GRADUATION THESIS - POST GRADUATE LEVEL

WITH MAJOR IN CARING SCIENCE
SCHOOL OF HEALTH SCIENCE
2009:34

Minor Field Study by
Swedish International Development Cooperation Agency (SIDA)
April – May 2009

Promotion of Hope
In critically ill patients, cared for in an intensive care unit
in Indonesia

Jenny Milton da Silva
Abstract

Indonesia is a developing country with diversity in cultures, religions and landscape. The country has the fourth biggest population in the world, spread over the world’s largest archipelagic country with more than 18,000 islands. Health care is slowly improving but still there is a problem in reaching people due to the cultural, financial and political situation. This study asks nurses how they can promote hope in patients that are critically ill, cared for in an intensive care unit in Indonesia. The intensive care unit patient is often very sick, sedated, intubated, monitored with many interventions and unable to communicate with the world other than through interpreted signs to and from the nurse. It is possible that it is difficult for the patient to address what or who helps him/her to develop any kind of hope in this situation. Five specialized intensive care nurses from two different intensive care wards were interviewed according to a qualitative approach with open-ended questions. The respondents each had more than 10 years of experience and consisted of both females and males. The interviews were transcribed verbatim and analyzed according to a content analysis (Lundman & Häggren Granheim, 2008), with categories and subcategories as a result. The interviews showed that the nurses influence hope by using much interaction with both the patient and the family. The factors of family and religion showed however an interesting and very important role in how the nurses could reach the patient and his/her subjective wish for hopes. There is literature that supports the findings in the study but still the result can be discussed, as it was a single researcher with a small number of respondents using an interpreter.

Keywords: hope, critically ill, patients and nurses.
TABLE OF CONTENTS

INTRODUCTION .................................................................................................................. 1

BACKGROUND .................................................................................................................. 2

Indonesia in general ............................................................................................................ 2
- Brief history ................................................................................................................... 2
- The country .................................................................................................................... 2
- Geology and Climate ..................................................................................................... 3
- Society ........................................................................................................................... 3

Religion and beliefs .......................................................................................................... 4

General health care and intensive care ............................................................................. 4
- Health care funding ....................................................................................................... 5
- Intensive care unit in Indonesia .................................................................................... 5
- Intensive care patient in Indonesia ................................................................................ 6

Evaluation by an ICU specialist Physician ...................................................................... 7
- Intensive care nurse in Indonesia ................................................................................ 7

The concept of hope ........................................................................................................ 7
- The diagnosis of hopelessness ...................................................................................... 9
- Hope inspiration ............................................................................................................ 9

RATIONALE FOR THE STUDY ...................................................................................... 10

AIM .................................................................................................................................. 10

METHOD .......................................................................................................................... 10

Sampling method ............................................................................................................ 10
- Interview preparations ................................................................................................ 11
- Selection of respondents ............................................................................................. 11
- Setting for data collection ........................................................................................... 12
- Ethical considerations .................................................................................................. 12

Method of data analysis .................................................................................................. 13
- Transcripting the data .................................................................................................. 13
- Analysis of collected data ........................................................................................... 13

RESULT ............................................................................................................................. 14

Illumination of hope to patients through communication .............................................. 14
- Promote hope through information .......................................................................... 14
- Promote hope through verbal and nonverbal communication .................................... 15
- Promote hope by including the family ......................................................................... 15

Illumination of hope to patients through religion ........................................................... 16
- Include religion as a natural part of nursing ................................................................. 16
- Inspire the patient to pray .......................................................................................... 16

Illumination of hope to patients ...................................................................................... 16

DISCUSSION ..................................................................................................................... 17

Discussion of the method ............................................................................................... 17
- Using an interpreter ...................................................................................................... 18

Discussion of the result ................................................................................................... 19

RELEVANCE TO CLINICAL PRACTICE ..................................................................... 21

CONCLUSION ............................................................................................................... 21

ACKNOWLEDGEMENT ................................................................................................. 21

REFERENCES ............................................................................................................... 22

Appendix 1 ....................................................................................................................... 25
INTRODUCTION

Nurses have the responsibility to build a global research network and exert leadership and influence at the international, national, and local levels to promote the contributions of nurse researchers to providing quality healthcare through evidence-based understanding of the assessment and application of hope in clinical populations. It is only through researchers and practitioners working together that the science of hope can move forward (Herth, 2005, p. 169).

The author of this thesis is studying Caring science with focus on advanced nursing, intensive care, at the University of Borås in Sweden. By receiving a scholarship from Minor Field Studies (MFS), it was possible to carry out this thesis in a foreign country. The scholarship is funded by Swedish International Development Cooperation Agency (Sida) and is supposed to bring knowledge and development in international cooperation work. Sida is an aid organization, and in order to research as a Sida ambassador, you are supposed to go to a country that is considered to be in the need of development (Sida, 2009). Since the University of Borås already has a solid cooperation together with the Gadjah Mada University in Yogyakarta, Indonesia, it was a good opportunity to seek answers there. The aspiration was to learn and find out how the nurses can promote hope in their patients and what they do to bring them hope.

Hope has been researched and discussed in different disciplinary perspectives for a long time. Many researches seem to have an interest in the concept of hope and hopelessness but unfortunately not much has been written about how to promote hope, especially in critically ill patients in developing countries. “The power of hope cannot be underestimated. Persons who are critically ill are particularly vulnerable to giving up.” (Fitzgerald Miller, 1989, p. 28)

The lack of scientific information is one of the reasons for making this effort in finding answers. The illumination of hope that might shine through the interviews will be applied to intensive care giving in both Indonesian and Swedish hospitals.

A documentary film has also been made parallel to the project and shows the beautiful country of Indonesia together with the findings of the thesis.
BACKGROUND

Indonesia in general

Brief history
The oldest trace of something human in Indonesia dates all the way back to 1.5 million years ago. Old buildings and the sultan tradition show living proof that many years of history have passed. One example is the old and impressive Buddhist temple, Borobudur, outside Yogjakarta, from the 8th century A.D. (Swedish Institute of International Affairs, 2009)

Traces from the Dutch people that colonized the Islands of Indonesia are still to be seen around the country. Many people, originally from Holland come here to live and work because of the former influence and roots from the Dutch/Indonesian link. Though, it was not until the beginning of the 17th century that the Dutch people took over the country and, with some exceptions from Napoleon, England and Japan, ruled Indonesia as one of their colonies until 1949 (Swedish Institute of International Affairs, 2009).

After World War II Indonesia was declared independent from Japanese and Dutch colonialism. Through the following decades, the country struggled with separate democratic views and Indonesia became led by a militant man called Sukarno. The president was a socialist that led the country through both financial and political difficulties until President Suharto radically replaced him in 1967. Suharto implemented the army in politics and made it into a military state. Strict rules, a financial crisis and a lot of corruption led to massive demonstrations and riots among the people. The president had to leave his post after 32 years of rigid management, giving way to something that would radically change Indonesian politics into more democratic views. Today the country has had their second democratic presidential election, in April 2009. The result has not until the date of writing this essay been published (Ministry for Foreign Affairs, 2008; Personally communicated, Sri Setiyarini, 04-04-2009; Swedish Institute of International Affairs, 2009).

The country
The republic of Indonesia is situated in Southeast Asia where the equator cuts straight through the country. It is the world’s largest archipelagic nation with more than 18 000 islands and is the fourth most populous state with 235 million inhabitants. Indonesia has a diversity of ethnic groups, many non-Asian influences and different religions. The islands attract many tourists for their beauty despite the fact that the country is very poor and only 6000 islands are inhabited. Jakarta is the overcrowded capital with 8.6 million inhabitants and is seen as a very important part of the country for obvious business reasons (Nationalencyklopedin, 2009a; Ministry for Foreign Affairs, 2008; Swedish Institute of International Affairs, 2009).

Oil and natural resources (i.e. gold mining) are still dominant contributors for growth and the major source of income for the country. Agriculture, tourism and paid work from home (i.e. crafts, artwork and babysitting) have also grown, but still, poverty and the deep gap between rich and poor remains. Health care is one of the biggest problems related to this fact and hangs over the country like a grey cloud. The country has however managed to lower their percentage of poverty during the last decades, mainly because of political changes (World Health Organization, 2009).
**Geology and Climate**

Giving a small insight of what kind of threat the Indonesian people are facing every day, “Indonesia is the supermarket for disasters!” was personally communicated with Sri Setiyarini, on April 3\textsuperscript{rd} 2009.

Most of Indonesia’s islands, including the biggest cities, are located on volcanic soil. In total, there are about 400 volcanoes in the country but only a hundred active ones. Along with this explosive lava there is a constant threat of earthquakes due to seismic activity and the last one in Yogjakarta, in 2006, claimed a number of lives together with many injured people. Only the biggest hospitals, Dr. Sardjito Hospital, in Yogjakarta had over 2000 injured people to take care of and patients even had to be medically treated on the street, outside the building. Simultaneously, the over 3000 meter high Merapi volcano became active and caused many burns and life losses (personally communicated, Sri Setiyarini, 03-04-2009/22-04-2009).

For many years, nature has been taking lives in Indonesia. In December 2004 a massive tsunami struck the Aceh province, and was the worst natural disaster for over 40 years. A horrible number of 130 000 Aceh inhabitants were killed by the massive flood that covered a big piece of land due to an earthquake on the ocean floor (Swedish Institute of International Affairs, 2009).

The equator and geographic location gives a tropical climate with high humidity. High mountains and volcanoes are mixed with low rice fields that get monsoon rain in different periods during the year. The geological location contributes to a variety in scenery and offers a broad wildlife in rainforest along with beautiful sunny beaches (Swedish Institute of International Affairs, 2009).

**Society**

As Indonesia is the fourth most populated country in the world it also has a major variety of ethnic groups where many speak their own language and have their own cultures. However the majority descends from the Malay people that moved in from the Asian mainland in the 6\textsuperscript{th} century B.C. Almost half of the population live on the biggest island, Java, which has contributed to overpopulated cities. During previous decades the government has encouraged people to move out to other islands with various results as the moving families often created a conflict with the locals about land rights and cultural disagreements. One other program to inhibit the increasing population is by encouraging families to live by the motto, “two children are enough” (Swedish Institute of International Affairs, 2009). According to the World Health Organization (2009) last counting in 2006, still every fifth Indonesian is under 15 years of age.

With so many ethnic groups there are many different languages. Carlsson (2002) and Swedish Institute of International Affairs (2009), claims that there are over 400 different languages spoken with even more dialects. The biggest dialect is Javanese, that is spoken by approximately 70 million people. Bahasa Indonesia is the official language but is commonly not the first language to be learnt, rather second. English is being taught in school and is often then spoken as a third language. Bahasa Indonesia is today the most common communicative language between all Indonesians with a different mother tongue (Swedish Institute of International Affairs, 2009).
The alphabetic number of people has dropped drastically only during the last couple of years and the school system is being focused on as an important part of society. Since 1994 there is nine years of mandatory school from the age of seven and the children can choose between public, Christian or Islamic schools. Unfortunately, not everyone is able to complete all nine years depending on the economy of the family. The school is supposed to be free of charge, but in reality families have to pay for school uniforms, books and material (Swedish Institute of International Affairs, 2009; World Health Organization, 2009).

**Religion and beliefs**

By law, all Indonesians must believe in one God. There is freedom of what religion to believe in as long as it is one of Hinduism, Buddhism, Islam, Protestantism or Catholicism. In other words, it is forbidden to be an atheist (Swedish Institute of International Affairs, 2009).

The Muslims are the majority but there has been a history of rebellion against the nation of Islam, no doubt because of the turbulent and rapid political and economic change associated with this faith. Today Indonesia is considered the biggest Muslim country in the world. The concentration of other religions differs however, depending on the area. In for example Bali, most of the population is Hindu and on Java a mix between the different religions and mysticism has created a deviation from Islam, but still considered as an Islamic religion (Swedish Institute of International Affairs, 2009).

Indonesians are very tolerant to other religions in general, but some tension between Muslims and Christians have been seen. As a proof of this, churches and mosques were burnt down, not that many years ago, as propaganda and demonstration (Swedish Institute of International Affairs, 2009).

**General health care and intensive care**

World Health Organization (WHO) in 2009 states that Indonesia has during the last three decades made major improvements in health care. It is now by law decided that the country must improve their health and nutritional status by improving the health service to the people. Along with a better economy and a more stable political situation the country shows good faith in improving the health care standard.

According to WHO there is still only one hospital bed per 650 inhabitants but there are health centers located all over the country with at least one doctor or mainly headed by nurses. Clinics have been built out on the countryside and vaccine programs have been introduced together with preventive and promotional health services. As a result of these improvements along with better access of fresh water, the health problems seem to decrease. Though, intestinal diseases, various virus and bacterial infections seem to still be a common problem (Swedish Institute of International Affairs, 2009).

There are both public and private hospitals in Yogyakarta; three public ones and four religious focused hospitals. All patients can go where they wish but are recommended to follow their belief, according to the hospital or according to the capacity of the hospital. RSUP Dr. Sardijito Hospital is the general referral hospital in Yogyakarta. It is a highly reanimated University Hospital where patients from all over Indonesia are being sent (personally communicated, Sri Setiyarini, 06-04-2009).
Health care funding
The Indonesian government supports the healthcare system, and in 2004 social healthcare was founded. However, the system is still developing very slowly and in 2006 only one fifth of the Indonesian people were covered. In other words, the government only supports 20% of the health care costs in the country and the rest is supported by private insurances, special tax funding for poor people and aid organizations. The ones that can afford private insurance are able to get it, either via their private company or private employer. A patient that becomes ill and in need of medical care will therefore be treated at all times, but the level of treatment will differ depending on the insurance. Patients in a surgical medical ward have three different “classes” of standard according to what their insurance will pay for (Swedish Institute of International Affairs, 2009; personally communicated, Sri Setiyarini, 03-04-2009).

An example of medical treatment funding in Indonesia, is when a woman gives birth to her third child. The government will support giving birth to the first two children, where as any additional deliveries will be funded by the parents (personally communicated, Sri Setiyarini, 03-04-2009).

Intensive care unit in Indonesia
The intensive care unit, ICU, in Indonesia has been given guidelines together with a written material from the government, that carefully describes what every ICU department must provide. However, Larsson and Rubertsson (2005) point out the important context within all intensive care units, which consists of a very busy environment and is both physical and psychologically demanding. The patients are critically ill and attached to many life supporting machines that also survey the condition of the patient. Radical changes in conditions can easily happen and is why the patients need the nurses to be available 24 hours. The machines are of very high technology and will alarm the nurse in case of the smallest mishap or impairment. Parallel to this loud and very hectic environment the team of nurses, doctors and the family are facing daily decisions about life and death. It can be decisions about starting a treatment, ending the supporting treatment or refrain the offered treatment.

The book of standard (Departemen Kesehatan, 2003) says that their evolution of intensive care started already in Scandinavia in early 1950, where a poliomyelitis outbreak took place. Not only Scandinavian standard of care, but also Dutch architects helped form the ICU that stands in RSUP Dr. Sardjito Hospital today. The guidelines say that the ICU must observe, take care and give therapy to patients that have a life threatening illness. Further more, an ICU must have strict medical ethics, patient indications and a multi-disciplined team that include several professions with a special intensive care trained physician in the lead. The ability to serve the need of the patient must meet a resuscitation of life support for vital organ function. The vital organ function is covered in airway, breathing, circulation, brain function and other vital organs such as, liver and kidneys.

With the above description, ICU departments in Indonesia have three levels of classification. The minimum standard, according to Departemen Kesehatan (2003), must however include:

1. Heart- and lung resuscitation
2. Airway management
3. Oxygen therapy
4. Continuously ECG and oxygen monitoring
5. Eternal nutrition
6. Special laboratory for diagnose testing
7. Syringe pumps and continuous infusions
8. Ability to apply special techniques to meet the needs of the patient's condition
9. Equipment to serve the transport of a critically ill patient

The highest standard of intensive care is only being held in the referral hospitals, such as the Intensive Care Unit (ICU) and the ICCU (Intensive Cardiac Care Unit) in RSUP Dr. Sardjito Hospital. It is the most advanced care, including complex multi system life support for unlimited time. Criteria for this department are specified as:
1. Special ward not to be combined with other wards or specialties
2. Specific criteria for patients being treated in the ICU (see below)
5. Nurse to patient ratio is 1:1 for patients demanding ventilator treatment or renal replacement treatment. Other treatment the nurse to patient ratio is 1:2.
6. More than 75% intensive care therapy trained nurses or minimum three years working experience in the ICU.
7. Monitoring and intensive therapy for non invasive and invasive procedure.
8. Ability to do laboratorial examinations, x-ray, diagnostic tests and physiotherapy
9. Minimum one person that is medical and paramedical trained to give optimal care to the patient at all times.
10. Have procedure for patients assessment and official report
11. Administration-, research- and document handling staff
(Departemen Kesehatan, 2003)

Intensive care patient in Indonesia
There is a reason why a patient ends up in an intensive care ward and not in a normal ward. The patient is often so affected from their illness that they demand the 24-hour care with drugs, interventions and surveillance. A critical condition like this results in lack of being able to take part in decision-making and conversations. The patients often don’t know if it is day or night and can have nightmares about what they are going through. Many patients feel safe but helpless and are in a big need of using the nurse as a voice and the family as a communicator about past life and background (Rattray, Johnston and Wildsmith, 2004).

The ICU criteria in Indonesia for a patient that is critically ill and possibly reversible critically ill are listed and are to be strictly followed by the receiving unit (Departemen Kesehatan, 2003):
1. Respiratory failure with clinical criteria
2. Chock by all means
3. Sepsis or initial sepsis
4. Post severe operation
5. Post Cardiac- Pulmonary- and Respiratory (CPR) failure
6. Unstable cardiac-, vascular- and respiratory condition
7. Other critically ill diseases with reversible prognosis.
The pathway of the critically ill patient through the caring system is carefully and strictly organized (Komite Keperawatan dan Kelompok Kerja Fungsional Keperawatan Intensif, 2007):

| Emergency room | Operation theater | General ward | Policlinic Room | Other Hospital |

The patient can possibly come from all the above different departments to an ICU. However, the patient must always be evaluated if needed to be treated at an ICU.

**Evaluation by an ICU specialist Physician**

If a patient does not meet the criteria, it will be rejected. If it does, it will be taken to the ICU and treated as below:

<table>
<thead>
<tr>
<th>Intensive care</th>
<th>Improved condition</th>
<th>Status Quo</th>
<th>Death</th>
<th>Other ward</th>
<th>Stay in ICU or send home</th>
<th>Morgue</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intensive therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ICU Dr.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ICU Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consultant therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intensive care nurse in Indonesia**

The general school for nurses in Indonesia is 4 years or 8 semesters and is a mix of academic studying and clinical training. To work as a nurse independently in the ICU, the requirement is to have special ICU training, or to have at least 3 years of supervised working experience in the ICU. The special ICU training lasts for three months and consists of basic critical care training and cardiac surgical critical care training (Direktorat Keperawatan dan Keteknisian Medik, 2006).

**The concept of hope**

The definition of hope in literature varies from “expectation and desire for something to happen” to “a person or thing that gives cause for hope” (Nationalencyklopedin, 2009b; Oxford English Dictionary, 2009). It seems that many things can define hope, depending on the person’s own situation and perception of the environment. Having said that, the most challenging question seems to be how people with limited supplies define hope in a critically ill situation. Nurses often meet patients from different cultures in the hospital, and have to understand the varieties of what is important and central to each person, especially when becoming severely ill (Benzein & Savemann, 1998; WHO, 2009).
Benzein, E., Saveman, B-I & Norberg (1999) means that hope is related to the life process and consists of being and doing. For a person’s survival, it is necessary to possess a form of being and belonging in life. Some kind of existing confirmation is required, which could be represented by the family, religion and the origin. The doing is more future and action oriented, with real-world impacts. There exists a hope for something to happen, and sometimes includes taking risks, on a global as well as personal level. A personal level of hope is further explained by Waterworth (2003) as something fundamental. First, to be able to be hopeful, a person has to have the ability to see life in past, present and future. The concept of time helps to understand the environment and identify what objects are important around the person. Especially in a difficult situation, as critical illness or near death, the hope in this environment is confronted and challenged. The hope can be expressed as an effort and desire for wellness, to conquer the illness. In other words, the hope shows itself more clearly if it is being challenged in a negative way.

Turner (2004) describes a young Australian mother that is forced through a turbulent life with many breathtaking turns and describes hope as something that drives you. This drive makes you want to achieve something and to move on, to proceed in life. Often this drive is built on love of some kind and has a lot to do with relationships. Without hope you have nothing to stand on and that can lead to the end of your life (Turner, 2004). Therefore hope is often related to and examined in threatening situations. If one gets sick, the family and nursing staff are infinitely more important and central for bringing this drive to the patient. This means a creation of trust and confidence that develop over time and result in hope. A related concept is then important to have, to rely on and be able to open up and show vulnerable sides (Benzein & Savemann, 1998).

The philosophical aspect of hope is carefully being described by Marcel (1965). Marcel reflects over the genuine matter of hope that is only being created between two people in their interaction. This interaction demands a full presence of the one being the giver and more a passive role to the receiver. In order to promote hope in another person there has to be active senses involved and a focused intention to serve someone.

As Marcel discuss the creation of hope between two people, Benzein & Savemann (1998) point out the possibility of creating hope in a more materialistic way. It is shown that critical attributes can be used as a symbol of hope. An example is a skier with a broken leg that might envision getting back on their skis. The confidence in getting well improves and overall the patient feels better to have their mind set on something specific. Another example from Benzein & Savemann, of critical attributes, can be the positive feeling of desire. When the desire for something, maybe materialistic or emotional, becomes possessive and there are goals to reach in a near future. This can be non-realistic things, such as expensive jeweler or forbidden love, but it is the imagination that creates hope.

To understand the concept of hope and especially for a specific group of people, like the Indonesian people, it is important to relate to their life world. The life world is the world that people live in together with other people and where they can communicate with each other. It is a social environment with human organization of life and where people make history together. The people get inspired and affected by their environment and the people around them. The life world is therefore different for each
and everyone but may be similar in some sense in different parts of the world (Bengtsson, 1999).

A Muslim in Indonesia, as a Muslim in any country, has a fundamental state of hope in their life. It starts already as soon as they are born. The parents should always name their children with the hope that they will become something good and meaningful. Khansa Rafidah is the name of Sri Setiyarini’s eldest daughter, presently living in Yogjakarta. Khansa means “good woman” and Rafidah means “lucky”. Every time Sri calls her daughter’s name, the daughter will be reminded to become a good, lucky woman and Sri gives the hope for her daughter to become such a person (personally communicated, Sri Setiyarini, 06-04-2009).

The diagnosis of hopelessness

When there is no hope there is hopelessness. To identify this nursing diagnosis, it is clearly defined in the book from NANDA-International (2007). A patient that suffers from hopelessness cannot mobilize energy on his/her own and is lacking the ability to see personal achievements or personal possibilities. The defining symptoms are:

- Closing eyes
- Decreased affect
- Decreased appetite
- Decreased response to stimuli
- Decreased verbalization
- Lack of initiative
- Lack of involvement in care
- Passivity
- Shrugging in response to speaker
- Sleep pattern disturbance
- Turning away from speaker
- Verbal cues (e.g., despondent content, “I can’t,” sighing) (NANDA-I, p. 107)

Hope inspiration

In order for a patient to see any reason to recover from hopelessness, the nurse must know and understand the outcome of his/her interventions. The patient uses the nurse as a key to unlock the unhealthy status, says Johnson, Maas and Moorhead (2000). The same authors have, in their classification of nursing outcomes, identified the importance of the patient making their own decisions and taking control over the depression as well as identifying the level of depression. Basic human needs, such as food and water give a better nutritional status. Nutrition is a vital outcome for any patient and contributes not only to better medical health but also to a better mood and the important factor for proper sleeping habits. Improvement in the patient’s quality of life and to maintain hope may be two of the biggest outcomes of inspiring hope.

Ashworth (1987) claims that critically ill patients need spiritual health. The spiritual health covers hope as a meaning and a purpose in life, whether or not the patient is religious. In a critical situation, Ashworth believes that a patient may think more about their purpose in life along with suffering and death. If the patient would have a religious belief, it is expected that the faith will become even more important. “It is
important to know what sources of support the person usually seeks in trouble.”  
(Ashworth, p. 188, 1987)

RATIONALE FOR THE STUDY

The literature says that fundamentally all people need hope to be able to see beyond the present and struggle for survival. What hope represents to each of us is highly subjective and takes a different shape for each person. Maybe there is a higher frequency of something that increases the hope in critically ill patients? It will for that reason benefit nurses to learn more about the relationship between hope, these patients in Indonesia and how they promote it.

For a long time in Indonesia, political views as well as an extremely harsh geological climate, a straining financial situation and a scarcity of health care has given the people limited exposure to advanced health care.

The expectation is to find greater knowledge and understanding about how nurses can promote hope in patients that are critically ill, in a developing country as Indonesia. There can be many disadvantages for patients to be able to find hope based on the financial, cultural, health, religious and employment situation. Hopefully, the illumination of hope that will shine through the interviews can be applied to intensive care giving in both Indonesian and Swedish hospitals.

When the health of a patient is being challenged in a developing country as Indonesia, it brings hope matters to a head. The inherent ability to be hopeful that the patient had before getting ill is being challenged. If the root of this emotion and concept – this hope – can be traced, it could help us to improve care for critically ill patients.

AIM

The purpose is to describe how the nurse promotes hope in critically ill patients, cared for in an intensive care unit in Indonesia.

METHOD

Sampling method

The data collection was made in Indonesia at the general referral university hospital in Yogjakarta, RSUP Dr. Sardjito Hospital. A qualitative approach with narrative interviews was used with focus on the life world in Indonesia. Narrative interviews means that the respondent can talk freely about the experiences and the phenomenon that is being studied and not forced to answer already given alternatives. The respondent is telling his/her own story and not getting interrupted by the interviewer. The “truth” in qualitative research, is only showing through the person’s eyes that are considering the phenomenon. It is highly subjective but through examining how more than one person interprets the phenomenon, patterns can be seen and answers can be given (Lundman & Häggren Granheim, 2008).

Important for this kind of approach is to always think about the context and bear that in mind throughout the result and the findings. As the results are highly subjective it is
impossible and wrong to be blind to the surrounding factors (Bengtsson, 1999; Lundman & Hällgren Granheim, 2008).

Interview preparations

The work started in Yogjakarta in March 2009 but had been planned already since October 2008. October was a grey month in Sweden, and a scholarship from SIDA lit the day with excitement and expectations for data collection in a foreign country. As a part of the general preparations, SIDA had organized a two days long preparation course, where information about the aid company, information about developing countries and useful advice for student travellers was given. Before taking off to Asia there had been several correspondence e-mails between Professor Mrs Widyawati and supervisor Mrs Setiyarini at the Department of Nursing, Gadjah Mada University.

A meeting at the University was held already the second day in Indonesia. During the meeting a proposal for the data collection was presented and discussed. Useful comments were made by the professor and supervisor but also from lecturers that are experts in international collaboration, methodology and interpretation. Extra focus was put on the interview questions as these had to be interpreted with the same content meaning in the foreign language, as in the native language of the interviewer.

Selection of respondents

All 5 were special trained ICU nurses with a minimum of 10 years of experience in the ICU/ICCU. The average age was 38 years and average experience was 15,2 years in the ICU. Below shows a demographic table (Table 1) of the respondents, according to Tong, Sainbury and Craig (2007).

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Age (years)</th>
<th>Sex</th>
<th>ICU/ICCU</th>
<th>Experience (years)</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>38</td>
<td>M</td>
<td>ICU</td>
<td>13 years</td>
<td>Islam</td>
</tr>
<tr>
<td>B</td>
<td>48</td>
<td>F</td>
<td>ICU</td>
<td>29 years</td>
<td>Islam</td>
</tr>
<tr>
<td>C</td>
<td>36</td>
<td>F</td>
<td>ICU</td>
<td>10 years</td>
<td>Islam</td>
</tr>
<tr>
<td>D</td>
<td>35</td>
<td>M</td>
<td>ICCU</td>
<td>12 years</td>
<td>Islam</td>
</tr>
<tr>
<td>E</td>
<td>33</td>
<td>F</td>
<td>ICCU</td>
<td>12 years</td>
<td>Islam</td>
</tr>
</tbody>
</table>

The criteria was chosen according to what the ICU/ICCU could offer and it turned out to be a combination of the interviewers wish for experienced, special trained ICU nurses, the resource of nurses in the ward, availability during the day and variety in sex. The interviewer together with the supervisor and the head nurse of the wards decided on whom to ask for participation. The head nurse provided information about the staff and all three discussed the criteria above. It was only possible to do the interviews during the day shift, as the nurses were fewer during the evenings and they would be short of staff. Any exclude criteria was lack of experience, not being an ICU trained nurse and the overrepresentation of females.

Respondent A was meant to become a test interview, to see if the questions were suitable and that the data collection method worked as planned (Thomsson, 2002). It turned out to be useful result and therefore the first interview is included in the final result.
Setting for data collection
The interview environment was a closed office space in the ICU for the ICU respondents, and a closed meeting room in the ICCU for the ICCU respondents. The space was offered from the hospital and chosen conveniently as the respondents had to be interrupted at their work. Apart from the interviewer and the filmmaker, there were also the interpreter and the supervisor attending. The supervisor was there to secure the data by typing the native language on a computer and to support the interpreter. Unfortunately the interpreter had to be changed after the three first interviews due to lack of time.

A good atmosphere and confidence between the interviewer and respondent was building through the opening questions of the interview. The introduction was based on a phase of getting to know the person and relevant questions were asked about family background, education, working experience and present position (Thomsson, 2002): Tell me about your name and where you come from? What does your family look like? Tell me about your education and your job at the ICU? Tell me about the kind of patient you normally treat and the care they get? These questions were not meant to be in the result of the study, only serving the purpose of getting to know the respondent.

The interview followed qualitative open-ended questions (Thomsson, 2002) and was tape-recorded and also filmed. To get a clear sound in the film, a microphone was attached to the respondent’s clothes. However, only the tape recording was used in the study. Open-ended questions led the respondent to give an informative answer to the question and to only stop giving information when there was nothing more to say. The questions were asked by thinking as openly as possible with focus on the situation and to be as present in the conversation as possible, to understand the respondent’s life world and the subjective phenomenon that is studied (Bengtsson, 1999; Lundman & Hällgren Granheim, 2008).

The interviewer had discussed the questions before hand with both Swedish nurses and Indonesian lecturers (also former nurses). The last question was originally put as the first question as the definition of a concept (second question) apparently was frightening to Swedish nurses. However, the question did not seem scary for Indonesians and was therefore decided in order as follows: As a nurse, what is your definition of hope? How do you recognise whether a patient is hopeful or hopeless and what is your action/intervention? Describe a situation in which you have promoted hope in a critically ill patient? Follow up questions were asked if the interviewer misunderstood or wanted the respondent to develop the answer further (Thomsson, 2002): How do you mean? Can you tell me more? What does this mean (to you)? Have I understood it right if I say xxx (repeated the answer of respondent)?

The interviews lasted in average about 45 minutes up to a full hour.

Ethical considerations
At least one day prior to the interview, the respondents were visited at work and given an information letter together with a letter of participation. Both letters were written in English but all respondents got it verbally translated into Bahasa Indonesia. It was important for the respondent to get information about the interview and was therefore deliberately prepared with the content of the study. The reason was to give the respondent more time to consider the questions and the answers. The interviewer made sure that the respondent understood the meaning of participation, confidentiality
and scientific publishing but also the ability to cancel the agreement. All respondents were also informed about the filming that was going to be made during the interview. On a voluntary basis, the respondents had to sign the letter of participation document for approval (Appendix 1).

The professor and the supervisor had approved the study before the interviewer came to the country. The Ethical Committee at Faculty of Nursing, Gadjah Mada University also had to approve as the interviews were going to be individually filmed. A detailed proposal of the study and the purpose of filming was send, and after some consideration also approved to take place accordingly.

Before the interviews took place the interviewer put an effort in making the respondent feel comfortable. Considering the subject of promoting hope in an intensive care unit, it would be possible to meet all kind of feelings. The expectation was that it could be hard and sensitive to talk about memories but maybe also good to vent about it and spread the knowledge on how to handle situations. The respondents were offered drinks and asked to approve the interviewing room with the film camera, before the interview questions were asked.

**Method of data analysis**

To analyse the result, a content analysis according to Lundman & Hällgren Granheim (2008) was used with the qualitative life world approach, inspired by Bengtsson (1999).

**Transcripting the data**

The transcript was made as soon as possible after each interview was completed. It was important to keep the interview and the respondent fresh in memory so that any emotions or actions and gestures could be noted and contributed to the data. It was also important to know as soon as possible if the interview was sufficient or if more data was needed. The five interviews showed good content and no extra interviews needed to be made or changed.

The tape recorded interviews were carefully listened to and verbatim, computer typed in both English and Bahasa Indonesian. All non-verbal expressions as small sounds, pauses and laughter were also noted in the material. The English part (questions and interpreted answers) was typed by the interviewer and the Indonesian part (the respondents native answer) typed by the supervisor. Comparing the written material afterwards made validation and only minor changes were made to quotes and facts.

**Analysis of collected data**

First, the whole interviews were read and re-read to get a clear understanding of the material. “Sentence units” that clearly gave an answer to the purpose, were highlighted and afterwards separately put in an overview table (Table 2). Sometimes the interviewer had to go back to the whole interview to be reminded of the context and therefore needed to know what quote belonged to which interview. To solve this, it was of great importance to mark each “sentence unit” with the respondents “interview code” and page number of the highlighted quotation. Afterwards, the “sentence units” were condensed in order to see similarities and differences. The interviewer formed sub categories and later also categories out of the condensed information that will be used to structure the result (Lundman & Hällgren Granheim, 2008).
RESULT

Illumination of hope to patients through communication

All respondents mentioned that the patient’s hope is something personal and depends on different factors. These factors can either be a supporting system or an inhibiting factor to their illumination of hope. If something is very important for the patient (i.e. the family), there can be a radical difference if that factor is present and supporting, present and not supporting or even not present at all. It seemed that the nurses are trying to reach the patient through finding different ways of communicating with the patient, conscious or unconscious. The best communication for each patient was decided individually and one of the nurses said that the nursing work could be close to artwork, as every action is so unique along with every patient being unique.

Promote hope through information

Verbal conversations with a normal voice as well a whispering was vital even if the patients were not conscious, to let the patients know that someone took care of them and gave attention. The conversations would sometimes consist of information about the disease, purpose of medication and state of condition to make the patient aware of what had happened and what was going to happen. Sometimes the nurse would talk about religious matters (see below) but would also remind the patient about his/her family and the need to get back to them and take care of, for example the children.

Some of the nurses claimed that the patients were lacking hope due to not enough information about their disease. Other nurses discussed the difficulty in perhaps giving too much information about the condition so that the patient loses hope instead of increasing it.

Table 2. Analysis overview table. For more, see Appendix 2.

<table>
<thead>
<tr>
<th>Sentence unit</th>
<th>Condensed sentence unit</th>
<th>Sub category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>I use the approaches by using the touch. I will ask while touching the patient “What happened to you madam, why don’t you eat, is there something wrong?” The point is so the patient will feel someone is eh… care about her. And in the end the patient will express his feeling to the nurse. E3</td>
<td>I approach the patient by using the touching and at the same time talking to them and asking about their condition. The point is to show that someone is caring.</td>
<td>Promote hope through verbal and nonverbal communication</td>
<td>Communication</td>
</tr>
</tbody>
</table>
It was also important for the nurses to communicate with the patients about possible social worries. The financial situation is a constant topic and the nurses must listen to the patients worry and explain the care taking system. It was important for the patients to be ensured by the nurses about the equal caretaking and that the financial support only was making a difference in expensive/inexpensive interventions.

...sometimes they (the patients) are afraid that the caregiver from the nurse, from the hospital is different with the patient that is well, rich!, or the patient with government insurance. (respondent E)

Promote hope through verbal and nonverbal communication
Along with the verbal communication the nurses also made sure to deliberately give physical touching whilst taking care of the patient. This includes normal procedures, such as showering, feeding, checking for vital signs, dress internal vein (IV) line, giving injections and medication. The physical touching could also consist of shaking the patients hand in the beginning of the shift whilst saying “hello”.

I am doing the communicating with the patient while I am doing the nursing intervention as well, like when helping them for showering because they in an unconscious condition (respondent B)

The nurses mentioned the purpose of how the talking, listening, touching and caring would increase the patients’ confidence and also how it would build trust and comfort. It would show the patient someone to rely on and cooperate together with. Some patients would also get more attention than others if the hopeless condition were obvious. The nurses would put more effort in to communicating verbally and physically.

Promote hope by including the family
If the patient for some reason could not communicate, the nurses would immediately include the family in trying to reach the patient. The family was however, almost always included in the care taking and decision making regarding the treatment of the patient.

...family is the most important factor in a persons life. A, a nurse is only a motivator but without family support it is nothing. I think it is the only way (respondent D)

The family was used for information about the background and how the patient could be best motivated, but also to inform the family about the illness, progress and condition. The information would sometimes even be more concentrated to the family instead of the patient, if the nurse thought that the patient could not handle the information and it would just be a burden.

The nurses also stressed the importance of communicating with the family as a way to encourage them to better support their ailing relative. The family sometimes needed to be reminded of their importance and also needed guiding in how to support the patient. The nurse used the family as some kind of tool to raise the patients’ hope. An example is to ask the family members to come and visit and bring the children. The patient will then see the relatives and realize his/her value and need in the family.
I am doing that communicating with the family as well, so not only just for the patient but also for the patient (meant family) because I believe, I believe that most of the family will grow this way as well when the patient in a terminal condition they will built hopeless. That is why I also communicating with the family members as well giving them information related to the patients condition. (respondent B)

Illumination of hope to patients through religion

According to the interviewed nurses, there was an obvious connection between religion and hope. Some of them almost forgot to mention the fact, as it is so delicately woven into the lifestyle. The majority of the patients that the nurses treat are Muslims, but patients belonging to other religions would not be uncommon.

Include religion as a natural part of nursing

A standard question to each patient is what religion he/she belongs to. By asking this, the nurse knows in what way to approach the patient regarding religious discussions, ceremonies and prayers. The nurse will know if they can pray together or if the nurse should call the Chaplain or ask one colleague of the same religion for help.

The religion is very much applied to the way of looking at sickness, according to the nurses. For example, when becoming sick as a Muslim it is seen as a trial from God. God also makes the final judgment, if the patient is going to get well or not. The nurse has to be active in their care and guide the patient in trying to find the cure.

If the patient is a Muslim I will remind him or her that the disease is a gift from God and every disease has a cure, as long as we (nurses) are proactive in finding it (respondent A)

When the patient is in severe pain or is unconscious, some nurses state that it is their job to remind the patient of the concept of religion. The nurses must encourage the patient to be in contact with God even if they are sick.

Inspire the patient to pray

It seemed like a normal routine for the nurses to remind the patients about prayers and to ask God for help in their sickness. It didn’t matter to the nurses what religious beliefs the patients had, the important thing was that the patients tried to pray. If needed or asked for by the patient, the nurses could call the Chaplain who could pray together with or for the patient. The Chaplain would then come to the ward and pray together with the patient and possibly also together with the family.

Usually I am communicating with the patient... If I got a patient with a different religion than me (muslim,) I will ask them to pray together although we have, you know, different type of praying, but I found that the patient has got the same ah... religion with me, I will ask them to pray.../..., pray easy prayer... (respondent C)

Illumination of hope to patients

It turned out that nurses sometimes meet patients that show unrealistic expectations, or in other words, have too much hope. One example is when a patient has had a heart surgery and thinks that he/she is perfectly well and cured. Maybe the patient wants to continue smoking as if he/she never had been sick. Or when a patient is not realizing his/her limitations and is not patient enough to let the body recover. Also, it can be patients with terminal illness and not realizing the condition and still think that he/she will be able to walk soon again.
Some comments from the nurses imply that they try to deal with this unrealistic expectation in two ways. Either they let the patient be this hopeful and keep encouraging the hope as if one day a miracle will happen, or they try to restrict and limit the patient through his/her family.

After the implantation he continue smoking. Okay. So for the patient like this, of smoking again, something like that… I tell him that even though you have implantation eh…the risk for the stenosis is still there. I tell them to obey rules but I do it slow. Step by step, because the patient like this, usually a patient with to much hope, usually does not take eh… yeah, information very well. Just they deny that they are sick.../...I involve the family. In Indonesia especially the wives, because the wives is the very important person for the man, and also his family I give motivations so they will motivate the patient to stop his bad habit. (in this case, smoking) (respondent D)

The nurses approach the patient slowly, as they have to work together and get him/her to understand the change and why it’s happening, not only complying because the nurse says so.

DISCUSSION

Discussion of the method

A qualitative content analysis method based on Lundman and Hällgren Graneheim (2008) was chosen for this thesis. Along the way, the inspiration has always been a life world focus as the studied phenomenon in this work is the concept of hope (Bengtsson, 1999). It is possible that a phenomenological analysis also would have been suitable for this study but the interviewer contemplated and saw difficulties in both deeply interpreting and describing the findings (Rosberg, 2008). The difficulties were identified as time consuming and too deep for this level of thesis.

The content analysis focuses on a description of varieties and similarities. This method seemed to suit the context in Indonesia very well, as the reading of the interviews demands awareness about the context and the respondent’s environment, culture and some personal history. It was a central matter to this study to be aware of the living situation, as the concept of hope is very subjective and personal (Lundman & Hällgren Graneheim, 2008; Waterworth, 2003).

As every person has a subjective understanding of a phenomenon (Bengtsson, 1999), so had the interviewer of the concept of hope. When arriving in another culture it was important to put the pre-understanding aside in order to consume all the information that there was. Several times during the interviews and the analysis, the interviewer had to remind herself of the context and step out of her own world and reflections. Inevitably, the result has been filtered through the interviewers senses, and therefore it is necessary to make a note of that. The interviewer also tried to avoid misunderstandings and minimize possible frictions between everyone involved, by getting educated about cultural and religious differences. For example, a good compliance to manners and dress code was noted to prevent unnecessary problems. Birks, Chapman, and Francis (2007) stress how important it is to have a basic understanding of relevant culture and environment. Also, the possibility of a proper content analysis demanded the preparation of cultural studies (Lundman & Hällgren Graneheim, 2008).
Before coming to Indonesia the interviewer had no preferences regarding respondents. A demand of this nature was not possible, as no information was given about the potential respondents. A request for respondents with a longer experience and a mix of genders was made according to Tong, et al. (2007). The participation was voluntary but it was difficult to ascertain the level of compliance due to language barriers (Kapborg & Berterö, 2001). It must also be noted that there were two other people in the interviewing room, apart from the respondent, the interviewer and the interpreter. In order to secure the translation, one person typed the whole Indonesian part of the interview and the other person filmed the respondent, which in itself could account for a comfort threat to the respondent. However, the two extra people attending the interview were not important in the actual conversation and were made sure not to be in direct eye contact with the respondent. The two had also met the respondent before hand to ensure that they were entitled to be there.

The English translation was secured by comparing to the Indonesian version with help from the supervisor, who speaks both languages. It was a good validation but could also have been made by letting the interpreter read through the material. However, the supervisor was also attending all the interviews, which can negatively make room for another persons’ interpretation or pre understanding, but also a fairly objective opinion in translation. The respondents often used a masculine form when refereeing to the patient. This has been treated as a reference to patients of both genders for the sake of clarity. An added question in the interviews covered this and confirmed that the respondent meant both genders.

**Using an interpreter**

Both interpreters (one interpreted three interviews and one interpreted two) were Indonesians and educated in the English language but had no previous experience in interpretation. Both of them had no immediate connection to the respondents other than working at the same hospital and some had studied at the same University but at different times. The interviewer is originated from Sweden and fluent in English but had no knowledge in the local language, which made the interpreter necessary. Several factors influence the success of an interview with a person from another part of the world and clearly this kind of research method demands training. Being aware of that fact, compensations have been made to try and optimize the procedure (Birks et al, 2007).

Kapborg and Berterö (2001) put a good light on the difficulties that the interviewer meets when having to communicate through another person. The information always goes through another person and is likely to be slightly altered. It was impossible for the interviewer to know what the interpreter told the respondent, as there was no knowledge in the local language. The interviewer totally had to rely on the interpretation skills but felt sometimes frustrated in not being able to control the situation. Had the interviewer been able to find an interpreter who spoke Swedish, the situation could have been better controlled.

The interviewer tried to note both verbal language and body language, and pay as much attention to the communication between the interpreter and respondent as possible. By doing this, the interviewer got a feeling for the conversation attitude and the length of answers/questions between the two. It was important for the interviewer to match this in order to follow up with questions and to be able to understand the answer. Also a possible threat to validation was the fact of both interpreters being
professional nursing lecturers. To be involved like that means that it is easy to interpret the answer from the respondent and mix with their own opinion. To prevent this, the interpreters were often reminded of the wish for verbatim translation (Birks et al., 2007; Kapborg & Berterö, 2001).

**Discussion of the result**

The nurses attending this study show that they carry an important role as a hope inspiring person. By using different keys, the nurses can better unlock hopeless patients and increase the hope in a critically ill patient. Fitzgerald Miller (1989) state that nurses are in a unique situation to either stimulate or reduce hope in patients. By using interaction areas that evaluate what is important to the patient, the nurse can renew the feeling of importance and confirm existence within the patient. Respect and value is being shown through physical care and touching, and should therefore be established without delay.

The interaction between the patient and the nurse is an interaction that is unique for every situation. Inevitably the nurses will work with the concept of hope in various ways. The “artwork” that the nurses claim that they use in Sardjito Hospital, demands active reflection in practice and awareness of the own internal beliefs and values. It requires the nurse to be a present listener to see the unique need for each patient, to be able to successfully create hope in others (Gelling et al., 2002; Herth, 2005). No information was given if the nurses in this study had some sort of mandatory reflection, nor concerning their individual reflection. It is possible that their experience had something to do with this humble attitude towards the subjective meeting with the patient.

Touching, talking and being close to the patient seemed to be obvious interventions for the nurses. This communication was identified as building trust and to let the patient feel supported and cared for. However, it was discussed whether it was a good idea to inform the patient about the condition and prognosis. Sometimes the nurses preferred to only talk to the closest family about this and be very careful in destroying the already existing hope within the patient. McCloskey Dochterman and Bulecheck (2004) advise nurses to install hope by telling reality and truth. The nurse should avoid masking any truth and if needed include the family to identify themes of how to find hope for the patient. It is hard to tell the bitter truth sometimes but is pointed out by Fitzgerald Miller (1989) and Gelling et al. (2002) that it is highly important to do so. By giving realistic hopes, the nurses can prevent misleading and feelings of frustration and loss. Information about the facts, outcomes and actions create a powerful setting and an attitude of being in control, both for the family and the patient. It gives knowledge and a choice that actively can affect the outcome. Further it is argued that the creation of goals is highly important to give and encourage the critically ill patient with. From small to more elaborate goals, that will encourage the patient to see the future and beyond the illness (Fitzgerald Miller, 1989; Herth, 2005; McCloskey Dochterman & Bulecheck, 2004) The question about what goals the Indonesian nurses give arises and it is possible that they find their situation complex in regards to this. As the divide between rich and poor is very wide, they might have to be very delicate in what goals they encourage, as they have to encourage realistic goals. The interviewer got the feeling that the nurses preferred to leave the physical goal developing to the family, and only concentrate on giving religious goals. This attitude also applied on how the nurses chose to deal with patients that have unrealistic hopes.
All respondents were Muslims, which must pose the question of impact on the strong religious influence in the collected data. According to the answers given from the nurses all patients were equally reminded to pray and to talk to their God. The nurses could even pray together with the patient, even if they had different religious beliefs. No information was found regarding agnostic patients and how they were treated. It is normal to think that the nurses never meet patients that are non-believers and never have to deal with it, as it is forbidden to be without a denomination in the country. Fitzgerald Miller, 1989; Gelling et al., 2002; Herth, 2005; McCloskey Dochterm & Bulecheck, 2004 supports the importance of spiritual and religious beliefs as one of the strongest identification in sources of hope. Hope is explained as something sustainable through prayers and continuously seeking contact with the God. Nurses must therefore encourage and make both physical and mental room for practicing the appropriate religion, together with both the patient and his/her family. Unforgettable is that there must be space left for all beliefs, as again, all patients are unique and have a different concept of how they want to have hope influenced.

There was full determination amongst the nurses regarding the importance of family. A great impact and importance in order to influence hope in a critically ill patient is the family and significant others. McCloskey Dochterm and Buleche (2004) list the family as a first assistance action of installing hope. Fitzgerald Miller (1989) continuously describes how the family most likely can identify areas of hope in the patient’s life and should be guided by the nurse. To be able to find the hope and also address it to the patient, the parents/children/spouses/close friends sometimes need to be pointed in a direction. It is most important to the patient to still feel like a member of the family and sustain the relationship throughout his/her critical illness. The family has the authority to let the patient feel there is someone to live for and there is someone to share the struggle with. Fitzgerald Miller (1989) and Herth (2005) support the nurses in this study when they say that the family is just as important as the patient sometimes. If the family is informed and feel in control, they can support the patient better and show the patient that he/she is needed and still has a place in his/her home.

Gelling et al. (2002) discuss the difficulty in dealing with unrealistic hope, as this was met by some of the interviewed nurses. The methods seem to focus on the patient’s family but also sometimes just leave the patient with the unrealistic hope. It can be very hard to inform the involved parties and create an understanding if the patient and/or even the family has unrealistic expectations. An extra challenge is added in providing support according to the ICU standard. The family and/or patient might have to face misplacement of their hope and maybe also have to question their fundamental beliefs.

As the study only put focus on how the Indonesian nurses promote hope in their critically ill patients, only these answers has been identified in the interviews. However, the nurses also identified their concept of hope that would have been interesting to include in this study but is not relevant due to the purpose.
RELEVANCE TO CLINICAL PRACTICE

This understanding about how the nurses in Indonesia can promote hope in their critically ill patients can better identify what actually promotes hope in a general sense. Hope seems to be something fundamentally different to each person and hope takes on just as many forms as there are people in the world. Due to these facts, the promotion of hope can be tailored to individual circumstances and possibly used in other wards but also in different countries.

- Interaction with the patients that demands active reflection and listening from the nurse – an “artwork”, individually for each patient.
- Touching, talking and being close to the patient, even if he/she is sedated or unconscious.
- Encourage culture and religion practice through making physical and mental room.
- Family centered care. Include the family and significant other in the care of the patient at all times.
- Keep the patient and family informed about the sickness and condition treatment but still respect the demand of information individually.

CONCLUSION

This study has illuminated practical ways in how nurses can bring hope to critically ill patients in a developing country such as Indonesia. By using “golden keys”, defined by interventions including communication and religion, the nurses can unlock boxes of hope within the patient. Many of these keys are cultural and socially bound which makes it difficult to apply the findings onto other contexts. Further research is needed, but pointed out is that hope will always be something subjective to each individual and therefore also unique in all situations.

ACKNOWLEDGEMENT

This project would not have been possible without sponsorship from SIDA and the wonderful cooperation between Högskolan in Borås and Gadjah Mada University in Yogjakarta, Indonesia. I would like to thank everyone involved in Indonesia, including Professor Mrs Vinny Widyawati at Gadjah Mada University and the support from ICU/ICCU at RSUP Dr. Sardjito Hospital. The study could not have been completed, of course, without the participation of the wonderful respondents. A special thank you to my supervisor in field, Mrs Sri Setiyarini at Faculty of Nursing at Gadjah Mada University. Not only did she put time and effort into the project but also her whole heart. The support from my local advisor, Ms Maria Henricson at Högskolan in Borås, has throughout the study been invaluable in regards of encouragement, academic guidance and positive energy. Last but surely not least there are not enough words for my appreciation of the family and friends whose support was indispensable to make this journey happen.
REFERENCES


Komite Keperawatan dan Kelompok Kerja Fungsional Keperawatan Intensif (2007). *Prosedur tetap khusus keperawatan Intensif RSUP Dr. Sardjito*. Yogjakarta: RSUP Dr. Sardjito


Appendix 1

Information letter about a Minor Field Study in Indonesia, April – May 2009.

Background
My name is Jenny Milton and I study Caring science with focus on advanced nursing, intensive care, at the University of Borås in Sweden. I have been honored to receive a scholarship, “Minor Field Studies”, in order to be able to complete my thesis in a foreign country. This scholarship is funded by Swedish International Development Cooperation Agency (SIDA) and is supposed to bring knowledge and development in international cooperation work.

My interest is what brings hope to people and how nurses can promote this in critically ill patients. The concept of hope is very different to each person and is therefore even more interesting to observe in different parts of the world. Describe a situation in which you have promoted hope in a critically ill patient? As a nurse, what is your definition of hope? How do you recognise whether a patient is hopeful or hopeless and what is your action/intervention?

Purpose
The purpose of the study is to describe how the nurse promotes hope in critically ill patients during their time at an intensive care unit in Indonesia.

Participation
To take part in this interview would be valuable for the future of caring. The participation is strictly on a voluntary basis and can be cancelled. If you for any reason would like to withdraw your participation, please give notice to Jenny Milton as soon as possible after your interview, see details below. By taking part in this study you will be send a copy of the final result.

Data processing
The results will be handled confidentially and your identification will not be shown anywhere in the thesis. The interviews will only be used for the purpose of this study and the University of Borås is responsible for the process of the data. If necessary, there will be an interpreter attending the actual interview. The material will be recorded and afterwards printed verbatim on paper for analysis. The findings in this study will be used for scientific publication.

Thank you for your time and if you have any questions don’t hesitate to contact us.

Jenny Milton, RN
Student at School of health Science University of Borås
E-mail: milton.jenny@gmail.com
Phone in Indonesia: 08995129707

Maria Henricson RN, CCRN, PhD
School of Health Science University of Borås
E-mail: maria.henricsson@hb.se
Participation

I hereby confirm to participate in an interview that is being recorded and used for scientific publishing. I have been informed about the study and have understood the written information that has been given to me.

Yogjakarta, Indonesia

................................................................................................................................................
Date

................................................................................................................................................
Signature

................................................................................................................................................
Name and address

................................................................................................................................................
Signature