Hope-based interventions in chronic disease: an integrative review in the light of Nightingale

Intervenções de esperança na doença crónica: uma revisão integrativa à luz de Nightingale

Intervenciones de esperanza en la enfermedad crónica: una revisión integrativa a la luz de Nightingale

Abstract

Objective: To identify the available evidence in the scientific literature about the strategies or interventions used to promote hope in people with chronic diseases. Method: An integrative literature review of literature published between 2009-2019, which was conducted in online browsers/databases: b-On, EBSCO, PubMed, Medline, ISI, SciELO, PsycINFO, Google Scholar. Forty-one studies were found, of which eight met the inclusion criteria. Results: Most studies used a quantitative approach. There was a predominance of studies from Asia and America, addressing patients with multiple sclerosis, diabetes, congestive heart failure, and cancer. Hope-based interventions were categorized by the hope attributes: experiential process, spiritual/transcendence process, rational thought process, and relational process. Conclusion: Hope-based interventions, in their essence, are good clinical practices in the physical, psychological, social and spiritual domains. This is congruent with the vision of nursing, first proposed by Florence Nightingale. There seem to be gaps in the literature regarding specific hope-promoting interventions.

Descriptors: Chronic Disease; Hope; Holistic Nursing; Patient Care; Review.

Resumen


Descritores: Doença Crônica; Esperança; Enfermagem Holística; Assistência ao Paciente; Revisão.

Resumo


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INTRODUCTION

Nursing, as an organized profession, appeared with Florence Nightingale, in the second half of the 19th century, in a period of great need to improve the living conditions of populations, namely in the control of infectious diseases, given that medicine had very limited resources[1]. Searching for Florence Nightingale’s current events, in her thinking and in her work, is an interesting exercise that takes us to the hygienist concerns “clean air, pure water, efficient drainage, cleanliness and light” - five essential points in the observation of a healthy home. Nightingale knew the germ theory, and before its wide publicity, she had deduced that cleanliness, fresh air, sanitary aspects, comfort and socialization were necessary for the cure. Besides, Nightingale’s message of health and healing, anticipated the holism perspective as recognized from today’s point of view.

After Nightingale, with the advent of modern nursing, caring became considered an end of the nursing profession, responding to the social demands of each age. At the beginning, it was based on essentially practical knowledge, characterized by a solicitude associated with a spirit of fraternal help and charitable dedication, having been influenced by technical-scientific developments, and by increasingly complex and diversified socio-cultural contexts, giving rise to a practice based on scientific knowledge, professional competence and the adoption of scientific methods of work[2]. Conceptual foreknowing’s of hope[3-5] assume that is a universal human universe living experience characterized by some patterns: a) hope hides in veiled shades of obscurity; b) strengthens dreams; c) hope-no-hope illuminates connections and hope keeps perseverance in fighting; d) linking the present to the future; and e) expands the horizon of possibilities.

This openness makes it possible to work on hope in the context of the nurse-patient relationship from a perspective that does not cure but it heals. The nurses’ commitment to the practice of promoting hope as a duty of care and a criterion for good clinical practice, led to the need to investigate the concept, and look for new ways to better inspire hope in patients and families. In Cutcliffe’s view[6], hope is interconnected with care and help, and is intrinsically related to the effectiveness of nursing practice. Nurses inspire hope by taking care of the person in a holistic way, considering their well-being in the context of a therapeutic relation of partnership, based on the recognition of the person being cared for and the affirmation of their value.

The standards of good clinical practice include the evaluation and promotion of hope as a criterion for quality of care[7]. Also, the most recent perspective of evaluating the quality of nursing care, includes comfort, hope and resilience as positive outcome indicators[8]. In an integrative review on the role of hope for adolescents with a chronic illness, hope was found to promote health, including comfort, hope and resilience as positive outcome indicators[9]. In an integrative review on the role of hope for adolescents with a chronic illness, hope was found to promote health, including comfort, hope and resilience as positive outcome indicators[9].

The scholars are unanimous in defining hope as a dynamic and multidimensional process that is central to life, oriented towards the future, intentional and highly personalized in each individual[10]. It also involves the presence of significant objects that are desirable and realistically possible to achieve and the willingness and capacity to make decisions and make choices[11]. Hope emerges as a process of anticipation that involves the interaction of thought, action, feeling and relationship, directed towards a future achievement that is personally meaningful. It provides comfort in the face of life’s threats and challenges[12], saving people from the agony of despair[8-9], it is an integral and determining part in the existence of sick people, a process that strengthens their capacity to endure suffering, favors transcendence[13], facilitates the recovery process, being both a powerful coping mechanism and an essential internal resource for quality of life[14]. By exploring the clinical applications of hope, Farran, Herth and Popovich[15] proposed a hope framework for guiding nursing interventions to enable hope and prevent hopelessness. This theoretical framework encompasses four central attributes of the dialectical relation between hope and hopelessness that fits the chronic illness experience:

a) An experiential process (the pain of hope) - involves the recognition and acceptance of suffering as part of the human experience. For the authors, in chronic conditions, hope encompasses ordeals and suffering and includes a potential for hopelessness inherent to impotence due to the inability to change external circumstances when personal resources are scarce. Working towards the acceptance of suffering (physical, psychological, social and spiritual), it simultaneously allows the occurrence of a creative and imaginative process, and resilience to modify the experience, overcome it and find hope again. In this process, the hope / hopelessness dialectic is highlighted as part of the learning process of hope, leading to different life experiences among people who learn to modify their life experiences and those whose hope has never been challenged;

b) A spiritual or transcendent process (the soul of hope) - The spiritual process involves the incorporation of a transcendent dimension of life. Hope is a spiritual need expressed in association with the meaning of life, forgiveness or acceptance, reassurance from religious faith, relationship and transcendence. Reconciliation is an integral part of the spiritual process of hope. As a spiritual process, hope maintains and is maintained by faith (in oneself and others), and it may be a theological faith, or even in something that has not yet been proven or in a sense of uncertainty;

c) A rational thought process (the mind of hope) - a process in which the person is actively involved in the expectation of reaching concrete goals, strengthened by the sense of control over their own destiny, assuming anticipation. In this process hope is associated with goals that are flexible and reality-based and motivates persons; pathways and resources, such as positive mental attitude;

d) A relational process (the heart of hope) – an intersubjective process requiring recognition and acceptance of others. Open caring relationships have been identified as crucial to the mobilization, support or maintenance of hope and prevention of hopelessness. A caring environment together with a sense of connectedness with others has the power of fostering hope in clients and their families regardless of age or health condition[11].

The standards of good clinical practice include the evaluation and promotion of hope as a criterion for quality of care[12]. Also, the most recent perspective of evaluating the quality of nursing care, includes comfort, hope and resilience as positive outcome indicators[8]. In an integrative review on the role of hope for adolescents with a chronic illness, hope was found to promote health, facilitates coping and adjustment, enhances quality of life, is essential in purpose in life and illness, improves self-esteem, and is an important factor in resilience[13]. This far, the meta-synthesis of hope-based interventions in chronic illness from the perspective of older adults[14] and family caregivers[15] comprehended the timeframe from 1980[16]/1987[17]-2008[18]/2010[19]. A systematic review of interventions for hope/ hopelessness revealed that cognitive-behavioral
interventions can improve hopelessness in depressed older adults. Life-review based interventions can positively impact hope in a range of older populations, but dignity therapy, physical exercise, and educational programs may not effectively improve hope/hopelessness in older adults\(^1\). A recent study of meta-analysis was conducted to evaluate the efficacy of nursing interventions to increase the level of hope in cancer patients\(^2\), concluding that nursing interventions has a positive effect on hope in cancer patients. Also nursing caring interventions that take into account the spiritual element was found to encourage positive ways of religious coping and, therefore, increase the levels of hope among cancer patients undergoing chemotherapy\(^3\). Nevertheless, since 2009 little is known about what the interventions are used to promote hope in people with chronic illness besides cancer, as Nightingale intentionally did, which is a gap to be covered by an integrative review. Based on the multidimensionality of hope, to know what interventions can be used from the patient’s and families’ perspective, “might help nurses and other healthcare professionals to inspire hope as Florence Nightingale did when she walked with the lamp through the dark corridors and spread hope and light to the patients”\(^4\). The work and life of Florence Nightingale, as described in the literature, are used throughout this literature review, by analyzing her view of nursing from a holistic perspective.

**OBJECTIVE**

To identify the available evidence in the scientific literature about the strategies or interventions used to promote the hope of people with chronic disease.

**METHODS**

**Ethical aspects**

The study had no involvement with humans, so no research evaluation was required by the Ethics Committee on Research with Human Beings. Since it is methodology that analyzes data that has already been ethically published and analyzed, consideration by the Research Ethics Committee was not required.

**Study design**

An integrative literature review consists of a research method that gathers and synthesizes the results of previous studies in a systematic and rigorous manner. For preparation of this integrative review, the following steps were followed: definition of the guiding question; search in the literature; extraction of data from the selected studies; evaluation of the studies and summary of the results; discussion and presentation of the integrative review\(^5\).

**Population, inclusion and exclusion criteria**

The following inclusion criteria were used: - articles published between 2009 and 2019, available in full text in English, Spanish and Portuguese; - empirical studies of a quantitative, qualitative nature or using the triangulation of methods with adult/elderly participants with chronic disease, with a description of the strategies intentionally used to promote hope.

The review excluded: - studies whose participants were exclusively families/caregivers; - children and adolescents; - studies associating hope with drug therapy; - studies in the context of acute, sudden illness or in the context of intensive care; - editorials, letters to the editor, review studies, theses, dissertations, repeated articles and studies that did not address the theme relevant to the purpose of this review.

**Study protocol**

For the elaboration of the guiding question of the integrative review, the PICO strategy was used\(^6\), where P (participants) corresponds to adult patients with chronic disease and nurses who provide care, I (intervention) to Interventions for hope promotion, C (control) does not apply to this proposal and O (outcome) refers to the evaluation of interventions for hope promotion. The guiding question thus was: what is the available evidence about the strategies or interventions used to promote the hope of people with chronic disease?

The search for the studies was held in January of 2020, and encompassed the following databases: b-On; EBSCO (CINAHL - Cumulative Index to Nursing and Allied Health Literature, British Nursing Index, The Cochrane Collection, Medic Latina, Medline with full text; DARE - Database of Abstracts of Reviews of Effects, Academic Search Complete, ERIC - Educational Resource Information Center; PubMed; Medline; Current Contents-ISI; SciEO; PsycINFO; Google Scholar.

**Figure 1 – Flowchart of the selection process to which the articles were submitted**

As research strategy, the Health Sciences Descriptors (DeCS) for the databases in Portuguese and the corresponding Medical Subject Headings (MeSH) for those in English were used, allied to the Boolean operators \(and\) or \(or\) enabling the following combinations: [hope* OR promoting hope OR enhancing hope OR instilling hope] AND (chronic disease OR end-of-life care OR palliative care OR long-term care) AND (nursing strategy OR nursing program OR nursing intervention) NOT (child* OR adolescent).

The search and selection of the studies followed the criteria recommended by the PRISMA group\(^7\) and was conducted simultaneously.

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by two researchers. In situations of disagreement, a consensus was sought for with the participation of an auxiliary researcher (Figure 1).

The first selection of articles happened through the reading of the titles and abstracts; then, the articles were read in their entirety and the information obtained was distributed in tables and charts, with subsequent categorization of data.

**Analysis of the results**

For analysis of the information, a spreadsheet created in Microsoft Excel® was used, consisting of the items: database, journal, language, year of publication, methodological approach used, type and description of evaluation, country where the intervention was performed, and finally the hope-based interventions according to the categorization proposed by Ersek(21).

**RESULTS**

The search resulted in 8 articles that met the criteria for inclusion proposed. Most publications included were found in CINAHL (58.1%), followed by PubMed (12.5%). The description of the selected articles is presented in Chart 1.

The 8 selected studies were published between 2011 and 2019. In relation to language, all studies were published in English. Most used a qualitative approach as methodology used for data collection. Regarding the location in which the interventions were performed, there was a predominance of studies from the Asian continent, followed by American. Regardless of recruitment efforts, the samples are composed by different chronic conditions such as Diabetes, Congestive Heart Failure, Cancer and Multiple Sclerosis.

Most of the programs, scientifically tested and selected for this review, were applied individually or in groups over 4-12 sessions of 0.5h-2h each one, in which participants performed various activities. This is the case of Brief Hope Intervention from China(22), the Living with Hope Program from Canada(23), the HOPE-IN from Norway(26) and the Hope Therapy Program from Iran(27-28). Based on these programs hope in chronic illness: (i) promote coping and emotional adjustment, (ii) enhances quality of life, (iii) is essential in spirituality/purpose in life and illness (iv) improves self-esteem, (v) and is an important factor in resilience.

The adaptation of Ersek’s categorization(21), presented in chart 2, contains interventions that, while not mutually exclusive, cover most of the themes found in the literature and provide a good organizational scheme, constituting a useful tool for nurses. Ersek(21), categorized interventions based on the four attributes of hope identified in the work of Farran et al.(11) and Herth(30-31), which in chronic disease involve the following six assumptions:

1. Hope is a tailored process that can occur at different levels of abstraction for the same person - includes identification of threats, resources and identification of objects of hope(30-31).
2. Hope is based on the past but lived in the present and oriented towards the future: the success of the past and its impact on the present, associated with the mobilization of energy makes us believe in future capacities(6-7);
3. Hope is essential to act in the face of adversity - personal attributes such as faith, trust, the ability to resist and motivation have a fundamental role(6,11);
4. Hope is a feeling of having possibilities, being able to deal positively with suffering and transcending the situation, maintaining a sense of dignity(21); it is fueled by the positive feelings associated with realistic goals and the ability to create successful plans to achieve them(30-31);
5. Hope is a coping strategy, used spontaneously by people with chronic illness, but highly influenced by interpersonal relationships, help and care(21);
6. The strategies that promote hope start, most of the time, by themselves, when faced with adversity, uncertainty and suffering, in situations that they perceive as threats(21), but are enhanced by nurses, considered important catalysts of hope in people with chronic disease.

**Chart 1 - Description of articles on the evaluation of interventions for promoting hope, according to author, year, country, type of approach, sample, type of intervention and the intervention’s characteristics**

<table>
<thead>
<tr>
<th>Author, year, country</th>
<th>Approach</th>
<th>Sample</th>
<th>Type of intervention</th>
<th>Intervention description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chan et al. (2019) China</td>
<td>Mixed-method study</td>
<td>40 cancer patients living in the community</td>
<td>The Brief Hope Intervention consisted of four one-on-one sessions: two (1-hour) face-to-face sessions and two (30-minute) telephone follow-up sessions in between.</td>
<td>There were three core features in the hope therapy: (a) goal thoughts: finding workable goals, (b) pathway thoughts: finding ways to reach the targets, and (c) agency thoughts: positive self-talk to optimize their motivation to accomplish the set goals(22).</td>
</tr>
<tr>
<td>Khaledi Saradasti et al. (2018) Iran</td>
<td>Quantitative Quasi-experimental</td>
<td>38 diabetic patients</td>
<td>The intervention consisted of eight 2-hour group sessions.</td>
<td>“The content of the sessions consisted of a combination of Snyder’s hope therapy and the hope plan in Islam. (…) Hope therapy is a narrative approach based on the life story of individuals. In addition, the life story of each individual is based on that individuals’ culture, and individuals retell their life story based on their culture”(p.283)(28).</td>
</tr>
<tr>
<td>Rakhshan, et al. (2018) Iran</td>
<td>Quantitative RCT</td>
<td>60 patients with multiple sclerosis and 60 of their family caregivers</td>
<td>The intervention group received an intervention based on the collaborative care model on hope (exclusively for each patient and his/her caregiver) through four stages and eight sessions over a period of 12 weeks.</td>
<td>This model is an educational method based on the patient’s participation in the management of chronic disease, including phases of motivation, preparation, involvement, and evaluation(24).</td>
</tr>
</tbody>
</table>

To be continued
### Chart 2 – Description of the articles on the evaluation of hope-based interventions according to the four attributes of hope

<table>
<thead>
<tr>
<th>Attributes of hope</th>
<th>Hope-based interventions</th>
</tr>
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</table>
| **Experiential process** | - Prevent and control the symptoms (27-28)  
- Use humor and joviality appropriately (29)  
- Encourage the patient/family to transcend the current situation (24)  
- Encourage aesthetic experiences (22)  
- Encourage involvement in creative and fun activities (21)  
- Encourage reminiscence, an expression of gratitude (22,25)  
- Assist the patient/family to focus on the joys of the past and the present (22)  
- Share positive inspirational stories of hope (22,25)  
- Support the patient/family to verbally express positive self-reflection (22,27) |
| **Spiritual/transcendent process** | - Facilitate participation in religious rituals and spiritual practices (21,25-26,29)  
- Referral to the clergy or other spiritual assistant (21)  
- Assist the patient/family in searching for meaning in the present situation (21,24,27)  
- Assist the patient/family to keep a newspaper (25)  
- Suggest literature, films and art that explore the meaning of suffering (28) |
| **Relational process** | - Minimize the isolation of the patient/family (26)  
- Establish and maintain an open relationship with others (24,25,29)  
- Strengthen the patient’s/family’s self-esteem (22,26)  
- Recognize the individuality and value of the patient/family (22,24-25,27,29)  
- Recognize and reinforce the reciprocity of hope between the patient/health system (24,25)  
- Provide time for relationships (especially in institutions) (24,25)  
- Assist the patient to identify significant people/objects (25)  
- Reflect with the patient on the characteristics and experiences that connect others to the patient (28)  
- Communicate the proper sense of hope (22,27) |

To be continued
Compared to Nightingales’ rounds (17), defining short-term goals (30, 35). “Being positive” is fundamental to meaning; valuing personal relationships, personal attributes and on the present, giving value to the little things of life. This means to sick people to keep hope living one day at a time (35), focusing ill elderly patients to promote their hope (6-7, 25). The situation of and reaching short-term goals are strategies used by terminally terminal phase (30). Turning off the mind, resorting to the support of family and friends, having symbols of hope, positive thoughts and referring to the spiritual assistant is another intervention reminiscence (6-7, 25, 30). Facilitating participation in religious rituals facilitate the expression of gratitude or forgiveness, encouraging the search for meaning in the present situation using films or exploring the meaning of suffering with the patient, assist in accepting the situation and hope (22, 25, 28). In this line, supporting the patient to express verbally or through writing, and fostering positive self-reflection of emotions and personal attributes (30), is an intervention that promotes hope as an experiential process (31), but also spiritual, in that it facilitates the attribution of meaning to experience and life (25-26, 30). This will allow the patient to recognize the importance to live the moment, recognizing the value of life in spite of the chronic condition. These interventions reinforce Florence Nightingale’s transcended vision of nursing (36). As she quoted, life is a splendid gift that is to be lived when we have it, and there in nothing small about it (37).

The use of therapeutic letters as a form of expression of forgiveness and gratitude as well as the clarification of values allows to transform the experience of suffering, challenging people to change their attitude, and to promote hope as a relational process (4, 5, 18).

Focusing on what can be done to control pain and other symptoms is an important aspect to reduce the fear of the future reported by patients. “I am not afraid to die but rather to suffer” is a concern voiced by people with chronic illness (35), Nightingale believed that everyone who is drawn to ease the pain and suffering of another is an instrument of genuine healing (30). Reinforcing information referring to various options for symptom control, bringing the topic to the conversation, helps patients and families to deal with the situation, reducing the fear of the unknown (18, 20). At home, it is essential to teach and train clients to use non-pharmacological strategies to control symptoms and promote comfort, thus increasing their skills to manage the situation (14, 20).

In the spiritual component of hope, it is important for nurses to explore the meaning of suffering with the patient, assist in the search for meaning in the present situation using films or literature, assist in the preparation of diaries or newspapers and facilitate the expression of gratitude or forgiveness, encouraging reminiscence (6, 7, 25, 30). Facilitating participation in religious rituals and referring to the spiritual assistant is another intervention valued by patients and nurses as a promoter of hope (25, 30). In today’s specialized world we often compartmentalize our lives as person and nursing professionals, separating our own professional interests from our spiritual concerns, in contrast to Nightingale vision of holistic nursing, where spiritual vision and professional identity were combined in one (36, 39).

The relational process encompasses interventions that have been shown to strengthen ties and between patients and families deal with cancer disease and treatments, which implies maintaining some normality of life in addition to the disease, having a fighting spirit and the ability to look at the good side of life, the ability to accept the situation and hope (32, 25, 38). In this line, supporting the patient to express verbally or through writing, and fostering positive self-reflection of emotions and personal attributes (30), is an intervention that promotes hope as an experiential process (31), but also spiritual, in that it facilitates the attribution of meaning to experience and life (25-26, 30). This will allow the patient to recognize the importance to live the moment, recognizing the value of life in spite of the chronic condition. These interventions reinforce Florence Nightingale’s transcended vision of nursing (36). As she quoted, life is a splendid gift that is to be lived when we have it, and there in nothing small about it (37).

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The relational process encompasses interventions that have been shown to strengthen ties and between patients and families
by fostering the support of significant people\cite{25,26}. Promoting and establishing relationships and making time available for them to be truly meaningful and allow the reciprocity of hope between the patient and the health system is reinforced by several authors\cite{25,33}.

As a rational thought process, interventions that promote hope are centered on the definition of objectives, paths and resources to achieve them as well as on the motivation to achieve those objectives\cite{22,24,30}. Providing adequate information according to the patient’s conditions, and taking into account good communication practices in the final phase of life is an important intervention in supporting and increasing the patients’ hope. Using communication techniques, nurses can strengthen patients’ hopes by helping to identify past successes, enhancing the capabilities of sick people\cite{25,30}.

### Study limitations

Limitations include the selection of databases, as studies addressing the topic may be found in other bases than those selected in this review. For future researches, the expansion in the number of databases is recommended, to supplement the results of this study. It should be noted that some of the interventions presented are limited in their application in other contexts of practice, because they are based on that individuals’ culture and require specific training for their application.

### Contributions to the field of nursing, health, or public policy

This study synthesized the existing evidence on the evaluation of hope-based interventions shedding light on the knowledge about this subject to provide information that could divert the attention and practices of health professionals and managers in relation to promoting this psychological resource, and for the evaluation of these interventions. These findings suggest that some populations could be prioritized in public mental health interventions to prevent the occurrence of hopelessness, and interventions need to be provided to enhance hope. The evidence reported in this article should help inform healthcare professionals, patients, and educators that nursing interventions have a beneficial effect on hope.

### CONCLUSION

Critical analysis of the selected articles in this integrative review made it possible to highlight different strategies or interventions used to promote the hope of people with chronic disease. Nightingale’s message moves us toward the integration of the scientific, moral, political, aesthetic, spiritual, and metaphysical aspects of nursing\cite{38}. In analyzing the listed interventions, it is important to emphasize some aspects. Firstly, most of the nursing strategies and interventions suggested to promote hope, in its essence are good clinical care practices in the physical, psychological, social and spiritual domains. There seem to be gaps regarding interventions specifically designed for hope and, however, if analyzed as a whole, much can be done by nurses to intentionally intervene in the hope of patients and families.

Another conclusion is that both strategies and interventions of hope are primarily the initiative of patients and/or their families. Since hope is a personal experience, it is essential to involve oneself, even though others (especially health professionals) may influence this experience\cite{35}. This involvement determines the effect of words or actions in promoting hope. At this point, Nightingale believed that sick persons should hear good news that would assist them becoming healthier\cite{37,39}. Many of the strategies used by people at the end of their lives are initiated with little influence from others\cite{21}, but their effectiveness can be improved if directed and monitored by others, namely nurses.

### REFERENCES


