

The Meaning of Hope and Social Support in Patients Receiving Chemotherapy

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Purpose/Objectives: To explore and describe the meaning of hope and social support in patients receiving chemotherapy.

Research Approach: Descriptive, qualitative.

Setting: One ambulatory care oncology center in the midwestern United States.

Participants: 6 men and 8 women with a mean age of 63.6 years.

Methodologic Approach: Semistructured interviews were conducted while patients underwent chemotherapy. Interviewers asked open-ended questions to elicit each participant's personal meaning of hope and social support. Meticulous notes were taken during each interview. The data were analyzed with an editing style that used codes to sort and organize meaningful statements. The statements were categorized and themes were developed to give meaning to the data.

Main Research Variables: Hope and social support.

Findings: Four themes emerged during data analysis. Focusing on the Bigger Picture represented adaptation to the diagnosis and learning to live beyond it. Taking Cover in the Storm signified sheltering oneself from the negative aspects of cancer. Keeping It Normal signified participants' desire to continue activities as they had prior to their illness. Reaching Out/Not in This Alone illustrated the need to seek faith, treatment potential, and others, including healthcare providers, for hope and support.

Conclusions: Hope aids in overall health and well-being. Support from family, friends, and healthcare providers was valuable to participants as they dealt with their disease and treatment.

Interpretation: Hope and social support are multidimensional with individualized meanings. Healthcare providers can teach proactive strategies to shelter patients from the negative aspects of cancer and chemotherapy. Healthcare providers are valuable sources of support and hope for the patients in their care.

The American Cancer Society ([ACS], 2008) estimated that about one of every two men and one of every three women in the United States will be diagnosed with cancer during their lifetime, and more than 1.4 million new case will be diagnosed in 2008. A cancer diagnosis often results in fear, uneasiness, and devastation, and affected patients undergo physical, emotional, and social changes. With the additional effects of chemotherapy treatment, patients with cancer experience overwhelming upheaval in their lives that can be extremely difficult to navigate alone. Changes in functional status can alter relationships as interdependence increases and individuals facing cancer may long for reassurance and peace.

Hope has been found to help patients adapt to and provide meaning in illness, maintain a high level of well-being, and give direction and a reason for being (Saleh & Brockopp, 2001). It also is important in coping with various phases of illness (Benzein, Norberg, & Saveman, 2001; Cutcliffe &

Key Points . . .

- ▶ Methods by which care is delivered to patients with cancer undergoing chemotherapy can be extremely influential on the patients' levels of hope and perceptions of support.
- ▶ Nurses can enhance care to patients with cancer undergoing chemotherapy by developing and maximizing available support networks.
- ▶ Hope and social support help provide strength for patients with cancer.

Herth, 2002; Herth, 2000; Rustoen & Wiklund, 2000). Similarly, social support helps individuals adjust to stressful life events (Flanagan & Holmes, 2000; Papadopoulos & Lees, 2004) such as a cancer diagnosis. Hope and social support have been explored extensively in the nursing research literature with different populations in various stages of health and illness. Although researchers have studied issues related to individual aspects of cancer care (e.g., palliative care, gender, phase of illness), qualitative exploration of the meaning of hope and social support on participants with cancer in various stages and actively undergoing chemotherapy was not found in the published literature. The purpose of this descriptive qualitative study was to explore and describe the meaning of hope and social support in patients with cancer undergoing chemotherapy. Using participants of both genders with varying cancer diagnoses and stages can provide rich descriptions of the phenomena. Results can help nurses better assist patients with cancer undergoing chemotherapy to transition through a health crisis and enhance their quality of life.

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Literature Review

Fostering Hope Through Social Support

To design, implement, and evaluate a theory-driven hope intervention program, Herth (2000) performed a quasi-experimental study with 115 participants who had a first recurrence of cancer. The intervention consisted of sessions that included (a) searching for hope (participants were encouraged to become aware of fears, questions, expectations, and hope), (b) connecting with others (helping participants to recognize the interdependent influence of family and friends), (c) expanding boundaries (participants reflected on the meaning and purpose of life, death, suffering, and identifying sources of strength), and (d) building the hopeful veneer (discussing the positive role of interaction with nature, positive memories, and use of lightheartedness). Participants were randomly assigned to the treatment group (the hope intervention was carried out), the attention control group (informational sessions were held about cancer and treatments), and the control group (usual treatment). Findings revealed that the level of hope and qualities of life were significantly higher ($p = 0.03$) in the treatment group immediately after the intervention and across time.

Herth (2001) conducted a follow-up study to further test the Hope Intervention Program with a sample of 38 adults with a first recurrence of cancer. Findings indicated that the Hope Intervention Program positively affected the participants in rebuilding and maintaining hope across time. Participants reported that the support they felt during the group intervention sessions was very helpful. Herth (2001) encouraged nurses to develop intervention programs that enhance and maintain hope in patients for whom they care.

Saleh and Brockopp (2001) performed a phenomenologic hermeneutic study to explore strategies used by adult bone marrow transplantation recipients to sustain and foster hope. The researchers collected data using a one-time semistructured interview. Identified sources of hope included feeling connected with God, affirming relationships, staying positive, anticipating survival, living in the present, and fostering ongoing accomplishment. Religious practices and family members were the most frequently identified sources of hope.

Buckley and Herth (2004) studied the meaning of hope and strategies used by terminally ill patients to maintain and foster hope during the final stage of life. Sixteen patients receiving hospice care were interviewed and evaluated with the 12-item Herth Hope Index. Hope was present regardless of nearness to death. Categories fostering hope included love of family and friends, spirituality, setting goals and maintaining independence, positive relationships with professional caregivers, camaraderie with other patients, personal determination, and uplifting memories.

Benzein et al. (2001) conducted interviews with 11 patients receiving palliative care to explore the meaning of the lived experience of hope. The researchers found a dialectical tension between hoping for something (a cure) and living in hope (reconciliation and comfort with life and death). In addition, they reported that relationships with healthcare staff and loved ones were critical in fostering and maintaining hope.

Lindholm, Holmberg, and Makela (2005) examined the significance of hope and hopelessness on patients' vitality in a study of 50 women diagnosed with breast cancer within three years of the study. Data were gathered using questionnaires and semistructured interviews. Patients found that the mean-

ing of life and communion with others gave them strength to live and endure periods of hopelessness. Lindholm et al. noted that hope and hopelessness are present in patients at different times throughout cancer diagnosis and treatment. The researchers recommended that healthcare providers listen attentively, allow patients to freely express hopelessness, provide access to care, show acceptance, and demonstrate a willingness to give information.

Factors Affecting Hope and Level of Hope

Ebright and Lyon (2002) performed a descriptive correlational study to determine the extent to which antecedent variables and appraisals differentiated levels of hope in 73 Caucasian women with a first-time diagnosis of breast cancer. Instruments included Lazarus' Appraisal Components and Themes Scales, the Herth Hope Index, Rosenberg's Self-Esteem Scale, the Personal Resource Questionnaire 85-Part 2, Helpfulness of Religious Beliefs Scale, and a demographic questionnaire. Participants completed the surveys 3 and 12 months after breast surgery. Results indicated that supporting interventions related to self-esteem (identifying and emphasizing individual strengths), social support (providing an environment where verbalizing perceptions is encouraged and supported), and religious beliefs (supporting expression of spiritual beliefs and practices) increased hope.

Esbensen, Osterlind, Roer, and Hallberg (2004) investigated the quality of life in 101 newly diagnosed patients with cancer who were 65 years of age and older. Data were gathered using the European Organization Research and Treatment of Cancer's 30-item Quality of Life Questionnaire, the Nowotny Hope Scale, the Katz Activities of Daily Living-Index, the Interview Schedule for Social Interaction, and a researcher-developed demographic questionnaire. Results showed that age did not influence quality of life. Factors contributing to low quality of life included having a low level of hope, having a poorer social support system, needing help with activities of daily living, having less income, and being told the cancer had not been cured.

Rustoen and Wiklund (2000) used the Nowotny Hope Scale to study the level of hope in 131 adults diagnosed with cancer within one year prior to the study with a life expectancy of at least one to two years. Results showed that 87% felt hopeful or moderately hopeful and 8% had low levels of hope. The remaining 5% of respondents had missing values. None of the participants reported hopelessness. Living with others was found to be the most positive contributing factor in regard to hope; younger people had less hope when they lived alone.

Chen (2003) studied the effect of pain on hope using a convenience sample of 226 inpatients with cancer. Hope was measured with the Herth Hope Index, and pain was measured with the Perceived Meaning of Cancer Pain Inventory. Results indicated that patients' disease stages did not affect their levels of hope. Those who perceived their disease as being improved with treatment had a higher hope score than those who perceived their disease had not improved. Pain levels did not influence levels of hope.

Felder (2004) performed a descriptive correlational study to explore hope and coping using the 30-item Herth Hope Scale and the Jalowiec Coping Scale in 183 patients with various cancer diagnoses. A positive relationship was found between hope and coping style use ($p = 0.013$) and coping effectiveness ($p < 0.001$). The level of hope was relatively

high even in those with advanced stages of cancer, and the positive aspects of hope and coping were not affected by age, gender, marital status, education, or site of malignancy. Felder's results support the need for nurses to help foster hope through active listening, establishing a support system, incorporating religion and humor into practice, and helping patients set realistic goals.

Social Support and Cancer

Flanagan and Holmes (2000) explored the research literature to examine the social perception of cancer and its impact on patients. Their findings showed that social support is strongly related to patients' adaptation and well-being. The authors found that patients' perception of available support was important to their psychological health, but families and friends might withdraw from or avoid the patient or become overprotective. Flanagan and Holmes also found that healthcare providers significantly contribute to the support network of patients diagnosed with cancer.

Makabe and Nomizu (2006) conducted a qualitative study using a convenience sample of 38 Japanese women with breast cancer and their husbands ($N = 76$). One to 10 days prior to surgery, the women and their husbands completed the Interpersonal Relationship Inventory (to measure social support), the General Health Questionnaire (to measure psychological states), and the Physical States Interview Form (to measure physical signs and symptoms commonly experienced by women diagnosed with breast cancer). The researchers found that women perceived much more support than the spouses did, although no difference existed in how each group perceived the availability of a social network. The authors recommended that healthcare providers assess support networks of patients with cancer to encourage use of those networks. They also noted that healthcare providers could help families adjust to the patient's diagnosis and prepare for the support roles they would need to fill.

Dirksen (2000) examined the influence of social support on self-esteem, resourcefulness, and well-being in a study of survivorship with 84 women who previously had undergone treatment for breast cancer and were considered disease-free at the time of the study. Dirksen found that social support could reduce anxiety when women were coping with the diagnosis of breast cancer and the stressful aspects of treatment.

Wilmoth, Tulman, Coleman, Stewart, and Samarel (2006) studied women with breast cancer and their perceptions of support and education. Seventy-seven women were interviewed via telephone to determine how a telephone support intervention influenced their perceptions of support and adaptation to breast cancer. Thirty-five women in an experimental group received additional telephone support after their diagnosis. The remaining 42 in the control group received mailed educational materials (standard care). The results supported the need for nurses to assist patients with coping by providing written information and telephone support.

Results from the literature review focused on how social support fosters hope and facilitates adjustment to illness and its treatment. Results also indicated that healthcare professionals have an impact on accessing support networks and fostering hope. Quantitative studies focused on fostering hope with intervention programs (Chen, 2003; Herth, 2000, 2001; Wilmoth et al., 2006). Aspects of social support or hope were studied in women with breast cancer (Dirksen, 2000; Ebright

& Lyon, 2002; Wilmoth et al., 2006) and some researchers also included husbands' perceptions (Makabe & Nomizu, 2006). Researchers focused on specific age groups (Esbensen et al., 2004) or stages of disease (Buckley & Herth, 2004; Rustoen & Wiklund, 2000). Only one quantitative study was identified in which participants had various types of cancer and phases of disease (Felder, 2004).

Qualitative exploration of the concepts of hope and social support was limited to terminally ill patients (Benzein et al., 2001; Buckley & Herth, 2004), those with breast cancer (Lindholm et al., 2005), and those awaiting bone marrow transplantation (Saleh & Brockopp, 2001). Therefore, a gap in the literature exists related to qualitative exploration of the meaning of hope and social support to participants diagnosed with varying types and stages of cancer. Rich descriptions provided by the qualitative exploration of hope and social support can help nurses better understand the concepts' meanings to patients with cancer undergoing chemotherapy.

Studies were found in which patients were undergoing or had completed treatment, or where treatment was no longer effective. However, no researchers actively collected data during treatment. Based on previous literature, the current study's researchers assumed that hope was present in all patients regardless of the disease stage. Patients actively receiving chemotherapy may inherently hope for improvement in their condition by choosing to undergo chemotherapy. Therefore, the researchers believed that interviewing participants during the course of chemotherapy would provide an even richer description of the patients' meanings of hope. The gaps identified in the literature and the assumptions based on the literature review provided the basis for conducting the current study.

Methods

Design, Sample, and Setting

A descriptive, qualitative approach was used in the present study to uncover the meaning of hope and social support in patients undergoing chemotherapy. Participants discussed the significance and meaning of hope and social support in an open-ended manner to provide rich descriptions of the phenomena. A convenience sample was drawn from an ambulatory clinic in an urban area in the midwestern United States. Inclusion criteria included being diagnosed with cancer and undergoing chemotherapy, aged 18 and older, able to speak and understand English, medically stable, and willing to participate.

Procedures

Approval to conduct the study was granted by the applicable institutional review board for the protection of human participants. A few weeks prior to the interview dates, the researchers posted flyers in an oncology office to promote interest and inform patients of the study and its upcoming interview dates. Over six days, the researchers approached patients waiting in the reception area of the oncology office. The purpose of the study, procedures, risks, and benefits were fully explained. Informed consent was obtained after patients agreed to participate and were taken to the treatment area for chemotherapy.

An interview guide (see Figure 1) was developed to ensure that all content areas were addressed with each participant. Probe questions were asked as needed until the researchers and patients were satisfied that the topic was fully explored. A demographics sheet also was used to gather data. Interviews

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- How did you find out you had cancer?
 - Do you remember what you were told about your prognosis at the time of diagnosis? Has it changed?
 - Tell me how you feel about your diagnosis and the prognosis you have been given.
 - Tell me how you have coped or dealt with your diagnosis.
 - Has anyone specifically helped you cope? How did he/she/they help?
 - How have people who know of your diagnosis reacted to your illness and your treatments?
 - Tell me about support you have received from people. Who has helped and in what way was the support helpful?
 - Hope is important to patients with cancer. Can you tell me about things you do personally to give you hope?
 - How has your spirituality influenced your hope?
 - Since your diagnosis, has anyone or anything made you feel less hopeful?
 - Can you explain?
 - What do you hope for now?
 - Can you tell me about any type of support since your diagnosis that you feel is lacking? Include family, friends, coworkers, and others.
 - If you were to tell nurses how to better support patients undergoing chemotherapy, what would you say?
-

Figure 1. Interview Guide

were conducted in the chemotherapy treatment area of the clinic after all laboratory work and healthcare practitioner visits were completed. The treatment area setting enabled participants to have a convenient, time-saving, and safe interview environment. The researchers believed that patients choosing to receive chemotherapy might hope inherently for improvement in their condition. The researchers also believed that interviewing participants during their chemotherapy would elicit very rich descriptions of the patients' meanings of hope.

The chemotherapy treatment area was a multibed unit. Patients who agreed to participate were taken to a more secluded bay for chemotherapy. However, the area was not in a separate room and was closed off from other patients only by a curtain. To comply with the Health Insurance Portability and Accountability Act regulations and to maintain confidentiality of all patients at the center, audiotaping the interviews was prohibited. Oncology office administrators believed that confidential information regarding nonparticipants could have been picked up inadvertently on an audiotape. Therefore, the researcher and participant sat close together in a secluded area of the treatment room and spoke in soft tones. The interviews were suspended temporarily during nurse checks or other interruptions. Meticulous handwritten notes were taken during each interview and typed verbatim by the interviewing researcher shortly after each interview. No identifying information was included on the interview guides or transcripts. Informed consent documents were kept separate from interview data. Only aggregate data were reported.

Rigor

According to Lincoln and Guba (1985), the principles of credibility, dependability, confirmability, and transferability are used to measure rigor in qualitative research. To ensure credibility, sufficient time was allowed for participants to answer questions and share thoughts. Open-ended questions gave participants the opportunity to respond in their own words. Each interview took 30–60 minutes, which was enough time for participants to fully describe their meanings

of hope and social support. Interviews were terminated only after participants noted that they had nothing more to share.

Dependability and confirmability are ensured if data were generated by reliable and rigorous methods and the interpretations and recommendations clearly emerged from the data (Lincoln & Guba, 1985). Researchers assumed that participants were honest in sharing their thoughts and meanings of hope and social support. To ensure dependability, three researchers reviewed transcripts and performed coding independently and then met to finalize categories and theme development.

The goal of qualitative research is to provide rich descriptions of data that consumers can apply to other contexts (i.e., transferability). Results from this study may be applicable to other patients undergoing chemotherapy in ambulatory care settings, but only after careful consideration and review.

Data Analysis

The researchers used an editing style to analyze the transcribed notes from the interviews (Polit & Beck, 2004). The researchers evaluated the transcripts independently and coded significant statements. The coded statements then were categorized into common themes, which were named based on the overriding essence of the statements. Conclusions regarding the meaning of hope and social support in patients receiving chemotherapy were made from the themes. Data analysis was ongoing with data collection, and sampling was terminated after data saturation was obtained. Study results were shared with participants by distributing copies of the final report at the ambulatory care center where the interviews took place.

Results

The study sample consisted of six men and eight women (N=14) being treated at one ambulatory care oncology center in the midwestern United States. All participants were Caucasian and ranged in age from 51–79 (\bar{X} = 63.6, SD = 8.36).

Patients were diagnosed with cancer from 2–104 months prior (\bar{X} = 45, SD = 41.7). Participants reported having zero to five children. Thirteen were married and one was widowed. Twelve participants lived with a spouse, one lived with a spouse and adult children, and one lived with a sibling. Twelve participants were being treated for a first diagnosis of cancer, whereas two were being treated for a secondary cancer. Types of cancer are listed in Table 1. When asked if they remembered what they were told about their prognosis at the time of diagnosis, half recalled details of the original prognosis and the other half either stated it was never clearly explained or avoided answering the question when researchers probed. Four participants said that their prognosis changed since diagnosis, seven said it had not changed, and three were unsure.

Four themes emerged during data analysis describing participants' meanings of hope and social support: Focusing on the Bigger Picture, Taking Cover in the Storm, Keeping It Normal, and Reaching Out/Not in This Alone. Supporting statements from the participants are provided for each theme. The supporting statements were taken verbatim from the field notes and accurately represent the essence of the participants' responses. Supporting statements represented in this article as quotes would be reported had the interviews been recorded.

Focusing on the Bigger Picture

This theme reflects the feelings and coping mechanisms used by participants to adapt to their diagnosis and remain hopeful. Participants consistently reflected that they were not focusing on the immediate issue (their cancer), but instead on the bigger picture of life. This theme did not necessarily represent acceptance of the diagnosis, but rather that the cancer did not control their lives. One participant's narrative reflected this: "I just deal with it. I have my good days and bad days. I try to maintain a good attitude. When I wake up in the morning, I think I am one more day [living my life]."

Although many participants described feelings of fear and unhappiness, one stated, "At certain times you feel bad, but it doesn't take long for those feelings to go away. [The cancer's] not the center of my universe anymore." Several participants acknowledged coming to terms with their diagnosis with phrases such as, "Right from the beginning, I accepted it," or "I live with it. I don't make a big deal of it. If it's to be, it's to be." Although shock was common when participants were diagnosed, many felt a resolve. One person stated, "I feel I have accepted it; it's just something that is there that I have to deal with. I will not give up."

One participant expressed initial anger with God, but said, "I moved on. You can't change your lifestyle; you can't let it get to you." One participant quoted a speaker she had heard when she said, "It's not what we are dealt but how we deal with it." When asked what they hope for most, participants focused on the bigger picture: seeing children get married, seeing grandchildren grow, traveling, not dwelling on illness regression, and doing more things in life.

Taking Cover in the Storm

The second theme that emerged from the data described participants' desire to shelter themselves from negative thoughts and fears associated with cancer. One participant compared himself to "an ostrich that sticks [his] head in the sand" when he saw or heard anything about cancer. He stated, "I don't like to think about it. I try to avoid anything that reminds me of cancer."

Other participants expressed similar desires to avoid things pertaining to cancer. One stated, "I don't want to be engulfed every day in the cancer. I don't like to read the newsletters from [the cancer center]." Others felt that certain knowledge might contribute to feelings of hopelessness. One noted, "I have realized it's better to be ignorant. The more you learn, the less hopeful you are." Another stated, "The statistics are

discouraging. People who are dumb are blessed." Participants consistently echoed that knowing less is better when referring to the negative aspects of cancer, such as a poor prognosis.

Keeping It Normal

This theme reflects the need for patients undergoing chemotherapy to continue living life in the same way as before receiving their diagnosis and starting chemotherapy. Many participants expressed the need to continue familiar routines, work, and activities while being treated the same as before the cancer diagnosis and living life as normally as possible. One participant said, "I feel there is nothing I can do to change the situation so I just try to live my life." Another talked about his attitude and how he continues to carry on.

I was so sick at first. I was always healthy prior to the diagnosis. At first I had a lot of questions. Why me? What did I do to deserve this? I was bitter about it. [Now] I just deal with it. I have my good days and bad days. I try to maintain a good attitude. . . . When I take my pills every day I am reminded of this. . . . I am not going to let it ruin my life. I feel there is nothing I can do to change the situation so I just try to live my life.

Several participants discussed wanting to continue working in some way. One woman close to retirement stated, "I had to stay and work for awhile after my diagnosis for the insurance. But [my employers] always worked around my schedule. They were wonderful." Another woman described how her boss "will ease up on my workload when I need him to." One participant explained how he was able to continue involvement with work by adapting to his current situation.

In my job, I just keep going at it. I have started parceling things out to people. Like I have gotten somebody to do [the administrative aspects] that I am responsible for. I have gotten two to three people to run the [competitive] meets at the local high schools and middle schools. I will be there in the background, but with my shortness of breath, I just can't do it.

Many participants discussed the importance of continuing what they described as normal daily activities prior to their diagnosis of cancer and chemotherapy. The types of normal activities varied. Continuing to work, modifying work as needed, being treated the same, and enjoying the same activities were very important.

Reaching Out/Not in This Alone

This theme reflected confidence in treatment potential, falling back on faith and prayer to gain strength, and social support. Participants described coping mechanisms used to foster hope and assist in adapting to cancer by reaching out beyond themselves to other people and beliefs as sources of support.

Reaching out was a mechanism used to foster hope. A commonality found was the positive belief and trust in treatment potential. Several participants stated their hope lay in the development of new cancer treatments and medications. One participant stated, "Advances in cancer in the last 10 years have provided hope." Another participant's words are typical of many respondents.

I like them to use new things and new drugs for me. I have granddaughters and I hope that the new drugs I am

Table 1. Types of Cancer Reported by Participants

Type	n
Breast	4
Leukemia	2
Multiple myeloma	1
Lung	1
Colon	1
Myelodysplastic syndrome	1
Peritoneal	1
Non-Hodgkin lymphoma	1
Bladder	1
Ovarian	1

N = 14

trying will help them. I have given [the oncologist] *carte blanche* to use whatever is best for me. You have to trust in your doctors.

Patients reflected that they were not facing their disease alone. All but one participant discussed the family and friends around them who helped with coping or support in some way. When asked the question, “Has anyone specifically helped you cope?” all but three participants responded with “my wife and kids,” “my husband,” or “my kids.” Several responded, “The staff here are angels,” referring to those at the ambulatory care center as sources of support. When asked, “How did he/she/they help you cope?” many participants responded that the staff assisted by “being there” and “listening.” One stated, “Just by being there, backing me up,” or “Comforting me. Letting me know it will all be fine.” One detailed the support given by her son and daughter-in-law.

My son and daughter-in-law sold their house [in a nearby city] and came to live with us. They moved here so they could pay for my medications. They are the ones that made this not so bad. I mean, I know how we raised our son, but for his wife to also make such a sacrifice really says something.

Participants were clear in recounting the social support they received. One participant said, “I have experienced the clearest sincerity [from support staff members] in what could be a clichéd line: ‘. . . [Call me with] whatever you need.’” Several participants remarked on receiving phone calls and cards from family members, friends, church members, and coworkers. One participant noted,

Many people sent e-mails. People call. People sent cards. One thing that has really meant a lot is that some people send a card every few weeks. I love to get the cards and it makes me so happy to see them keep coming.

Other participants went into detail about how support was enhanced by talking with others. “Friends that have had other health problems have really helped just by talking. We rub things off of each other.” Another participant described her perception of social support as “lots of phone calls from friends asking how I am. Visits from them. They are very encouraging. They often give examples of others who have survived.”

When asked about any support that might be lacking, participants overwhelmingly responded that little or nothing was lacking as they reflected on the support they had received. One participant noted how it could have been better.

The bulk of my faith is with my church. I was always seen as a strong leader there. Since I have been sick, they see me differently. Certain people, especially in the church who I thought would have been supportive, were not. The pastor has not contacted me. I know that he is busy, and they probably know I have other support since I am such a strong person. Maybe they think I don’t need it. It really is okay; I am doing fine.

A resounding common reflection that contributed to hope was the positive encouragement, compassion, and support from healthcare providers including nurses, physicians, and other staff at the oncology office. One participant stated, “It’s hopeful here. It’s like family here.” Another subject’s summary was reflective of many.

This place is fantastic. This place is so warm, so human, so caring. How can you tell someone to be real? If you are phony, people will see through that. Here they are so concerned. . . . [My oncologist] is a Christian and he goes to the chapel every day to pray for his patients. When I come for blood work, for treatment, I come back here to talk. They are like family.

Another woman echoed those thoughts when she said, “I feel like I am in somebody’s arms here. I feel like that every time I come in here that somebody is picking me up.”

Participants also noted how they reached out to a higher being and found hope and support through spirituality and religion. One participant explained he was not a practicing member of a religious organization but said he was very spiritual. “I have a clear idea of where I fit in the cosmic thing. That makes it easier to cope.” Several participants expressed their close connection to God and prayer. One participant stated, “Spirituality has helped me in every dimension of my life,” and another noted, “I don’t know how anyone who doesn’t believe in God could get through this. You have to have someone to turn to.” Another patient said,

I journal on a daily basis. I don’t just write, “I did this,” or, “I did that.” . . . I also include prayers in my journal and pictures. . . . I look at this as my adventure. I concentrate on looking at the blessings. I look at the whole thing not saying “Why me?” but I say, “Why not me?”

The connection to God was evident as participants described the inner strength that spirituality provided. The theme of Reaching Out/Not in This Alone addressed how the participants perceived hope and social support given to them by religion, family members, friends, healthcare providers, fellow church members, and coworkers. The participants described how communication by phone calls, cards, letters, and visits helped them to feel encouraged and supported. The participants further described how having help with meals, work schedules, and projects, and having someone with whom to discuss feelings, made it easier to cope with their diagnosis and treatment.

Discussion

When asked what they hoped for, participants were Focusing on the Bigger Picture when they noted they had adapted to their diagnosis but were not letting it control their lives. They focused more on daily activities and cautiously set goals for the future. This supports the findings of Saleh and Brockopp (2001), who found that patients undergoing bone marrow transplantation had more hope if they lived in the present. Chen (2003) found that people who perceived cancer treatment to be effective had more hope. In the current study, only a few patients hoped for a cure, but many noted that their doctors and new treatments fostered hope. Participants wanted continued time with family, to be pain-free, and to maintain the status quo. Participants did note their desire to see future-oriented activities and family accomplishments (e.g., watching children or grandchildren grow). However, the desire was more of a reflection on their focusing on the bigger picture of life instead of diagnosis or treatment.

The theme Taking Cover in the Storm signified an avoidance of some of the negative aspects that accompany cancer and its treatment. This theme was not evident in previous research. Some participants said they wanted to shield themselves from

prognosis statistics that may have decreased their hope. An important nursing role is teaching patients about their disease and prepare them for treatment. The finding that some patients wish to “stick [their] head[s] in the sand” supports the need for nurses to individualize teaching plans based on each patient’s needs and not to assume that all patients want to know everything.

Felder (2004) reported that hope seemed to be present in patients with cancer regardless of their stage of illness. Direct comparisons of hope and phase of illness cannot be made in this study. However, the participants’ descriptions of hope were very similar regardless of whether they had been diagnosed two months or eight years ago. Saleh and Brockopp (2001) found that hope was necessary and gave patients a reason for living. Many participants in the current study noted that they were “taking cover in the storm” as they avoided negative thoughts and people to foster personal feelings of hope.

The theme Keeping It Normal showed that patients receiving chemotherapy wanted to adapt to the situation and continue viewing themselves in the same manner as they had prior to the cancer diagnosis. Flanagan and Holmes (2000) found that patients reported dissatisfaction when people treated them differently after they were diagnosed with cancer. Participants in the current study supported that finding.

Perhaps the most resounding and highly supported finding in this study was the influence that others, including family, friends, and healthcare providers, had on participants’ level of hope and feelings of support. This was reflected in the present study’s theme of Reaching Out/Not in This Alone. Participants reported that hope and social support were important in adapting to the physical, social, and emotional changes accompanying their cancer and the therapy required. Herth (2000, 2001) and Wilmoth et al. (2006) found that specific hope interventions significantly increased patients’ level of hope. Interventions were not used in the current study, but many participants noted that ambulatory care center services, such as group activities, newsletters, and classes, increased hope and provided opportunities for support.

Participants noted that talking to others was a way to cope and deal with the rigors of the illness and effects of chemotherapy, thereby supporting findings by other researchers (Dirksen, 2000; Ebright & Lyon, 2002; Papadopoulos & Lees, 2004). Rustoen and Wiklund (2000) found that living with others was a positive contributor to hope. All participants in the present study lived with someone and reflected on the support those people provided.

Several researchers found that healthcare providers can positively influence hope (Benzein et al., 2001; Buckley & Herth, 2004; Felder, 2004; Flanagan & Holmes, 2000; Makabe & Nomizu, 2006). Herth (2000) and Lindholm et al. (2005) found that healthcare professionals positively influenced hope by providing information in a compassionate, honest, and respectful manner, and by listening and being friendly, polite, positive, and confident. Patients in the present study overwhelmingly noted the caring atmosphere in the oncologists’ office. The researchers also observed the extremely positive behaviors of the staff (e.g., smiling, touching, hugging, laughing, being present, open body language) that were described frequently in the field notes. This supports the recommendation by Lindholm et al., who advocated for healthcare providers to perform such caring behaviors to foster hope in patients with cancer.

Several conclusions can be drawn as a result of the current study. Patients undergoing chemotherapy perceived that the

social support provided by family, friends, coworkers, church members, and healthcare providers contributed to hope. Participants viewed social support to mean presence and acceptance of those around them. Acceptance and assistance from others formed the basis for hope by enabling participants to adapt to the challenges of the cancer diagnosis and rigors of chemotherapy. Altering workloads and responsibilities can assist patients with cancer to continue being productive and feel valued in a meaningful way, contributing to their quality of life.

Limitations

Several study limitations were identified. Participants were recruited from one oncology practice and all were Caucasian. The participants may have had more financial and social resources and better access to health care than other more diverse groups, which could influence their perceptions of hope and support. The participants all were fairly mobile and independent even though they were in various stages of disease and treatment. Patients who are less independent and less mobile may have different perceptions of social support and its meaning. Several participants were interviewed with a significant other present, which may have influenced their responses. The researchers noted that all participants freely and openly responded to the questions and continued with the interview until they told the researcher that they had nothing else to share. However, the researchers cannot be certain that participants fully answered all questions. The researchers did not choose to limit the presence of significant others because of the nature of the situation and need for support as patients were receiving chemotherapy.

Administrators of the oncology office did not allow audiotaping of the interviews out of concern for the privacy of nonparticipating patients in the treatment room. Meticulous, objective notes, including verbatim statements, were taken during the interviews as much as possible. The researchers are confident that the essence of the participants’ responses was captured accurately without researcher bias. The researcher who conducted each interview transcribed it immediately after it was completed to ensure accuracy. Although audiotaping and transcribing would have been ideal and are the norm for qualitative research, that model could not be followed in the present study.

Implications for Nursing

Study findings support the need for nurses and other healthcare providers to recognize the importance of hope and social support for patients with cancer. Nursing care involves assessing and treating patients in a holistic manner to assist them in adapting to illness and obtaining optimal health. Saleh and Brockopp (2001) stated, “The most robust resource an individual can possess is hope” (p. 308). Nurses have the opportunity to contribute to hope through interpersonal connectedness when providing compassionate care. Simple qualities and interventions often taken for granted include being present, listening, respecting, caring, and providing information in an honest, respectful, and compassionate manner. Esbensen et al. (2004) found that having a poor social support system contributed to low quality of life. Nurses need to understand the value of support and assist patients to develop or access available support networks.

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