redacted]

This dissertation was typed by the author.