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Nursing Student Perceptions of Hope in Children: A Qualitative Descriptive Study

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Abstract

Hope has been linked to positive health outcomes in the literature. Hope is abstract, multidimensional, future-oriented, and occurs cognitively making it difficult to assess in children. Most of the research on hope has been conducted with adults and adolescents. Therefore, it is essential to analyze the concept of hope in children to provide nurses with tools to identify hope behaviors in children. The aim of this qualitative descriptive study was to describe hope behaviors in children from a nursing student perspective. Data were gathered from three focus groups ($N=19$) of nursing students enrolled in a pediatric clinical rotation using a semistructured interview technique. Three themes of hope behaviors emerged from the three focus groups and were: (a) future oriented, (b) goal oriented – getting up and doing things, and (c) pathways thinking processes – getting from point A to point B. Healthcare providers should consider hope behavioral cues, which can warrant interventions to increase hope in their young patients. Current findings demonstrate the need for the development of hope interventions that involve younger patients, thereby making their effects more sustainable across the lifespan.

Introduction

Hope is a strength-based concept that is an important therapeutic factor in nursing and healthcare. Childhood chronic diseases are on the rise (Perrin, Bloom, & Gortmaker, 2007), and hope is central to recovery and threatened at diagnosis and during treatment (Felder, 2004; Herth, 2000). The nursing diagnosis *Readiness for Enhanced Hope* is defined as a “pattern of expectations and desires that is sufficient for mobilizing energy on one’s behalf and can be strengthened” (Ackley & Ladwig, 2008, p. 427). Nurses are called upon to promote, instill, and maintain hope especially when working with children encountering a stressor or illness.

The research on hope has continued to develop over the past four decades, with a focus on the positive effects of hope for promoting psychological and physical well-being ([blinded for review purposes], 2017; Marques, Lopez, Fontaine, Coimbra, & Mitchell, 2015; Snyder

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et al., 1991; Snyder et al., 2005). The concept of hope includes a future orientation (Bauckham & Hart, 2000; Morse & Doberneck, 1995; Snyder, Lopez, Shorey, Rand, & Feldman, 2003), the envisioning of alternatives and an active setting of goals (Morse & Doberneck, 1995; Snyder, 2002), the determination to persevere (Herth, 2000; Morse & Doberneck, 1995; Snyder, Shorey, & Cheavens, 2002), a high likelihood of success (Schrunk, Stanghellini, & Slade, 2008; Snyder, 1995), and interconnectedness (Herth, 1998; Schrunk et al., 2008). Additionally, hope has been linked to positive health outcomes in the literature such as self-efficacy (Davidson, Feldman, & Margalit, 2012; Feldman, Davidson, Ben-Naim, Maza, & Margalit, 2016), self-worth (Marques, Pais-Ribeiro, & Lopez, 2011; Marques et al., 2015), and well-being, including subjective and spiritual well-being (Demirli, Türkmen, & Arık, 2015; [blinded for review purposes], 2017; Rawdin, Evans, & Rabow, 2013; Smedema, Chan, & Phillips, 2014).

Background

Hope is abstract, multidimensional (Bauckham & Hart, 2000; Herth, 2001; Morse & Doberneck, 1995), future-oriented (Bauckham & Hart, 2000; Herth, 1992; Morse & Doberneck, 1995; Snyder, 2002), and occurs cognitively (Snyder, 2002), making it difficult to assess in children. It is believed that hope is acquired and nurtured within a safe trusting environment with a consistent caregiver (Snyder, 1995). Children are reliant on caregivers, and trust begins to develop in the first year of life with a belief that hope is fully formed by the age of 2 (Erikson, 1980). It is not clear when children develop a future orientation. For example, in a study of hope in homeless youth ($N=60$), there was a marked difference in time orientation according to the age of the child (Herth, 1998). School-age children demonstrated a present orientation, while adolescents demonstrated a future orientation (Herth, 1998).

The word *hope* is used in everyday speech as a noun or adjective: *hope/s*, *hopeless*, *hopeful*, and as a verb or adverb: *hope/d*, *hoping*, *hopefully* (Elliott & Olver, 2002). As a noun *hope* exists independently and can vary in degree and resilience, or can be unrealistic or false (Elliott & Olver, 2002). The verb *hope* is either subjective or the active desiring of a possible future outcome (Elliott & Olver, 2002). Consequences of hope include the progression of cancer (Elliott & Olver, 2002) from cure to end of life (Herth, 2000). Sposito et al. (2015) found that keeping alive the hope of cure was an essential coping mechanism in their exploration of persons undergoing chemotherapy for cancer. Hope has been related to better health outcomes in several chronic diseases such as asthma (Berg, Rapoff, Snyder, & Belmont, 2007), irritable bowel disease (Nicholas et al., 2007), cancer (Herth, 2000; Hinds et al., 1999; Martins et al., 2018; Sposito et al., 2015), renal and liver transplant (Maikranz, Steele, Dreyer, Stratman, & Bovaird, 2007), sickle cell disease (Lewis & Kliever, 1996), and juvenile rheumatoid arthritis (Connelly, 2005; Sällfors, Fasth, & Hallberg, 2002). Specifically, it has been documented in previous studies that children with higher hope with chronic illnesses, have better treatment adherence including inhalers with asthma (Berg et al., 2007), renal and liver transplant medications (Maikranz et al., 2007), and irritable bowel disease treatment (Nicholas et al., 2007).

Due to the positive association between hope and various psychological and physical health outcomes, investigators have developed interventions aimed at increasing hope and, in turn, hope outcomes. Some of these interventions have successfully improved psychological well-being and quality of life. The most notable was in Herth's (2000) development of a hope intervention program for adults with the first recurrence of cancer. In this quasi-experimental study ($N = 115$), six hope sessions were delivered (e.g., searching for hope, connecting with others, expanding the boundaries, and building the hopeful veneer) which resulted in an increased quality of life after 2 weeks and a higher quality of life across time points at 3, 6, and 9 months (Herth, 2000). Two other short hope interventions (90 minutes) conducted in young adults attending college which focused on choosing a goal, psychoeducation, hope-based goal mapping, and goal visualization showed significant improvements in hope immediately after the intervention, but this effect was short-lived (less than 1 month after the intervention) (Feldman & Dreher, 2012). Thus, it is unclear what factors might sustain hope over time.

It is essential for healthcare providers to recognize that a taxonomy of hope exists (Elliott & Olver, 2002). Limited work has been done in developing hope interventions in children. The noticeable absence of hope interventions that target young children may be due, at least in part, to the failure of exploratory work in how children experience and communicate hope.

Snyder's Hope Theory (2002) was used to guide the current study. According to Snyder (2002) hope is the "perceived capability to derive pathways to desired goals, and motivate oneself via agency thinking to use those pathways" (p. 249). A children's hope tool was developed based on Snyder's Hope Theory, but is only validated for ages 7–17 (Snyder et al., 1997). Also, this provides a general level of hope and not distinctly what the child is hoping for or specific pathways thinking to achieve what is hoped for. This leaves a gap in the knowledge of younger children and for a systematic way for healthcare providers to assess behavioral indicators of hope. Defining the concept of hope is difficult because it is value-laden, context-specific, and socially constructed. It seems, despite the extensive research on observing, assessing, describing and relating hope to other variables scientifically, that conceptual clarity is lacking and the applicability and predictive value of hope remains unclear (Schrack et al., 2008). Also, most work has been done with adults and adolescents. Therefore, it is essential to analyze the concept of hope in children to provide nurses with tools to identify hope in children. The purpose of this qualitative descriptive study was to describe hope behaviors in children from a nursing student perspective during a pediatric clinical rotation (inpatient, outpatient, and school). The nursing students had the opportunity to draw from recent relevant examples after being provided with operational definitions of hope. The pediatric rotation included 40 hours on a general pediatric hospital unit, 8 hours in a primary care or specialty pediatric clinic, and 40 hours in an urban school setting.

Methods

Research design and participants

Inclusion criteria for participants included nursing students at the participating institution who were (a) 18 years old, (b) enrolled in a pediatric nursing clinical rotation, (c) able to

read and sign the informed consent, and (d) willing to participate in the study. The students' pediatric nursing rotation was a planned and experiential clinical experience, during which these students worked with children in the school, hospital, and ambulatory care settings. Qualitative description was chosen as it enabled an exploration of common contributing factors and perceived observable behaviors in children of the complex phenomenon of hope. This method is preferential in a beginning analysis as it allows the researcher to stay close to the data and to events (Sandelowski, 2000; 2010). Twenty-four nursing students enrolled in a pediatric clinical rotation were invited to participate by e-mail, with correspondence sent by a member of the research team who was not directly involved in the students' pediatric clinical experience.

Data collection procedure

Institutional review board approval was obtained from the [participating institution – blinded for review purposes] prior to data collection (Protocol ID: 2015–2458). Upon receiving informed consent, participants were provided with a complete description of the study. Gender and race were the only demographic data collected from the focus group participants. Data were collected from participants in semistructured focus groups, utilizing an open-ended interview technique with a flexible interview guide (see Table 1). The interview guide was developed by the interdisciplinary members of the research team and peer reviewed by another group who met regularly to design and review research related to hope (primarily in breast cancer research). Focus groups were conducted with 1–2 investigators (see Table 2). The senior author trained the other investigator in conducting the focus groups and was present for the first group session ($n = 11$). The role of the second investigator in the first interview was to facilitate the learning of the other investigator and to take and compare notes to ensure consistency in findings. For the second focus group, a focused interview was conducted with the one participant in attendance. The findings from the focused interview were corroborated with the other two focus groups although agreement/disagreement with statements could not be confirmed in real time (e.g., with focus groups). The discussion from each focus group was audio-recorded, then transcribed verbatim initially with Dragon dictation software™. Manual corrections were made to the transcripts after listening for accuracy.

Data analysis

Data were analyzed and coded for themes using qualitative content analysis (Graneheim & Lundman, 2004). First, the focus group transcripts were read in their entirety to get a sense of the whole. Codes were applied to the transcripts along with word frequency counts in a Word document and with NVivo (Version 11 for Mac) coding software. The data were analyzed using qualitative content analysis with a low level of interpretation applied in order to stay close to the data and accurately describe the events and discussions that occurred in each focus group, as suggested by Sandelowski (2000). Researchers conducted the coding individually. Over the course of several weeks, individual statements were moved from one category to another until an agreed-upon fit from the team members was found. Finally, for the third phase of data analysis, synthesis of findings from the two sources began (literature and focus groups). Strategies of scientific merit included the four main strategies of trustworthiness: credibility, transferability, dependability, and confirmability (Lincoln &

Guba, 1985). The researchers used an audit trail to track decision-making and to triangulate the data. (See Table 3 for specific strategies used).

Results

Sample

A total of 19 participants (out of 24 who were invited) were recruited for the three focus group interviews (see Table 2). The focus group participants were enrolled in a pediatric clinical semester at a large public university in the northeast United States. Two focus groups (Groups 1 and 3) were conducted in a conference room on a pediatric unit, and one was conducted in an academic classroom (Group 2). The participants were mostly female (89.5%) and Caucasian/White (73.7%). Other ethnicities included Asian (15.8%), Hispanic/Latino (5.2%), and African American/Black (5.2%).

Hope themes

Three themes of hope behaviors emerged from the three focus groups and were: (a) future oriented, (b) goal oriented – getting up and doing things, and (c) pathways thinking processes – getting from point A to point B.

Future oriented

Our focus group participants described children as being future oriented in many instances, stating that children talked about the future, planned for the future, and were “*more hopeful about the future*” (Focus Groups 1, 2, and 3). One participant described a future orientation by stating “*Their asking of questions about the future told me that they believed there was one*” (Focus Group 2). Another future orientation description included this: “*They would spin sort of elaborate fantasies about what was going to be*” (Focus Group 2). Descriptions about the ways in which a child might plan for the future included making a piggy bank, planting and tending a garden, and actively attempting to communicate. Further, a participant described a child hospitalized with asthma planning to play in a soccer game that weekend (Focus Group 1).

Additionally, participants were asked to further elaborate on children being “*more hopeful about the future*” as this came up in each of the group interviews, and there was much agreement about this statement. It was difficult for participants to describe, but one offered this: “*They don’t have as much of a history to base off of*” (Focus Group 3). Another said “*They’re just trying to live their life like they want to live*” (Focus Group 1). The dialectic about hope and denial was brought up in reference to a child with asthma wanting to play in a soccer game: “*So how do you know that they are old enough to comprehend [hope]? How do you know that they aren’t just denying the fact that they want to play in that soccer game because of course they want to play with their friends? How do you know that?*” (Focus Group 1).

Goal oriented- getting up and doing things

Children were described as having a lot of energy towards their goals and being motivated when confronted with a challenge such as not being able to go home from the hospital or

play in a game. Focus group participants described children in their care as setting specific goals with a personal significance in the outcome. Type 1 goals (positive goal outcome) were the focus of the discussions. Participants described the children they were working with as being goal oriented. In several instances, they stated specifically that the children did the following: worked hard to reach goals, just got up and did things, were compliant with health, pushed boundaries, actively planned ways to achieve a goal, and refused to give up on their goals. Specific goals mentioned were these: being discharged home when hospitalized, playing in a soccer game, seeing someone special to them, getting out of bed after surgery, and playing a board game.

One example shared by a participant was about a young school-age patient, postoperatively: *“I took too long to get a board game for a kid once, and he just hopped out of bed and got it”* (Focus Group 1). Other examples of hope behaviors that exemplified a goal orientation included requesting phone calls, writing letters, and actively attempting to communicate with the person they’re hoping to see (Focus Group 2). An example was shared of goal-oriented health behaviors they had seen *“Well if it’s in a health situation, if they are old enough to reason, it would be compliance, doing what they need to do to get better.”* (e.g., an early school age girl demonstrating she could self-administer an inhaler when wanting to play in a soccer game that weekend) *“* (Focus Group 1).

In the focus groups, several participants shared their observations that children in their care *“just [got] up and [did] things.”* What follows is one example shared from a Focus Group 1 participant

Like I have found that a child I was working with—he had spina bifida and he can’t use his lower extremities, and he’s not “I can’t do this, I don’t want to do this”—he just gets up and does things.

Another example offered was

I’ve seen some kids in the hospital who are supposed to be resting and what not and, because they have so much energy and are like I feel good right now, and I wanna get up and do things—so I kind of feel like their willingness to get up and go and kind of defy what adults think is good for them—is them exhibiting hopefulness too (Focus Group 1).

Pathways thinking processes — getting from point A to point B

There were several examples shared of how children demonstrated pathways thinking — how to get from point A to point B—while in their care. One focus group participant shared a story of a child going to see an uncle in another state and asking questions such as *“Will we take a train?”* or *“Will we take an airplane?”* or *“Will we stay with him?”* and so the children were described as trying to figure out the logistics of how the thing they hoped for was going to work (Focus Group 2). Another participant described pathways thinking behavior offering the following: *“Like a repeated behavior; whatever you see as the hopeful behavior they repeat it if that makes sense”* (Focus Group 1).

Discussion

Hope behaviors in children were described following focus groups conducted with nursing students currently working with pediatric patients with the opportunity to draw from recent relevant examples after being provided with operational definitions of hope. The common themes of hope that emerged from the discussions described children as being future oriented, goal oriented, and using agency and pathways thinking in pursuit of their goals. A future orientation is an attribute of hope commonly cited in the literature (Bennett, Wood, Goldhagen, Butterfield, & Kraemer, 2014; Dufault & Martocchio, 1985; Hendricks-Ferguson, 2008) and seems to develop as children age (Herth, 1998). When discussing hope, patients are referring to the future, and that future is informed by past and present experiences (Lopez, 2013; Snyder et al., 2003). It was noted that the children discussed in the focus groups were more presently or near-future oriented which is similar to Herth's (1998) research conducted with homeless youth.

Consistent with Snyder's Hope Theory (2002), the focus group participants frequently discussed how children in their care planned for the future, set specific goals (mostly positive goal outcomes), and were motivated by their goals (e.g., agency). Specifically, children described in the study perceived their capability to derive pathways to desired goals such as to demonstrate inhaler use (pathways) in order to play in a soccer game that weekend (goal). Children were often described as being energetic and motivated towards achieving their goals (e.g., getting out of bed after surgery to get a board game). When a child was confronted with a challenge (e.g., not being able to see an uncle due to being hospitalized), their persistence was a demonstration of pathways thinking towards their goal (Lopez, 2013; Marques et al., 2015; Snyder, 2002).

Nursing implications

Medical constructions of *hope* render it as either (a) the availability of treatment resulting in cure or remission or (b) an attribute of an individual (Elliott & Olver, 2002). Nurses, including nursing students, and other healthcare professionals should strive for the coexistence of the medical, the theoretical, and the patient's perceptions. Healthcare providers should consider the findings of this study in their interventions. Limiting a child's options may hinder hope, and healthcare providers should be aware of this when planning interventions. On the other hand, success during treatments and interventions should build hope in children. Decreasing anxiety (Martins et al., 2018) before treatments and procedures can help with success in treatments and procedures. This can be done in a multitude of ways including use of pharmacologic and nonpharmacologic agents (Nunns et al., 2018). Also, including another discipline such as child life specialists (Hanrahan, Kleiber, Miller, Davis, & McCarthy, 2018) who have specific training in psychosocial care and development, using distraction, or having another designated person during the treatment or procedure who can direct the child may be helpful.

In Hope Theory, attachment to the caregiver is described as being crucial for learning goal-directed thought (Snyder, 2002, p. 263). Therefore, nurses should engage the children they are working with in a discussion about their goals and about what makes them hopeful about the future. Alternatively nurses could have younger children who are less communicative

draw a picture of something they hope for and ask open ended questions about the picture. The information gleaned from these discussions or illustrations may facilitate the establishment of trust and rapport and be used when planning care. Also, working with children and families to identify alternative plans for their goals may help to promote pathways thinking. An important role for a healthcare provider is to keep up the morale of a child in their care. Overall, healthcare providers should promote a child's determination to persevere.

Conclusion

This analysis supported the need for future research from a child's perspective. All of the intervention work to date has been with adolescents, adults, and older adults. Hope in research has varied definitions, meanings, and is context dependent. Key attributes of hope were identified and can serve as a basis for future research with children. Attempting to determine a common definition and conceptualization of hope that will be universally accepted is impractical. Instead, researchers and practitioners should explore hope for use in localized contextual studies (Herrestad, Biong, McCormack, Borg, & Karlsson, 2014).

The helping relationship, such as the nurse-patient relationship, is a prime arena for future hope research and application (Snyder, 2002). The correlation between hope and therapeutic alliance is strong, but further development is needed in this area especially discipline-specific patient relationships. An opportunity exists for hope in both disciplinary and interdisciplinary praxis, as each discipline has a unique lens and strength to bring to patient care.

Current findings demonstrate the need for the development of hope interventions that involve younger patients, thereby making their effects more sustainable across the lifespan. There is a need for pilot work in the development of child-specific hope interventions based on theoretical perspectives that acknowledge the complexities of health, wellness, and developmental considerations. Before such pilot work can be implemented, the themes generated from this analysis should be tested in child populations.

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Table 1:

Focus group questions

Questions for focus groups
1. Have you worked with a child who displayed hope?
2. What is your personal definition of hope?
3. Based on the scientific definitions of hope provided have you seen any examples of this in the children you have worked with?
4. If a child were to demonstrate hope what would that look like?
5. What behaviors have you seen in children you consider to have high hope?
6. What behaviors have you seen in children you consider to have low hope?
7. What factors contribute to hope?
8. Do you have any other thoughts on the concept of hope you would like to share?

Table 2:

Focus group description

Focus group 1	$n = 11$
Focus group 2	$n = 1$
Focus group 3	$n = 7$

Table 3:

Lincoln & Guba (1985) Framework for Trustworthiness of Data.

Criterion	Specific strategy used
Credibility (internal validity)	Data collected with both interviews and audio-recording. Confirmation of findings done with member checking throughout interview (in process) and with three members (1 from each focus group) following data collection (terminal).
Dependability (reliability)	Field notes, audio-tapes were transcribed verbatim and checked by a 2 nd researcher.
Transferability (external validity)	Thick description of methodology and findings reported to 2 nd researcher and other team member. Participants had varied backgrounds (age, gender, and ethnicity).
Confirmability (objectivity)	Audit trail